HOSPITALS USE THE PERNICIOUS CHARGEMASTER PRICING SYSTEM TO TAKE ADVANTAGE OF ACCIDENT VICTIMS: STOPPING ABUSIVE HOSPITAL BILLING

George A. Nation III *

ABSTRACT

Hospitals often take advantage of vulnerable patients by billing them excessive amounts for healthcare. For example, hospitals charge uninsured patients and out-of-network patients many times the price that the same hospitals accept as full payment from government-insured patients or privately insured in-network patients. Hospitals use a complex, confusing, deceptive, and corrupt chargemaster-based billing system to allow them to price gouge various groups of vulnerable patients. There is a huge difference between the amount of the "charges" listed in the chargemaster and the reimbursements hospitals actually accept as full payment under contracts with third-party payers. Hospitals claim, disingenuously, that they bill all patients at chargemaster rates, but they fail to mention that most patients receive a huge discount and are only expected to pay a fraction—usually one-third or less—of the chargemaster-based amount. However, when hospitals see a chance to collect their excessive chargemaster-based rates they go for it aggressively.

This Article focuses on another group of vulnerable patients: those who have suffered injuries as a result of another person's negligent conduct. These patients come to the hospital through the emergency department often as a result of a motor vehicle accident. In these cases, hospitals seek to take advantage of the fact that the negligent person (or the negligent person's insurance carrier) is liable to pay for the harm caused by the negligent conduct, including the medical expenses incurred by the injured victim/patient. Hospitals refer to these situations as third-party liability cases or TPL cases.

In TPL cases, hospitals refuse to accept the patient's insurance even if the insurance is in-network or government sponsored. As a result, Hospitals claim they are not bound to accept discounted rates and claim the right to recover excessive chargemaster rates. In other words, by refusing to accept the patient's insurance, hospitals claim they can recover 300 percent or more of the amount

* Professor of Law and Business, Lehigh University.

they otherwise agreed to accept under contracts with the patient's insurers. Moreover, hospitals enforces their claims for these grossly excessive medical expenses against the victim/patient's recovery from the negligent party, and most states provide the hospitals with liens to ensure their recovery. The net result is that hospitals receives an exorbitant amount for their services, patients lose the benefit of their insurance, and grossly inflated medical expenses mislead juries into providing excessive judgments in negligence cases. This Article suggests that once courts properly understand the complex world of hospital billing, they can use contract-law principles to protect vulnerable patients from hospital price gouging.

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I. INTRODUCTION

Jean Smith was stopped at a traffic light waiting to turn into a shopping center when another vehicle crashed into the back of her car.[1] Jean was injured and rushed to the local hospital—a nonprofit, tax-exempt, charitable hospital. In the emergency department (ED), after Jean had received a medical screening exam and any necessary stabilizing treatment,[2] she was presented with a form Admission Agreement that required her signature; she signed it without reading the three-page agreement that consisted of 14 single-spaced paragraphs.[3] Usually Jean tries to read any document before signing it, but in this case she did not because she was in the ED, and similar to all patients in the ED, she was in no condition to read, understand, or negotiate the agreement placed in front of her by the admitting nurse.[4] Nor,

1. The case of Jean Smith discussed here is fictional, although it is based on an amalgamation of actual cases with which the Author is familiar.

2. *See* Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd (2012) [hereinafter EMTALA]. Under the Emergency Medical Treatment and Active Labor Act (EMTALA), hospitals are required to perform a medical screening exam and any necessary stabilizing treatment before they inquire about a patient's method of payment or insurance status. *See generally id.* (showing the general requirements of the Act).

3. *See, e.g.*, Cape Reg'l Med. Ctr. v. Sanchez, No. CPM DC 109-11, slip op. at 2–3 (N.J. Super. Ct. Law Div. Mar. 26, 2012) (on file with author). In the case of hospital care, even a hospital does not know the exact amount it will bill a patient at the time of purchase. Patients sign open-ended agreements, such as an Authorization for Treatment or Statement of Financial Responsibility, 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. In reality, however, this type of agreement amounts to a blank check given by the patient to the hospital with the amount to be filled in unilaterally by the hospital at a later date.

4. *See, e.g.*, Phx. Baptist Hosp. & Med. Ctr., Inc. v. Aiken, 877 P.2d 1345, 1347 (Ariz. Ct. App. 1994) (denying summary judgment where husband signed admission agreement for wife that purported to make the husband, as signer, personally liable for services provided to his wife and noting the husband may not have understood the agreement or may have felt he had no choice but to sign); Tunkl v. Regents of Univ. of Cal., 383 P.2d 441, 447 (Cal. 1963) (rejecting hospital admissions agreement with exculpatory clause and noting patients are "in no position to reject the proffered agreement, to bargain with the hospital, or in lieu of agreement to find another hospital"); Wheeler v. St. Joseph Hosp., 133 Cal. Rptr. 775, 783–86 (Ct. App. 1976) (rejecting agreement to arbitrate and noting a hospital admission agreement "possesses all of the characteristics of a contract of adhesion"—contracts offered on a take-it-or-leave-it basis with no realistic

realistically, was there anything Jean could have done if she read the agreement and disagreed with some or all of its provisions. For example, if the agreement stated Jean promised to pay the hospital any amount it demanded for the medical care the hospital's employees would provide to her—this is essentially what all admission agreements say[5]—what was Jean to do? Refuse to sign and hobble out of the hospital?

Notwithstanding its obvious absurdity, the agreement contained the following statement right above Jean's signature: "The undersigned certifies that s/he has read the foregoing, understands it, accept its terms, has received a copy of it and is the patient or is duly authorized by the patient as their agent to execute the above."[6] If only wishing could make it so! Note, according to the agreement, the patient does not just agree, but "certifies," as if that could possibly have any significance in this context.[7] Another sleazy provision says if the patient is physically unable to sign the agreement, then the Good Samaritan who brought the patient to the ED must sign as a "duly authorized agent" of the patient.[8] Does this make any sense? Very few

opportunity to bargain and the goods or services cannot be acquired without agreeing to the terms offered—and "admission to a hospital is an anxious, stressful, and frequently a traumatic experience"); St. John's Episcopal Hosp. v. McAdoo, 405 N.Y.S.2d 935, 937 (Civ. Ct. 1978) (holding hospitals dealing with emergency admissions "should not be permitted to enforce a contractual obligation entered into under such tension-laden circumstances"). In such circumstances, the patient cannot reasonably be expected to read the printed agreement in detail, much less to fully comprehend its terms. *St. John's Episcopal Hosp.*, 405 N.Y.S.2d at 936.

5. *See infra* Part III.C.1.

6. For a sample admissions agreement [hereinafter Sample Admissions Agreement], see App. A, p. 1–3.

7. *Id.* Legally, to certify something means, in this context, to give "[a] written assurance, or official representation, that some act has or has not been done, or some event occurred, or some legal formality been complied with." *What Is Certificate?*, LAW DICTIONARY, https://thelawdictionary.org/certificate (last visited June 14, 2018). Thus, in this case the ED patient, or other person signing on the patient's behalf, is giving official representation and assurance that the signer has read the foregoing, understands it, accepts its terms, etc. Of course, if patients thought they understood the terms correctly, but in reality did not, how would they know at the time they signed the form? For example, the hospital claims the patient, by signing the form, has agreed to pay on average at least three times the amount most of the hospital's patients pay for the same healthcare. However, what if the patient understood the form to mean that the patient was agreeing to pay a fair amount, that is, the same amount most other patients pay for the medical services? In any event, the question in this context is merely academic, as a patient in the ED has no capacity to enter into an enforceable contract. *See supra* note 4 and accompanying text.

8. *See* Sample Admissions Agreement, *supra* note 6, at 3.

people as a normal course happen to have duly authorized agents.[9] Moreover, it seems very unlikely that after the occurrence of the emergency precipitating the trip to the ED, the patient would have the capacity to duly authorize an agent any more than the patient would have the capacity to freely and knowingly accept the Admissions Agreement.[10]

With respect to the accident, Jean was lucky her injuries turned out not to be life threatening.[11] Jean was released from the ED later that day and went home. The treatment provided by the hospital included a medical exam, two CT scans, and two x-ray studies. Based on the hospital's chargemaster—a comprehensive list of pricing for all goods and services provided by a particular hospital[12]—the hospital's list price for this care was $10,773. However, Jean took comfort in knowing she had medical insurance and was taken to a hospital within her insurer's network. That is, Jean's health insurance company had entered into a contract with the hospital.[13] As a result, Jean is considered to be an in-network patient, and the total amount owed to the hospital for the care Jean received is not the excessive chargemaster-based list price of $10,773. Instead, the amount owed is the much lower rate, the "contract rate" or "discounted rate," agreed to in the contract between the hospital and Jean's insurance company, which was $750.[14] To be clear, that is not a typo; the price that the hospital has freely

9. In general, the capacity to authorize an agent or to sign a power of attorney is the same that is required to enter into a contract. *See* RESTATEMENT (THIRD) OF AGENCY § 3.04(1) (AM. LAW INST. 2006) ("An individual has capacity to act as a principal in a relationship of agency . . . if, at the time the agent takes action, the individual would have capacity if acting in person."). That is, the patient must have an ability to comprehend the nature and quality of the transaction, along with an understanding of its significance and consequences. *See* JOSEPH M. PERILLO, CALAMARI AND PERILLO ON CONTRACTS § 8.10 (5th ed. 2003) (noting the modern view is that capacity requires an ability to understand and act in a reasonable manner in relation to the transaction).

10. *See* RESTATEMENT (THIRD) OF AGENCY § 3.04(1).

11. As noted, this example is hypothetical but is informed by actual cases with which the Author is familiar.

12. George A. Nation III, *Hospital Chargemaster Insanity: Heeling the Healers*, 43 PEPP. L. REV. 745, 746–47 (2016) [hereinafter Nation, *Chargemaster Insanity*].

13. *See infra* notes 89–114 and accompanying text.

14. Today, on average, hospital chargemaster prices exceed payments by more than a factor of three. Michael Batty & Benedic Ippolito, *Mystery of the Chargemaster: Examining the Role of Hospital List Prices in What Patients Actually Pay*, 36 HEALTH AFF. 689, 689 (2017). However, in many instances, chargemaster rates can be even

and willingly agreed to accept from Jean's insurance company for the care Jean received is $750 or a whopping 93 percent discount off of the chargemaster price.[15] Jean must pay any copayment, any coinsurance amount (figured on the discounted amount), and any deductible, and her insurance company will pay the balance of the discounted rate. It is important to note, because this is the point really at the heart of the matter, the phrase *discounted rate*, while it normally implies a special rate lower than that paid by most customers, in the world of healthcare is actually the rate paid by almost all patients.[16] In other words, the discounted rate paid by insured patients is the normal rate.[17]

However, unknown to Jean, the hospital decided *not* to submit her claim to her insurance company because Jean's injuries were the result of a motor vehicle accident (MVA).[18] Due to the bizarre world of hospital billing, anytime there may be third-party liability (TPL), whenever someone other than the patient or the patient's health insurance company (like the driver of the other vehicle or even the patient's own no-fault auto insurance) may be liable to pay for the medical care provided to the patient, hospitals see an opportunity to collect a financial windfall.[19] By demanding payment from the third party who is liable for causing the patient's injuries, the hospital

higher. For example, California Pacific Medical Center, owned by Sutter Health, has a chargemaster rate of $96,642 to treat a stroke, while Medicare reimbursement for this treatment is $9,583. *See* Nation, *Chargemaster Insanity*, *supra* note 12, at 762 (discussing this and other examples of egregious chargemaster rates). In other words, Medicare reimburses less than 10 percent of the billed chargemaster rate. *Id.*

15. *See* sources cited *supra* note 14.

16. Nation, *Chargemaster Insanity*, *supra* note 12, at 756–57 (explaining the discounted rate is the rate insurers contract to pay). Over 90 percent of Americans now have health insurance. *See* JESSICA C. BARNETT & MARINA VORNOVITSKY, U.S. CENSUS BUREAU, U.S. DEP'T COMMERCE, P60-257(RV), HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2015, at 1 (2016), https://www.census.gov/content/dam/Census/library/publications/2016/demo/p60-257.pdf.

17. Nation, *Chargemaster Insanity*, *supra* note 12, at 757.

18. *See* Michael K. Beard & Dylan H. Marsh, *Arbitrary Healthcare Pricing and the Misuse of Hospital Lien Statutes by Healthcare Providers*, 38 AM. J. TRIAL ADVOC. 255, 257–58 (2014) (referring to a nationwide trend of hospitals and other providers seeking to recover their full chargemaster rates through the use of hospital lien statutes and stating: "Providers who believe the patient may pursue a personal injury claim may refuse to file a claim with the patient's health insurer or government sponsored plan, preferring instead to gamble on the possibility of much greater reimbursement by filing a lean on the patient's tort recovery.").

19. *Id.* at 257 (noting the exorbitant and arbitrary nature of chargemaster rates and the problems they create when paired with a hospital lien statute).

claims it may collect its full undiscounted chargemaster list price rather than the contract rate.[20] Because the hospital contracted to accept the discounted rate only from the patient's health insurance company, no other insurer is entitled to claim the benefit of the discounted rate.[21] Because chargemaster rates, which are unilaterally set by the hospital, are greatly inflated—often running 5, 10, or even more times the discounted contract rate—the hospital hopes to gain a huge financial windfall by collecting the full nondiscounted rate from a third party; however, the windfall is one ultimately paid for by the accident victim.[22]

In Jean's case, because her injuries were sustained in an MVA—a fact hospital admissions staff are trained to look for—there is the possibility that the other driver, the other driver's auto insurance company, or Jean's auto insurance company may be liable to pay for Jean's medical care.[23] By purposely avoiding billing Jean's health insurance company, the hospital claims that it is not required to accept the discounted contract rate.[24] However, this is very unfair to Jean because Jean loses the benefit of her insurance and ultimately may wind up paying far more for her medical care.[25]

Note that in Jean's case, there is a huge $10,023 difference between the contract rate of $750 and the hospital's chargemaster-based list price of $10,773. In other words, the list price is 14.36 times greater than the contract rate. Unfortunately, an extreme difference between chargemaster-based prices and the price actually paid (and accepted by the hospital as full payment) for healthcare by most patients is not unusual.[26] On average, hospitals receive only 33 percent of their chargemaster prices from all

20. *See infra* notes 89–114 and accompanying text.

21. *See infra* notes 89–114 and accompanying text.

22. *See infra* notes 89–114 and accompanying text.

23. When someone is found responsible under tort law for causing another person's injuries, the responsible person, the tortfeasor, must pay damages to the injured party. One part of those damages consists of any medical expenses incurred by the injured party due to the tortfeasor's conduct. Thus, when the injured party seeks medical treatment, the tortfeasor (or his or her liability insurance company) becomes liable to pay for the medical services received by the victim. *See generally* WILLIAM L. PROSSER, HANDBOOK OF THE LAW OF TORTS 313–23 (4th ed. 1971) (discussing generally the law of negligence). A full discussion of negligence is beyond the scope of this Article.

24. *See* Beard & Marsh, *supra* note 18, at 264–66.

25. *See infra* Part II.B.1.

26. Batty & Ippolito, *supra* note 14, at 689.

payers.[27] However, for those unfortunate enough to be subjected to chargemaster-based price gouging (including the uninsured, out-of–network patients, other self-pay patients, or patients with potential TPL claims), the consequences can be devastating and often result in personal bankruptcy.[28]

Anytime a hospital or other healthcare provider gets a whiff of a possible TPL claim, they begin to salivate like Pavlov's dogs because of the possibility of collecting so much more money—up to 10 times or more in some cases—for the care they provide.[29] To be clear, nothing about the care provided by the hospital changes; the only thing that changes is the amount of money the hospital gets paid for the care.[30] This potential windfall is due to the fact that hospitals maintain list prices in a chargemaster, and these chargemaster list prices are exorbitant.[31] They are not set by the hospital to

27. *Id.*

28. *See* Melissa B. Jacoby & Elizabeth Warren, *Beyond Hospital Misbehavior: An Alternative Account of Medical-Related Financial Distress*, 100 NW. U. L. Rev. 535, 548, 550 (2006) (noting that between 46 percent and 56 percent of bankruptcy filers have identified a medical reason for bankruptcy); George A. Nation III, *Healthcare and the Balance-Billing Problem: The Solution Is the Common Law of Contracts and Strengthening the Free Market for Healthcare*, 61 VILL. L. REV. 153, 154–55 (2016) [hereinafter Nation, *Balance Billing*] (noting the ironic unfairness of the fact that uninsured patients are expected to pay exorbitant chargemaster rates and that even insured patients are burdened by exorbitant chargemaster prices through balance billing and higher overall medical insurance costs); Christopher Tarver Robertson et al., *Get Sick, Get Out: The Medical Causes of Home Mortgage Foreclosures*, 18 HEALTH MATRIX 65, 66–68 (2008) (stating 49 percent of home foreclosures were partially caused by a health problem and 23 percent by medical bills).

29. Nation, *Chargemaster Insanity*, *supra* note 12, at 748–49, 756 (noting many hospitals are unwilling to reduce their ridiculously high chargemaster rates even for uninsured patients at least in part because of revenue motive); *see* Steven Brill, *Bitter Pill: How Outrageous Pricing and Egregious Profits Are Destroying Our Health Care*, TIME, Mar. 4, 2013, at 16, 20 (noting Medicare would have reimbursed the hospital at less than one-tenth the price an uninsured patient was billed for some items); Elisabeth Rosenthal, *As Hospital Costs Soar, Single Stitch Tops $500*, N.Y. TIMES, Dec. 3, 2013, at A1, A16 ("How do hospitals set prices? They set prices to maximize revenue, and they raise prices as much as they can —all research supports that.") (quoting Glen Melnick, a Professor of Health Economics at the University of Southern California).

30. Jordan Rau, *Hospital Charges Bear Little Relationship to the Quality of the Care, Study Says*, WASH. POST (July 22, 2013), https://www.washingtonpost.com/national/health-science/hospital-charges-bear-little-relationship-to-the-quality-of-the-care-study-says/2013/07/22/a3a2a8fc-efd1-11e2-9008-61e94a7ea20d_story.html?noredirect=on&utm_term=.4dbdc548a232.

31. *See* Nation, *Chargemaster Insanity*, *supra* note 12, at 746–50 (discussing hospital chargemasters and the fact that the prices they contain are exorbitant and arbitrary).

be paid; rather, they are set to be discounted in negotiations with insurance companies and to game the Medicare reimbursement system.[32] However, if a hospital—regardless of whether it is a for-profit or a tax-exempt, nonprofit "charity"—sees the opportunity to grab its exorbitant chargemaster prices, the hospital goes for it aggressively and relentlessly.[33]

Charles Dickens, in *A Christmas Carol*, describes Scrooge's fondness for money by saying, "[H]e was a tight-fisted hand at the grindstone . . . a squeezing, wrenching, grasping, scraping, clutching, covetous old sinner! Hard and sharp as flint, from which no steel had ever struck out generous fire . . . ."[34] When it comes to most modern hospitals and healthcare systems, their fondness for money can be aptly described by Dickens's description of Scrooge.[35] Of course, the supernatural intervention of Marley's Ghost and the three spirits was necessary to redeem Scrooge.[36] Unfortunately, the redemption of hospital billing practices may require the intervention of the much scarier specter of government.[37]

In Jean's hypothetical case, the following two sentences were included in the multipage admissions form: "I understand that I am responsible for

32. *Id.* at 748 ("The purpose of these fictitious list prices is to serve as a starting point or anchoring point for negotiations with third-party payers . . . .").

33. *See* George A. Nation III, *Non-Profit Charitable Tax-Exempt Hospitals—Wolves in Sheep's Clothing: To Increase Fairness and Enhance Competition in Health Care All Hospitals Should Be For-Profit and Taxable*, 42 RUTGERS L.J. 141, 174–79 (2010) (discussing harsh collection tactics used by many charitable hospitals); *see also infra* note 39 and accompanying text (noting patient price gouging by both for-profit and not-for-profit hospitals).

34. CHARLES DICKENS, A CHRISTMAS CAROL 5 (1st ed. 1843), https://babel.hathitrust.org/cgi/pt?id=mdp.39076002191398;view=1up;seq=25.

35. *See, e.g.*, Ge Bai & Gerard F. Anderson, *Extreme Markup: The Fifty US Hospitals with the Highest Charge-to-Cost Ratios*, 34 HEALTH AFF. 922, 924 (2016) (noting fifty hospitals in the United States are charging uninsured consumers more than 10 times the actual cost of patient care, and all but one of the facilities are owned by for-profit entities); Lena H. Sun, *These Hospitals Make the Most Money off Patients—and They're Mostly Nonprofits*, WASH. POST (May 3, 2016), https://www.washingtonpost.com/news/to-your-health/wp/2016/05/02/these-hospitals-make-the-most-money-off-patients-and-theyre-mostly-nonprofits/?utm_term=.1b07edaad230 (noting 7 out of 10 of the most profitable hospitals are nonprofit "charity hospitals" and these hospitals are able to dominate the local market and charge more, and they do—their supposed charitable mission notwithstanding).

36. DICKENS, *supra* note 34, *passim*.

37. *See infra* Part IV.

any charges not covered by my insurance company. I understand that I am obligated to pay the account of the Facility in accordance with the regular rates and terms of the Facility."[38] In this agreement, the phrase *regular rates* means chargemaster-based list prices, notwithstanding the fact that these rates are actually paid by less than 5 percent of patients.[39] As noted, based on the hospital's regular chargemaster rates, Jean's charges were $10,773. However, Jean's insurance company had negotiated a contract with the hospital, and pursuant to that contract, the hospital agreed to accept $750 as full payment for the medical care provided to Jean.[40] Moreover, since the hospital freely negotiated with Jean's insurance company, it is very unlikely the hospital agreed to accept an amount that did not include a reasonable profit.[41] In other words, the hospital would make a reasonable profit on its services by charging $750 even though its list price is set at more than $10,000. In addition, Medicare would have paid even less than the contract rate, and Medicaid even less than Medicare.[42]

The current chargemaster-based pricing system is essentially a game of hospital-price roulette. That is, every time a patient comes into the hospital, the wheel spins, and the hospital gets to see whether it is a winner or loser. The best odds for the hospital/casino are found in the ED.[43] If Medicaid

38. Sample Admissions Agreement, *supra* note 6, at 1.

39. George A. Nation III, *Obscene Contracts: The Doctrine of Unconscionability and Hospital Billing of the Uninsured*, 94 KY. L.J. 101, 104 (2005) [hereinafter Nation, *Obscene Contracts*]; *see also infra* Part III.A (discussing that hospitals and other providers bill all patients chargemaster rates, claiming these are the regular rates because they are billed to all patients, even though the vast majority of patients are not expected to pay them).

40. *See supra* note 19 and accompanying text.

41. *See* Beard & Marsh, *supra* note 18, at 276 ("It seems obvious that private hospitals will not routinely accept unreasonably low reimbursement rates."); 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 L. REV. 425, 460–61 (2013) [hereinafter Nation, *Fair and Reasonable*] (noting the price is actually paid by private insurers, reflecting a strong and effective free market); Dave Barkholz, *Commercial Insurance Margins Offset Rising Medicare Losses*, MOD. HEALTHCARE (May 7, 2016), http://www.modernhealthcare.com/article/20160507/MAGAZINE/305079963 (noting many hospitals have a negative margin on their Medicare business, but make that up by posting higher margins on their nongovernment reimbursed patients).

42. *See, e.g.*, Roberts v. Univ. of Ala. Hosp., 27 So. 3d 512, 515–17 (Ala. Civ. App. 2008) (discussing the amounts various insurers would have paid the hospital for a chargemaster-based bill of $23,055.84).

43. This is because most TPL patients are admitted via the emergency department

covers the patient, the hospital usually loses (the exception as discussed *infra* is TPL Medicaid patients)[44] because many hospitals claim that the Medicaid reimbursement rate is below cost.[45] Medicare patients are usually considered essentially a breakeven,[46] but again the hospital can be a big winner in a case like that of the TPL Medicare patients.[47] Commercially insured in-network patients are winners for the hospital. The hospital receives the amount agreed to with the insurance company, and as noted, the hospital would not agree if the reimbursement amount was not profitable.[48] Additionally, the hospital is potentially a big winner in the case of commercially insured TPL patients like Jean.[49] Commercially insured out-of-network patients (OON), uninsured patients, and patients covered by workers' compensation insurance are potential big-time winners for the hospital even if there is no TPL.[50] Of course, when hospitals win the price roulette game, patients lose! Moreover, as discussed in this Article, TPL patients covered by Medicaid, Medicare, and in-network commercial insurance may lose the benefit of their insurance and effectively their in-network status.[51]

This is exactly what happened to Jean in the hypothetical. The hospital

because their injuries are usually caused by accidents. *See, e.g.*, Audrey J. Weiss, *Overview of Emergency Department Visits in the United States, 2011*, HEALTHCARE COST & UTILIZATION PROJECT, June 2014, at 1, 8, https://www.hcup-us.ahrq.gov/reports/statbriefs/sb174-Emergency-Department-Visits-Overview.pdf (explaining injuries consistent with run-of-the-mill accidents, such as contusions, cuts, and sprains, are the most common purposes of an ED visit).

44. *See infra* notes 202–04 and accompanying text.

45. Nation, *Fair and Reasonable*, *supra* note 41, at 459.

46. *See id.* at 459–60 (discussing government reimbursements and noting not all Medicare reimbursement rates are unprofitable for hospitals); Matthew Yglesias, *Do Health Care Providers Lose Money on Medicare Patients?*, SLATE: MONEYBOX (Feb. 22 2013, 3:10 PM), http://www.slate.com/blogs/moneybox/2013/02/22/medicare_provider_payments_do_hospitals_lose_money_treating_medicare_patients.html (suggesting such claims are dubious and noting that even though Medicare reimbursement rates may be below fully allocated costs for some hospitals, the rates are in excess of marginal costs and therefore add significant profits once fixed costs are covered).

47. *See infra* notes 202–04 and accompanying text.

48. *See* Nation, *Fair and Reasonable*, *supra* note 41, at 460–61.

49. *See infra* Part II.A.

50. *See* Nation, *Balance Billing*, *supra* note 28, at 154–55 (noting in addition to the uninsured, hospitals attempt to collect their obscenely high chargemaster rates from insured but out-of-network (OON) patients and other self-pay patients through the process of balance billing).

51. *See infra* Part II.B.

Jean was taken to, similar to many hospitals, had a policy which refused to bill the patient's health insurance carrier in cases of potential TPL.[52] Rather, the hospital would go for the big payoff of its chargemaster rates from those liable to pay for Jean's injuries (like Jean's auto insurer, the other driver's auto insurer, the other driver's liability insurer, or the other driver personally).[53] However, it turned out the only party liable to pay for Jean's medical care was the other driver, and he did not have sufficient insurance or enough money to pay Jean or the hospital for Jean's medical care. By the time the hospital figured this out, it had delayed too long in submitting its claim to Jean's health insurance. Jean's health insurer denied the claim because it was not filed in a timely manner as required in Jean's insurance policy, and the hospital brought a claim personally against Jean—not for $750, but for the full chargemaster price of $10,773![54]

The situation with Jean is especially egregious and somewhat unusual in that the hospital evaluated the TPL potential incorrectly.[55] When an MVA patient like Jean has been treated in the ED, it is much more common for the hospital to refuse to seek payment from the patient's health insurer and instead file a hospital lien against the patient.[56] A hospital lien, which most states provide for by statute, ensures the hospital's bill will be paid first from any judgment or settlement reached between the patient and the liable third

52. *See* Beard & Marsh, *supra* note 18, at 257–58.

53. *See id.*

54. For a similar fact pattern, see Cape Reg'l Med. Ctr. v. Sanchez, No. CPM DC 109-11, slip op. at 5 (N.J. Super. Ct. Law Div. Mar. 26, 2012) (on file with author). This case involved a patient who received emergency-room services at Cape Regional following a car accident. *Id.* at 1. The patient turned out not to be covered by her auto insurer for medical care but was covered by her Medicaid carrier. *Id.* at 3. However, by the time Cape Regional submitted their claim to the Medicaid carrier, it was too late and, thus, denied. *Id.* Cape Regional sued Sanchez for the total billed charge of $1,495 even though it would have accepted $494.85 from Medicaid as full payment. *Id.* at 5.

55. As discussed, hospitals train their staff to look for patient situations involving TPL, and because there is a lot of money at stake, they do not usually make mistakes. *See* Beard & Marsh, *supra* note 18, at 257–58.

56. *See, e.g.*, Parnell v. Adventist Health Sys./W., 109 P.3d 69, 79 (Cal. 2005) (noting the hospital filed a lien but the court rejected it, in part, because the hospital had accepted payment from the patient's commercial insurer); Speegle v. Harris Methodist Health Sys., 303 S.W.3d 32, 37–38 (Tex. Ct. App. 2009) ("[W]henever services provided to a Medicare beneficiary are also covered by a liability insurance policy, providers have the right either to bill Medicare or to maintain a lien against a potential liability insurance settlement.").

party.[57] Moreover, it is very common for hospitals to claim a lien for the full amount of their inflated chargemaster rates.[58] As a result, when patients recover for their injuries from the third-party that caused them (or from the third-party's insurer), the hospital's outrageously inflated bill is paid from the patient's recovery.[59] For example, if Jean had settled with the driver of the other vehicle for a total of $25,000 (a typical amount for personal injury liability insurance under an auto insurance policy),[60] the hospital would take $10,773 from that settlement amount, leaving Jean with only $14,227 before deducting the other expenses associated with the settlement. As a result, patients with potential TPL claims typically lose the benefit of the insurance they purchased and the hospital agreed to accept.[61]

Of course, there would be nothing illegal, unfair, or unjust about a hospital receiving payment for the *reasonable value* of the medical care provided, which in the case of in-network patients like Jean, would be the contract rate of $750.[62] Moreover, the hospital could have accomplished this very easily by simply filing its claim in a timely manner with the patient's health insurer.[63] What is unfair, unjust, and should always be prohibited is the hospitals taking advantage of the TPL situation and hospital lien statutes to price gouge the patient for the hospital's exorbitant chargemaster-based prices.[64] Hospital lien statutes were created to ensure hospitals received fair payment when they treated indigent patients, not to provide a financial

57. *See* Beard & Marsh, *supra* note 18, at 258–59 (noting 41 states and the District of Columbia currently have some version of a hospital lien statute and listing the states at n.14).

58. *See id.* at 261–72.

59. Daniel L. Sarr, Note, *Blindsided (Again): Iowa Hospitals' Abuse of the Hospital Lien Statute and What Has Been Done to Correct It*, 56 DRAKE L. REV. 463, 500 (2008) (noting patients without insurance may still have the entire tort recovery consumed by the hospital's lien and, as a result, may be unable to recover any damages for themselves).

60. *See Liability Insurance*, DMV.ORG, https://www.dmv.org/insurance/liability-insurance.php (last visited May 24, 2018) (noting while minimums will vary amongst states, they are often listed as follows: $15,000 for bodily injury per person, $25,000 for total bodily injury, and $10,000 for property damage).

61. *See* Sarr, *supra* note 59, at 500.

62. *See infra* notes 147–50 and accompanying text.

63. Beard & Marsh, *supra* note 18, at 258. As discussed, the hospital purposely refuses to do this in order to gamble on a much larger reimbursement pursuant to the hospital lien. *Id.*

64. *See infra* Part II.B.2.

windfall to hospitals.[65]

First, this Article provides some background about areas of law that converge in the case of TPL patients. Next, the Article analyzes the issues related to TPL patients and suggests a solution to the TPL-patient problem that involves both courts and the legislature. Finally, the Article concludes.

II. BACKGROUND

A. *What Price Healthcare? Chargemasters and the Corrupt Consequences of a Reprehensible System*

Hospitals maintain a computer file which contains the list price for all of the goods and services provided by the hospital.[66] Each hospital has complete control over its chargemaster and can increase its list prices or, at least in theory, decrease them whenever the hospital sees fit.[67] There is no consistency in the list prices of hospitals, and in fact variations, even among similar hospitals in the same geographic region, are common and often extreme.[68] Also, no relationship exists between list prices and the quality of medical care provided by the hospital.[69] From a pricing perspective, the list prices contained in the chargemaster are truly arbitrary and capricious.[70] The list prices are exorbitant and bear no consistent relationship either to costs

65. Beard & Marsh, *supra* note 18, at 257–58 (noting although the lien statutes were not designed to be used in this fashion, hospitals continue to attempt to bypass the payment available for the patient's health insurer or government plan in hopes of misusing the lien to get a much greater reimbursement based on chargemaster rates); *see also* Meta Calder, *Florida's Hospital Lien Laws*, 21 FLA. ST. U. L. REV. 341, 345–47 (1993) (noting a windfall for hospitals was not the original intent of the hospital lien statute).

66. Nation, *Chargemaster Insanity*, *supra* note 12, at 746–47.

67. *Id.* at 747–48.

68. *Id.*; *see Medicare Provider Utilization and Payment Data: Inpatient*, CTRS. MEDICARE & MEDICAID SERVS., https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Inpatient.html (last updated Apr. 4, 2018) (databases showing prices for in-patient procedures); *see also Medicare Provider Utilization and Payment Data: Outpatient*, CTRS. MEDICARE & MEDICAID SERVS., http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Outpatient.html (last updated Mar. 1, 2018) (databases showing prices for out-patient procedures). Chargemaster rates for inpatient and outpatient services vary significantly—even among neighboring hospitals. *Id.*

69. *See* Rau, *supra* note 30.

70. *See* Nation, *Chargemaster Insanity*, *supra* note 12, at 746–50.

or to the amount a hospital actually receives in payment for the goods and services it sells.[71]

71. *See, e.g.*, Howell v. Hamilton Meats & Provisions, Inc., 257 P.3d 1130, 1137 (Cal. 2011) (citing Melone v. Sierra Ry. Co. of Cal., 91 P. 522, 523 (Cal. 1907)) (explaining medical expenses actually paid by or on behalf of the patient—not billed charges based on chargemaster rates—are proper measures of medical expenses); Greenfield v. Manor Care, Inc., 705 So. 2d 926, 928 (Fla. Dist. Ct. App. 1997), *overruled by* Beverly Enters.-Fla., Inc. v. Knowles, 766 So. 2d 335 (Fla. Dist. Ct. App. 2000) (holding healthcare agreements have an implied covenant to charge reasonable fees); Payne v. Humana Hosp. Orange Park, 661 So. 2d 1239, 1241 (Fla. Dist. Ct. App. 1995) ("A patient may not be bound by unreasonable charges in an agreement to pay charges in accordance with 'standard and current rates.'") (quoting Mercy Hosp., Inc. v. Carr, 297 So.2d 598, 599 (Fla. Dist. Ct. App. 1974)); Victory Mem'l Hosp. v. Rice, 493 N.E.2d 117, 119 (Ill. App. Ct. 1986) (permitting jury question as to whether charges presented by a hospital were reasonable); Butler v. Ind. Dep't of Ins., 904 N.E.2d 198, 202 (Ind. 2009) (discussing an Indiana statute allowing recovery of reasonable medical expenses and explaining such expenses do not include the difference between the amount billed and the actual amount paid); *In re* Adoption of N.J.A.C., 979 A.2d 770, 785 (N.J. Super. Ct. App. Div. 2009) (presuming regulation of physician fee schedule was reasonable and valid); Kastick v. U-Haul Co. of W. Mich., 740 N.Y.S.2d 167, 167 (App. Div. 2002) (agreeing with defendants that plaintiff could not recover damages in amount she was never obligated to pay for medical services); Nassau Anesthesia Assocs. v. Chin, 924 N.Y.S.2d 252, 255 (Dist. Ct. 2011) (citing Temple Univ. Hosp., Inc. v. Healthcare Mgmt. Alts., Inc., 832 A.2d 501, 510 (Pa. Super. Ct. 2003)) (finding reasonable value of medical services is the average amount the provider would have accepted as full payment from third-party payers, such as private insurers and federal healthcare programs); Moorhead v. Crozer Chester Med. Ctr., 765 A.2d 786, 789 (Pa. 2001), *abrogated by* Northbrook Life Ins. Co. v. Commonwealth, 949 A.2d 333, 337 (Pa. 2008) (holding patient's recovery for medical expenses in a malpractice suit was limited to the amount paid and accepted for services, rather than the fair and reasonable market value of services); *Temple Univ. Hosp., Inc.*, 832 A.2d at 510 (finding the chargemaster rate "bears no relationship to the amount typically paid for those services"); Doe v. HCA Health Servs. of Tenn., Inc., 46 S.W.3d 191, 199 (Tenn. 2001) (affirming lower court holding that patient was obligated to pay reasonable charges for medical services and fair value of goods furnished); Haygood v. de Escabedo, 356 S.W.3d 390, 397 (Tex. 2011) (explaining medical expenses actually paid by or on behalf of patient, not billed charges based on chargemaster rates, are the proper measure of medical expenses); Daughters of Charity Health Servs. of Waco v. Linnstaedter, 226 S.W.3d 409, 411 (Tex. 2007) (finding chargemaster prices are not the value of medical services in the context of hospital lien statute); *cf.* Eufaula Hosp. Corp. v. Lawrence, 32 So. 3d 30, 46 (Ala. 2009) (noting rates paid by Blue Cross, Medicare, and Medicaid "may not be the baseline on which to calculate a reasonable charge for the medical services rendered"); Univ. of S. Ala. Hosp. v. Blackmon, 42 So. 3d 1258, 1261 (Ala. Civ. App. 2009) (noting the amount insurance companies pay hospitals is not necessarily the reasonable charge); Holland v. Trinity Health Care Corp., 791 N.W.2d 724, 728 (Mich. Ct. App. 2010) (finding chargemaster rates usual and customary).

Chargemaster prices are not derived from market forces; rather, they are set unilaterally by the hospital.[72] In fact, in most cases hospitals keep chargemaster prices secret and consider them proprietary.[73] As a result, there is no awareness of and, therefore, no possible competition based on a hospital's chargemaster pricing.[74] Some states have attempted to change this; for example, California requires hospitals to publish their chargemasters.[75] However, as discussed elsewhere in this Article, this is not really useful to patients because patients cannot use these chargemasters, which often contain 20,000 to 30,000 individual line items, to calculate the price they will actually owe for the medical procedure they are considering.[76] Rather, in order to encourage price competition, hospitals should publish procedure-based prices such as those used by Medicare and commercial health insurers.[77]

In more than 90 percent of cases, the amount a hospital actually gets *paid* (remember in healthcare there is a very big difference between the amount paid and the amount charged) for its goods and services is not determined directly by the hospital's chargemaster.[78] In fact, chargemaster prices are so rarely paid in full (less than 5 percent of the time)[79] that some hospital administrators have stated, incorrectly, that the exorbitant and arbitrary chargemaster prices are not relevant because patients do not pay them. [80] However, these administrators are incorrect because the fact hospitals rarely collect the full amount of their chargemaster list prices does

72. *See* Nation, *Chargemaster Insanity*, *supra* note 12, at 747–50.

73. *See* Nation, *Fair and Reasonable*, *supra* note 41, at 428–32 (discussing the lack of price transparency for healthcare and the negative impact it has on prices).

74. *Id.* at 429–30.

75. Uwe E. Reinhardt, *The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy*, 25 HEALTH AFF. 57, 59 (2006) ("With the exception of California, which now requires hospitals to make their chargemasters public, hospitals are not required to post their chargemasters for public view."); *see* Beard & Marsh, *supra* note 18, at 282 n.139 (citing state statutes promoting healthcare price transparency).

76. Nation, *Fair and Reasonable*, *supra* note 41, at 427–29 (noting chargemasters would not be useful to consumers—even those knowledgeable regarding the procedures they are shopping for—but advocating for procedure-based pricing that consumers could compare from one hospital to another).

77. *Id.* at 429.

78. *See supra* note 19 and accompanying text.

79. *See, e.g.*, Temple Univ. Hosp., Inc. v. Healthcare Mgmt. Alts., Inc., 832 A.2d 501, 510 (Pa. Super. Ct. 2003) (noting chargemaster rates are paid by less than 5 percent of patients).

80. Nation, *Chargemaster Insanity*, *supra* note 12, at 760.

not mean they do not, in certain types of cases, attempt to collect them and in the process cause great harm—even cruelty—to the unfortunate patients who are commanded to pay them.[81] Moreover, as discussed *infra*, in the case of TPL patients, hospitals do often collect all or most of their exorbitant chargemaster prices by misusing hospital lien statutes.[82]

The amount a hospital actually gets paid for medical care varies dramatically, depending on who the payer is.[83] The big government insurers, Medicare and Medicaid, are price setters, and when hospitals agree to participate in these programs, the Provider Agreement they sign usually requires them to accept the amount that Medicare and Medicaid decide to pay. [84] As noted, TPL cases are an exception, and most courts have interpreted the Medicare and Medicaid rules (Medicare Secondary Payer Act) to allow hospitals to elect to forgo payment by the government and to instead pursue their full chargemaster rates against the patient's tort recovery or settlement from the person that caused the patient's injuries.[85] With respect to commercial health insurers, individual hospitals enter into negotiations with individual insurance companies and agree on contracts that set the discounted amount the insurer will pay and the hospital will accept as full payment for any medical services provided to patients covered by the insurance company.[86] As discussed *infra* hospitals use their exorbitant chargemaster-based list prices in order to negotiate higher reimbursements with insurers.[87]

However, when a patient has medical insurance from an insurance company that has not entered into a contract with the hospital, that patient is said to be OON and is not entitled the contracted discounts, so the hospital claims it is free to charge such OON patients its exorbitant list prices.[88] Typically, the OON patient's insurance company has a predetermined

81. *See id.* at 761–66.

82. *See generally* Beard & Marsh, *supra* note 18 (discussing the misuse of hospital lien statutes to collect excessive chargemaster rates); Calder, *supra* note 65; Sarr, *supra* note 59.

83. *See* Nation, *Fair and Reasonable*, *supra* note 41, at 430–32 (discussing price discrimination by hospitals and the importance of the identity of the payer).

84. *Id.* at 431.

85. *See supra* notes 48–51 and accompanying text.

86. *See* Nation, *Balance Billing*, *supra* note 28, at 154–55.

87. *See infra* notes 95–112 and accompanying text.

88. Nation, *Balance Billing*, *supra* note 28, at 155 (discussing OON patients).

amount it will pay for OON care, but since there is no contract between the insurance company and the hospital pursuant to which the hospital has agreed to accept this amount as full payment, the hospital is free to bill the patient for the balance or difference between the hospital's chargemaster-based list price and the amount the insurance company paid.[89] This is what is referred to as balance billing and is one of many pernicious consequences of the chargemaster pricing system.[90]

An obvious question is: why do hospitals insist on maintaining chargemasters with exorbitant prices? The answer to this question is complex and discussed in detail in other works.[91] It is sufficient for the purposes of this Article to state hospitals have every incentive to set their chargemaster prices ever higher and absolutely no incentive to lower them.[92] That is, while chargemaster prices are no longer used directly to set reimbursement rates either by Medicare, Medicaid, or most private health insurance companies, they are used indirectly in setting reimbursement rates. [93] While there is no dollar-for-dollar relationship between chargemaster prices and reimbursement rates, overall there is a positive relationship between the two, which means the higher a hospital sets its chargemaster prices, the higher its reimbursement from payers is likely to be.[94] Moreover, as noted above, since hospitals do not compete based on their chargemaster prices, no downside exists to the hospital constantly setting the prices contained in their chargemasters ever higher.[95] In addition, hospitals benefit from exorbitant chargemaster prices because they are used as anchoring points in their negotiations with commercial insurance companies.[96] If the commercial insurance company does not agree to the reimbursement levels suggested by the hospital, then the insurance company knows its customers may be subjected to the hospital's much higher list prices via balance billing.[97] This threat creates tremendous pressure on

89. *Id.*

90. *Id.* at 154.

91. *See* Nation, *Chargemaster Insanity*, *supra* note 12, at 756–60 (discussing the issue of exorbitant chargemaster pricing in detail).

92. *Id.*

93. *See* Nation, *Balance Billing*, *supra* note 28, at 162–64 (discussing how excessive chargemaster rates and balance billing increase the overall cost of healthcare in the United States).

94. *Id.* at 163.

95. *Id.* at 161–63.

96. Nation, *Chargemaster Insanity*, *supra* note 12, at 748.

97. Nation, *Balance Billing*, *supra* note 28, at 162. To be clear, these reimbursement

insurance companies to agree to the reimbursement rates suggested by the hospital.[98] Of course, the higher the reimbursement rates agreed to by the insurance company, the higher the insurance company must set its premiums.[99]

Many other pernicious consequences, in addition to balance billing and the misuse of hospital lien statutes with respect to TPL patients, are caused by this crazy chargemaster-based pricing system.[100] For example, workers' compensation insurers, including those employers that self-insure for workers' compensation coverage, are also often hit with exorbitant chargemaster-based bills because they do not typically enter into contracts with hospitals.[101] As a result, unless protected by statute, many employers face exorbitant medical expenses under workers' compensation coverage due to this pernicious chargemaster-based pricing system.[102] Another example is self-pay patients, who also generally do not negotiate contracts with hospitals; because they lack health insurance, they do not have the benefit of contract negotiated discounts and are, therefore, often subjected to being charged the full chargemaster-based list prices for their healthcare.[103] As a result, those individuals without insurance are charged exorbitant prices.[104] Ironically, this typically means the poorest individuals are charged the highest prices for their medical care.[105] It should also be

levels are still well below the chargemaster rates because there is a limit to how far insurance companies can be pushed on reimbursements and because it is simply not possible for the hospital to objectively justify its chargemaster-based rates. As already stated elsewhere, chargemaster rates are set to be discounted and not paid.

98. *See id.*

99. *Id.* at 163–64.

100. *Id.* at 162–65.

101. *See, e.g.*, First Choice Surgery Ctr. v. Fresh Pickin's Mkt., Inc., 102 So. 3d 795, 800 (La. Ct. App. 2012) (stating "[o]utpatient hospital and ambulatory surgery services will be reimbursed at covered charges less a ten percent (10%) discount[;]" "covered charges" is a reference to chargemaster rates, and since hospitals are free to set their chargemaster rates at any level they wish, the 10 percent discount is essentially meaningless).

102. *Id.*

103. *See* Nation, *Chargemaster Insanity*, *supra* note 12, at 761–66 (providing examples and discussing how chargemaster rates are unfair and cruel to self-pay patients).

104. Nation, *Obscene Contracts*, *supra* note 39, at 123 (discussing the shocking unfairness of demanding the excess of chargemaster rates from the uninsured).

105. *Id.* at 122–23.

noted that one of the leading causes of personal bankruptcy is unpaid medical debt.[106] However, patients subjected to balance billing, workers' compensation insurers, and self-pay patients are not the only ones negatively impacted by the chargemaster system. As noted *supra* even patients who have insurance and receive their medical care in-network pay more for their insurance because of the chargemaster system.[107] In other words, this reprehensible chargemaster-based pricing system negatively impacts everyone.[108]

B. *Hospital Liens, Subrogation, and the Collateral Source Rule*

In order to fully understand the problem faced by TPL patients, those whose injuries were caused by a third party and treated by the hospital, it is necessary to understand some issues typically associated with personal injury claims.

Under general tort law, if someone acts negligently—defined as not acting the way a hypothetical reasonably prudent person would have acted—and that negligent conduct causes injury to another person, then the negligent party—the tortfeasor—is liable to pay the injured party for the harm caused by the negligent conduct.[109] For example, in the hypothetical case involving Jean, the driver of the other vehicle acted negligently by failing to stop at the red light.[110] As a result, under tort law the driver of the other vehicle is the tortfeasor and is responsible for paying for the harm caused to Jean.[111] Part of the harm caused to Jean includes her medical expenses.[112] Other types of harm for which Jean may receive damages under tort law include reimbursement for property loss or property damage, pain and suffering, and loss of earning capacity.[113]

Medical expenses include the cost of the medical care required to treat the injuries caused to the victim by the tortfeasor's negligence.[114] One of the

106. *See* Nation, *Balance Billing*, *supra* note 28, at 161 n.46.

107. *See* Nation, *Chargemaster Insanity*, *supra* note 12, at 766–69 (discussing how exorbitant chargemaster prices cause higher overall prices for healthcare).

108. *See id.*

109. *See generally* PROSSER, *supra* note 23, at 143–80 (discussing generally the law of negligence). A full discussion of negligence is beyond the scope of this Article.

110. *See id.*

111. *See id.*

112. *See id.* at 731.

113. *See id.*

114. John Dewar Gleissner, *Proving Medical Expenses: Time for a Change*, 28 AM.

concepts underlying tort law is that individuals should be responsible for the harm caused by their unreasonable conduct, even if the harm caused was accidental.[115] The purpose of damages in tort law is to shift the cost of the harm from the victim to the tortfeasor.[116]

Someone unfamiliar with the wacky practices of hospital billing might be forgiven for thinking, of the various types of damages mentioned above, medical expenses would be one of the easier types to measure. After all, by the time the lawsuit gets to court, the patient has already received treatment, and one need only consult the hospital and doctor bills to determine the amount of medical expenses involved.[117] However, because of the odd practices associated with hospital and chargemaster-based billing, determining the amount of medical expenses becomes unnecessarily complex.[118] As noted above, in the context of healthcare, different payers pay different amounts.[119] Moreover, even though less than 5 percent of patients actually pay full chargemaster rates, hospitals nonetheless continue to insist that chargemaster prices also represent the usual, customary, and reasonable prices for their services.[120]

Additional complexity results from the fact that plaintiff's counsel, on behalf of the patient/victim, as well as hospitals and other medical care providers have attempted to take advantage of the oddities of healthcare

J. TRIAL ADVOC. 649, 649–50 (2005) ("A bewildering number of methodologies, agreements, regulations, statutes, limitations, schedules, accounting systems, software, review policies, reports, and practices control the coding, billing, and reimbursement for a diverse and expanding range of medical services.").

115. *See* PROSSER, *supra* note 23, at 143–50.

116. *Id.* at 6.

117. *See infra* notes 124–27.

118. *See* Gleissner, *supra* note 114, at 650.

119. *See supra* notes 89–90 and accompanying text.

120. *See, e.g.*, Temple Univ. Hosp., Inc. v. Healthcare Mgmt. Alts., Inc., 832 A.2d 501, 508 (Pa. Super. Ct. 2003) (noting the hospital was paid its full published charges in only 1 to 3 percent of its cases); Haygood v. de Escabedo, 356 S.W.3d 390, 393–94 (Tex. 2011) ("Although reimbursement rates have been determined to be reasonable under Medicare or other programs, or have been reached by agreements between willing providers and willing insurers, providers nevertheless maintain that list rates are also reasonable. . . . [E]ven though those charges were four times the amount they were entitled to collect [under Medicare]."); Daughters of Charity Health Servs. of Waco v. Linnstaedter, 226 S.W.3d 409, 410 (Tex. 2007) ("Few patients today ever pay a hospital's full charges, due to the prevalence of Medicare, Medicaid, HMOs, and private insurers who pay discounted rates.").

billing practices in the TPL situation.[121] For example, some patients/victims in litigation with the tortfeasor have asserted as their medical expenses the full chargemaster-based list price of the medical care they received even though the patient was insured and in-network, and in fact the hospital received only a fraction of that amount from the patient's insurance company.[122] Some patients argue, in the context of the personal liability lawsuit, the hospital's full chargemaster-based price of their care is the appropriate measure of medical expenses.[123] Moreover, often the same patient, in the action by the hospital to collect payment for the care provided to the patient, argues the hospital's chargemaster-based bill is exorbitant.[124] In other words, the patient tries to have it both ways: claiming the exorbitant chargemaster-based amount is the correct one for measuring the recovery from the tortfeasor and then claiming the exorbitant chargemaster amount is unfair when the hospital seeks payment from the patient.[125] Clearly, when a patient recovers the chargemaster-based amount from the tortfeasor in a case where the actual amount paid for the patient's treatment at the hospital was much lower, the patient receives a significant windfall.[126] The patient is recovering, as medical expenses, phantom expenses that were never owed and never paid.[127]

Of course, as noted, hospitals attempt to misuse hospital lien statutes and use other means to try to collect their full chargemaster-based list prices

121. *See, e.g.*, *Haygood*, 356 S.W.3d at 396. In the tort action, the patient/victim attempted to recover the full chargemaster list price for medical care, and the court held recovery, and consequently the evidence at trial, was limited to expenses the provider has a legal right to be paid, i.e., the discounted insurance amount. *Id.*

122. *Id.* at 393, 397.

123. *See* Gleissner, *supra* note 114, at 657, 677 (noting hospital bills usually reflect both the higher chargemaster rates and the lower reimbursement amount based on insurance contracts, and each side in a tort case seeks to prove different aspects of the same "two-headed" bills).

124. *See, e.g.*, *Linnstaedter*, 226 S.W.3d at 412 (noting the medical expenses of the patient or tort victim were paid at a discounted workers' compensation rate, but patients submitted the full rate in their case against the tortfeasor).

125. *See id.* at 410, 412; Gleissner, *supra* note 114, at 675–77.

126. *Linnstaedter*, 226 S.W.3d at 412 (noting if patients/victims recover full medical charges billed by the hospital rather than the reduced amount paid by their compensation carrier, that would be a windfall; as the hospital had no claim for these amounts against the patients, they in turn had no claim for them against the tortfeasor).

127. *See, e.g.*, Howell v. Hamilton Meats & Provisions, Inc., 257 P.3d 1130, 1133–34 (Cal. 2011) (noting the defendant moved to exclude evidence of medical bills that neither the plaintiff nor her health insurer had paid).

in TPL cases even though these prices are grossly excessive.[128] Allowing hospitals to collect these excessive charges produces a significant windfall for the hospital.[129] Unfortunately, in either case it is society that loses. Allowing patients to recover these phantom charges or allowing hospitals to collect them unnecessarily increases the overall cost of healthcare.[130] Plaintiffs should recover their actual medical expenses, and hospitals should be paid for their services in an amount representing the fair value of the services in question.[131] As discussed elsewhere, market forces best measure fair value.[132] As a result, the best place to start to calculate fair value is with the discounted reimbursement rates hospitals agree to accept from insurance companies with whom they have a contract.[133]

A number of courts have begun to recognize it is unfair to allow tort plaintiffs to measure their medical expenses by using chargemaster rates because they produce an excessive value for medical expenses.[134] However, some of these same courts refuse to recognize the substantial windfall the hospital receives when it is permitted to collect its chargemaster rates through the misuse of hospital liens.[135] This Article advocates for consistency in both of these situations. That is, patients should never be required to pay more than fair value for their medical care, and tortfeasors should not be required to pay more than fair value (measured in the same way) for the

128. *See infra* Part II.B.2.

129. *See infra* Part II.B.2.

130. *See* Nation, *Chargemaster Insanity*, *supra* note 12, at 770, 772 (noting exorbitant chargemaster prices cause higher overall prices for healthcare).

131. *See infra* Part III.C.

132. *See* Beard & Marsh, *supra* note 18, at 276 ("Moreover, the rates negotiated by insurers and providers are the closest example of free market pricing available, which is why they should not be ignored."); Nation, *Chargemaster Insanity*, *supra* note 12, at 775 ("[T]he most competitive market for hospital services exists with regard to private healthcare insurers.").

133. Nation, *Fair and Reasonable*, *supra* note 41, at 460–61 (noting the price actually paid by private insurers is a good place to start to calculate the fair and reasonable value of medical services).

134. Beard & Marsh, *supra* note 18, at 273–74 (noting a minority of courts have prevented plaintiffs from using chargemaster rates to measure their medical expenses, but in disputes between hospitals and their patients dealing with medical charges, some of these same courts do not even permit the patient to attack the reasonableness of the chargemaster rate by showing the provider routinely accepts lower payments from the health insurance companies).

135. *Id.* at 274.

medical care required as a result of the tortfeasors' negligence.[136] Application of this rule would have the significant benefit of reducing both tort recoveries and the cost of healthcare.[137]

1. *Plaintiff's Counsel, Subrogation, and the Collateral Source Rule*

Unfortunately, patients/victims have been aided in collecting the type of windfall discussed above by the misapplication of an evidentiary doctrine known as the collateral source rule.[138] The collateral source rule is an evidentiary rule that prevents the defendant in a personal injury/tort case from introducing evidence that shows the plaintiff (patient/victim) received payment for the injuries suffered from a source other than the defendant.[139] The problem is not with the collateral source rule; however, the problem is caused by the rule's application in the bizarre world of hospital billing.[140] For example, assume the same facts as previously presented in the Jean hypothetical, except the hospital acted appropriately and billed Jean's insurance company. Further, assume Jean's insurance company paid the hospital $750 pursuant to its contract with the hospital. Also, assume in Jean's lawsuit against the other driver, the tortfeasor, Jean claimed $10,773 as the medical expense portion of her damages. When the collateral source rule is used to prevent the plaintiff's attorney from challenging this claim, it does a disservice.[141] As noted, the difference between $10,773 and the $750 the hospital actually accepted as full payment represents phantom charges

136. *See infra* Part II.B.2.

137. *See infra* Part IV.

138. *See, e.g.*, Lopez v. Safeway Stores, Inc., 129 P.3d 487, 491, 497 (Ariz. Ct. App. 2006) (discussing a slip-and-fall case in which the plaintiff's medical bills totaled $59,700, the healthcare providers were contractually bound to accept $16,837 as full payment from the plaintiff's health insurers, but the court, applying the common law collateral source rule, allowed the plaintiff to recover $59,700 as economic damages); *see also* Gleissner, *supra* note 114, at 680 (noting some courts allow the full chargemaster rate into evidence under the collateral source rule to prove medical expenses even though only partially paid); Lori A. Roberts, *Rhetoric, Reality, and the Wrongful Abrogation of the Collateral Source Rule in Personal Injury Cases*, 31 REV. LITIG. 99, 99–100 (2012) (discussing the *Lopez* case and arguing unwarranted rhetoric is wrongly being used to abrogate the collateral source rule).

139. Nation, *Chargemaster Insanity*, *supra* note 12, at 770 (discussing the collateral source rule); *see generally* William Schwartz, *The Collateral-Source Rule*, 41 B.U. L. REV. 348 (1961).

140. *See* Gleissner, *supra* note 114, at 657, 677.

141. *See supra* notes 129–32 and accompanying text.

Jean should not be able to recover.[142] With the proper application of the collateral source rule, the plaintiff's attorney could tell the jury the actual amount Jean's insurance company paid for her medical expenses.[143]

However, limiting Jean's recovery for medical expenses to $750 is both incorrect and unfair. This result is unfair because it allows the tortfeasor to steal Jean's benefit of having medical insurance.[144] Recall, an important principal of tort law is personal responsibility.[145] Jean's foresight and prudence in acquiring medical insurance should not be permitted to benefit the tortfeasor. Rather, the tortfeasor should be responsible for paying the expenses caused by his negligent conduct. Those expenses fairly include Jean's medical expenses, and the fact Jean's insurer paid for the expenses is irrelevant as far as the tortfeasor's responsibility is concerned. The result is incorrect because Jean's insurance company, pursuant to something called subrogation, has the right to recover from Jean's recovery against the tortfeasor the $750 the insurance company paid.[146]

Subrogation is a right created by common law recognizing when someone pays an obligation owed by someone else, the payer has a right to recover from the person who should have paid the claim.[147] In essence, subrogation is a substitution of one person (the payer) for another (the person who received the payment or its benefit) with respect to a legal claim.[148] For example, the tortfeasor should have paid for Jean's medical

142. *See supra* notes 129–32 and accompanying text.

143. *See* Gleissner, *supra* note 114, at 660 (suggesting the jury be shown both sets of figures—full chargemaster rates as well as the discounted insurance reimbursement amount).

144. *See, e.g.*, Howell v. Hamilton Meats & Provisions, Inc., 257 P.3d 1130, 1145 (Cal. 2011) (noting one purpose served by the collateral source rule is that it ensures the plaintiff and not the defendant or tortfeasor will receive the benefit of the plaintiff's decision to carry insurance, and this will encourage others to carry insurance as well).

145. *Id.* (noting another purpose of the rule is to ensure the tortfeasor pays the full expenses associated with his misconduct in order to serve the deterrent function of tort law).

146. Subrogation refers to the right of the insurance company that paid for the plaintiff's medical expenses to recover the amount paid from the tortfeasor (defendant), which reduces the amount recovered by the plaintiff. *See* ROBERT E. KEETON & ALAN I. WIDISS, INSURANCE LAW: A GUIDE TO FUNDAMENTAL PRINCIPLES, LEGAL DOCTRINES, AND COMMERCIAL PRACTICES § 3.10(a)(1) (Student ed. 1988).

147. *Id.*

148. *Id.*

expenses, but since Jean's insurance company already paid the hospital (which redounded to Jean's benefit), the insurance company is subrogated to Jean's right against the tortfeasor for recovery of the medical expenses it paid. This then allows the insurance company to bring a claim, a healthcare lien,[149] against Jean's recovery of $750 from the tortfeasor. As a result, if Jean were not able to recover at least $750 from the tortfeasor, Jean, rather than the tortfeasor, could wind up paying for her own medical expenses.[150] Thus, it is incorrect to say there is no need for Jean to recover her medical expenses from the tortfeasor even in cases where the hospital has already been paid by the patient's insurance carrier. Moreover, as discussed elsewhere, the rates insurance companies negotiate with hospitals represent certain benefits the insurance company provides to the hospital, including things such as increased volume of patients and quick and assured payment.[151] It is not appropriate for the tortfeasor to benefit from these discounts.[152] However, these insurer discounts come nowhere close to the difference between the excessive chargemaster-based prices and the discounted contract rate.[153] The insurer discounts represent no more than 10 to 15 percent of the discounted payment amount under the hospital/insurer contract.[154] Thus, in the hypothetical, the tortfeasor should be obligated to reimburse Jean roughly 110 to 115 percent of the amount her insurance company paid for her care, $825 to $862.50.[155] Jean would then pay $750 to reimburse the insurance company and keep the balance, which she is entitled to as a result of the foresight, prudence, and expense involved in her

149. Insurance companies will usually have a health insurance lien or subrogation interest on the proceeds of the patient/victim's lawsuit against the tortfeasor. The insurance company is first able to recoup the medical bill expenses it paid before the patient/victim is paid. Most health insurance companies include subrogation clauses in their agreements, which guarantee them the right to reimbursement. *See, e.g.*, MATTHIESEN, WICKERT, & LEHRER, S.C., MED PAY/PIP SUBROGATION IN ALL 50 STATES *passim* (2018), https://www.mwl-law.com/wp-content/uploads/2013/03/med-pay-pip-subrogation-in-all-50-states1.pdf (discussing subrogation rights of auto insurers and citing state cases and statutes).

150. This would violate the idea that the tortfeasor should bear the cost of his negligent conduct. *See supra* notes 114–16 and accompanying text.

151. *See* Nation, *Fair and Reasonable*, *supra* note 41, at 458–61 (discussing and placing a value on such benefits).

152. *See id.*

153. *See id.* at 458.

154. *See id.* at 463.

155. *See id.*

acquisition of health insurance.[156]

2. *Hospitals and Hospital Liens*

A lien is a claim by a creditor against specific assets of a debtor in order to satisfy a debt.[157] For example, when someone borrows money to purchase an automobile, a lien against the automobile is commonly created in favor of the lender to secure payment of the debt.[158] If the owner does not repay the lender as promised, the lender can, pursuant to the lien, force a sale of the automobile and receive repayment of the loan from the proceeds of the sale.[159] Liens may be created in a variety of ways including by common law, judicial process, and statute.[160]

Many jurisdictions have statutes that create a lien in the TPL context to ensure healthcare providers receive the fair value of the care they provide.[161] The purpose of these liens is to ensure recovery, especially in cases involving indigent patients. [162] That is, hospitals should be encouraged—or even required as today's law provides—to treat any patient brought to the ED regardless of the patient's ability to pay.[163] When a patient's injuries were caused by a third party's negligence, that negligent third party should pay the hospital for the treatment it provided to the indigent patient.[164] Hospital lien statutes are designed to accomplish that objective.[165]

These liens typically attach to a patient's right of recovery from the tortfeasor, the party responsible for causing the injuries treated by the hospital.[166] As noted, problems occur when hospitals misuse the hospital lien statute to recover their exorbitant chargemaster-based list prices rather than

156. *See id.*
157. *Lien*, BLACK'S LAW DICTIONARY (5th ed. 1979).
158. *See id.*
159. *See id.*
160. *See id.*
161. *See* Beard & Marsh, *supra* note 18, at 257–58.
162. *Id.* at 257.
163. *See* EMTALA, *supra* note 2.
164. *See* Beard & Marsh, *supra* note 18, at 257.
165. *Id.*
166. *Id.*

to recover the fair value of the medical care provided.[167] As noted *supra*, some hospitals even refuse to submit bills to an in-network patient's health insurance company, Medicare, or Medicaid and instead file a hospital lien against the patient's potential recovery for the full (excessive) chargemaster-based list price.[168] For example, as discussed in the hypothetical involving Jean, the hospital refused to bill her insurance because doing so would lower the hospital's return to $750. Instead, the hospital filed a lien for $10,773 against Jean's recovery from the other driver.[169] In order to understand how egregious this problem is, one must keep in mind that the hospital makes an acceptable profit by charging $750, which is why the hospital agreed to accept that amount in the contract with the health insurance company.[170]

The problems associated with hospital liens are similar to those associated with the collateral source rule.[171] The problem is not with hospital liens per se; it is entirely reasonable and appropriate that hospitals should be able to recover the *fair value* of the care they have provided.[172] This induces hospitals to provide the care in the first place, which benefits patients who need the care. Rather, the problem is the result of misuse of the lien to recover excessive chargemaster-based prices.[173] This practice occurs due to the greed of hospitals and the confusion of courts and legislatures concerning hospital billing practices.[174] Hospital liens are merely a tool designed to allow hospitals to recover the *fair value* of the medical care they have provided.[175]

With respect to hospital liens, the debtor is the patient, the creditor is the hospital, and the specific asset to which the lien attaches is the patient's cause of action (the right to sue or to enter into a settlement agreement) against the third party who is liable for causing the injuries treated by the hospital.[176] The problems associated with hospital liens occur because

167. *Id.* at 257–58.

168. *Id.* at 258.

169. *See* Parnell v. Adventist Health Sys./W., 109 P.3d 69, 79 (Cal. 2005) (discussing how the hospital accepted discounted payment from the patient's health insurer was important in rejecting the hospital's lien against the patient's cause of action against the tortfeasor).

170. *See supra* notes 46–71 and accompanying text.

171. *See supra* Part II.B.1.

172. *See supra* notes 157–65 (discussing the purposes behind hospital lien statutes).

173. *See* Beard & Marsh, *supra* note 18, at 257–58.

174. *See infra* note 250 and accompanying text.

175. *See supra* note 161 and accompanying text.

176. *See* Beard & Marsh, *supra* note 18, at 257–58.

opportunistic hospital billing departments see a chance to price gouge accident patients/victims by misusing the power of hospital lien statutes to collect their grossly inflated chargemaster-based prices.[177] Price gouging is exactly what occurs in the case of TPL patients.

C. *Coordination of Benefits*

In some cases a patient may have medical insurance coverage from more than one insurance policy.[178] For example, in the case of a married couple where both spouses are employed, each may be covered by his or her own employer's health insurance and may also be covered by the other spouse's insurance.[179] Other common examples include employees injured at work who may be covered by both workers' compensation insurance and health insurance and individuals involved in TPL situations like MVAs.[180] For example, in the case of an MVA, an injured party may be covered by the party's own health insurance, no-fault auto insurance (in states that have it), the other party's automobile bodily-injury insurance (if the other party was at fault in causing the accident), and the injured party's uninsured or underinsured motorist coverage (if the other driver is at fault and does not have adequate insurance).[181]

In these types of cases, where more than one insurer may be responsible to pay for the medical care provided to a patient, coordination-of-benefit (COB) rules are used to determine the order in which the various insurers must pay and how much they must pay.[182] COB rules are complex

177. *See id.*

178. *See, e.g.*, *Dual Coverage*, LIFETIME HEALTHCARE, INC., https://www.excellusbcbs.com/download/files/cob (last visited Feb. 2, 2018) ("Most health insurance contracts have a clause that allows the benefits of one policy to be coordinated with the benefits of other policies. This clause, referred to as Coordination of Benefits (COB), prevents duplicate payment of health care services. The COB rules follow guidelines established by the National Association of Health Insurance Commissioners (NAIC). . . . Medicare Secondary Payer rules take precedence over NAIC guidelines.").

179. COORDINATION OF BENEFITS HANDBOOK ¶ 100, Westlaw (database last updated Apr. 2018).

180. *Dual Coverage*, *supra* note 178 (discussing workers' compensation and motor vehicle accident situations).

181. COORDINATION OF BENEFITS HANDBOOK ¶¶ 112, 114, Westlaw (database last updated Apr. 2016).

182. *See* JACQUES CHAMBERS, HCV ADVOCATE, COORDINATION OF BENEFITS:

because different COB rules apply to different situations.[183] In cases where state law controls, different states have different COB rules, and in some cases, individuals are free to adopt their own rules via contract.[184] For patients covered by Medicare or Medicaid, state law does not apply because Medicare and Medicaid have their own rules.[185] In addition, commercial group health plans covered by the Employee Retirement Income Security Act of 1974 (ERISA) are exempt from any state law requirements, and they may use a contract to provide for the COB rules applicable to the policy.[186] A full discussion of COB rules is beyond the scope of this Article. What follows is an overview of various COB rules and their potential impact on the TPL patients that are the focus of this Article. The most important point to remember with respect to COB rules in the context of TPL patients is that hospitals often misuse these rules as an excuse to ignore their contract with the accident victim's/patient's health insurance company pursuant to which they agreed to accept a discounted rate (remember that in healthcare, the discounted rate is really the reasonable, fair rate), and instead the hospital claims it is entitled to collect its excessive chargemaster-based list price for the medical care provided.[187]

The concept behind the need to coordinate healthcare insurance benefits is based upon the premise that an injured party should not profit from medical insurance.[188] The insured party should not recover more than the value of the medical care received.[189] If more than one insurer paid the full value of the medical expenses incurred by the patient, the patient would be profiting from the insurance.[190] Even though the patient has paid for both policies, this double payment is usually deemed to be improper.[191]

COVERAGE UNDER MULTIPLE HEALTH PLANS 5 (2014), http://hcvadvocate.org/hepatitis/hepC/Multiple_coverage_2014.pdf.

183. *Id.* at 5.

184. *Id.* at 3.

185. *Id.*

186. *Id.* at 5.

187. *See infra* Part III.C.1; *see also* Palmer Hamilton, *Strategies to Improve Motor Vehicle Accident Claim Collections*, REVENUE CYCLE STRATEGIST, Dec. 2011–Jan. 2012, at 1, 1 (discussing the importance of hospitals "properly" managing TPL cases due to the significant potential to increase hospital revenue).

188. *See* CHAMBERS, *supra* note 182, at 1–2.

189. *Id.* at 1.

190. *Id.*

191. *Id.*; *cf.* Tomlinson v. Combined Underwriters Life Ins. Co., 708 F. Supp. 2d 1284, 1296–98 (N.D. Okla. 2010) (discussing the public policy relating to dual insurance

Coordinating benefits involves several issues. These include determining which insurance policy is primary and which is secondary, identifying the method by which the primary and secondary insurers calculate the amount they will each pay, and handling the timing of the payments made by the primary and secondary insurers.[192]

In general the determination of which insurance is primary in situations involving group health plans is based on the guidelines established by the National Association of Insurance Commissioners (NAIC).[193] These rules are designed to evenly distribute the burden among group health insurers.[194] For example, if two spouses are each covered by the other's health insurance (each as an employee under their respective employer's health insurance and each as a dependent under their spouse's employer's health insurance), the NAIC rules say that the individual's health insurance from their employer is primary.[195] In the case of children of a couple like this, the NAIC rules use the "birthday rule," which provides that the plan covering the parent whose birthday is first in the calendar year will cover the couple's children.[196] Also, a health plan covered by ERISA is not subject to state law and may reserve secondary status in its contracts.[197] Generally, under state law, auto or other liability insurance is treated as primary.[198]

recoveries; noting no reasonable person desires illness or injury that health insurance policies are designed to cover and insurance companies can use coordination of benefits clauses in their policies to guard against situations where an insured can recover more than his or her expenses; and concluding there is no clear indication that the public policy of Oklahoma prohibits the recovery sought by the plaintiff (the insurer claimed the recovery sought would allow the insured to recover more than her actual expenses)).

192. *See* NAT'L ASS'N INS. COMM'RS, COORDINATION OF BENEFITS MODEL REGULATION § 6, at 120-6–120-9 (2013), http://www.naic.org/store/free/MDL-120.pdf.

193. *See generally id.*

194. *See id.* § 2(B), at 120-1.

195. *Id.* § 6(A)(1), at 120-6.

196. *Id.* § 6(D)(2)(a)(i), at 120-7.

197. *See* Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 (2012) [hereinafter ERISA]; MOLLY R. BERKERY, CDC, SELECTED ISSUES REGARDING ERISA, HEALTH BENEFIT PLANS, AND STATE LAWS THAT ADDRESS HEALTH SYSTEM TRANSFORMATION 2 (2013), http://www.cdc.gov/phlp/docs/erisa-brief.pdf.

198. *See, e.g.*, *Dual Coverage*, *supra* note 178 ("In states where No-Fault Automobile Insurance is mandated, it is primary to the patient's health insurance plan."); *cf.* Metro. Prop. & Cas. Ins. Co. v. Blue Cross & Blue Shield of Mass., Inc., 885 N.E.2d 825, 831 (Mass. 2008) (stating no-fault auto insurance primary but only for the first $2,000); Nelson P. Miller, *The Affordable Care Act's Uncertain Impact on Michigan's No-Fault*

Both Medicare and Medicaid provide by statute that their coverage is secondary to all forms of liability insurance.[199] However, notwithstanding the fact both Medicare and Medicaid prevent balance billing by healthcare providers, hospitals have convinced the majority of courts that the secondary status of the government insurance makes the prohibition on balance billing inapplicable and therefore allows hospitals to choose to forgo the government insurance and bring a hospital lien in the excessive chargemaster amount against the Medicare or Medicaid patient's tort recovery.[200] As a result of this egregious practice, Medicare or Medicaid patients who have been the victim of automobile accidents, for example, are often left with only a small inadequate portion of their recovery.[201] In addition, these patients have completely lost the benefit of their Medicare or Medicaid insurance.[202] Again, this problem is not caused primarily by the

Act, MICH. B. J., Mar. 2014, at 20, 20–21 (discussing issues related to Michigan's decision to allow no-fault insurance to be secondary to health insurers).

199. Omnibus Budget Reconciliation Act of 1980, Pub. L. No. 96-499, 94 Stat. 2599. For a discussion of these provisions, see Beard & Marsh, *supra* note 18, at 267–68.

200. *See, e.g.*, Miller v. Gorski Wladyslaw Estate, 547 F.3d 273, 285 (5th Cir. 2008) (noting if a hospital accepts Medicaid payment, it may not maintain its lien against a patient's tort claim); Or. Ass'n of Hosps. v. Bowen, 708 F. Supp. 1135, 1138 (D. Or. 1989) (Medicare); Joiner v. Med. Ctr. E., 709 So. 2d 1209, 1221 (Ala. 1998) (Medicare); Speegle v. Harris Methodist Health Sys., 303 S.W.3d 32, 37–38 (Tex. Ct. App. 2009) (noting if medical care is provided to a Medicare beneficiary who is also covered by a liability insurance policy, then "providers have the right either to bill Medicare or to maintain a lien against a potential liability insurance settlement"); Laska v. Gen. Cas. Co. of Wis., 830 N.W.2d 252, 260 (Wis. Ct. App. 2013) (noting a hospital is permitted to bill Medicare and withdraw its lien against a patient's tort claims or continue to maintain its lien and forego payment from Medicare).

201. *See, e.g.*, Roberts v. Univ. of Ala. Hosp., 27 So. 3d 512 (Ala. Civ. App. 2008) (discussing how the hospital asserted a lien for its chargemaster-based charges of $23,055.84 and explaining that Roberts would have been covered by Medicare had the hospital asserted a Medicare claim, but the hospital was not required to and did not do so).

202. *See id.* Note that CMS states its "liability insurance billing policy is that providers are required to drop their claims/liens and terminate all billing efforts to collect from a liability insurer or beneficiary once the Medicare timely filing period [one year after the date of service] expires, unless the liability insurance claim was paid or settled prior to the expiration of the Medicare timely filing period." MED. LEARNING NETWORK, BILLING IN MEDICARE SECONDARY PAYER (MSP) LIABILITY INSURANCE SITUATIONS 2 (2017). Because Medicare coverage is secondary, providers are required to bill the liability insurance first, but after expiration of the "promptly period," "120 days after the earlier of: 1) the date the claim is filed with an insurer or a lien is filed against a potential liability settlement; or 2) the date the service was furnished or, in the case of inpatient hospital services, the date of discharge," the provider may bill Medicare.

secondary status of Medicare or Medicaid, but rather this problem is caused by the pernicious chargemaster pricing system and the failure of courts to properly understand it.[203]

There are three common methods used for determining the amount the primary and secondary insurance carriers will pay: full COB, nonduplicative COB (also called the "maintenance of benefits approach"), and supplemental COB.[204] Under all of these methods, the primary insurer calculates the amount it will pay based on the amount it would pay if it were the only insurer involved.[205] The difference in these methods lies in the method used to calculate the amount to be paid by the secondary insurance. Under full COB, the secondary insurer calculates payment as if no other insurance was involved; however, the total paid by both the primary and secondary insurers cannot exceed the total bill submitted by the provider.[206] Under the nonduplicative method, the secondary insurer calculates its payment as if no other insurance was involved, then subtracts the amount already paid by the primary insurer, and pays only the remaining balance.[207] Under the supplemental COB method, the secondary insurer calculates its payment based on the allowable amount under the primary insurance carrier's contract and limits its payment to the primary insurance carrier's allowable amount that the primary insurance carrier did not pay.[208] That is, the secondary insurance would pay things like deductibles, copayments,

Id. If the provider chooses to bill Medicare, then it can never recover any more than the Medicare payment amount. *Id.* Whether courts will follow this guidance with respect to requiring providers to drop liens or claims after the timely filing period remains to be seen. Even if courts do follow this guidance, it offers only a partial solution because it does not prevent hospitals from price gouging accident victims if the claims are paid or settled within one year.

203. For example, in the *Roberts* case, there is nothing unfair about making Medicare secondary to the liability insurance of the individual that caused Roberts's injuries. *See Roberts*, 27 So. 3d at 512. The problem arises when the amount that must be paid for the injuries escalates from $5,936 to $23,056 for no reason other than opportunistic price gouging by the hospital. The problem is not making Medicare secondary—the problem is the chargemaster pricing system.

204. McGraw Wentworth, Inc., *Coordination of Benefits Primer*, BENEFIT ADVISOR, Aug. 2007, at 1, 2–3, http://www.mcgrawwentworth.com/Benefit_Advisor/2007/BA_Issue_8.pdf.

205. *Id.*

206. *Id.*

207. *Id.*

208. *Id.*

coinsurance, and any amounts that were allowable but exceeded of the limits of the primary policy.[209]

With respect to when payment is made, the real issue is whether there is another insurer responsible to pay for the medical care and whether that question must be definitively answered before any payment is made.[210] It is clear in the case of a TPL patient who has health insurance that the health insurer is liable to pay for medical care provided to the patient. But, if the injuries treated were the result of an accident (which is always the case for TPL patients), then there is a strong possibility a liability insurance carrier may also be liable to pay for medical care.[211] In this case, the issue is the approach to payment timing taken by the health insurance company.[212] Specifically, three common approaches exist: pay-and-pursue, passive-pay-and-pursue, and aggressive-pay-and-pursue.[213] Under the pay-and-pursue approach, the health insurance carrier pays right away (assuming of course the hospital immediately submits the bill), and if it finds out later there is another insurer who should have paid the bill, it pursues payment or reimbursement from them.[214] Under the passive-pursue-and-pay approach, the health insurer sends out a letter of inquiry (LOI) regarding whether there is any other insurance, and if it receives no response within a certain time, it pays the bill as if it is the only insurer.[215] Under the aggressive-pursue-and-pay approach, the health insurer sends out an LOI, and if it receives no response within a certain time, e.g. 45 days, then it denies the claim.[216]

The most important COB issue related to the topic of this Article is the designation of the primary insurer and the secondary insurer. However, it is not the order of payment that is important to the hospital; rather, making sure the primary insurer is not entitled to discounted rates from the hospital is of critical importance.[217] Hospitals claim if the primary insurer is not

209. *Id.*

210. *See id.*

211. *See supra* note 23 and accompanying text. By definition, the TPL context ensures there is a liable third party; however, if the patient/victim has no health insurance, then the patient/victim is self-paying.

212. *See supra* note 23 and accompanying text.

213. *See* McGraw Wentworth, Inc., *supra* note 204, at 3.

214. *Id.*

215. *Id.*

216. *Id.*

217. *See supra* notes 188–216 and accompanying text.

Medicare, Medicaid, or a commercial health insurance carrier with whom the hospital has entered into a contract, then the discounted (aka fair and reasonable) contract-based rates agreed to by the hospital do not apply to limit the amount the hospital may recover for its treatment of the patient.[218] That is, hospitals claim that even if the patient is covered by Medicare or Medicaid and the hospital participates in those programs, or if the patient is covered by in-network commercial insurance, the hospitals can unilaterally decide not to submit the patient's bill to the patient's health insurance and avoid having to accept the discounted rates they agreed to with the patient's health insurance company.[219] As a result of this practice, in TPL cases, hospitals that have treated even Medicare, Medicaid, or in-network commercially insured patients use hospital liens to claim an exorbitant amount for treatment based on the hospital's excessive chargemaster-based rates.[220] Speaking plainly, the hospital, simply by refusing to submit its bill to the patient's health insurer, increases its revenue from treating the patient by an average of 300 percent for commercially insured in-network patients and even more for Medicare and Medicaid patients.[221]

The rules related to COB, such as hospital lien statutes and the collateral source rule, have been misused by hospitals in an attempt to collect exorbitant fees for their services in cases involving TPL patients. The problem, however, does not lie directly with the COB rules, hospital lien statutes, or the collateral source rule; the problem is the reprehensible chargemaster-based pricing system.[222] While the chargemaster-based pricing system may have developed for legitimate reasons,[223] today this system is used illegitimately to allow hospitals to exploit a number of different patient situations (balance billing, uninsured patients, TPL patients, workers' compensation claims, and others) to price gouge patients for their healthcare.[224] In addition, the chargemaster pricing system also indirectly raises the cost of healthcare for all other patients who receives healthcare in

218. *See supra* notes 188–216 and accompanying text.

219. *See supra* notes 209–11 and accompanying text (noting that a number of courts agree with this erroneous analysis).

220. *See, e.g.*, Roberts v. Univ. of Ala. Hosp., 27 So. 3d 512, 515 (Ala. Civ. App. 2008).

221. *See, e.g.*, *id.* (noting that bill increased by a shocking 388 percent).

222. *See* Nation, *Chargemaster Insanity*, *supra* note 12, at 760–61.

223. *See id.* at 751–60 (discussing the development of the chargemaster pricing system).

224. *Id.* at 761–73 (discussing problems caused by the chargemaster pricing system).

the United States.[225] As a result, the most efficient solution to the unconscionable behavior of hospital price gouging is to eliminate, or at least rein in, the chargemaster-based pricing system.

III. ANALYSIS

A. *To Determine the Usual, Customary, and Reasonable Value of Healthcare, Focus on Paid Charges and Not Billed Charges*

Today, hospitals continue to use the chargemaster-based pricing system because it allows them to illegitimately derive higher revenue for their goods and services.[226] To be clear, this Article takes the position that there is nothing per se wrong with sellers trying to maximize the revenue they can derive from their products. Moreover, this Article takes the position that hospitals should be able to set their prices at any level they desire, just like any other seller. What this Article objects to is the use of, or threatened use of, the chargemaster pricing system by hospitals to *unfairly* impose exorbitant prices on parties who never knowingly agreed to pay them.[227]

Higher revenues from exorbitant chargemaster rates are primarily the result of hospitals threatening to use these excessive rates against OON patients in negotiations with private health insurance companies.[228] These excessive rates are used as anchoring points in order to allow hospitals to negotiate ultimately higher reimbursements from insurers.[229] An additional reason that hospitals continue the chargemaster-based pricing is that it allows them to exploit vulnerable patient populations by demanding full payment of excessive chargemaster-based prices whenever possible.[230] Examples of patient populations subjected to exorbitant chargemaster-price exploitation include patients who, through no choice of their own, are treated in the emergency departments of OON hospitals or by OON emergency-department physicians; in-network patients, such as TPL

225. *Id.* at 766–73.

226. *See generally id.* at 748.

227. *See supra* notes 5–10 and accompanying text.

228. Nation, *Chargemaster Insanity*, *supra* note 12, at 766–69.

229. *Id.*

230. *Id.* at 761–73 (discussing exploitation of the uninsured); *see* Nation, *Balance Billing*, *supra* note 28, at 158–62 (discussing the exploitation of insured patients who are OON); *supra* notes 1–33 and accompanying text (discussing the exploitation of TPL patients).

patients who are treated in the emergency department; uninsured and underinsured patients; and patients covered by workers' compensation.[231]

Recent research suggests that on average chargemaster prices are more than 300 percent of the amount hospitals actually get paid for their goods and services.[232] In specific cases the markups are often much greater. In fact, recent research indicates chargemaster rates can be in excess of 10 times the Medicare allowable cost.[233] Not surprisingly, hospitals actually collect their full chargemaster rates from less than 5 percent of their patients.[234]

Notwithstanding the fact that hospitals rarely actually collect their chargemaster rates, and in fact do not expect to collect these rates from the vast majority of their patients, hospitals continue the disingenuous practice of billing all of their patients at chargemaster rates.[235] Hospitals reflect full chargemaster-based charges on the bills they send to all of their patients even though 95 percent of patients are not expected to pay these rates.[236] Most patient's bills from the hospital also include huge discounts.[237] For example, in the case of a Medicare patient (with the exception of TPL Medicare patients), even though the bill will reflect chargemaster-based charges, the patient is not responsible to pay any more than the Medicare fee-schedule amount.[238] The bill also reflects a huge deduction from the chargemaster-based charges in order to arrive at the amount the hospital

231. *See supra* notes 1–33 and accompanying text.

232. Batty & Ippolito, *supra* note 14, at 689.

233. Bai & Anderson, *supra* note 35, at 924.

234. Nation, *Obscene Contracts*, *supra* note 39, at 104. It is very likely hospitals try to collect their excessive chargemaster rates from more than 5 percent of their patients, with their efforts causing great difficulty, destruction, and heartache for patients. However, many of the vulnerable patients subjected to these unconscionable demands are simply unable to pay. *See generally* Nation, *Balance Billing*, *supra* note 28.

235. *See* Nation, *Fair and Reasonable*, *supra* note 41, at 429–30 (noting hospitals submit, for all of their patients, detailed bills based on the hospital's chargemaster).

236. Nation, *Obscene Contracts*, *supra* note 39, at 104.

237. Nation, *Fair and Reasonable*, *supra* note 41, at 429–30.

238. *See, e.g.*, Roberts v. Univ. of Ala. Hosp., 27 So. 3d 512, 514–15 (Ala. Civ. App. 2008) (showing the various amounts different insurers, government and private, would pay under their contracts with the hospital for the same exact medical care and comparing those amounts to the chargemaster rate; the chargemaster rate was $23,055.84); Lopez v. Safeway Stores, Inc., 129 P.3d 487, 487–88 (Ariz. Ct. App. 2006) (showing the chargemaster price of $59,700 and a contract rate between the insurer and the hospital of $16,837).

actually has a right to be reimbursed for—the paid charges.[239] A similar situation exists with respect to in-network insured patients; the bill reflects chargemaster-based rates, but then a huge discount is taken in order to arrive at the negotiated discounted rate for which the patient is actually responsible.[240] Hospitals engage in this deceptive billing practice so they may claim all of their patients are billed at chargemaster rates.[241] This then allows hospitals to continue to claim, disingenuously, that their exorbitant chargemaster-based prices are in fact their usual and customary prices because they are the prices billed to all of the hospital's patients.[242] In order to stop the deceptive practice, courts must learn to focus on paid charges and not on billed charges.[243]

Once courts and legislatures become educated regarding hospital billing practices, they will understand why, in the case of hospital billing, they must focus on the amounts hospitals are usually and customarily paid (and agree in advance to accept as full payment) and not on the amount they claim to usually and customarily charge.[244] Thus, when the question arises as to whether a particular hospital's charges are reasonable and fair, the focus of the court must be on comparing the amount claimed by the hospital with the amount the hospital usually and customarily receives in payment for the services in question.[245] This is what *paid charges* means.[246] In other words, chargemaster rates are irrelevant to a court's inquiry into whether the particular charges demanded by a hospital are fair and reasonable.

B. *The Real Problem Is the Chargemaster Pricing System and Not the Ins*

239. *See Roberts*, 27 So. 3d at 514–15; *Lopez*, 129 P.3d at 487–88.

240. *See* Nation, *Balance Billing*, *supra* note 28, at 157–67 (discussing the exploitation of insured patients who are OON).

241. Nation, *Fair and Reasonable*, *supra* note 41, at 429–30 (noting hospitals submit, for all of their patients, detailed bills based on the hospitals' chargemaster).

242. *Id.* at 430.

243. *See, e.g.*, *id.* at 442.

244. *See infra* Part III.B.

245. *See infra* Part III.B.

246. *See, e.g.*, Temple Univ. Hosp., Inc. v. Healthcare Mgmt. Alts., Inc., 832 A.2d 501, 508 (Pa. Super. Ct. 2003) ("While the Hospital's published rates for services may be the same or less than rates at other Philadelphia hospitals, the more important question is what healthcare providers actually receive for those services. As Mr. Lux [the vice president and chief financial officer of the hospital] readily admitted, the Hospital rarely recovers its published rates. Therefore, those rates cannot be considered the value of the benefit conferred because that is not what people in the community ordinarily pay for medical services.").

and Outs of Hospital Liens, Subrogation, the Collateral Source Rule, or the COB Rules.

Things like the CBO rules, the collateral source rule, and especially hospital lien statutes, as explained above, facilitate the problem of hospitals exploiting vulnerable patients through chargemaster-based price gouging.[247] However, none of these things directly causes the problem, and addressing these tangential issues cannot efficiently solve the problem. For example, the collateral source rule quite properly requires tortfeasors to bear the cost of the harm they have caused.[248] In addition, hospital lien statutes are meant to serve the very important purpose of ensuring hospitals are fairly compensated for the care they provide to accident victims.[249] The chargemaster-based pricing system, with its grossly excessive prices and the confusion it creates regarding the usual, customary, and reasonable value of healthcare, is the real cause of the hospital price-gouging problem.[250] Hospital misuse of the COB rules and hospital lien statutes is only possible because hospitals maintain chargemasters that contain exorbitant list prices. As a result, courts have been confused into thinking that these excessive prices represent the usual, customary, and reasonable payments that hospitals receive.[251] Solving the hospital price-gouging problem requires courts and legislatures to provide guidance regarding a clear and transparent method *based on payments and not on charges* for establishing the usual, customary, and reasonable price for medical care.[252] Two methods courts, as well as legislatures, could use to provide that guidance are discussed next.

1. *Average Negotiated Private Insurance Rate Plus 10 to 15 Percent*

The first method that can be used to establish the usual, customary, and reasonable charge for medical care is based on market-determined paid charges.[253] This method recognizes and takes advantage of the fact that the

247. *See supra* Parts II.B, II.C.

248. S*ee* Malinda S. Matlock, *The Collateral Source Rule & Write-Offs: What Is True Value of Medical Services?*, USLAW NETWORK, INC. (Oct. 10, 2013), http://web.uslaw.org/counsel-corner/collateral-source-rule-write-offs-true-value-medical-services.

249. Beard & Marsh, *supra* note 18, at 257–58.

250. Nation, *Fair and Reasonable*, *supra* note 41, at 429–30.

251. *See supra* Part II.A.

252. *See* Nation, *Balance Billing*, *supra* note 28, at 169.

253. *See* Nation, *Fair and Reasonable*, *supra* note 41, at 460–70 (describing the

only effective free market that exists with respect to healthcare is the market between hospitals and private insurance companies.[254] Hospitals knowingly and freely enter into contracts with private insurance companies.[255] These contracts are robustly negotiated between hospitals and insurers, often on an annual basis.[256] Moreover, both hospitals and insurance companies usually operate from positions of significant knowledge and market power.[257] As a result, these negotiated rates are usually a true representation of market-based rates.[258]

However, it is important to realize in certain contexts, private insurance companies provide benefits to hospitals that self-pay patients do not provide.[259] These benefits include the promise of many new patients as a result of becoming in-network with an insurer who insures many thousands

market-determined paid charges method in detail).

254. *Id.* at 460.

255. *Id.* at 460–61.

256. *Id.*

257. *Id.* The statement is qualified by the use of the word *usually* because, in some situations, specific hospitals may have excessive bargaining power when compared to insurers. Commentators often refer to these hospitals as "must have" hospitals. That is, in some markets, a particular hospital has been able to acquire dominant market power. In these markets, competition among hospitals does not exist or is weak. Therefore, from a business perspective, an insurance company must have the dominate hospital in its network and may have to agree to reimbursement rates that are higher than rates in truly competitive markets. *See* Bai & Anderson, *supra* note 35, at 925 (noting that high chargemaster rates motivate insurers "to include hospitals in their networks to reduce the likelihood of having subscribers pay high OON prices"); Nation, *Chargemaster Insanity*, *supra* note 12, at 762–64 (discussing California Pacific Medical Center as a "must-have" hospital due to its market power and citing the work of Professor Glenn Melnick); Robert Murray, *Hospital Charges and the Need for a Maximum Price Obligation Rule for Emergency Department & Out-of-Network Care*, HEALTH AFF., BLOG (May 16, 2013), http://healthaffairs.org/blog/2013/05/16/hospital-charges-and-the-need-for-a-maximum-price-obligation-rule-for-emergency-department-out-of-network-care/ (noting high chargemaster rates "undermine the negotiating leverage of private [insurers] relative to hospitals").

258. Nation, *Fair and Reasonable*, *supra* note 41, at 460. This statement is also qualified by the use of the word *usually* for the same reasons as discussed in note 257 *supra*.

259. *Id.* at 450–51 (noting large health insurance companies provide benefits to hospitals that self-pay patients do not provide, and these benefits come nowhere close to accounting for the huge difference between chargemaster-based rates and the average rate paid by private commercial health insurance companies).

of patients.[260] In addition, insurers offer quick and assured payment.[261] It is also important to note these benefits come nowhere close to accounting for the huge difference between negotiated contract-based rates and grossly inflated chargemaster rates.[262] In fact, as argued elsewhere, these benefits likely represent no more than 10 to 15 percent of negotiated rates.[263] The usual, customary, and reasonable market-based price for self-pay patients would be approximately 110 to 115 percent of the average, negotiated private insurance rate the hospital has contracted for with private insurance companies.[264] However, in the case of TPL patients, the adjustment made to contracted rates would be even less than 10 to 15 percent because there is no benefit of new patients associated with emergency care.[265] EMS providers take accident victims to the hospital, and the patients have no say as to which hospital they are taken.[266] Thus, in the case of TPL patients and other accident victims, no adjustment need be made for the promise of thousands of new patients associated with insurance company contracts.

2. *The Medicare-Based Rate*

The second method that can be used to establish the usual, customary, and reasonable price, based on paid charges, for medical care is based on Medicare reimbursement rates.[267] Medicare rates are not set by the market; they are set by the Centers for Medicare and Medicaid Services (CMS).[268] The main benefit to using Medicare rates is that they are readily available and updated regularly by CMS.[269] However, these rates also cannot be used without adjustment.[270] For many hospitals, Medicare reimbursements are below the hospital's costs.[271] One commentator has argued fair

260. *Id.* at 450.
261. *Id.*
262. *Id.* at 460–61.
263. *Id.* at 463.
264. *Id.*
265. *See id.* at 464–65.
266. *See id.*
267. *Id.* at 463–65 (discussing a proposal made by Gerard F. Anderson); *see infra* note 281.
268. *Id.* at 431.
269. *Medicare Provider Utilization and Payment Data: Outpatient*, *supra* note 68.
270. *See id.*
271. Virgil Dickson, *Slumping Medicare Margins Put Hospitals on Precarious Cliff*, MOD. HEALTHCARE (Nov. 28, 2017), http://www.modernhealthcare.com/article/

reimbursement would be 125 percent of the Medicare reimbursement rate.[272] The Medicare plus 25 percent-based rate is very similar to the average negotiated private insurance rate plus 10 to 15 percent advocated herein.[273] The main drawback to the Medicare-based rate is that it is not a market-based rate. [274] This rate is essentially a form of price setting. This is ameliorated to some extent because the formula used to increase the Medicare-based rate by 25 percent is based in part on the private insurance company reimbursement rate.[275]

This Author prefers the average negotiated private insurance rate plus 10 to 15 percent because it is a market-based rate. As such, it continues to allow hospitals to set their rates at any level they wish as long as they can get insurance companies—the only other market participants with the knowledge and market power to fairly negotiate with them—to agree to pay those rates.[276] Recall the reason chargemaster-based rates are excessive; they are set unilaterally by hospitals without any market restraint.[277] In addition, because the average negotiated private insurance rate plus 10 to 15 percent is based on an average, it does not require hospitals to reveal any proprietary information regarding the specific reimbursement rates agreed to with specific insurance companies.[278] Moreover, the average negotiated private insurance rate is information that is readily available to hospitals and is calculated by them on an annual basis.[279] However, as noted, the methods

20171125/NEWS/171129969?template=print ("In 2015, the aggregate margin hit a negative 7.1% across hospitals, according to the Medicare Payment Advisory Commission; margins are expected sink to a negative 10% this year.").

272. *See A Review of Hospital Billing and Collection Practices Before the Subcomm. on Oversight & Investigations of the H. Comm. on Energy & Commerce*, 108th Cong. 21 (2004) (statement of Gerard F. Anderson, Director, Johns Hopkins Center for Hospital Finance and Management) (noting 14 percent is added because it is the average difference between the Medicare rate and the average private insurance reimbursement rate, an additional 1 percent is added to this to account for the benefit of prompt payment that insurance companies provide, and 10 percent is added to account for the fact that the 14 percent added first was based on the *average* private insurance rate and many private insurers pay more).

273. *See* Nation, *Fair & Reasonable*, *supra* note 41, at 463–65.

274. *See id.* at 460–65.

275. *Id.* at 463–65.

276. *Id.*

277. *Id.* at 429–30.

278. *Id.* at 463–65.

279. *Id.* at 468–70 (discussing the ACA's use of "amounts generally billed" (AGB) for tax-exempt hospitals to use in calculating permissible charges to patients eligible for

are very similar and will arrive at comparable values.[280] Also, as noted above, some markets are not adequately competitive and therefore, resorting to the Medicare-based rate may be necessary.[281] As a result, this Author prefers the market-based rate, but either method is acceptable for determining the usual, customary, and reasonable value of medical services. It is important to note neither of these methods uses or relies upon the chargemaster-based rates set unilaterally by hospitals.

C. *Using Contract Law to Protect TPL Patients*

Fundamentally, a hospital's claim to payment from a patient is based on contract law.[282] Contract law is the law of voluntary obligations.[283] That is, contracting parties must, *inter alia*, knowingly and freely agree in order to enter into an enforceable contract.[284] Moreover, the terms of the agreement between the parties must be reasonably definite and certain if the words of the parties alone are to create a contract.[285] These requirements are clearly met in the agreements hospitals enter into with in-network insurance companies.[286]

This is not the case, however, with respect to self-pay patients. These patients usually sign a price ambiguous admissions agreement that simply refers to the patient's obligation to pay "regular rates" or "chargemaster rates." Given the complex nature of healthcare billing and payment, the imbalance of knowledge between hospitals and patients, and the stressful conditions under which patients enter the hospital, it is doubtful whether these admissions agreements are definite and certain enough concerning the price to create a contract.[287] In the nonemergency context, as discussed *infra*, the parties often behave in a way that suggests they both believe a contract has been created. This often occurs despite the uncertainty surrounding the price. Specifically, healthcare services are provided and accepted under

financial assistance).

280. *Id.* at 463–65.

281. *See supra* note 265 and accompanying text.

282. *See* Nation, *Balance Billing*, *supra* note 28, at 175–81 (discussing contract principles and contracting in the context of healthcare).

283. *Id.* at 176.

284. *Id.*

285. *Id.* at 179–80.

286. *Id.* at 158.

287. *Id.* at 178.

circumstances where both parties expect the patient will pay for the care received.[288] But, both parties often have very different expectations concerning the price to be paid; the patient expects a fair and reasonable price (a price comparable to that paid by most patients of the hospital for the same services), while hospitals often attempt to collect their excessive chargemaster rates from self-pay patients.[289] In addition to TPL patients, self-pay patients include uninsured patients, underinsured patients, patients subject to balance billing, and any other patient not covered by in-network medical insurance (e.g. patients covered by workers' compensation).[290]

1. *Contracts Between Patients and Hospitals*

As noted, when self-pay patients contract for healthcare, one of the most important terms of the contract, the price, is not included.[291] Self-pay patients, similar to other patients, may receive care either through the ED of the hospital or as nonemergency inpatients or outpatients. Of course, when patients enter the hospital via the ED, they are in no position to read, understand, or negotiate a contract.[292] Moreover, the inability of patients to contract in the ED is not changed one bit by the common and reprehensible practice of hospitals having emergency patients, or the person who brought the patient to the ED, sign an admission or other agreement.[293] Indeed, the patient may not even be conscious.[294] As a result, contracts signed by patients in the ED are not enforceable.[295] Moreover, even in cases that do not involve the ED, the self-pay patient and the hospital do not know, and do not agree to, the specific price the patient will pay for the healthcare the patient is to receive.[296]

As discussed *infra*, hospitals incorrectly argue nonemergency patients

288. *Id.* at 185–86.

289. *See, e.g.*, Lopez v. Safeway Stores, Inc., 129 P.3d 487, 491 (Ariz. Ct. App. 2006) (discussing a hospital seeking a chargemaster price of $59,700 and a patient objecting to the price as too high where the health insurance reimbursement price was $16,837).

290. Nation, *Fair and Reasonable*, *supra* note 41, at 465–67. What all self-pay patients have in common is that the medical care they have received is not covered at all or not completely covered by health insurance.

291. *See* Nation, *Balance Billing*, *supra* note 28, at 175–81.

292. *See supra* notes 3–10 and accompanying text.

293. *See supra* notes 3–10 and accompanying text (discussing the Jean hypothetical in the Sample Admissions Agreement in Appendix A).

294. *See supra* notes 3–10 and accompanying text.

295. *See supra* notes 3–10 and accompanying text.

296. *See* Nation, *Fair and Reasonable*, *supra* note 41, at 465–67.

have agreed—by signing a price ambiguous Admission Agreement, Authorization for Treatment, Statement of Financial Responsibility, or some other similar open ended "agreement" like the one discussed in the Jean hypothetical—to a price formula based on the hospital's chargemaster rates and that this formula can and should be used after the healthcare has been provided to calculate the price the patient is liable to pay. [297] This argument is incorrect and should be rejected by courts.[298]

In the case of patients admitted through the ED, there has been no agreement between the hospital and patient concerning price or anything else.[299] Thus, in both the emergency and nonemergency contexts, there have been no agreements on a specific price. As a result courts are required to set the price self-pay patients owe for the hospital care they have received.[300] When courts attempt to set prices in the context of medical care, they attempt to determine the usual, customary, and reasonable rate for the services provided.[301]

Hospitals use a number of deceitful arguments to convince courts they should apply the hospital's chargemaster rates to determine the usual, customary, and reasonable price. [302] For example, in the case of nonemergency patients, hospitals argue it is not necessary for the court to set the price, something many courts are understandably reluctant to do,[303]

297. *See infra* Part III.C.3. The pricing-formula-agreement argument is based on the following type of language previously discussed in the context of the Jean hypothetical: "I understand that I am responsible for any charges not covered by my insurance company. I understand that I am obligated to pay the account of the Facility in accordance with the regular rates and terms of the Facility." Sample Admissions Agreement, *supra* note 6, at 1. By signing a price-ambiguous Admission Agreement, Authorization for Treatment, Statement of Financial Responsibility, or some other similar open-ended "agreement" discussed previously in the Jean hypothetical, hospitals argue patients agreed to a price formula. As noted above, *regular rates* refers to chargemaster rates. Thus, once treatment has been provided to the patient, the hospital uses the billing codes associated with each good or service provided to the patient to identify the chargemaster price and then totals the charges to arrive at the amount the hospital claims the patient owes. *See supra* notes 3–10 and accompanying text.

298. *See infra* Part III.C.3.

299. *See supra* notes 3–10 and accompanying text.

300. *See infra* Part III.C.3 (discussing price formulas based on chargemaster rates in the nonemergency context).

301. *See* Nation, *Balance Billing*, *supra* note 28, at 178–79.

302. *See infra* notes 312–15.

303. Nation, *Balance Billing*, *supra* note 28, at 176–79 (noting contracts are to be

because the parties have agreed to a pricing formula based on the chargemaster.[304] In the emergency-care context discussed next, the hospital argues its chargemaster prices are usual, customary, and reasonable.[305] In addition, hospitals commonly have their billing manager or other financial officer provide an affidavit or testimony stating, disingenuously, all of the hospital's patients are billed or charged at its chargemaster rates, and further the patient's billed charges, based on its chargemaster rates, represents the usual, customary, and reasonable charges of the hospital.[306] This is very deceiving because hospitals use the word *charges* to confuse courts by implying charges are a proxy for payments. The hospital implies, without ever saying explicitly, its chargemaster rates are actually the rates most of the hospital's patients pay.[307] This of course is completely false. In fact, on average, less than 5 percent of hospital patients ever pay excessive chargemaster rates.[308] Moreover, chargemaster rates are, on average, more than 300 percent of the amount hospitals are actually paid for their goods and services and are about 500 percent of Medicare rates. [309] Thus, chargemaster rates are clearly not reasonable, customary, or usual.

2. *Emergency-Department Patients and Quasi-Contracts*

Under the doctrine of quasi-contract, the law recognizes patients who receive emergency care must pay the provider the fair value of the services received, notwithstanding the fact the patient has not and could not agree to this at the time the services were provided since the patient could not enter into a real contract at that time.[310] The law recognizes there is not a real contract between the parties but gives the provider a right to recover fair value by recognizing a quasi-contract.[311] This doctrine furthers public policy

written by the parties and enforced by the court). Courts are not to write the contract for the parties nor are courts to decide whether the contract is a good or wise one. *Id.* This idea is reflected in the fundamental concept of freedom of contract. *Id.*

304. *Id.* at 185–86.

305. *See supra* Part II.A.

306. Nation, *Fair and Reasonable*, *supra* note 41, at 438.

307. *See supra* notes 70–112 and accompanying text (discussing how hospitals take advantage of the fact that in most industries the price listed for a product is very close to the price usually paid for the product).

308. *See supra* Part II.A.

309. *See supra* Part II.A.

310. *See* PERILLO, *supra* note 9, § 1.8(c) (discussing express, implied, and quasi-contracts).

311. *See id.*

by encouraging healthcare providers to render aid in an emergency by giving them the right to be paid a fair price for the services rendered and ensuring patients are not unjustly enriched by requiring the patient to pay the fair value of the services received.[312] Essentially, this doctrine is based on the reasonable assumption patients would have agreed to pay fair value for the services had they been able to.[313]

As a result of the doctrine of quasi-contract, the hospital's claim for payment should be limited to the reasonable value of the services provided for patients entering a hospital through the ED.[314] Because there has been no agreement on price—or anything else—in the case of a quasi-contract, the court must determine the reasonable value of the healthcare services provided.[315] Thus, it would appear at first glance that the law has adequately protected patients from price gouging, at least in the context of emergency medical care.[316] However, as the TPL cases demonstrate, this is not the case for several reasons.[317]

First, hospitals, even in this context, use the same deceptive arguments discussed above to claim either their chargemaster rates represent the fair value of their services or the patient is liable to pay chargemaster rates based on the price formula contained in the Admissions Agreement signed by or on behalf of the patient.[318] If the court accepts either argument, it winds up in the same place, using chargemaster rates to determine the amount owed by the patient.[319] As noted, to achieve this result, hospitals engage in a linguistic sleight of hand with respect to the words *billed charges* and *paid charges* by implying (without ever explicitly saying) that because every patient's *billed charges* are calculated at chargemaster rates (which

312. *See id.*

313. *See id.*

314. *See id.*; *see also* Nation, *Balance Billing*, *supra* note 28, at 182–84 (discussing quasi-contracts in the context of healthcare).

315. *See, e.g.*, Temple Univ. Hosp., Inc. v. Healthcare Mgmt. Alts., Inc., 832 A.2d 501, 508–11 (Pa. Super. Ct. 2003) (rejecting a hospital's billed charges as a proper measure of reasonable value under the theory of unjust enrichment and instead using the market value based on the amount most patients actually paid for services).

316. *See, e.g.*, *id.* at 507.

317. *See, e.g.*, *id.* at 510.

318. *See supra* notes 311–14 and accompanying text (referring to the ED or quasi-contract context).

319. *See, e.g.*, Roberts v. Univ. of Ala. Hosp., 27 So. 3d 512, 517 (Ala. Civ. App. 2008) (holding the full chargemaster rate represented the reasonable value).

incorrectly implies these are the charges most patients *pay* and billed charges are the same as paid charges), then billed charges based on chargemaster rates must represent the fair value of medical services.[320] Of course, as discussed above, nothing could be further from the truth. The claim that all patients' billed charges are calculated at chargemaster rates, while formalistically correct, is in fact substantively false.[321] As discussed, the truth is that even though all patients are charged or billed at chargemaster rates, very few patients are even expected to pay them and even fewer actually do pay them.[322]

Another problem occurs when courts apply older cases that held reasonable value in the case of healthcare should be determined by the usual, customary, and reasonable charges of healthcare providers in the area where the services were rendered.[323] Historically this may have been a reasonable approach, but today significant changes have occurred with respect to healthcare billing and payment, resulting in chargemasters that contain grossly excessive rates.[324] Thus, courts must be made to understand that, notwithstanding precedent, this is no longer an appropriate method for determining reasonable value. Today, fair and reasonable value must be determined based on usual, customary, and reasonable paid charges and not

320. *Id.* ("The trial court's determination, based upon the evidence adduced at trial that the hospital had billed the [patient] only for services that were medically necessary and that the unenhanced [the hospital estimated at 15 percent of its billed charges represented expenses unpaid by government insurers; the court reduced the billed charges by 15 percent] charges for those services had been determined by reference to a uniform, industry-standard pricing list that is updated annually [the chargemaster], was consistent with Alabama precedents indicating that evidence from hospital personnel concerning the reasonableness of treatment rendered and charges billed to patients [testimony of hospital administrators] is competent to demonstrate 'reasonable charges' to which a hospital lien . . . will extend."); Parnell v. Madonna Rehab. Hosp., Inc., 602 N.W.2d 461, 464 (Neb. 1999). The court noted the lien statute "plainly states that a lien attaches to 'the usual and customary *charges*' of the service provider. However, [patient's] interpretation would require that the amounts actually collected by a [medical] service provider be considered instead of the amount charged. Such an interpretation is contrary to the plain language of the statute." *Parnell*, 602 N.W.2d at 464 (emphasis in original).

321. *See supra* notes 84–87 and accompanying text.

322. *See supra* Part II.A.

323. *See, e.g.*, *Ex parte* Univ. of S. Ala., 761 So. 2d 240, 244 (Ala. 1999) (citing J. F. Rydstrom, Annotation, *Construction, Operation, and Effect of Statute Giving Hospital Lien Against Recovery from Tortfeasor Causing Patient's Injuries*, 25 A.L.R.3d 858 § 5(b) (1969)).

324. *See supra* Part II.A.

on usual, customary, and reasonable billed charges.[325]

3. *Nonemergency Patients and Real Contracts*

Outside of the emergency context, patients and hospitals can enter into real contracts.[326] It is possible for them to negotiate a free and knowing agreement with respect to which the hospital will provide services to the patient, and the patient will pay the price agreed to in the contract. However, in practice, as discussed elsewhere, one of the unique characteristics of the sale of healthcare directly to self-pay patients (even outside of the ED context) is that the patient and the hospital do not agree on the specific price that will be paid for the healthcare provided.[327] Specifically, nonemergency patients, just like emergency patients like Jean in the opening hypothetical, usually sign a price-ambiguous Admission Agreement, Authorization for Treatment, Statement of Financial Responsibility, or a similarly open-ended agreement that, with respect to price, provides that the patient agrees to pay for all medical goods and services provided by the hospital at the hospital's "regular rates," "list," or "chargemaster" prices.[328]

325. *See supra* Part II.A.

326. *See* Nation, *Fair and Reasonable*, *supra* note 41, at 426.

327. Nation, *Balance Billing*, *supra* note 28, at 168–69 (noting 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).

328. *Id.* at 185–86 (noting the argument made by hospitals that the parties have established a formula to arrive at the ultimate price the patient will pay for the services provided based on the hospital's chargemaster is incorrect because the chargemaster-based formula is illusory; all aspects of it remain completely within the control of the hospital). "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. 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." *Id.* at 178–79. In the hypothetical case of Jean, as discussed in the introduction to this Article, the following two sentences were included in the multi-page admissions agreement that she signed in the emergency department: "I understand that I am responsible for any charges not covered by my insurance company. I understand that I am obligated to pay the account of the Facility in accordance with the regular rates and terms of the Facility." *See supra* notes 41–42 and accompanying text. Hospitals routinely include language similar to this in their so-called Admissions Agreement. Hospitals argue the phrase "in accordance with the regular rates and terms of the facility" allows the hospital to use its chargemaster-based rates to calculate the amount the patient owes, and because of the quoted language, the patient has agreed to this. *See supra* notes 41–42 and accompanying text.

However, clearly the hospital and the patient have not really agreed upon a price.[329] The supposed chargemaster-based formula is illusory; all aspects of it remain completely within the sole control of the hospital.[330] In fact, there is no way for the patient to even know what the chargemaster prices were at the time the patient signed the Admissions Agreement and whether those prices were actually used to calculate the charges on the patient's bill.[331] Specifically, hospitals can change their chargemaster prices at any time, and they often do not keep a record of past chargemaster prices.[332] Practically speaking, this means the hospital can charge the patient any amount it wishes. As one court has quite correctly observed, if courts were to interpret these supposed "agreements" according to their terms, it would have the same effect as if the patient had agreed to pay for the care received by giving the hospital a blank check and authorizing the hospital to fill in any amount it wishes.[333] This is why no sane person, properly informed, would ever freely agree to the terms of an admissions or other agreement that required the patient to pay for care at the hospital's chargemaster rates. This is also why no court should accept any hospital's argument that the patient has agreed to a pricing formula based on the hospitals chargemaster prices. Any agreement to pay chargemaster rates is blatantly and grossly unfair, and the only reasons patients sign such agreements are because they are faced with an emergency and would sign anything or because they are not properly informed regarding the meaning of what they are signing.[334]

In summary, the missing specific price in hospital contracts with self-pay patients raises two important questions. First, does the missing specific price render the agreement too indefinite and uncertain to create a legally enforceable agreement—a contract?[335] If the court reaches this conclusion, and medical services have been provided to the patient, then the court will use the quasi-contract doctrine to prevent an unjust enrichment to the

329. *See* Nation, *Balance Billing*, *supra* note 28, at 185.

330. *Id.*

331. *Id.*

332. *Id.*

333. *See* Cape Reg'l Med. Ctr. v. Sanchez, No. CPM DC 109-11, slip op. at 9 (N.J. Super. Ct. Law Div. Mar. 26, 2012) (on file with author).

334. *See supra* notes 1–10 and accompanying text. Even if a court accepts the price formula argument, it will not be able to enforce an obligation of the patient to pay chargemaster prices because to do so would be a violation of the hospital's obligation to enforce the contract in good faith. *See* Nation, *Balance Billing*, *supra* note 28, at 184–85.

335. *See* Nation, *Balance Billing*, *supra* note 28, at 179–86.

plaintiff.[336] Under this scenario the hospital would have a right to recover only the fair and reasonable value of the medical care provided.

Second, if the court concludes that a real contract has been entered into between the parties, should it be treated as one with a missing price term or should the court accept the price-formula argument? As discussed above, courts should reject the price-formula argument and treat the contract as one with a missing price term.[337] If the court decides a real contract, albeit one with a missing price term, has been created, then the court must provide the price by determining the usual, customary, fair, and reasonable price.[338]

Thus, in both the ED and the non-ED context, the law arrives at the same conclusion: patients should only be obligated to pay the usual, customary, fair, and reasonable value of the medical care they have received.[339] Thus, once again the real solution to the problem of hospital price gouging is to educate courts and legislatures about modern healthcare pricing, billing, and payment practices.[340] Specifically, the most important information to provide to courts and legislatures is that paid charges, and not billed charges, represent usual, customary, fair, and reasonable healthcare prices.[341]

4. *Hospital and Healthcare Liens*

The hospital lien statutes of some states also create a similar charges/payments problem because of the wording used in the statutes.[342] For example, the Nebraska hospital lien statute provides that a lien attaches to "the usual and customary *charges*" of the service provider.[343] This

336. *See supra* Part III.C.2.

337. *See supra* note 329 and accompanying text.

338. *See supra* Part III.C.3.

339. *See supra* note 314 and accompanying text.

340. *See supra* note 316 and accompanying text.

341. *See supra* note 316 and accompanying text.

342. *See, e.g.*, Parnell v. Madonna Rehab. Hosp., Inc., 602 N.W.2d 461, 464 (Neb. 1999). The court noted the lien statute plainly states a lien attaches to "the usual and customary *charges*' of the service provider. However, [patient's] interpretation would require that the amounts actually collected by a [medical] service provider be considered instead of the amount charged. Such an interpretation is contrary to the plain language of the statute." *Id.*

343. *Id.*; *see also* TEX. PROP. CODE ANN. § 55.004(b) (West 2018) (providing the lien is for the amount of "the hospital's charges for services provided to the injured

wording, especially the word *charges*, has allowed hospitals in Nebraska to argue, incorrectly, that they are entitled to a lien in an amount based on their billed charges (i.e. chargemaster rates) because the legislature's use of the word *charges* indicates their intent to set the lien amount in reference to usual and customary billed charges, rather than in reference to usual and customary payments received for the services provided (i.e. paid charges).[344] Again, the solution to this problem is for courts and legislatures to draft and interpret hospital lien statutes so they provide for liens in an amount that is no greater than the usual, customary, and reasonable paid charges the hospital receives for the services provided.

5. *Specific Contract-Law Protections for TPL Patients*

In certain cases involving TPL patients, specific contract-law arguments can be used to prevent hospitals from price gouging.[345] For example, a number of courts have held if there is no debt owed by the patient to the hospital, then there can be no hospital lien.[346] As a result, if the hospital submits an in-network patient's bill to the patient's health insurer and the health insurer pays the discounted contract amount owed, then the debt of the patient has been extinguished, and the hospital may not use a hospital lien to collect its chargemaster-based billed charges.[347] As discussed *supra* this is also the case with government insured TPL patients.[348] For example, if Medicare covers a TPL patient and the hospital submits the bill to Medicare, then when Medicare pays the claim at Medicare rates (on average about one-fifth of the chargemaster rate) the patient's debt to the hospital is discharged, and no hospital lien can be enforced.[349] Moreover, some courts have expanded the no-debt/no-lien concept to include all patients covered by in-network insurance regardless of whether the hospital filed a claim with the patient's health insurer.[350] These courts conclude that

individual").

344. *See, e.g.*, *Parnell*, 602 N.W.2d at 464.

345. For an excellent discussion of the various legal theories that that can be used to protect patients from hospital price gouging in the TPL context, see generally Beard & Marsh, *supra* note 18.

346. *Id.* at 263–64.

347. *Id.*

348. *See supra* notes 207–11 and accompanying text.

349. *See* Beard & Marsh, *supra* note 18, at 267–70.

350. *Id.* at 279 ("In fact, some courts have suggested that the amount that the hospital would accept from an insurer or governmental payer is the defacto reasonable charge incurred.").

no lien can exist when an agreement for payment exists between the provider and the patient's insurer.[351]

In addition, if a TPL patient is covered by a commercial insurer that is in-network with the hospital, it is very important to thoroughly examine the contract between the insurer and the hospital to see if it contains language requiring the hospital to submit its bills to the health insurer or if it contains a hold-harmless provision (common in HMO contracts) protecting the patient from liability.[352] If these provisions or similar ones are included in the hospital-insurer contract, then the patient can use the theory of intended third-party beneficiary to enforce these contract provisions against the hospital.[353] In addition, a TPL patient may be able to use the contract doctrine of mitigation of damages to prevent the hospital from recovering damages it caused to itself by failing to submit its claim to the patient's health insurance in a timely manner.[354]

While the above discussion may be of great practical value to TPL patients and their attorneys involved in litigation with price-gouging hospitals, none of the legal theories discussed above can completely prevent hospital price gouging in the TPL context. Even if courts were to uniformly apply the theories discussed above—even though courts do not uniformly accept these theories—at best only insured patients would be protected. There would still be no solution for uninsured patients.[355] Moreover, some of these theories, while they reach the proper result, are unduly complicated. For example, it is clear a patient who receives medical treatment is obligated (owes a debt) to the provider for the services provided.[356] In other words, the real issue is not whether there is a debt, the real issue is the amount of the

351. *Id.* at 263 n.38 (citing cases).

352. *Id.* at 263–67.

353. *Id.*

354. *See* PERILLO, *supra* note 9, § 14.15 (discussing how the law does not permit a party to a contract to recover from the breacher the damages which he should have foreseen and could have avoided by reasonable effort without undue risk, expense, or humiliation).

355. Beard & Marsh, *supra* note 18, at 274 (noting when courts refuse to look at the amounts actually paid to hospitals to determine reasonableness, they prevent uninsured patients from presenting sufficient evidence to dispute a provider's claim that its chargemaster rates are reasonable).

356. Even if an unconscious patient is treated, the law recognizes an obligation to pay under the theory of quasi-contract discussed previously in Part III.C.2.

debt owed.[357] In the case of insured patients, the hospital has agreed in the contract/provider agreement with the patient's insurer to accept a specific amount for treating the patient.[358] The hospital is entitled to no more. In the case of uninsured patients, the hospital is entitled to its usual, customary, and reasonable paid charges and no more.[359] Recognition of these basic facts would provide a simple and straightforward solution to the hospital price-gouging problem not only in the TPL context, but in other self-pay contexts as well.

IV. CONCLUSION

Today, the market for healthcare in the United States is huge, complex, and dominated by large healthcare systems, government insurers, and commercial insurers. However, there are still many instances where individual patients are required to pay directly to hospitals and other providers for the healthcare they receive.[360] These self-pay patients are the focus of this Article. In the case of insured TPL patients, hospitals in particular work very hard to make sure these patients become self-pay patients by refusing to bill the patient's insurer in order to be able to recoup the hospital's grossly excessive chargemaster rates from the liable third party.[361]

Self-pay patients, unlike large insurers, have very little if any bargaining power when entering into transactions with hospitals or other providers. As a result, hospitals and other providers largely dictate the terms of any agreement signed by self-pay patients. Many of these purported agreements are unenforceable as contracts because the patient did not knowingly and freely enter into the agreement, either because it was signed in an emergency situation or because no specific price was included.[362] Most hospital-written, form agreements signed by patients contain price ambiguity and illusory payment formulas tied to the hospital's chargemaster.[363] As a result, courts and legislatures should recognize they are required to set the price most self-pay patients must pay for the

357. *See supra* Part III.C.2.
358. *See supra* Part II.A.
359. *See supra* Part II.A.
360. *See supra* Part II.A.
361. *See supra* Part II.A.
362. *See supra* Parts III.C.1–3.
363. *See supra* Parts II.C.1–3.

healthcare they receive.[364]

In setting the price for self-pay patients, courts and legislators must understand healthcare pricing and billing is unique, and as a result the proper price—the usual, customary, reasonable, just, and fair-market-value price—must be based on payments and not on charges.[365] That is, the fair and reasonable price of healthcare is the usual and customary price paid by or on behalf of patients and not the usual and customary amount of charges billed to or on behalf of the patients.[366] Once courts and legislatures understand the complexities of healthcare pricing in billing, they will then understand why, in the case of healthcare, they must focus on paid charges and not on billed charges.

It is important to note that even the universal recognition by courts and legislatures of the fact that paid charges (rather than billed charges) are relevant to determining the fair and reasonable price of healthcare would not and should not stop hospitals from setting prices at any level they choose, but it would stop hospital price gouging of vulnerable self-pay patients.[367] In setting list prices, hospitals and other providers should be treated just like the seller of any other good or service. Specifically, all hospitals and other providers would continue to be free to set their chargemaster rates at any level they wish, but those charges would only be relevant to a court or legislature when trying to set a fair and reasonable price for healthcare if those charges were knowingly and freely accepted by the marketplace.[368] Again, this is simply treating hospitals and other providers just like sellers of any other good or service.

Now, for the reasons discussed in this Article, hospitals enjoy an unfair advantage: they may unilaterally set their prices at excessive levels and can unilaterally impose them on self-pay patients.[369] This is something sellers of other goods and services do not have the right to do.[370] Hospitals unilaterally set their charges at grossly excessive levels that the market rejects, and thus the vast majority of patients do not pay, which is why these exorbitant

364. *See supra* Parts II.B.1–3.
365. *See supra* Part II.A.
366. *See supra* Part III.A.
367. *See supra* Part III.A.
368. *See supra* Part III.A.
369. *See* Nation, *Chargemaster Insanity*, *supra* note 12, at 750–51.
370. *See* Nation, *Fair and Reasonable*, *supra* note 41, at 447.

chargemaster-based rates are not a proper measure of the price anyone should pay for healthcare.[371] But, because of the complexities involved in healthcare billing and payment systems and the confusion they cause, hospitals are permitted to enforce these excessive and market-rejected rates against self-pay patients, and even worse, in the TPL situation, hospitals may use (misuse) the force of a government-granted lien to enforce these unilaterally set excessive charges.[372]

Once courts and legislatures begin to base a reasonable healthcare prices on actual payments and not on billed charges, this unfair advantage will cease. As a result, hospitals will no longer have an incentive to maintain chargemasters that contain ridiculously excessive prices, and the tyranny of the pernicious chargemaster-based pricing system will come to an end. Until then self-pay patients will continue to suffer, and the tyranny of the current chargemaster pricing system will continue to unnecessarily push healthcare prices in the United States ever higher.

V. APPENDIX A: INPATIENT/OUTPATIENT CONDITIONS OF ADMISSION AND CONSENT TO MEDICAL TREATMENT

The text of a sample admissions agreement reads as follows:

1. ASSIGNMENT OF INSURANCE BENEFITS / PROMISE TO PAY:
   I hereby assign and authorize payment directly to the Facility, and to any facility-based physician, all insurance benefits, sick benefits, injury benefits due because of liability of a third-party, or proceeds of all claims resulting from the liability of a third-party, payable by any party, organization, et cetera, to or for the patient unless the account for this Facility, outpatient visit or series of outpatient visits is paid in full upon discharge or upon completion of the outpatient series. If eligible for Medicare, I request Medicare services and benefits. I further agree that this assignment will not be withdrawn or voided at any time until the account is paid in full. I understand that I am responsible for any charges not covered by my insurance company.

   I understand that I am obligated to pay the account of the Facility in accordance with the regular rates and terms of the Facility. If I fail to make payment when due and the account becomes delinquent or is turned over to a collection agency or an attorney for a collection, I agree to pay all collection agency fees, court costs and attorney's fees. I also agree that any patient or guarantor overpayments on the above Facility visit may be applied directly to any delinquent account for which I or my guarantor is legally responsible at the time of the collection of the

371. *See* Nation, *Chargemaster Insanity*, *supra* note 12, at 755–56.
372. *See supra* Parts I, II.A.

overpayment. I consent for the Facility to appeal on my behalf any denial for reimbursement, coverage, or payment for services or care provided to me.

2. NURSING CARE:
The Facility provides only routine nursing care. Private duty nursing is not provided but may be arranged directly between an agency and me at my expense. The Facility is hereby released from any and all liability arising from the fact that I am not provided private duty care by the facility.

3. EMTALA:
The Facility is obligated to treat medical emergencies regardless of my ability to pay. Therefore, if I or my guarantor have a medical emergency or if I am a pregnant woman in labor, I have the right to receive, within the capabilities of this Hospital's staff and facilities, an appropriate medical screening examination, necessary stabilizing treatment, and, if medically necessary, an appropriate transfer to another hospital, even if I cannot pay or do not have medical insurance or am not eligible to receive Medicare or Medicaid.

4. PRIVATE ROOM DIFFERENCE [Inpatient]:
I agree and understand that if I request and receive a private room, I am responsible for the difference between the entire room rate and the semi private room rate.

5. PERSONAL VALUABLES:
I understand that the Facility maintains a safe for the safekeeping of money and valuables, and the Facility shall not be liable for the loss or damage to any articles of personal property unless said articles are deposited with the Facility in the safe and receipts are issued describing said items. At no time shall the Facility be responsible for more than $500 for said deposited items.

6. WEAPON / EXPLOSIVES / DRUGS:
I understand and agree that if the Facility at any time believes there may be a weapon, explosive device, biohazard material, any type of illegal substance or drug, or any alcoholic beverage in my room or with my belongings, the Facility may search my room and belongings, confiscate any of the above items that are found, and dispose of them as it determines appropriate, including delivery of any item to law enforcement authorities.

7. NOTICE OF PRIVACY PRACTICES:
Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I have received a copy of the Facility's Notice of Privacy Practices. I hereby consent to the use and disclosure of my protected health information as described in the Notice of Privacy Practices. This will include all of my protected health information generated during hospitalization and outpatient treatment at the Facility, including but not limited to treatment for mental health, drug and alcohol abuse, communicable diseases such as HIV/AIDS,

developmental disabilities, genetic testing, and other types of treatment received.

8. GENERAL CONSENT FOR TESTS, TREATMENT, PHOTO, VIDEO, AND SERVICES:
I hereby voluntarily consent for treatment / admission to the Facility. I permit the Facility and its employees, physicians, fellows, residents, interns, and others involved in my care to treat me in ways they judge to be beneficial to me. I understand that I have the right to ask questions and to receive information about my care and treatment, and the right to withdraw my consent for treatment or tests.

I consent to examinations, blood tests (including blood tests for communicable diseases such as hepatitis and HIV/AIDS when healthcare personnel have been exposed to my blood and/or body fluids), laboratory and imaging procedures, medications, infusions, nursing care and other services or treatments rendered by my physician, consulting physicians, fellows, residents, interns, and their associates and assistants, or rendered by Facility personnel under the instructions, orders or direction of such physician(s), fellow(s), resident(s), or intern(s).

I agree and understand that all physicians (including fellows, residents, and interns), dentists, oral surgeons, and podiatrists involved in my care in anyway are responsible and liable for their own acts and omissions, and the Facility is not responsible or liable for the acts or omissions of the aforementioned. Services may be performed by independent contractors who are not employed by the Facility. I am aware that the practice of medicine is not an exact science and further understand that no guarantee has been or can be made as to the results of the treatments, care or examinations in the Facility.

I have been informed of the treatment procedures considered necessary for me and that the treatments/procedures will be directed by a physician and may be performed by such physician and/or one or more additional physicians, fellows, residents, interns, and employees of the Facility. I understand that one or more physicians, fellows, residents, and/or interns at the Facility may treat me or participate in my treatment. I understand that no guarantee or assurance has been made regarding (1) which physicians and/or fellows, residents, or interns will treat me or participate in my treatment and/or (2) the results that may be obtained from treatment.

I consent to the photographing or videotaping, including appropriate portions of my body, for medical and medical record documentation purposes, provided said photographs or videotapes are maintained and released in accordance with protected health information regulations.

9. ADVANCE DIRECTIVE ACKNOWLEDGEMENT:
Federal law requires that patients be provided information about their rights to make advance health care decisions, including a Living Will, Durable Medical Power of Attorney or designation of a surrogate decision maker for healthcare decisions. If you have already completed any of these documents, please inform

your physician and the Facility. **Please check one:**

__ I have executed an advance directive and have supplied a copy to the Facility.
__ I have executed an advance directive and have been requested to supply a copy to the Facility.
__ I have reviewed the directive(s) on file with this Facility and it is / they are my current directive(s).
__ I have not executed an advance directive. I have received information about advance directives from this Facility.
__ I have not executed an advance directive. I have requested advance directive information from this Facility.
__ I have not executed any advance directives, and I do not wish to receive information about advance directives form this Facility.

10. RESEARCH STUDIES: **Please check one:**
__ No __Yes Are you currently a participant in any research study or project: *If yes, please briefly describe what is being studied (drug, medical device or other)*
_____
Who can the Facility contact with questions about the study? _____

11. SMOKING CESSATION INFORMATION:
__ Upon admission, I received the Smoking Cessation Information Packet, which includes information on: health risks associated with smoking, community resources for smoking cessation programs and health risks associated with second hand smoke. If I have further interest in smoking cessation programs and education, I will request informing form the facility staff or my physician.

12. EMAIL:
__ Yes __No I hereby consent to provide my e-mail address, so that representatives from the Facility can e-mail information to me about health education or disease prevention and up-to-date information about the Facility, its affiliated physicians, and our services. I understand I will be able to change my preference at any time.

13. IMAGING SERVICES:
__ Please check this box to allow the facility's Imaging Services to share your images with affiliated facilities, when requested, for continuing medical treatment.

14. CELL PHONES:
__ Yes __No I hereby consent to provide my telephone number(s), including my wireless telephone number(s) so that representatives from the facility, its successors or assigns can contact me in any manner including but not limited to by manually placing a call, by using an automatic telephone dialing system or an artificial or prerecorded voice, by texting, or by emailing, regarding any matter, including but not limited to my medical treatment, prescriptions, insurance eligibility, insurance coverage, scheduling, billing or collection matters. This

consent includes any updated or additional contact information that I may provide. I understand that I will be able to change my preference at any time.

The undersigned certifies that s/he has read the foregoing, understands it, accepts its terms, has received a copy of it and is the patient or is duly authorized by the patient as their agent to execute the above.

<table>
<tr><td colspan="4">Patient's Signature or Legal Representative</td><td>Date</td><td>Time</td></tr>
<tr><td colspan="3">Relationship to Patient</td><td>Interpreter, if Utilized</td><td>Date</td><td>Time</td></tr>
<tr><td>Witness Signature</td><td>Date</td><td>Time</td><td>If Telephone Consent, Second Witness Signature</td><td>Date</td><td>Time</td></tr>
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