Volume 61 | Issue 1 Article 4

4-1-2016

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2016]

HEALTHCARE AND THE BALANCE-BILLING PROBLEM: THE SOLUTION IS THE COMMON LAW OF CONTRACTS AND STRENGTHENING THE FREE MARKET FOR HEALTHCARE

George A. Nation III*

Introduction

COURTS across the country are beginning to understand that hospital bills based on list or chargemaster prices are exorbitant and unfair, because they reflect prices that are set to be discounted and not paid.[1] As

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1. *See, e.g.*, Howell v. Hamilton Meats & Provisions, Inc., 257 P.3d 1130, 1137 (Cal. 2011) (citing Melone v. Sierra Ry., Co, 91 P. 522, 523 (Cal. 1907)) (explaining medical expenses actually paid by or on behalf of patient, not billed charges based on chargemaster rates, is proper measure of medical expenses); Greenfield v. Manor Care, Inc., 705 So. 2d 926, 930–31 (Fla. Dist. Ct. App. 1997) (holding healthcare agreement to have implied covenant to charge reasonable fee), *receded from by* Beverly Enters.-Fla., Inc. v. Knowles, 766 So. 2d 335 (Fla. Dist. Ct. App. 2000); 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.'"); 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 hospital were reasonable); Butler v. Ind. Dep't of Ins., 904 N.E.2d 198, 202 (Ind. 2009) (explaining medical expenses actually paid by or on behalf of patient, not billed charges based on chargemaster rates, is proper measure of medical expenses); *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., 292 A.D.2d 797, 798–99 (N.Y. 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. P.C. v. Chin, 924 N.Y.S.2d 252, 255 (N.Y. Dist. Ct. 2011) (agreeing reasonable value of medical services is average amount that provider would have accepted as full payment from third-party payers such as private insurers and federal healthcare programs (citing Temple Univ. Hosp., Inc. v. Healthcare Mgmt. Alternatives, Inc., 832 A.2d 501, 510 (Pa. Super. Ct. 2003))); Moorhead v. Crozer Chester Med. Ctr., 765 A.2d 786, 789 (Pa. 2001) (holding patient's recovery for medical expenses in malpractice suit was limited to amount paid and accepted for services, rather than fair and reasonable market value of services), *abrogated by* Northbrook Life Ins. Co. v. Commonwealth, 949 A.2d 333, 337 (Pa. 2008); Hosp. Inc. v. Healthcare Mgmt. Alts., Inc., 832 A.2d 501, 510 (Pa. Super. Ct. 2003) (chargemaster rate "bears no relationship to the amount typically paid for those services"); Doe v. HCA Health Servs., Inc., 46 S.W.3d 191, 198–99 (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, is proper measure of medical expenses); Daughters of Charity Health Servs. v. Linnstaedter, 226 S.W.3d 409, 411 (Tex. 2007) (finding chargemaster prices are *not* value of medical services in context of hospital lien statute); *cf.* Holland v. Trinity Health Care Corp., 791 N.W.2d 724, 728 (Mich. Ct. App. 2010) (finding chargemaster rates are usual and customary).

a result, courts are becoming aware of the fact that the list prices or chargemaster rates that hospitals claim are usual and customary are instead exorbitant amounts, arbitrarily set by hospitals, as a starting point for negotiating huge discounts with insurers.[2] Much attention has been focused by commentators on the ironic unfairness of the fact that uninsured patients—that is, those least likely to be able to afford to pay for healthcare even at a reasonable price—are often expected to pay these exorbitant rates in full.[3] However, while this attention is certainly well-deserved, focusing only on the uninsured misses the fact that it is not just the uninsured that are burdened by obscenely high chargemaster rates.

A large and growing group of insured patients is also being unfairly burdened by hospitals' exorbitant chargemaster prices.[4] The burden is brought to bear on these patients through a process known as balance billing.[5] When a patient's insurance company has not negotiated a con-

2. *See, e.g.*, Stanley v. Walker, 906 N.E. 2d 852, 857 (Ind. 2009) ("Thus, based on the realities of health care finance, we are unconvinced that the reasonable value of medical services is necessarily represented by either the amount actually paid or the amount stated in the original medical bill."); Cape Reg'l Med. Ctr. v. Sanchez, No. CPM DC 109-11, at *9 (N.J. Super. Ct. Law Div. Mar. 26, 2012) (noting that most patients, upon entering hospital, sign "Authorization for Treatment," "Statement of Financial Responsibility," or another similarly open-ended agreement pursuant to which patient purports to agree to pay for all medical goods and services provided by hospital at hospital's list (chargemaster) prices; in reality, however, this type of agreement amounts to blank check given by patients to hospitals with amounts to be unilaterally filled in by hospitals later). However, not all courts have yet come to this realization, especially in balance-billing context. *See, e.g.*, Allen v. Clarian Health Partners, Inc., 980 N.E.2d 306, 310–11 (Ind. 2012) (rejecting central premise of this Article that hospitals' chargemaster rates should *not* be used as basis for pricing on contracts for healthcare services).

3. *See, e.g.*, Gerard F. Anderson, *From 'Soak the Rich' to 'Soak the Poor': Recent Trends in Hospital Pricing*, 26 HEALTH AFF. 780 (2007) (stating hospitals often bill uninsured patients full list charges); George A. Nation III, *Obscene Contracts: The Doctrine of Unconscionability and Hospital Billing of the Uninsured*, 94 KY. L.J. 101, 101–05 (2005) [hereinafter Nation, *Obscene Contracts*]; Uwe E. Reinhardt, *The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy*, 25 HEALTH AFF. 57, 58 (2006) [hereinafter Reinhardt, *U.S. Hospital Services*] (explaining that self-payers usually forced to accept full charges set by hospital); Christopher P. Tompkins, Stuart H. Altman & Efrat Eilat, *The Precarious Pricing System for Hospital Services*, 25 HEALTH AFF. 45, 52 (2006) (same); Lucette Lagnado, *Anatomy of a Hospital Bill*, WALL ST. J., Sept. 21, 2004, http://www.wsj.com/articles/SB109571706550822844 [https://perma.cc/9Q6V-FTZS]; *cf.* Glenn A. Melnick & Katya Fonkych, *Hospital Pricing and the Uninsured: Do the Uninsured Pay Higher Prices?*, 27 HEALTH AFF. 116 (2008) (asserting that uninsured pay more than some but less than others).

4. *See generally* Melnick & Fonkych, *supra* note 3 (observing that insured individuals suffer from chargemaster rates).

5. *See, e.g.*, Uwe E. Reinhardt, *The Many Different Prices Paid to Providers and the Flawed Theory of Cost Shifting: Is It Time for a More Rational All-Payer System?*, 30 HEALTH AFF. 2125 (2011) (discussing high prices faced by insured patients who receive care outside of their insurers network); Steven Brill, *Bitter Pill: Why Medical Bills Are Killing Us*, TIME, Mar. 4, 2013, *available at* http://www.claims.org/pdf/time_article.pdf [https://perma.cc/DE7X-HWD7] (discussing outrageous bills imposed on *insured* patients who receive care from providers who are outside of patient's insurance network); Caroline Chen, *Surprise Medical Bills Lead to Protection*

tract with the hospital that provides services to the patient, the patient is considered out of network—"OON," in hospital speak—and as a result, the discounts that the hospital has negotiated with other insurers do not apply to the OON patient.[6] The patient's insurer pays the hospital the amount that the insurance company is obligated to pay for the services received, but this amount, being reasonable, is always far less than the unreasonably high list price set by the hospital.[7] Because the OON patient's insurer has no contract with the hospital, the hospital is not obligated to accept the payment from the insurance company as full payment, and therefore the hospital is permitted to bill the patient for the balance that is the difference between the obscenely high hospital list price and the reasonable amount that the insurance company paid. Moreover, for a variety of reasons, hospital networks are becoming narrower as hospital systems contract with fewer insurers, and as a result, more and more patients are receiving balance bills.[8]

In addition, not only do the price and collection limitations included in the Affordable Care Act (ACA or Act)—Obamacare—not prevent balance billing, the Act allows for the sale of narrow network health insurance, enshrines exorbitantly high chargemaster rates, and encourages balance billing.[9] Finally, the practice of balance billing puts upward pressure on healthcare prices in general.[10] That is, this practice leads to

Laws: Health, BLOOMBERG (Apr. 4, 2014), http://www.bloomberg.com/news/articles/2014-04-04/surprise-medical-bills-lead-to-protection-laws-health [https://perma.cc/QTG5-5ZJU] ("It's important to protect the consumer now [since the passage of the Affordable Care Act], because there's a little more chaos in the system and a lot more people, [and] balance-billing is the most-common payment problem seen at her nonprofit advocacy organization, which handled 65,000 healthcare cases last year." (quoting Elisabeth Benjamin, Vice President of Health Initiatives, Cmty. Serv. Soc'y of N.Y.) (internal quotation marks omitted)). *See generally* JACK HOADLEY, KEVIN LUCIA & SONYA SCHWARTZ, CAL. HEALTHCARE FOUND., UNEXPECTED CHARGES: WHAT STATES ARE DOING ABOUT BALANCE BILLING (2009), *available at*, http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20U/PDF%20UnexpectedChargesStatesAndBalanceBilling.pdf [https://perma.cc/5Z7G-KG55].

6. *See* HOADLEY ET AL., *supra* note 5, at 3–5.

7. *See, e.g.*, George A. Nation III, *Determining the Fair and Reasonable Value of Medical Services: The Affordable Care Act, Government Insurers, Private Insurers and Uninsured Patients*, 65 BAYLOR L. REV. 425, 434–35 (2013) [hereinafter Nation, *Determining Fair and Reasonable Value*] (providing actual hospital pricing for hypothetical gall bladder surgery that would have list price of $14,000; $5,600 price for HMOs; price of $4,700 for Blue Cross/Blue Shield; price of $5,000 for Aetna; price of $2,590 for Medicare; and $1,260 for Medicaid—for same exact services).

8. *See, e.g.*, Reed Abelson, *More Insured, but the Choices Are Narrowing*, N.Y. TIMES, May 12, 2014, http://www.nytimes.com/2014/05/13/business/more-insured-but-the-choices-are-narrowing.html?_r=0 [https://perma.cc/F4BS-SH8A] (noting that because many health insurance policies sold on Affordable Care Act (ACA) exchanges use narrow networks, out-of-network care and balance-billing are becoming more frequent).

9. *See infra* notes 24–83 and accompanying text.

10. *See* Ge Bai & Gerard F. Anderson, *Extreme Markup: The Fifty US Hospitals with the Highest Charge-to-Cost Ratios*, 34 HEALTH AFF. 922, 925 (2015) (noting that

higher prices across the board for the uninsured, the out-of-network insured, and even the in-network insured.[11]

I have written about the balance-billing problem in other work and have suggested there the adoption of government regulations directed at hospitals that would both address the balance-billing problem and improve the functioning of the free market for healthcare by providing price transparency.[12] A few states have attempted to address this problem legislatively with mixed success.[13] The focus of this Article is on the practice of balance billing, what courts can do now under existing law to address this problem, and the type of legislation that will provide a long-term solution to the broader problem of market failure regarding the sale of healthcare. This Article argues that more government price-fixing is not the solution. The primary goal of healthcare policy in the United States should not be to increase access and control the price of healthcare; rather, it should be to develop the best healthcare in the world at the lowest price.[14] The only

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high markups [chargemaster rates] may add to private insurance premiums and play role in rise of overall healthcare spending); 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/ [https://perma.cc/JWC4-XDLE]. Murray states as follows:

> Charges Do Matter—They Matter a Great Deal.
>
> Counter to the belief of both hospital industry representatives and many of my colleagues, hospital charge levels and rapidly escalating charges matter a great deal. While individual states and the Affordable Care Act (ACA) have instituted limits on the amounts low-income uninsured patients pay hospitals, insured patients that receive care at hospitals that are "Non-Par" or "out-of-network" are still victims of hospital's exorbitant charging practices. When patients receive emergency services at an out-of-network hospital, the patient and/or insurance company (depending on insurer cost sharing for out-of-network care) pay full charges.
>
> High and increasing hospital charges, combined with increasing proportions of cases admitted through the hospital Emergency Department (ED), are major factors behind the ever-declining negotiating leverage of private health insurers. This situation, coupled with the increased pricing power of the ever-more-concentrated provider industry, will be a major contributor to the almost certain rapid escalation in total U.S. health care costs in coming years.

Id.

11. *See supra* note 10 and accompanying text.

12. *See generally*, George A. Nation III, *Hospital Chargemaster Insanity: Heeling the Healers*, 43 PEPP. L. REV. (forthcoming 2016) [hereinafter Nation, *Chargemaster Insanity*]; Nation, *Determining Fair and Reasonable Value*, *supra* note 7; Nation, *Obscene Contracts*, *supra* note 3.

13. *See, e.g.*, HOADLEY ET AL., *supra* note 5, at 6–9. (noting that nine states have enacted legislation in attempt to deal with balance billing and problem of these efforts have met with mixed results).

14. *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, 198–209 (2010) [hereinafter Nation, *Wolves in Sheep's Clothing*] (citation omitted within title) (argu-

mechanism we have for doing that is the free market.[15] While there is additional government regulation that would be helpful in strengthening the free market for healthcare,[16] I argue here that we do not have to wait for such regulation; the common law of contracts contains the tools necessary to allow courts to provide a free market solution to the balance-billing problem now.[17]

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

I. BACKGROUND: THE PROBLEM

In a recent newspaper article a journalist recounted the story of a fifty-year-old construction worker who experienced chest pains and was admitted to St. Francis Hospital in Bartlett, Tennessee, in 2014.[18] His wife said they were not told either at the time of admission or during their visit that the hospital did not accept their health insurance.[19] The couple received a bill from the hospital for $22,945.[20] As the article points out, under the ACA, a family's out-of-pocket expenses (this would include charges for things like co-pays, co-insurance, etc.) for 2014 were capped at $12,700.[21] However, this limitation under the ACA does not apply to non-emergency room charges provided by an out-of-network hospital.[22] That is, the limitation does not protect patients from balance billing, and thus the family received a bill for $22,945. In this case, the family was lucky; they appealed the charges, and the hospital eventually reduced their bill

ing that definition of word *better*—as in better healthcare—is key to policy formulation).

15. *See id.* at 181–85 (arguing that non-profit, tax-exempt business model is not appropriate for hospitals and that only free market competition can accomplish healthcare goals).

16. *See infra* notes 98–125 and accompanying text.

17. *See infra* notes 84–148 and accompanying text.

18. *See* Stephanie Armour, *Surprise Bills for Many Under Health Law*, WALL ST. J., June 11, 2015, http://www.wsj.com/articles/surprise-bills-for-many-under-health-law-1434042543 [https://perma.cc/Y6EP-2N9F].

19. *Id.*

20. *Id.*

21. *Id.*

22. *Id.*

to $600—but only after the bill had been sent to a collection agency, which the family worries will hurt their credit rating.[23]

A. *Narrow Networks*

In 2015, under the ACA, out-of-pocket costs were capped at $6,600 for an individual and $13,200 for a family.[24] But again, these caps do not apply to out-of-network providers who charge patients for the portion of their bills that their insurance does not pay.[25] Moreover, this balance-billing problem is getting worse because networks are becoming narrower.[26]

A network consists of the hospitals with which an insurer has contracted.[27] Pursuant to those contracts, hospitals agree to dramatically discount their list prices.[28] If a provider is not in-network, that means that the insurance company has no contract with the hospital, and patients who are insured by that company are not entitled to the huge discounts and instead are, according to the hospital, responsible for the fully undiscounted, obscenely high, list price for the services they receive.

A network is narrow if it only includes a few hospitals.[29] A wide network, which includes many hospitals, gives patients more choice as to

23. *Id.*

24. *Id.*

25. *Id.*

26. *See id.* (noting that plans with narrow networks make up about half of all health law exchange networks and about two-thirds of networks in large cities); *see also* Abelson, *supra* note 8 (acknowledging balance-billing becoming more frequent).

27. *See* HOADLEY ET AL., *supra* note 5, at 3–5.

28. *See* Nation, *Chargemaster Insanity*, *supra* note 12, at *19–23 (noting that self-pay patients billed chargemaster rates are asked to pay are at least 2.5 times amount paid by health insurers for same exact care); Nation, *Determining Fair and Reasonable Value, supra* note 7, at 429–30.

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

Id. (footnotes omitted).

29. *See* Armour, *supra* note 18 (explaining health plans offered by employers also have been reducing number of doctors and hospitals in their networks, but what have come to be known as narrow networks are more prevalent in plans offered on ACA exchanges).

where to seek care. A poll conducted by the Kaiser Family Foundation found that more than half of Americans believe that it is important to make sure that health plans have sufficient networks to provide a wide choice of doctors and hospitals.[30] However, according to a 2015 report by McKinsey & Company, plans with narrow networks make up half of all insurance networks offered through the ACA, and narrow networks make up about two-thirds of the insurance networks offered through the ACA in the largest cities.[31] As insurance networks become narrower, more patients are burdened with exorbitant hospital debt pursuant to balance billing.[32]

The reason that networks are becoming narrower is the desire on the part of hospital systems to increase profits.[33] For example, in some cases, insurance companies cannot afford the reimbursement levels being

30. *Id.*

31. *Id.*

32. *Id.*

33. *See* Murray, *supra* note 10.

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

Id.

demanded by hospital systems in order to become in-network.[34] Some hospital systems choose to purposely limit the size of their networks because they feel that this strengthens their financial bargaining position and allows them to recoup higher payments from insurers and patients.[35] An important cause of this is the increased concentration that has occurred on the provider side of the market.[36] As hospitals consolidate, more large healthcare systems are created, and these dominant systems do not feel any competitive pressure to contract with insurance companies at reasonable reimbursement rates.[37]

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34. *Id.*

35. *Id.*

36. *Id.*

> It is a well-documented fact that provider consolidation—which research shows leads to higher prices—is already extreme and once again on the rise.
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> . . . .
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> As Barak Richman from the Duke School of Law has discussed, health care providers with market power enjoy substantially more pricing freedom than monopolists in other industries because of the presence of U.S. style health insurance, which largely insulates consumers from the full implications of monopoly pricing. This dynamic results in much greater potential for revenue generation and much greater distribution of wealth than would result from monopoly power in markets where consumers face the prices and price increases directly.
>
> Thus, the prospects for cost control are greatly diminished as long as providers are allowed to exercise their monopoly power, particularly where they face a highly inelastic demand curve—namely for emergency department services. The ability to hold a gun to the head of private insurers in this fashion is a by-product of provider consolidation, the enhanced pricing flexibility of health care monopolies, and the increasing proportions of admissions through hospital EDs.

Id. (citations omitted).

37. *See id.*; Elisabeth Rosenthal, *As Hospital Prices Soar, a Stitch Tops $500*, N.Y. TIMES, Dec. 2, 2013, http://www.nytimes.com/2013/12/03/health/as-hospital-costs-soar-single-stitch-tops-500.html?pagewanted=all&_r=0 [https://perma.cc/VU7N-LWP9?type=image] (quoting Glenn Melnick, Professor of Health Econ., Univ. of S. Cal.) (regarding California Pacific Medical Center, which is owned by Sutter Health Inc., whose chargemaster rates are 5.5 to more than 10 times the Medicare reimbursement rate).

According to Professor Melnick, "Sutter is a leader—a pioneer—in figuring out how to amass market power to raise prices and decrease competition." *Id.* (internal quotation marks omitted). Research shows that today's hospital mergers tend to drive up prices. For example in the case of Sutter, it operates the only hospital in some California cities. As a result, employers have limited ability to fight back against Sutter's high fees. Professor Melnick notes that hospitals set prices to maximize revenue, and they raise prices as much as they can. In addition, Professor Melnick notes that chargemaster prices are basically arbitrary, not connected to underlying cost or market prices; hospitals can set them at any level they want. There are no market constraints. Hospitals are the most powerful players in the healthcare system and there is little or no price regulation in the private market. *See* MARTIN GAYNOR & ROBERT TOWN, ROBERT WOOD JOHNSON FOUND., POLICY BRIEF NO. 9, THE IMPACT OF HOSPITAL CONSOLIDATION—UPDATE 2 (2012), *available at* http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261

B. *No Notice, No Control, and Unfair Surprise*

Even patients who are aware of the risks of balance billing and who, given their medical condition, are in a position to make a choice regarding where to seek treatment, find it difficult, if not impossible, to prevent balance billing.[38] This is because it is often extremely difficult for a patient to determine whether the provider from whom they are seeking medical services is in-network or out-of-network.[39] Moreover, the mere fact that a patient seeks medical services from an in-network hospital does not ensure that the doctors treating the patient are also in-network.[40] That is, it is very common for in-network hospitals to employ physicians who are not in that network.[41] As a result, patients treated at an in-network hospital may receive balance bills from the out-of-network physicians who treated them.[42] This is confusing and unfair to patients.

C. *Exorbitant, Obscenely High Charges*

The problem of balance billing would not be of nearly as much concern if the balance bills were not so outrageously high.[43] That is, if hospitals and other healthcare providers set their list prices at a fair and reasonable level to begin with, the balance bills would not represent a crippling financial burden for patients.[44] Rather, they would simply represent the difference between a reasonable list price and a likewise reasonable reimbursement amount set by the insurance company. In this economically sensible world (one that a properly functioning free market would create), balance bills would often be zero or a minimal amount. Unfortunately, this does not represent the current reality of hospital billing, as illustrated by the fact that in the case cited above, once the hospital reduced its charges, the bill went from $22,945 down to $600.[45]

What makes the problem of balance billing so pernicious is that the bills not only surprise patients, but the total cost of the bills is often financially devastating.[46] I have written before about outrageously high charge

[https://perma.cc/45J8-QNNU] (identifying hospital bargaining leverage as main determinant of relative expensiveness within same hospital market).

38. *See, e.g.*, Armour, *supra* note 18; Chen, *supra* note 5. *See generally* HOADLEY ET AL., *supra* note 5.

39. *See* Chen *supra* note 5 ("It's a pretty good bet that if you're hospitalized or having any kind of surgery, somebody along the way who touches you or your slides or films will not be in network[.]" (quoting Karen Pollitz, Senior Fellow, Menlo Park, California-based Kaiser Found.) (internal quotation marks omitted)).

40. *Id.*

41. *Id.*

42. *Id.*

43. *See, e.g.*, Nation, *Determining Fair and Reasonable Value*, *supra* note 7, at 427.

44. *Id.*

45. *See supra* notes 18–23 and accompanying text.

46. *See e.g.*, Melissa B. Jacoby & Mirya Holman, *Managing Medical Bills on the Brink of Bankruptcy*, 10 YALE J. HEALTH POL'Y L. & ETHICS 239, 247 (2010) (arguing medical debt makes it difficult to get further healthcare); Melissa B. Jacoby & Eliza-

master prices that hospitals insist are usual and customary, and I do not wish to repeat that work here.[47] It is sufficient to note that the amounts reflected on balance bills, when based on chargemaster prices, are outrageously high, set to discounted and not paid, bear no relationship to the hospital's cost, and, if they are paid, yield truly enormous profits to the hospital.[48]

D. *Balance Billing Increases the Overall Cost of Healthcare*

Because the profit maximizing conduct of hospitals, both for-profit and not-for-profit, is unrestrained by competitive market forces, the overall cost of healthcare in the United States is inflated.[49] The lethal combination of exorbitantly high chargemaster prices and the practice of balance billing combine to put upward pressure on prices for healthcare across the board.[50] These practices not only directly increase the cost of healthcare for the uninsured and out-of-network patients; they also indirectly increase the cost of healthcare for everyone.[51] While government insurers who pay for more than half of the healthcare provided in the United States no longer set reimbursement rates based directly on chargemaster rates, higher chargemaster rates do indirectly put upward pressure on government reimbursement amounts.[52] However, more importantly and the focus of this Article is the fact that the combination of obscenely high chargemaster rates and the practice of balance billing in-

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beth Warren, *Beyond Hospital Misbehavior: An Alternative Account of Medical-Related Financial Distress*, 100 NW. U. L. REV. 535, 548 (2006) (asserting about 46%–56% of personal bankruptcies were caused by medical reasons); Christopher Tarver Robertson, Richard Egelhof & Michael Hoke, *Get Sick, Get Out: The Medical Causes of Home Mortgage Foreclosures*, 18 HEALTH MATRIX 65, 66–68 (2008) (noting 23% of home foreclosures were caused by "unmanageable medical bills").

47. *See generally* Nation, *Chargemaster Insanity*, *supra* note 12; Nation, *Determining Fair and Reasonable Value*, *supra* note 7; Nation, *Obscene Contracts, supra* note 3; Nation, *Wolves in Sheep's Clothing*, *supra* note 14.

48. *See, e.g.*, Reinhardt, *U.S. Hospital Services*, *supra* note 4, at 63 (explaining chargemaster prices "would yield truly enormous profits" if paid).

49. *See* Nation, *Chargemaster Insanity*, *supra* note 12, at *26 ("[H]igh chargemaster prices lead to [overall] higher prices for healthcare."); Nation, *Wolves in Sheep's Clothing*, *supra* note 14, at 154 ("[T]he primary reason that the non-profit model has dominated the hospital industry is that it provides camouflage and autonomy for the real profit seeking motives and/or elitist wealth transfer motives of those in de facto control, and it affords a tax deduction that enhances profits.").

50. *See supra* note 10.

51. *See supra* note 10.

52. *See* Nation, *Chargemaster Insanity*, *supra* note 12, at *26–30 (noting exorbitant chargemaster prices cause higher overall prices for healthcare); Nation, *Determining Fair and Reasonable Value*, *supra* note 7, at 454 (discussing main reason chargemaster prices are so high is that higher chargemaster prices lead to higher revenues, though not dollar-for-dollar, for hospitals from government and private insurers as well as from self-pay patients).

crease the cost of healthcare for both uninsured and privately insured patients.[53]

It is obvious why uninsured and out-of-network patients pay more—because the dysfunctional market for healthcare allows hospitals to set unreasonably high chargemaster rates and insist on balance billing out-of-network, uninsured, and other self-pay patients.[54] What is less obvious is why this also increases the cost of healthcare for in-network patients. Remember that patients are considered to be in-network if their insurance company has entered into a contract with the hospital providing medical services, and as a result, in network patients typically cannot be balance billed.[55]

However, the negotiation of the contract that makes a patient "in-network" is affected directly by exorbitant chargemaster rates and the practice of balance billing. For example, when a hospital or hospital system and an insurance company negotiate reimbursement rates, the hospital system's bargaining power is increased by the fact that if the insurance company fails to agree to the reimbursement rates desired by the hospital system, then all of the insurance company's customers are balance billed at chargemaster rates.[56] This threat—*agree to our reimbursement rates or your insureds will face huge charges for healthcare*—is strengthened each time the hospital raises its chargemaster rates.[57] This threat-based bargaining power is irresistible in the case of a hospital or hospital system that is dominant in its market.[58] Insurers simply cannot sell health insurance policies if those who buy them will be punished with exorbitant balance bills for receiving care from the dominant provider in the market.[59] As a result, many insurers have no option but to agree to the high reimbursement rates requested by the hospital system and to pass these costs along to their customers/insureds in the form of higher prices for health insurance.[60]

53. *See supra* note 10.

54. *See supra* notes 24–48 and accompanying text.

55. *See supra* notes 5–11 and accompanying text.

56. *See* Bai & Anderson, *supra* note 10, at 923 (noting that high chargemaster rates motivate insurers "to include hospitals in their networks to reduce the likelihood of having subscribers pay high out-of-network prices"); Murray, *supra* note 10 (noting that high chargemaster rates "undermine the negotiating leverage of private [insurers] relative to hospitals").

57. *See* Murray, *supra* note 10 (discussing hospitals' options when negotiating with insurers).

58. *See, e.g.*, Nation, *Chargemaster Insanity*, *supra* note 12, at *21–22 (discussing California Pacific Medical Center—owned by Sutter Health—and its amassed market power allows it to charge "5 1/2 to over 10 times the Medicare reimbursement rate").

59. *See id.* at *28 (discussing how private insurers, even these with significant market power, are forced to agree to high contractual reimbursement rates with must have hospitals in their market).

60. *See id.* at *26 (discussing how "insanely high chargemaster prices lead to over all higher prices" for insured patients as well as "self-pay patients").

The price of insurance (what insured patients pay for healthcare) consequently goes up.[61]

An alternative for insurance companies is to simply sell narrow network policies to uninformed customers and let these patients be shocked and surprised by the balance bills they receive. Narrow network policies are of course cheaper, and the low price often attracts customers who do not fully understand the risks posed by narrow network policies.[62] As noted, the majority of policies sold on ACA exchanges are narrow network policies.[63] In addition, several newspaper articles have focused on the frustration, shock, and surprise of patients who receive huge balance bills.[64]

Make no mistake, even non-profit, tax-exempt, so-called charitable hospitals act exactly like their for-profit competitors when it comes to setting obscenely high chargemaster prices and balance billing their patients.[65] I have written before about the very uncharitable conduct of so-called charitable hospitals, and there is no need to repeat that work here; it is sufficient to note that there is no meaningful difference between the conduct of non-profit and for-profit hospitals when it comes to conducting their financial affairs, except of course that the non-profits make more money because they do not pay taxes.[66] Moreover, while the pricing and collection limitations included in the ACA apply only to non-profit hospitals, these provisions do not solve the balance-billing problem even in the context of non-profit hospitals as discussed in the next Section.[67] Thus, there is little to be gained from simply applying the ACA's ineffective price and collection limitations to for-profit hospitals.

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61. *See id.* at *28 ("[H]igher chargemaster rates do indirectly produce higher hospital revenue from all private insurers.").

62. *See* Armour, *supra* note 18 (discussing that customers who purchased coverage through ACA are surprised by balance bills).

63. *See id.* (discussing how "plans sold on ACA exchanges have limited networks").

64. *See supra* note 5.

65. *See* Nation, *Wolves in Sheep's Clothing*, *supra* note 14, at 174–79 ("The many instances in which non-profit hospitals seem to place the pursuit of profit over charity care has led the Commissioner of the IRS to observe that there is now very little difference between for-profit hospitals and not-for-profit hospitals."); *cf.* Bai & Anderson, *supra* note 10, at 924 (finding that 98% of top 50 hospitals with highest chargemaster rates were for-profit). These findings are misleading with respect to the difference between for- and non-profit hospitals. The sample is small at fifty, most of the top fifty were owned by just two for-profit systems, but most importantly the average chargemaster rate for *all* hospitals was 3.4 times Medicare allowable cost. *Id.* at 923.

66. *See generally* Nation, *Wolves in Sheep's Clothing*, *supra* note 14, at 170–79 (discussing issues with non-profit hospitals).

67. *See infra* notes 68–83 and accompanying text.

E. *The ACA Actually Encourages Balance Billing*

The ACA started out with laudable goals, however, much got lost in its translation into legislation. As noted above, the ACA contains limits on what patients may be asked to pay out-of-pocket if they are covered by a qualified health insurance policy, but these limits do not apply to non-emergency charges of out-of-network providers.[68] In other words, the out-of-pocket limits established by the ACA do not apply to balance billing.[69] The ACA also establishes limits on the amount that indigent, uninsured patients may be charged for healthcare and the type of collection techniques that may be used to recover healthcare debt.[70] It is important to note, however, that these limitations apply only to not-for-profit, tax-exempt hospitals; they do not apply to for-profit hospitals.[71] For-profit hospitals make up approximately 20% of the hospitals in the United States, and, while not directly relevant here, I have argued elsewhere that all hospitals should be for-profit and taxable.[72]

In any event, an indigent patient eligible for a (not-for-profit, tax-exempt) hospital's financial assistance policy (FAP) may not be charged more than the hospital's generally billed amount (GBA).[73] GBA is a reasonable amount established under the ACA and may be based on either the average amount the hospital bills private insurance and Medicare for the services provided or the prospective Medicare reimbursement rate alone.[74] Moreover, these hospitals and their collection agencies are forbidden from using extraordinary collection techniques to collect hospital debt from FAP-eligible patients.[75]

However, these provisions fail to solve the balance-billing problem even for not-for-profit, tax-exempt hospitals for several reasons. First, these hospitals are free to define who is eligible for their financial assis-

68. *See* Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 119, 855–858 (2010) (codified as amended at 26 U.S.C. § 501(r)(5)–(6) (2012)). Emergency out-of-network charges are covered to some extent under the ACA. *See* ACA, §§ 1001, 10101(h), 42 U.S.C. 300gg-19a (2012) (amending Public Health Service Act § 2719A); 29 C.F.R. § 2590.715–2719A (2016); 45 C.F.R. § 147.138(b) (2016).

69. *See* ACA § 1302(c) (codified at 42 U.S.C. § 18022(c)); Bai & Anderson, *supra* note 10, at 923 ("The ACA requires nonprofit hospitals to provide discounts to eligible uninsured patients. However, the same provision lets individual nonprofit hospitals determine their own eligibility standards, does not address the levels of the markup faced by out-of-network patients and casualty and workers' compensation insurers, and does not apply to for-profit hospitals.").

70. *See supra* note 67.

71. *See supra* note 67.

72. *See generally* Nation, *Wolves in Sheep's Clothing*, *supra* note 14.

73. *See* I.R.C. § 501(r)(5)(A) (2012), *amended by* Pub. L. No. 114-113, 129 Stat. 2242 (2015).

74. *See* 26 C.F.R. § 1.150(r)–1 (2016) (defining amounts generally billed).

75. *See* I.R.C. § 501(r)(6).

tance programs.[76] Many hospitals define FAP eligibility according to income levels based on the Federal Poverty Guidelines (FPG). The problem is that, in addition to the FPG limits, most of these hospitals also limit eligibility for their FAPs to those who are uninsured.[77] Obviously, this offers no protection for patients subject to balance billing, who, by definition, are insured but have received care outside of their network.

Second, the recently finalized regulations implementing the ACA's limitations on hospital charges for FAP-eligible patients specifically allow balance billing of patients who qualify for financial assistance.[78] That is, if, under a specific hospital's FAP, an insured patient is eligible for financial assistance and therefore the amount the hospital may charge is limited to the hospital's GBA, the hospital is specifically permitted to recover this amount from both the insurance company *and* the patient.[79] The hospital may balance bill the FAP-eligible patient for an amount up to the GBA amount even though the hospital has already collected the GBA amount—an amount deemed to be the reasonable value of the services provided according to the ACA, from the insurance company.[80]

Finally, the ACA specifically refers to a hospital's "gross" charges,[81] clearly indicating their chargemaster rates. While the ACA does this with good intentions, specifically requiring not-for-profit, tax-exempt hospitals to charge less than their list prices to FAP-eligible patients (the ACA does not say how much less) nevertheless references to chargemasters effectively require that chargemasters—with their exorbitant prices—stay in existence. In addition, hospitals continue to have the same incentives to continually raise their chargemaster rates.[82] As noted above, high

76. *See id.* § 501(r)(4)(A); Additional Requirements for Charitable Hospitals, 77 Fed. Reg. 38148, 38149 (June 26, 2012) (codified at 26 C.F.R. pt. 1) ("Neither the [ACA] nor these proposed regulations establish specific eligibility criteria that a [financial assistance policy] must contain.").

77. *See, e.g.*, Cleveland Clinic, Summary of Financial Assistance (PWO 13998), *available at* https://my.clevelandclinic.org/ccf/media/Files/Patients/financial-assistance-app.pdf?la=en [https://perma.cc/9BMS-JBPJ] (last updated Jan. 2013) ("[W]e provide financial assistance . . . if you are a resident of the state in which you are seeking care . . . *do not have insurance*, and your family income does not exceed four times the FPG." (emphasis added)).

78. *See* 26 C.F.R. § 1.501(r)–5(b)(2) (stating it is no violation of regulations if the total amount paid by individual and health insurer exceeds AGB, so long as individual's portion—including co-payments, co-insurance, and deductibles—does not exceed the AGB).

79. *See id.*

80. *See id.*

81. *See id.* § 1.501(r)–1(b)(16) ("Gross Charges, or the chargemaster rate, means a hospital facility's full, established price for medical care that the hospital facility consistently and uniformly charges patients before applying any contractual allowances, discounts, or deductions.").

82. Higher chargemaster rates mean greater revenue, though not dollar-for-dollar. *See supra* note 49.

chargemaster rates contribute significantly to the severity of the balance-billing problem.[83]

II. ANALYSIS: THE SOLUTION

It is important to recognize that our healthcare goals are not only to control prices and to provide access to all Americans to basic healthcare, but first and foremost, to develop the best healthcare in the world.[84] The best healthcare is that which can cure or treat the greatest number of diseases and ailments with the greatest success.[85] A thriving free market for healthcare will accomplish our goals with regard to pricing and the development of the best healthcare.[86] The point is that the issue of how to provide access to basic healthcare for low-income populations is separate and distinct from the issue of how to develop the best healthcare.[87] To develop the best healthcare and to control costs, we must enhance the free market for healthcare.[88] Also, a robust free-market economy is the best remedy for poverty and its effects, including lack of access to healthcare.

A. *More Price Fixing Will Not Help*

There is no question that when hospitals seek to collect their chargemaster rates, they are acting unreasonably and, especially in the case of charitable hospitals, unfairly.[89] But hospitals are also responding predictably—which is to say somewhat reasonably, though certainly not charitably—to existing market forces.[90] The solution is to change the market conditions, such as the current lack of price transparency, that are preventing the free market for healthcare from functioning properly.[91] Price-fixing does not strengthen the free market; it destroys it and replaces it with central planning. Not only does prior experience suggest that this will ultimately fail to control prices, it will also destroy quality.

83. *See supra* notes 43–48 and accompanying text.

84. *See* Nation, *Wolves in Sheep's Clothing*, *supra* note 14, at 151–55 (discussing how United States can better its healthcare system).

85. *See id.* at 151–52 & n.33 (discussing difference between "healthcare system" versus "healthcare").

86. *See id.* at 152 n.34 (discussing why free-market system is better for hospitals). I have written before about the dangers associated with incorporating the access goal too tightly with the goal of developing the best healthcare, and I do not want to repeat that work here. *See generally id.*

87. *See id.* at 207–09 ("[T]he issue of how to pay for medical care for the poor, while it is not completely unrelated, is best treated as separate and distinct from the issue of how to develop the best medical care at the lowest cost." (footnote omitted)).

88. *See id.* at 154–55 (discussing what changes should be made to healthcare market).

89. *See supra* notes 42–47 and accompanying text.

90. *See* Nation *Chargemaster Insanity*, *supra* note 12, at *6–18 (discussing evolution of higher chargemaster rates).

91. *See, e.g.*, Bai & Anderson, *supra* note 10, at 925 (discussing policy implications to market failure caused by lack of price transparency).

The United States healthcare market already has too much price-fixing. Government insurers such as Medicaid and Medicare are price fixers.[92] Moreover, they represent a large share of the U.S. healthcare market.[93] Price-fixing, whether in the form of a single-payer system or in the form of full-blown government healthcare, is not the solution because it ignores the real goal: to develop a properly functioning free market for healthcare, because this is the only way to develop the *best* healthcare.

B. *Enhancing the Free Market for Healthcare*

Enhancing the free market for healthcare will require the government to work to prevent and reduce market concentration and ensure relatively equal bargaining power of both providers and consumers (or insurance companies as the consumers' representatives).[94] In addition, a properly functioning free market requires price and quality transparency so that consumers can actively choose the best value in healthcare[95]—that is, the best healthcare at the cheapest price. When consumers have this information, providers are forced to compete in quality and price. This is the essence of a free market, and it is from this that all of its benefits flow.

Other than observing that certain provisions of the ACA are, unfortunately, encouraging concentration in an already overly concentrated provider side of the market, I focus in this Part on how to increase price transparency.[96] It is also important to note that this Article seeks to strengthen the free market for healthcare, and that necessarily includes recognizing that providers should be free to set their prices at any level they wish, with the exception of services provided in the emergency department.[97] However, a properly functioning free market will force them to set reasonable prices.

C. *Increasing Price Transparency Using the Common Law of Contracts*

One of the most significant problems in the market for healthcare is the lack of price transparency.[98] Patients do not know at the time of contracting how much they are agreeing to pay for the services that will be

92. *See, e.g.*, Reinhardt, *U.S. Hospital Services*, *supra* note 3, at 60 (discussing price setting by Medicare).

93. *See* Nation, *Wolves in Sheep's Clothing*, *supra* note 14, at 186 n.237 (noting that "the [g]overnment is now responsible for paying for more than fifty percent of U.S. healthcare via various programs, principally Medicare and Medicaid").

94. *See supra* notes 35–36 and accompanying text (discussing how hospitals hold more financial bargaining power).

95. *See, e.g.*, Bai & Anderson, *supra* note 10, at 924–25 (discussing lack of transparency in market failure).

96. *See infra* notes 99–123 and accompanying text (discussing how to increase price transparency).

97. *See supra* note 67. For a discussion of contract prices, see *infra* notes 124–33.

98. *See, e.g.*, Nation, *Determining Fair and Reasonable Value*, *supra* note 7, at 426–29 (discussing lack of price transparency in healthcare contracts).

provided to them.[99] As a result, it is virtually impossible for patients to compare hospitals based on price.[100] This, in turn, means that hospitals are not forced to compete on price. As mentioned above, it is also important for hospitals to compete on quality, but in the current market environment, it is much easier for patients to get an idea of the relative quality of hospitals than it is for them to get an idea of how much they will be responsible for paying for the services that they receive.[101] My focus here is on increasing price transparency.

Not only is price transparency critical for the proper functioning of the free market, but basic principles of contract law also require that the parties clearly establish the terms of their agreement or, if the court is convinced the parties intended a contract but did not clearly establish some terms, including the price, the court will imply a reasonable price to the contract consistent with the parties' presumed intent.[102] At the heart of the common law requirements for the creation of a contract is its recognition of the freedom of individuals to knowingly and freely enter into enforceable agreements.[103] The problem with healthcare contracts entered into directly with patients is that they are not knowingly and freely entered into with respect to price.[104]

As discussed in more detail in the next Section, courts can now use the common law principles of contracts to rein in the abusive balance-billing practices of hospitals.[105] In this Section, I renew a suggestion I have made previously for regulation that will enhance the functioning of the free market by increasing price transparency.[106] In addition, I recommend here specific patient disclosures designed to ensure healthcare contracts entered into directly with patients are knowingly and freely entered into with respect to price.[107] My recommendation regarding price disclo-

99. *See id.* (discussing how patients are not aware of full costs of healthcare).

100. *See id.* at 429 ("[A]s long as hospitals use á la carte pricing based on chargemasters, consumers will not be able to effectively negotiate price.").

101. There are many ranking services available regarding the relative quality of healthcare. *See, e.g.*, *U.S. News Best Hospitals 2015–16*, U.S. NEWS & WORLD REP., http://health.usnews.com/best-hospitals/rankings [https://perma.cc/6L2M-2YWV] (last visited Mar. 3, 2016).

102. *See infra* notes 166–70 and accompanying text (discussing creation of contracts between parties).

103. *See infra* notes 151–70 and accompanying text (discussing common law of contracts).

104. *See supra* notes 98–100 and accompanying text.

105. *See infra* notes 225–32 and accompanying text (discussing how common law contract principles can be used in healthcare).

106. *See* Nation, *Chargemaster Insanity*, *supra* note 12, at *36–44 (discussing proposed solution for cost of healthcare).

107. *See infra* notes 108–23 and accompanying text (proposing recommendation for price disclosures by hospitals).

sure are similar to Regulation Z[108] (Regulation Z is issued by the Board of Governors of the Federal Reserve System to implement the federal Truth in Lending Act, which is contained in Title I of the Consumer Credit Protection Act[109]), which applies to consumer lending and ensures that consumers know and understand the credit terms of the loan they are agreeing to.[110] Similarly, in the context of healthcare contracts, the government's role should be to require disclosure of the relevant pricing information.

Requiring the following would be helpful to provide patients with the relevant information they need regarding price to enter into an enforceable contract with a hospital regulation: (1) all providers should be required to adopt the same pricing system, but not the same prices[111] and (2) a number of disclosures including the following need to be made to the patient prior to the creation of the contract.[112] First, the patient should be told the total amount that the hospital will charge (including amounts charged to the patient's insurance or any other third-party payer) for the care to be provided. Second, the patient should be told the maximum amount, in dollars and cents, that the patient will be expected to pay for the services for which they are contracting.[113] Third, the hospital must disclose the amount, in dollars and cents, that the hospital receives from Medicare for the same services and the average amount the hospital receives from private insurers for the same services.[114] Fourth, hospitals must tell the patient explicitly that the hospital accepts these amounts, from private and government insurers, as full payment for these services. Fifth, the hospital must disclose explicitly, again in dollars and cents, how much *more* the hospital is asking the individual patient to pay for these

108. Regulation Z is issued by the Board of Governors of the Federal Reserve System to implement the federal Truth in Lending Act, Title I of the Consumer Credit Protection Act, as amended at 15 U.S.C. §§ 1601–1616 (2012).

109. 15 U.S.C. § 1601.

110. *See id.*; *see also* Keith T. Peters, *What Have We Here? The Need for Transparent Pricing and Quality Information in Health Care: Creation of an SEC for Health Care*, 10 J. HEALTH CARE L. & POL'Y 363, 364 (2007) (noting that with proper information healthcare consumers can make rational decisions).

111. This is a recommendation that others and I have made before. *See* Bai & Anderson, *supra* note 10, at 927 (regarding legislation requiring all reimbursements to be based on the same system such as diagnostic-related groups); Nation, *Chargemaster Insanity*, *supra* note 12, at *38.

112. *See* Bai & Anderson, *supra* note 10, at 925–26 (proposing required price disclosures by hospitals).

113. I have previously argued that a reasonable price for medical services is no more than 115% of the Medical reimbursement rate. *See* Nation, *Determining Fair and Reasonable Value*, *supra* note 7, at 460–65.

114. *See* Nation, *Obscene Contracts*, *supra* note 3, at 118–19 (discussing how hospitals usually do not collect full amount of charges from government and private insurers).

exact same services.[115] Sixth, the hospital should also inform the patient that it negotiates rates with private insurers and, if the hospital in fact does so, with self-pay patients on a case-by-case basis. Finally, a prominent space should be provided on the disclosure form for the total negotiated price the patient and the hospital have agreed to and the amount of discount received by the patient.[116]

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

If these disclosures regarding price are not made prior to contracting for any reason, then the court must decide if the parties intended to contract, which would clearly be the case if the patient received any treatment from the hospital, and if a contract was created, the court must provide a reasonable price term for the parties.[117] For example, a hospital may continue to use its price-ambiguous "Authorization for Treatment," "Statement of Financial Responsibility," or some other similar open-ended agreement pursuant to which the patient purports to agree to pay for all medical goods and services provided by the hospital at the hospital's chargemaster prices.[118] But if these open-price agreements were used, the patient would not be liable to the hospital for any more than a reasonable amount as decided by the court.[119] That is, whenever the provider does not make the required disclosures, the court will apply a reasonable price to the contract based on the average price paid for the same services by private insurers plus a modest percentage between 1% and 15%.[120]

As discussed more fully in the next Section, even in the absence of legislation requiring these price disclosures, courts should not interpret typical admission forms signed by patients—such as an "Authorization for Treatment," "Statement of Financial Responsibility," or some other similar open-ended agreement, which purport to establish a formula based on the hospital's chargemaster to arrive at the price the patient has agreed to pay for the services the hospital may provide—as establishing a definite price.[121] Rather, these types of forms have been compared "to a blank

115. *See id.* at 119 ("However, while all patients and payors are billed the 'full charges,' the only ones actually expected to pay these charges are those patients without medical insurance.").

116. This is similar to the disclosure box required by Regulation Z. *See supra* notes 108–09.

117. *Cf.* U.C.C. § 2-207(3) (2012).

118. *See infra* notes 121–25 and accompanying text.

119. *See supra* note 111.

120. *See supra* note 111.

121. *See* Nation, *Determining Fair and Reasonable Value*, *supra* note 7, at 426–27.

check given by the patient to the hospital with the amount to be unilaterally filled in by the hospital at a later date."[122] This is not at all consistent with common law contract principles that require parties to knowingly and freely enter into contracts.[123] As a result, the court should not find that these writings are binding with respect to establishing the price for the goods and services provided by the hospital to the patient.[124] Simply put, under the common law of contracts, the hospitals that fail to fully disclose relevant pricing information, as discussed above, may recover no more than the fair market value of the goods and services provided.[125]

D. *Price Setting Freedom in a Free Market*

One of the hallmarks of a free market is freedom of contract.[126] That is, individual market participants are free to enter into contracts on any terms that they knowingly and freely agree to within the parameters established by the common law.[127] These parameters include requirements such as capacity and legality, and compliance with normal contract policing tools such as fraud, duress, undue influence, and unconscionability.[128] Thus, in a free market, businesses are typically free to establish their prices at any levels they see fit, and potential customers are of course free to reject prices that they consider to be too high. In order to come to an agreement, the parties negotiate the terms—including the price—of the contract.

Because the purpose of the recommendations made here are to strengthen the operation of the free market, this Article takes the position that providers of medical goods and services must be free to set their prices as they see fit. Direct government price controls are not only inconsistent with the idea of freedom of contract that underlies the free market; they also disrupt the functioning of the free market and prevent it from achieving its ultimate goal of efficient resource allocation.[129] Moreover, a properly functioning free market will control prices.[130] In addition, as discussed in the next Section, I argue that the common law of contracts

122. *Id.* at 427.

123. *See infra* note 151 and accompanying text.

124. *See infra* notes 225–32 and accompanying text (discussing application of contract principles to healthcare).

125. *See infra* notes 228–34 and accompanying text (discussing how prices should be set in contracts whether its by parties or courts).

126. *See infra* notes 151–70 and accompanying text (discussing freedom of contract).

127. *See infra* notes 151–70 and accompanying text (same).

128. *See infra* notes 234–41 and accompanying text.

129. If prices are set too high, the excess profits attract more sellers and in turn the increased supply cause prices to come down. As a result, the proper level of resource allocation is achieved and maintained.

130. *See supra* note 128.

includes sufficient flexibility to allow judges to apply its principles to ensure that hospitals cannot engage in unfair pricing practices.[131]

The common law of contracts also leaves hospitals and other providers sufficient pricing flexibility to charge extremely high rates to patients who are able and willing to pay them. Commentators as well as hospital administrators often recount the "Arab Sheik" scenario.[132] This scenario involves an Arab Sheik, invariably extremely wealthy, arriving at the hospital seeking medical services; the Sheik is supposedly able and willing to pay any price that the hospital demands.[133] Hospital administrators, clearly misunderstanding the common law of contracts, fear that without their exorbitant chargemasters, they would not be able to charge the Sheik an exorbitant, overpriced amount for the hospital's services.[134] Why it is acceptable to overcharge a wealthy Arab Sheik, especially in the case of a so-called charitable hospital (which is an implicit assumption in this scenario) is unclear to me. Freedom of contract and the rules established by the common law of contracts allow hospitals to charge any patient any amount the hospital wishes as long as the patient and the hospital freely and knowingly agree.[135] The frequency with which one encounters the Arab Sheik scenario would seem to suggest that it is quite common, however, even without the advantage of empirical evidence, I am tempted to conclude that it may represent more wishful thinking than reality. In any event, to maintain such a ridiculous and pernicious chargemaster pricing system in the vein hope for the arrival of an Arab Sheik certainly seems to be an example of the tail wagging the dog.

E. *The "Just Say No" Approach*

Some companies that self-insure for health insurance and their third-party administrators have created health insurance plans that dispense with networks altogether.[136] Under these direct-pay plans, contracts are not entered into with any providers.[137] Employees insured under these plans are free to go to any provider they like.[138] When the bill is presented, the company pays an amount determined to be reasonable

131. *See infra* notes 151–241 and accompanying text (discussing how courts can apply common law contract principles to healthcare).

132. *See, e.g.*, Rosenthal, *supra* note 37.

133. *See id.*

134. *See id.*

135. *See infra* notes 151–72 and accompanying text.

136. *See, e.g.*, Jay Hancock, *Radical Approach to Huge Hospital Bills: Set Your Own Price*, KAISER HEALTH NEWS (May 13, 2015), http://khn.org/news/radical-approach-to-huge-hospital-bills-set-your-own-price/ [https://perma.cc/8EGM-DJV7] ("When hospitals send invoices with [jaw-dropping] charges . . . [ELAP Services] tells its clients (generally medium-sized employers) to just say no.").

137. *See id.* ("Under ELAP's main [approach], neither employers nor their claims administrators sign contracts with hospitals.").

138. *See id.* (discussing how individuals can use any provider they choose because there is no network).

based on reference to the amounts paid by other payers.[139] For example, the company may reimburse the hospital at the Medicare reimbursement rate plus a percentage, such as 25% or 30%. Hospitals are not required to accept this amount as full payment, because they have not entered into a contract with the company/insurer. Moreover, the hospital may balance bill the patient/employee for the difference between the hospital's chargemaster amount and the amount paid by the company/employer.[140]

However, the companies that offer such plans and their third-party administrators typically fight such balance-billing efforts on behalf of the employee/patient.[141] The few companies offering such plans report great success so far.[142] One such third-party administrator is ELAP Services, a small benefits consulting firm, based in Chester Springs, Pennsylvania.[143] According to an ELAP spokesperson, when ELAP clients are sued by hospitals in pursuit of balance bills, the company "fights back with lawyers and several arguments. How can hospitals justifiably charge employers and their workers so much more than they accept from Medicare . . . ? How can hospitals bill $30 for a gauze pad? How can employee-patients consent to prices they will never see until after they've been discharged?"[144] ELAP reports that "[e]ventually, 'overwhelmingly, the providers just accept the payment' and leave patients alone."[145] Whether this approach will be upheld in court in hospitals' balance-billing claims against patients is unknown.

ELAP was named as a defendant in a federal district court case in Georgia, which was decided in 2012 in ELAP's and the employer's favor—but the issue in that case was limited to whether the administration of the direct payment plan was consistent with the Employee Retirement Income Security Act (ERISA).[146] The court held that it was, but as the provider was acting in the place of the insured pursuant to an assignment of the insured's rights to benefits under the plan the case did not involve balance billing.[147] That is, no state law claims, the balance-billing claim would be a contract claim, were part of the proceeding.[148]

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139. *See id.* ("[ELAP] estimate[s] costs . . . based on the hospital's financial reports filed with Medicare. Then it add[s] a cushion so the hospital [can] make a modest profit.").

140. *See id.* (discussing how ELAP fights back when clients are balance billed).

141. *See id.*

142. *See id.*

143. *See id.*

144. *Id.*

145. *See id.* (quoting Steve Kelly, Chief Exec. Officer, ELAP).

146. *See*, Floyd Med. Ctr. v. Warehouse Home Furnishings Distribs. Inc., No. 4:11–CV–15(CDL), 2012 WL 1438470, at *5 (M.D. Ga. Apr. 25, 2012) (addressing whether charges were "reasonable" and "customary" and whether they were covered).

147. *See id.* at *5–6.

148. *See id.* (stating that plaintiff did not "assert[ ] any type of state law claim that was independent of the federal ERISA claim").

III. WHAT COURTS CAN AND SHOULD DO NOW

Courts can use the common law of contracts to rein in abusive balance-billing practices. As this Part discusses, the common law of contracts is based on the premise that courts will enforce agreements that are entered into knowingly and freely by individuals.[149] Contracts entered into between healthcare providers and patients are not knowingly and freely entered into with respect to price, and therefore the courts should not

149. *See, e.g.*, Mark Klock, *Unconscionability and Price Discrimination*, 69 TENN. L. REV. 317 (2002).

> The consideration can be as nominal as a peppercorn for the agreement to be legally enforceable. Courts do not inquire into the distribution of benefits between the parties. This legal fact is deeply rooted in a strong faith in the efficiency of free markets. Individuals do not voluntarily enter into agreements that they expect to make them worse off than before the agreement. If the agreement was made voluntarily, everyone is presumed to have been made better off by the agreement. This presumption can be justified by economic thought which, given a few simple axioms, demonstrates that markets will channel resources to their most valued use and maximize society's wealth when all market participants are permitted to freely make their own decisions. Government intervention cannot improve the allocation of resources and can even impede it.

Id. at 343–44 (footnotes omitted); *see also, e.g.*, JOHN D. CALAMARI & JOSEPH M. PERILLO, THE LAW OF CONTRACTS §§ 1.3–1.4, at 4–10 (4th ed. 1998) (discussing freedom of contract and philosophical foundation of contract law respectively). *Ellsworth Dobbs, Inc. v. Johnson*, for example, involved a real estate broker who found a buyer for the seller. *See* 236 A.2d 843, 846 (N.J. 1967). The seller and buyer entered into a contract for sale, but the contract was never performed due to breach by the buyer. The broker brought suit against the seller, alleging that, based on the express terms of the listing agreement, the commission was earned upon execution of the contract between buyer and seller. The court ruled that any contractual provision in the listing agreement that required the seller to pay the commission even though the buyer of the land was unable to arrange financing and therefore breached the contract of sale, was "so contrary to the common understanding of men, and also so contrary to common fairness, as to require a court to condemn it as unconscionable." *Id.* at 857. In so ruling, the court applied the following reasoning, which is equally applicable to hospital admission contracts:

> Courts and legislatures have grown increasingly sensitive to imposition, conscious or otherwise, on members of the public by persons with whom they deal, who through experience, specialization, licensure, economic strength or position, or membership in associations created for their mutual benefit and education, have acquired such expertise or monopolistic or practical control in the business transaction involved as to give them an undue advantage. Grossly unfair contractual obligations resulting from the use of such expertise or control by the one possessing it, which result in assumption by the other contracting party of a burden which is at odds with the common understanding of the ordinary and untrained member of the public, are considered unconscionable and therefore unenforceable.
>
> . . . .
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> The perimeter of public policy is an ever increasing one. Although courts continue to recognize that persons should not be unnecessarily restricted in their freedom to contract, there is an increasing willingness to invalidate unconscionable contractual provisions which clearly tend to injure the public in some way.

Id. at 856, 857 (citation omitted).

enforce the ridiculous prices alleged to be due pursuant to these contracts.[150]

A. *Common Law of Contracts*

1. *Law of Voluntary Agreements: Freedom of Contract*

A contract may be defined as a promise the courts will enforce.[151] The concept of freedom of contract, which plays a central role in the law of contracts, reflects the idea that individuals should be free to enter into contracts on any terms they wish.[152] There are, of course, limits to the

150. *See supra* notes 43–48 and accompanying text; *see also, e.g.*, Phoenix Baptist Hosp. & Med. Ctr., Inc., v. Aiken, 877 P.2d 1345 (Ariz. Ct. App. 1994) (denying summary judgment where husband signed admission agreement for wife that purported to make husband as signer personally liable for services provided to his wife, noting that husband may not have understood agreement or felt he had no choice but to sign); Tunkl v. Regents Univ. of Cal., 383 P.2d 441, 447 (Cal. 1963) (rejecting contract with exculpatory clause, noting that 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, noting that hospital admission agreement "possess[es] all of the characteristics of a contract of adhesion"—contracts offered on a take-it-or-leave-it basis with no realistic opportunity to bargain and such that the goods or services cannot be acquired without agreeing to the terms offered—and that "admission to a hospital is an anxious, stressful, and frequently a traumatic experience" as result patient cannot reasonably be expected to read the printed agreement in detail much less to fully comprehend its terms); St. John's Episcopal Hosp. v. McAdoo, 405 N.Y.S. 2d 935, 937 (Civ. Ct. 1978) (holding that in emergency admission hospital should not be permitted to enforce contractual obligation entered into under such tension-laden circumstances).

151. *See* RESTATEMENT (SECOND) OF CONTRACTS § 1 (1981) ("A contract is a promise or a set of promises for the breach of which the law gives a remedy, or the performance of which the law in some way recognizes as a duty.").

152. *See* CALAMARI & PERILLO, *supra* note 149, § 1.3, at 5.

> The crux is that as England changed from a relatively primitive backwater to a commercial center with a capitalistic ethic, the law changed with it. As freedom became a rallying cry for political reforms, freedom of contract was the ideological principle for development of the law of contract. In Maine's classic phrase, it was widely believed that "the movement of the progressive societies has hitherto been a movement from *Status to Contract*." Williston adds: "Economic writers adopted the same line of thought. Adam Smith, Ricardo, Bentham and John Stuart Mill successively insisted on freedom of bargaining as the fundamental and indispensable requisite of progress; and imposed their theories on the educated thought of their times with a thoroughness not common in economic speculation."
>
> In the twentieth century the tide turned away from the nineteenth century tendency toward unrestricted freedom of contract. Today, while the parties' power to contract as they please for lawful purposes remains a basic principle of our legal system, it is hemmed in by increasing legislative restrictions. . . .
>
> Apart from legislative restrictions on freedom of contract, it seems likely that in the future there will be greater restrictions imposed by courts in the exercise of their function of developing the common law. There has been increasing recognition in legal literature that the bar-

freedom of contract doctrine, which reflect other policy concerns of our legal system.[153] For example, one cannot enter into an enforceable contract to sell illegal drugs.[154] However, within the broad parameters established by the legal system, freedom of contract is a fundamental principle of contract law. Moreover, the principle of freedom of contract is consistent with the idea of a free-market economy, and one of the most important functions served by contract law is to facilitate the operation of the free market.[155] That is, buyers and sellers may use contract law to create agreements on whatever terms they see fit.[156] In addition, the principle of freedom of contract counsels that the role of the courts is to enforce the agreement created by the parties.[157] Courts are not to create contracts for the parties, nor are courts required to approve the agreement the parties created, except to ensure that it falls within the broad parameters of contract law principles.[158] The parties must create their own contracts because it is only through the aggregate interactions (contracts) of market participants that the market can determine the appropriate allocation of resources.[159]

However, the doctrine of freedom of contract does not mean that the courts do not play a role in the contract formation process; on the contrary courts play a very important role by both establishing and enforcing the rules that must be followed to create a contract.[160] For example, courts apply these rules to ensure that only agreements knowingly and freely entered into by the parties are enforced.[161] Courts require that

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> gaining process has become more limited in modern society. In purchasing a new automobile, for example, the individual may be able to dicker over price, model, color and certain other factors, but, in order to consummate the contract to purchase, the individual usually must sign the standard form prepared by the manufacturer (although the contract is with an independent dealer). The individual has no real choice and must take that form or leave it. Such contracts, called contracts of "adhesion," constitute a serious challenge to much of contract theory.
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> Most of contract law is premised upon a model consisting of two alert individuals, mindful of their self-interest, hammering out an agreement by a process of hard bargaining. The process of entering into a contract of adhesion, however ". . . is not one of haggle or cooperative process but rather of a fly and flypaper." Courts, legislators and scholars have become increasingly aware of this divergence between the theory and practice of contract formation, and new techniques are evolving for coping with the challenges stemming from this divergence.

Id. § 1.3, at 5–6 (second alteration in original) (footnotes omitted).

153. *See id.*

154. S*ee id.*

155. *See id.*

156. *See id.*

157. *See id.*

158. *See id.*

159. *See id.*

160. *See id.*

161. *See, e.g.*, *supra* note 150.

contracts be knowingly and freely entered into because, to agree, both parties must know what they are agreeing to and voluntarily agree.[162]

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.[163] 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.[164] The doctrine of freedom of contract allows parties to agree to whatever terms they wish, but it does require that the parties agree.[165] Freedom of contract does not allow for the enforcement of the law of the jungle in the guise of a contract. If one party purports to agree to allow the other party to charge any amount he wishes as the price of the contract, such an agreement is not likely a contract, because it was not likely knowingly and freely entered into.[166] Who would knowingly and freely agree to such a term? No one. Yet, as discussed *infra*, this is precisely what hospitals claim.

Traditionally courts have required the parties to specifically agree to all necessary terms in order to create a contract.[167] However, modern courts are more willing to supply missing terms for the parties if the court is convinced that the parties in fact intended to enter into a contract even if the words or writings of the parties do not clearly establish all necessary terms.[168] When the court fills in this term, it provides a term that is consistent with the reasonable expectations of the parties.[169] For example, if

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162. *See supra* note 150.

163. *See* RESTATEMENT (SECOND) OF CONTRACTS § 77 (1981) (defining *illusory promise* as one that furnishes no basis for a contract because of lack of consideration); CALAMARI & PERILLO, *supra* note 149, §§ 2.1, 2.13, at 25, 73 (discussing mutual assent and indefiniteness respectively).

164. *See, e.g.*, *supra* note 152.

165. *See supra* notes 150 & 164.

166. *See supra* note 150.

167. *See supra* note 163.

168. *See* CALAMARI & PERILLO, *supra* note 149, § 2–13, at 45–46 (2d ed. 1977).

> There is an important distinction between cases in which the parties have purported to agree on a contractual provision and have done so in a vague and indefinite manner and cases in which they have remained silent as to a material term or have discussed the term but did not purport to agree upon it. When parties are silent as to a material term, often the reasonable conclusion is that they intended that the term be supplied by implication. Thus, if *A* and *B* agree that *A* will perform a service for *B* and no mention is made of price, it will be implied that the parties intended that a reasonable price should be paid and received. The same is true if goods are involved. It will be assumed that the parties contracted in terms of a reasonable price which will ordinarily be the market price. Where there is no market price the reasonable price may be determined by actual cost plus a reasonable profit or other means of valuation.

Id. (emphasis added) (footnotes omitted); *see also* RESTATEMENT (SECOND) OF CONTRACTS § 204 (1981) (discussing how to supply omitted essential terms).

169. *See* RESTATEMENT (SECOND) OF CONTRACTS § 204 ("When the parties to a bargain sufficiently defined to be a contract have not agreed with respect to a term which is essential to a determination of their rights and duties, a term which is

the court is called upon to fill in the price term of the contract, it will seek to determine a fair and reasonable price, because this is what reasonable contracting parties would intend.[170]

2. *Objective Intent and the Essential Requirements of Contract*

While a contract is a promise the courts will enforce and while all contracts are promises, not all promises are contracts. The common law of contracts uses the concept of objective intent and from it has derived the essential requirements of contract in order to determine which promises are contracts and which are not.[171] Objective intent is very different than subjective intent.[172] Objective intent makes no attempt to pick the brain of the person whose intent is in question.[173] Rather, to determine objective intent, we do not focus at all on the person whose intent we are trying to determine; we instead focus on a hypothetical reasonable person in the position of the other party—the party interacting with the person whose intent we are trying to determine.[174] The law uses the hypothetical reasonable person to determine the objective intent of the other person based on the other person's objective manifestations.[175] Objective manifestations are the things done and said—in this context by the person who's intent we are trying to determine—that may be perceived by others.[176] Thus, for contract law purposes, a person's intent is

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reasonable in the circumstances is supplied by the court."); CALAMARI & PERILLO, *supra* note 149, § 2.9.

170. *See* RESTATEMENT (SECOND) OF CONTRACTS § 204 cmt. d (citing U.C.C. § 2-305).

171. *See, e.g.*, CALAMARI & PERILLO *supra* note 149, § 2–2, at 24–25 (2d ed. 1977) (discussing objective and subjective intention).

> A party's intention will be held to be what a reasonable man in the position of the other party would conclude his manifestations to mean. By testing the meaning to be given to a party's words from the point of view of the reasonable man in the second party's position, the subjective element of this party's particular knowledge is incorporated into the objective test. In other words, the test considers what the second party knows or should know about the intention of the first party.
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> The objective theory is strongly supported by those who place the basis of contract law upon the promisee's justified reliance upon a promise or upon the needs of society and trade. An objective test is believed to protect "the fundamental principle of the security of business transactions." Even those who espouse intention as the basis of contract obligations are generally willing to hold a promisor to the reasonable meaning of his words, basing such liability on a theory of negligence, but are inclined to wish that the objective theory be held on a short leash, and to allow subjective intention a high degree of relevance in the resolution of many contractual issues.

Id. (footnotes omitted).

172. *See id.*

173. *See id.*

174. *See id.*

175. *See id.*

176. *See id.*

deemed to be that which is consistent with the perceptions of a hypothetical reasonable person in the other party's position.[177]

Using an objective standard to determine intent for contracts provides certainty, which is especially important given the role that contract law plays in facilitating business transactions. Under the doctrine of freedom of contract, whether the parties have entered into a legally enforceable agreement, a contract is and should be based on the intent of the parties involved. However, the intent we are concerned with is their objective intent. As a result, the essential requirements of contract reflect what we would expect hypothetical reasonable people to do if they intended to enter into an enforceable exchange of promises. Specifically, the essential requirements of contract are (1) offer and acceptance, (2) consideration, (3) legal abject, and (4) capacity. In particular, the specific requirements for the offer and acceptance reflect the objective intent idea.[178]

3. *Offer and Acceptance: Knowingly and Freely Agreeing*

In order for an offer to be made, three requirements must be satisfied. The first is intent to contract.[179] That is, the person making the offer, the offeror, must indicate a willingness to exchange one thing for another.[180] The second requirement is that the terms of the offer must be reasonably definite and certain.[181] Not only does this requirement indicate that the parties have fully developed their agreement, it also, as a practical matter, is necessary for the court to determine if a breach has occurred and, if so, the appropriate remedy.[182] The third requirement is that the offer must be communicated to the person who is trying to accept it.[183]

For example, if one party, a new car dealer, says to another, "I would like to sell this car," and the other party, after test driving the car and fully examining it, says, "I would like to buy it," no contract has yet been formed, because the parties have not specified the terms of the contract with reasonable certainty. That is, we do not know the price the seller is willing to accept or the price the buyer is willing to pay. Moreover, without this information, it seems unlikely that the parties have actually entered into a contract; rather, they seem to still be in the process of

177. *See id.*

178. *See e.g.*, *id.* § 2.1, at 26 (5th ed. 2003) (noting that essential prerequisite to formation of informal contract is agreement—mutual manifestation of assent to same terms).

179. *See id.*

180. *See id.* § 2.5, at 31 (citing RESTATEMENT (SECOND) OF CONTRACTS § 2) (specifying that parties must make commitment to do or refrain from doing some specified thing in future).

181. *See id.* § 2.13, at 75 (noting performances to be rendered by both parties must be reasonably certain).

182. *See id.*

183. *See id.* § 2.15, at 78 (adding that generally offeree must know of offer to accept).

negotiation.[184] However, a problem arises where the parties act as though they have a contract, even though their words or writings have not spelled out all of the terms.[185]

In the above example, this situation would be illustrated if the seller had delivered the car to the buyer, and the buyer accepted it notwithstanding the fact that they had not agreed on a specific price.[186] Given the actions of the parties, it is clear that they both thought that they had a contract; why else would the car have been delivered and accepted?[187] However, if the parties cannot agree on a specific price, for example, the seller sends a bill to the buyer, which is higher than the buyer is willing to pay, then a court may be called upon to determine the price.[188] In doing so, the court will seek to determine a reasonable price, one to which reasonable contracting parties would agree.[189] While reasonable people may differ somewhat concerning what constitutes a fair price, the MSRP or manufacturer's suggested retail price of the car is clearly not a reasonable price because it is set to be discounted and not paid.[190] The same is true of list prices in healthcare except that in healthcare the list price is set much higher as a percentage of reasonable value than in the case of an automobile.[191]

4. *Types of Contracts*

There are various types of contracts, including express, implied-in-fact, and implied-in-law.[192] All real contracts (as discussed below, implied-in-law contracts are not real contracts) must satisfy the same essential requirements discussed above. The difference between an express contract and an implied-in-fact contract is the way in which the parties create the contract.[193]

An *express contract* is created by the use of words, either written or oral.[194] For example, a typical type of express contract is an Agreement of Sale for real estate. This contract is formed by words, the words written in the Agreement of Sale and agreed to by the parties as evidenced by their signature at the end of the agreement. An *implied-in-law contract* is created

184. *See supra* notes 170–83 and accompanying text.

185. *See, e.g.*, CALAMARI & PERILLO, *supra* note 149, § 2.18, at 82 (5th ed. 2003).

186. *See, e.g.*, U.C.C. § 2-207(3) (2013) (describing "[c]onduct by both parties which recognizes the existence of a contract").

187. *See id.* § 2-207(1)–(2).

188. *See supra* notes 170–83 and accompanying text.

189. *See* CALAMARI & PERILLO, *supra* note 149, § 2.9, at 55 (5th ed. 2003) (discussing that courts fill gaps with terms that "comport[ ] with community standards or fairness and policy").

190. *See id.*

191. *See supra* notes 46–51 and accompanying text.

192. *See* CALAMARI & PERILLO, *supra* note 149, § 1.11, at 21 (4th ed. 1990) (discussing express, implied, and quasi contracts).

193. *See generally id.*

194. *See id.*

by the actions of the parties. For example, assume that Joe often visits Jane's Candy Store on his lunch break and usually buys a candy bar for one dollar. One day during his lunch break, Joe visits Jane's candy store and selects a candy-bar but observes that Jane is busy with a customer and has several other customers waiting. Joe catches Jane's attention shows her the candy bar and walks out of the store.[195] Based on these facts, Jane and Joe have entered into a contract pursuant to which Joe is legally obligated to pay for the candy bar.[196] The contract is based on the actions of the parties.[197] Specifically, Jane has made an offer by setting up her store, inviting the public to shop there, and placing the candy out for sale. Joe has accepted by taking the candy bar, acknowledging it to Jane and leaving the store. The requirement of consideration is satisfied because the candy is being exchanged for the money. There is nothing illegal about buying and selling candy, and as long as both parties have capacity to contract, all of the essential requirements for a contract have been satisfied and enforceable contract has been formed. In this case, the price, like the other terms of the contract, is established by the conduct of the parties.[198] Specifically, their prior dealings establish one dollar as the price.[199]

Of course, in a free market, Jane is free to change her prices at any time. However, in order for a changed price to become part of the contract, the other party must agree to it.[200] For example, if Jane had decided to raise her prices the night before Joe came into the store, would Joe be bound to pay the new price? The answer depends on whether the parties intended (objectively) the new price to apply.[201] In this case, if Jane had clearly marked the new price on the candy, then the new price would become part of the contract.[202] In other words, if the new price were clearly marked, a reasonable person in Joe's position would only have taken the candy bar if he were willing to pay the posted price.[203] On the other hand, if Jane had failed to take actions necessary to bring the new price to the attention of a reasonable person in the buyer's position, then the new price would not apply to the contract.[204]

An implied-in-law contract, also called a *quasi-contract*, is not a real contract and therefore does not depend upon these essential requirements for its enforceability.[205] The requirements for a quasi-contract are that a benefit has been given by one party to the other, the party receiving

195. *See* RESTATEMENT (SECOND) OF CONTRACTS § 4 illus. 2 (1981).
196. *See id.*
197. *See id.*
198. *See id.*
199. *See id.*
200. *See supra* notes 151–83 and accompanying text.
201. *See supra* note 171.
202. *See id.*
203. *See id.*
204. *See id.*
205. *See* CALAMARI & PERILLO, *supra* note 149, § 1.11, at 21.

the benefit has kept it—that is, refused to return it—and the court finds that allowing the party to keep the benefit without payment is unfair.[206] When a court decides that a quasi-contract exists, it will require the benefitted party to pay the amount necessary to remedy the unfairness. A quasi-contract is not a real contract because it is not based on the agreement of the parties; rather it is based on the equitable policy of furthering justice by preventing an unjust enrichment.[207] Moreover, since there is no agreement between the parties, the court has to provide the appropriate amount to be paid.[208] In most real contract cases, the court enforces the amount that the parties have agreed upon.

A fair question at this point is *what does all of this have to do with contracting for healthcare?* The principles just discussed apply to contracting in general and thus apply to contracting for healthcare. Moreover, some commentators get confused regarding the distinction between implied-in-law contracts and implied-in-fact contracts, especially in the healthcare context.[209] This may be due in part to a very common law school example involving healthcare services.

The law school example involves a doctor, licensed and in good professional standing under the applicable state law, happening upon an injured motorist on the side of the highway who has been in an accident.[210] The injured person is unconscious and in need of medical attention.[211] The doctor provides medical attention and then sends a bill to the patient.[212] May the doctor recover for the services he provided?[213] There is certainly no real contract between the doctor and the patient, since there was never any agreement between them due to the fact that the patient was unconscious. However, under the doctrine of implied-in-law contract, the doctor may recover the fair value of his services from the patient.[214] It is reasonable to assume that most patients in this situation would want the

206. *See id.* at 22 (describing quasi-contract as "the body of law to which we look for the reallocation of gains and losses between the parties").

207. *See id.*

208. *See id.*

209. *See id.*

210. *See id.* at 21.

211. *See, e.g.*, Barak D. Richman, Mark A. Hall & Kevin A. Schulman, *Overbilling and Informed Financial Consent—A Contractual Solution*, 367 NEW ENG. J. MED. 396 (2012) (recounting this example and mislabeling it as implied-in-fact contract).

212. *See id.* ("A staple law-school hypothetical illustrates the usual function of implied contracts: a physician encounters an unconscious stranger in the street who requires immediate medical attention. The physician promptly gives the stranger the requisite emergency care and later submits a bill for her services. Is she entitled to payment?").

213. *Id.*

214. *Id.*; *see also* CALAMARI & PERILLO, *supra* note 149, § 1.11, at 21 (providing similar example).

doctor's services, and therefore the patient will receive an unjust enrichment unless required to pay the doctor.[215]

When it comes to the question of how much the doctor should be paid, obviously this cannot be based on the agreement of the parties, so the court must fill in the amount.[216] In setting the price, the court uses the fair market value of the services because it is reasonable.[217] While this scenario may be relevant to an emergency department situation, it is not directly relevant to the balance-billing context. As discussed in the next Section, in typical balance-billing contracts, there is no question that the parties have entered into an agreement for medical services, pursuant to which the patient expects to pay for the medical services received.[218] The problem in the balance-billing context is that the parties have not specifically agreed to a price; hospitals typically require patients to sign some agreement pursuant to which the patient purports to agree to pay for the services received at the hospital's chargemaster, usual, or customary prices.[219] The problem, as discussed above, is that chargemaster prices are not usual or customary; they are exorbitant, grossly unfair, and are set to be discounted rather than paid.[220] In other words, in the balance-billing context, it is as though the parties have entered into a contract for medical services but have not specified a price.[221]

5. *Good Faith*

The common law recognizes an obligation of good faith in every contract.[222] Good faith is generally defined as honesty in-fact and the observance of reasonable commercial standards of fair dealing.[223] As a result, all parties to a contract must act in good faith in the performance and enforcement of every term of a contract. The obligation to act in good faith strengthens this Article's conclusion. That is, to pay the hospital based on its chargemaster or similar rates in cases where a patient has agreed by signing a "Statement of Financial Responsibility" or some other open-ended financial agreement at the time of admission to the hospital, the common law requires that this provision be performed and enforced in good faith. Good faith, as noted, requires observance of reasonable commercial standards of fair dealing. As a result, it would be inconsistent

215. *See id.*

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

217. *See id.*

218. *See infra* notes 227–29 and accompanying text.

219. *See supra* notes 1–17 and accompanying text.

220. *See supra* notes 43–48 and accompanying text.

221. *See supra* notes 178–90 and accompanying text.

222. *See* RESTATEMENT (SECOND) OF CONTRACTS § 205 (1981) (imposing duty of good faith on parties to contract).

223. *See id.*

with the common law of contracts to allow the hospital to recover based on its chargemaster rates. Rather, the observance of reasonable commercial standards of fair dealing would require that the hospital be permitted to recover no more than a reasonable price for its services.[224]

B. *Contracting for Healthcare*

1. *Promise to Pay Regular, List, Customary, or Chargemaster Rates*

In the balance-billing context, however, hospitals argue that the parties have established a formula to arrive at the ultimate price that the patient will pay for the services provided based on the hospital's chargemaster, and therefore the court must use this formula to determine the amount the patient owes.[225] But have the hospital and the patient really agreed on a price? The answer is clearly no, as the supposed chargemaster based formula is illusory; all aspects of it remain completely within the control of the hospital.[226] The problem of inexact price information at the time of contracting is not unique to the sale of healthcare, but healthcare is the only area in which the parties purport to use a blank check as payment.[227] For example, many professionals such as lawyers base their charges on an hourly rate, and it is often not possible to know at the time of engagement how many hours a matter will take. However, unlike the healthcare situation, the hourly rate is agreed to at the time of engagement and cannot be changed unilaterally by the lawyer. In contrast, hospitals often do not provide any price information, a copy of their chargemaster, or any other specific information to the patient at the time of contracting, and worse—hospitals retain the right to change their chargemaster rates at any time.[228]

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

224. *See supra* notes 1–2 and accompanying text.

225. *See e.g.*, Allen v. Clarian Health Partners, Inc., 980 N.E.2d 306, 310–11 (Ind. 2012) (stating chargemaster rates should be used to set contract prices).

226. *See, e.g.*, Rosenthal, *supra* note 37 (quoting Professor Glenn Melnick) (noting that hospitals may set chargemaster rates at any level they want and set them to "maximize revenue"); *see also* Nation, *Chargemaster Insanity*, *supra* note 12, at *1–18 (same).

227. *See* Nation, *Determining Fair and Reasonable Value*, *supra* note 7, at 426–32 (describing patient as giving hospital ability to unilaterally determine prices later).

228. *See* Anderson, *supra* note 3, at 786 (noting that hospitals may change their chargemaster rates at any time).

obligation of good faith discussed in Part IV(A)(5) requires that the mechanic exercise discretion to set the price in good faith;[229] that is, the mechanic must set a commercially reasonable price.[230] The mechanic cannot charge any more than the fair market value for the work the mechanic has performed. If the mechanic and customer cannot agree as to what a reasonable price is, then the court will set the price.[231]

Similarly, in the case of contracting for healthcare, the court must step in and provide the price for the parties since it is clear—based on both the conduct and words of the patient and the hospital—that they intend to have a contract. The court should reject the hospital's claim that it should be free to calculate the price, based on its elusive and ever-changing chargemaster rates, and should, consistent with the common law principles of contract, imply a term into the contract that requires the patient to pay a reasonable price for the services received.[232]

2. *Patients Required to Pay Prior to Treatment*

Where the hospital requires an upfront payment of all, or a certain percentage of the overall amount that the patient will be liable for, the parties have effectively established a specific price for the services that will be provided by the hospital. In this case, usually there is still a good argument that under contract law principles, the patient should be liable for no more than the reasonable value of the services received. This argument focuses on the common law requirement that contracts be knowingly and freely entered into.[233] Chargemaster prices are simply unreasonable; no reasonable person would knowingly and freely agree to pay such exorbitant rates.[234] That is, if the hospital had informed the patient that they were being asked to pay at least 2.5 times the amount that in-network patients pay and that the hospital gladly accepts this lower amount as full payment for the same exact services, no reasonable patient who had a choice would agree to pay the exorbitant chargemaster rates.[235] As a result, a good argument also remains that an agreement to pay chargemaster prices is unconscionable.[236] That is, the patient either did not make an informed choice to pay these prices or the patient had no

229. *See supra* notes 224–26 and accompanying text.

230. *See supra* notes 169–74 and accompanying text (discussing implied contracts that rely on reasonable terms).

231. *See* RESTATEMENT (SECOND) OF CONTRACTS § 204 (explaining courts infer terms such as price that are reasonable under circumstances).

232. *See infra* notes 240–62 and accompanying text.

233. *See supra* notes 150–92 and accompanying text.

234. *See supra* notes 43–48 and accompanying text.

235. *See* Bai & Anderson, *supra* note 10, at 923 (noting that in 2012 on average U.S. hospital charges were 3.4 times Medicare-allowable cost); *see also supra* notes 43–48 and accompanying text.

236. *See* Nation, *Obscene Contracts*, *supra* note 3 (arguing that contracts with hospitals pursuant to which patients purportedly agreed to pay chargemaster rates are unconscionable).

choice but to agree. If the patient did not have the ability to acquire the services elsewhere, the contract is procedurally unconscionable, and because the chargemaster rates are grossly unfair, the contract is also substantively unconscionable.[237] Thus, the contract should not be enforced.[238] Other common law theories might also be applicable in this context, including fraud in the inducement or undue influence. Ultimately, what gives all of these arguments strength is the truth of the basic facts underlying the transaction. Specifically, chargemaster prices are exorbitant and unfair and no sane person properly informed would agree to pay them.

3. *Determining the Reasonable Price of Healthcare*

I have written previously and in detail about how courts should determine the reasonable price for healthcare.[239] It is sufficient here to note that I strongly support using, when possible, a price set by the free market as a basis from which to establish the reasonable price. When this is not possible, it may be necessary to alternatively use the Medicare price as a basis.

4. *Rejecting Usual, Customary, and Necessary*

How do we determine the fair and reasonable price for healthcare? Hospitals would prefer to frame the question in its traditional manner: what is the usual and customary charge for the necessary medical services provided? Hospitals, of course, answer this question with reference to their chargemasters. They support this argument with a deceptive statement that "all patients are billed chargemaster rates," and therefore those rates are their usual and customary rates.[240] However, while all patients may be *billed* chargemaster rates, all patients are not expected to and do not in fact *pay* chargemaster rates.[241]

Moreover, the hospital knows, accepts, and plans on treating the majority of its patient's pain on less—*much* less—than chargemaster rates.[242] Chargemaster rates are a fiction, they are not set to be paid; they are set to be discounted.[243] Statements by hospital administrators to the contrary are disingenuous. Once the relevance of chargemaster rates are rejected, then the question can be phrased properly: what is the value established by the market of the services provided by the hospital? In other words, what is the fair market value of the services the hospital has provided? Thus, the focus is on what is actually paid and accepted for the services,

237. *See id.* at 128–32 (discussing cases in which courts did not enforce excessive hospital bills).

238. *See id.* at 132–34.

239. *See generally* Nation, *Determining Fair and Reasonable Value*, *supra* note 7.

240. *See id.* at 430.

241. *See id.*

242. *See id.*

243. *See id.*

and not on some phantom chargemaster-based billed charges that very few ever pay and that no one should be expected to pay.[244]

5. *Prices Based on Fair Market Value*

The fair and reasonable value of medical expenses must be based on the usual amount actually paid to the provider, not by the amount billed by the provider.[245] A hospital invoice of itemized billed charges at chargemaster rates is, when it comes to measuring fair value, a complete fiction and should not be used by courts or others to establish the fair and reasonable value of medical services.[246] Hospitals engage in price discrimination. They charge different amounts to different patients for the same exact services, depending upon the identity of the party paying the bill.[247] Government insurers pay the least, private insurers pay more, and self-pay patients, including individuals with private insurance that receive balance-bills, pay the most.[248] As a result of the perceived unfairness of this price discrimination, some commentators have called for an all-payer system.[249]

Under an all-payer system, various methods may be used to arrive at a particular price for a good or service.[250] For example, the government may set prices or each hospital may set its own price. However, regardless of how prices are set, once they are set, the price must be posted for public view and must apply to all patients without discrimination.[251] Although I recognize that it is unfair to allow hospitals to charge any patient chargemaster rates, I have argued against all-payer systems, because a part of what appears to be price discrimination is really market-driven discounting designed to purchase value from specific buyers.[252] Because of this, imposing an all-payer system would be disruptive to the market and create inefficiency.[253]

Hospitals charge lower rates to insurers because insurers provide certain benefits to hospitals.[254] These benefits include an increased volume of business through access to patients who are insured by the insurance company, assurance of quick and full payment of discounted charges from the insurance company, as well as marketing and advertising benefits that result from being listed as "in-network" by the insurance company.[255]

244. *See id.*

245. *See id.* at 457–65 (arguing that amount should be "determined by the lowest amount the hospital/provider accepts as full payment from government or private insurers").

246. *See id.* at 446–57 (detailing hospital pricing and relationship to insurers).

247. *See id.*

248. *See id.*

249. *See id.*

250. *See id.*

251. *See id.*

252. *See id.*

253. *See id.*

254. *See id.*

255. *See id.*

These benefits are valuable to hospitals and result in a portion, but only a portion, of the discount from chargemaster rates that private insurers receive. It is likely that the most important of these benefits to hospitals is the increased volume of business that results from entering into a contract with a large insurer.[256] After all, any patient who pays with a credit card provides an assurance of payment similar to that provided by the insurance company. Hospitals reason that because individuals do not bring the extra benefits such as an increased volume of business, which insurance companies bring to hospitals, individuals should pay more than the amount paid by insurers.[257]

The best way for courts and others to determine the fair and reasonable value of medical services is to start with the average amount the hospital would be paid by private insurers and then add to this an amount between 10% and 15% to account for the value of the benefits private insurers provide to hospitals.[258] It is important to note that the system I recommend, while it may be described as a form of price-fixing, is different than a government-controlled, all-payer system. The formula I suggest to determine a fair and reasonable price is based on a price freely set by the market.[259] No individual market participant, provider or insurer, may control the base.[260] Encouraging a freer and more transparent market for the sale of healthcare is the only approach that will result in appropriate pricing while simultaneously encouraging the development of the best healthcare in the world. More price-fixing will only make the problem worse.[261]

IV. CONCLUSION

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

256. *See id.*

257. *See id.*

258. *See id.* at 460–65 (suggesting method to determine "fair and reasonable value of medical services"); *see also* Anderson, *supra* note 3 (developing another method).

259. *See* Nation, *Determining Fair and Reasonable Value*, *supra* note 7 (explaining how method takes supply and demand principles into account).

260. *See id.*

261. *See id.*

However, courts can and should begin now to rein in the balance-billing problem. As this Article explains, the common law of contracts provides the necessary tools for courts to use to enforce fair and reasonable prices in contracts for healthcare. When an individual contracts with a hospital for healthcare, courts should use these common law tools to ensure that the patient is not liable to pay any more than a fair and reasonable price for the services received. Moreover, a fair and reasonable price should be based on the average amount the hospital receives from private insurers for the services provided to the patient.