In a free market businesses may usually set their prices as they see fit. Of course potential customers may refuse to accept the prices set by a particular business if they perceive them as too high. These customers may choose instead to purchase goods or services from a lower priced competitor. In fact, most regulations regarding price aim to insure that the customer has complete price information before a contract is created.[1][1] The business of healthcare, however, has certain characteristics that distinguish it from most other businesses and that in some cases should limit the ability of health care businesses to freely set prices.

One important characteristic of health care is that medical services, especially those provided by hospitals, are usually purchased by consumers who do not know at the time of purchase how much the services will cost.[2][2] In the case of hospital provided care, even the hospital does not know the exact amount it will bill the patient at the time of purchase. Patients sign an "Authorization for Treatment" and/or "Statement of Financial Responsibility" or other similar open-ended agreement pursuant to which the patient purports to agree to pay for all medical goods and services provided by the hospital at the hospital's list (chargemaster) prices.[3][3] In reality however, this type of agreement amounts to a

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

[2][2] *See infra* notes 7-20 and accompanying text.

[3][3] *See e.g., Cape Regional Medical Center v. Karen Sanchez* an unpublished decision of the Superior Court of New Jersey, on file with the author (hereinafter *Sanchez*) at 2. (This case involved a patient who received Emergency Room services at Cape Regional following a car accident. The patient was not covered by her auto insurer for medical care but was covered by her Medicaid carrier, however by the time Cape Regional submitted their claim to the Medicaid carrier it was too late and thus denied. Cape Regional sued Sanchez for the total billed charges $1,495 even though it would have accepted $494.85 from Medicaid as full payment. The court notes that Cape Regional based its claim against Sanchez on the "authorization for treatment signed by the Defendant and the authorization for financial responsibility also signed by

blank check given by the patient to the hospital with the amount to be filled in unilaterally by the hospital at a later date.[4][4] This situation would, perhaps, be tolerable if hospitals or other providers of healthcare used their discretion in these cases to charge (fill in) a fair and reasonable price for the medical goods and services provided.[5][5] After all, the problem of inexact price information at the time of contracting is not unique to the sale of healthcare. For example, when a client hires a lawyer the client and lawyer know the lawyer's hourly billing rate, but neither party can know how much time the matter will ultimately take. Or for instance, in the case of auto repair, often neither party knows at the time of contracting the exact amount of the ultimate repair bill. But, in the case of healthcare, for reasons discussed *infra*, the amount ultimately charged by the hospital or other provider, when based on the provider's list or chargemaster prices is not reasonable but is exorbitant and grossly unfair.[6][6]

A chargemaster is an extensive price list created and maintained by hospitals and other providers.[7][7] A hospital's chargemaster, lists a price for each good and service provided by the hospital (20,000 or more separate items may be

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Defendant." *Id*. The court noted that these documents routinely form the basis of a hospital's collection effort. *Id.*

[4][4] *Id.* at 9("The patient or one of his or her loved ones signs the authorization form for payment which is in reality a blank check with the numbers to be filled in by the hospital billing department.") *Id.*

[5][5] In fact one may argue that hospitals should not be permitted to collect their chargemaster or list prices from any patient based on an agreement signed at the hospital at the time of treatment. *See generally*, George A. Nation III, *Obscene Contracts: The Doctrine of Unconscionability and Hospital Billing of the Uninsured*, 94 Kentucky Law Journal 101 (2005-2006).

[6][6] *See infra* notes 21-42 and accompanying text.

[7][7] *See e.g.*, Uwe E. Reinhardt, *The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy* 25.1 Health Affairs 57 at 58 (Jan/Feb 2006). ("A hospital's chargemaster is a lengthy list of the hospital's prices for every single procedure performed in the hospital and for every supply item used during those procedures.").

included).[8][8] Hospitals update, that is increase these list prices frequently.[9][9] From 1984 to 2004 for example, chargemaster prices increased 10.7% per year, and this was much faster than Medicare allowable costs (6.3%) or hospital net-revenues (6.6%).[10][10] Thus, as discussed *infra* while increases in list prices do not add dollar-for-dollar to the net revenues a hospital receives, higher chargemaster prices do for a variety of reasons result in an increase in net revenues.[11][11] In addition, there are other reasons for a hospital to set continually higher list prices[12][12] and no reason for them not to constantly increase list prices.[13][13] Hospitals in general do not provide prospective patients with a copy of the chargemaster.[14][14] However, even if a copy of the hospital's chargemaster were provided to each potential patient prior to treatment, it would mean very little to the patient. With regard to healthcare the patient does not know what he is purchasing in a way that would allow the patient to use the chargemaster to calculate the price.[15][15] A patient may know for instance that he needs a hernia repair procedure and he may have discussed the various procedures in detail with

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[8][8] *Id*. (noting that a sample chargemaster posted on the website of California's state government contains close to 20,000 items).
[9][9] *Id*.
[10][10] See Gerard F. Anderson, *MARKETWATCH: From 'Soak the Rich" to "Soak the Poor': Recent Trends in Hospital Pricing*, 26.3 Health Affairs 780 (May/June 2007) at 781.
[11][11] *See e.g.*, C.P. Tompkins, S.H. Altman and E. Eilat, *The Precarious Pricing System for Hospital Services*, 25(1) Health Affairs 45 (2006) (individual items in the chargemaster are subject to smaller- or larger-than average increases based on the advice of an "array of consultants and computer software to determine optimal increases in charges for various services (where optimal means "the largest increase in net revenues for a given increase in charges")). Id. at 49. See also *infra* notes 206-233 and accompanying text.
[12][12] *See infra* notes 233-240 and accompanying text.
[13][13] There is no downside to high list or chargemaster prices (chargemasters are very rarely made public so no customers are frightened away) only potential reward.
[14][14] *See* Reinhardt *supra* note 7 at 59 ("With the exception of California, which now requires hospitals to make their chargemasters public, hospitals are not required to post their chargemasters for public view.")
[15][15] *See* Anderson *supra* note 10, at 784 noting the reasons that chargemaster information will not allow self-pay patients to negotiate lower prices (patients don't know in advance the services they need from the hospital, chargemasters contain on average 25,000 items, chargemasters are written in billing code that most patients would not understand, and hospitals may change chargemaster rates at any time). *Id*.

his doctor in order to determine which one is best for him, but even if the patient is very well informed regarding hernia repair options, he has no idea how many pairs of surgical gloves or how much operating room time, or how much suture material etc. is needed to perform this procedure. Moreover, in some cases such as emergency services a patient may not even know in a general way what treatment he is seeking.[16][16] In other words, while a hospital's chargemaster is like a menu or pricelist, it is not something that (even if it were available) most patients could read in a meaningful way to calculate in advance how much they will owe for their treatment.[17][17]

This is not to say that consumers may not be effective advocates for lower prices, in this case I am simply recognizing the reality that as long as hospitals use a la carte pricing based on chargemasters, consumers will not be able to effectively negotiate price.[18][18] But, neither government insurers nor most private insurers accept a la carte pricing, rather they demand procedure based pricing based either on DRGs (diagnostic related groups) for inpatient care or on APCs (ambulatory payment classification) for outpatient services.[19][19] It should be noted, however, that even in the case of Medicare reimbursement, higher chargemaster rates result indirectly in higher net revenues for hospitals.[20][20] If hospitals published procedure based prices, and applied them to individual

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[16][16] *Id*.
[17][17] *Id*.
[18][18] *Id*.
[19][19] *See* Reinhardt *supra* note 7 at 59-60 discussing various billing/price setting methods for various payers.
[20][20] *Id*. at 60 (noting that the DRG Weights used by Medicare are recalibrated regularly on the basis of average standardized, billed charges for all cases falling into each DRG in the most recent Medicare file.)

consumers, then non-emergency patients could effectively compare prices among providers.

Another important characteristic of health care is that chargemaster or list prices are not fair or reasonable. They are grossly inflated because they are not set to be paid; they are set to be discounted.[21][21] Hospitals, in general, do not expect to recover these inflated prices, but for reasons discussed *infra* they are very reluctant to reduce them for self-pay patients.[22][22] Nevertheless, hospitals and other providers maintain that the grossly inflated list prices contained in their chargemasters are "reasonable and customary," in part because every patient, insured or uninsured, receives a detailed itemized bill reflecting chargemaster prices.[23][23] As a result, hospitals sometimes claim, disingenuously, that all patients are billed at chargemaster rates.[24][24] However, while all patients are billed chargemaster rates all patients are *not* expected to pay the billed charges.[25][25] As discussed *infra*, for insured patients the billed (chargemaster based) amount is dramatically (at least 50%) discounted![26][26] Thus, while hospitals claim that the chargemaster rates reflect their usual and customary charge for services they certainly do not represent the usual price actually paid for the listed goods and services. Self-pay patients, who represent a small portion of a

[21][21] *Id*. at 57 (chargemasters rates are much higher than the prices U.S. hospitals are actually paid; in 2004 U.S. hospitals were actually paid only about 38% of their charges by patients or their insurers).
[22][22] *See infra* notes 206-233 and accompanying text.
[23][23] *See* Reinhardt, *supra* note 7 at 58 ("Typically, a hospital will submit for all of its patients, detailed bills based on its chargemaster, even to patients covered by Medicare.") (It might be argued that because hospitals initially bill all of their patients at their chargemaster prices they do not engage in "price discrimination" … but the author finds such argument unpersuasive) *Id*. at 60.
[24][24] *Id.*
[25][25] *Id.* At 57 (in 2004 hospitals were actually paid only about 38% of their charges), and 58-60 (discussing the specifics of discounting chargemaster charges for government and private insurers).
[26][26] *See infra* notes 206-233 and accompanying text.

hospital's patients, are the only patients expected to actually pay the full hospital bill based on chargemaster rates.[27][27] Self-pay patients include: the uninsured, (it is important to note that even with the Patient Protection and Affordable Care Act (aka "ObamaCare") hereinafter the ACA there will still be a significant number of Americans without health insurance, for example it is estimated that ten years after the ACA becomes fully operational there will be 30 million Americans uninsured)[28][28] international visitors who receive medical care here, and people insured by health plans lacking contracts with hospitals (out-of-network patients subject to so called "balance billing" or those who self-insure via reliance on a heath savings account).[29][29]

A third important characteristic of the sale of healthcare is that hospitals and other providers engage in extensive and significant price discrimination.[30][30] As discussed *infra* providers of medical services routinely and significantly discount their chargemaster prices pursuant to specific contracts with HMOs and private insurance companies.[31][31] While all insurers pay discounted rates, the amount of the discount and thus the amount paid by insurers for the same health care varies widely with no two insurers necessarily paying the same price for the same care.[32][32] Government insurers, such as Medicare and Medicaid set their own reimbursement rates that hospitals and

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[27][27] *See* Anderson *supra* note 10 at 780 (hospitals often present self-pay patients with bills that reflect the hospitals full charge), Tompkins et al., *supra* note 11 at 49 (self-payers usually forced to accept the full charges set by the hospital).
[28][28] *See* Heather R. Higgins and Hadley Heath, *Informed Patients Cool to ObamaCare*, THE WALL STREET JOURNAL, Fri. Oct. 5, 2012, pg. A13 (opinion).
[29][29] *See* Anderson *supra* note 10 at 780 (listing the various groups of self-pay patients who were required to pay for care at chargemaster rates).
[30][30] *See infra* notes 152-180 and accompanying text.
[31][31] *See infra* notes 206-233and accompanying text.
[32][32] *See*, Reinhardt, *supra* note 7, at 60 ("The reality is that hospitals accept different payments from different payers for identical services, and that can properly be called price discrimination.") *id*.

doctors agree to accept as full payment, and these amounts are usually significantly less than the amounts paid by private insurers and HMOs.[33][33] Discounts from chargemaster prices given to insurers overall average about 62%,[34][34] but in specific cases can be 80% or even more.[35][35] To put it another way, hospitals and other providers typically and routinely accept less than 50% of the chargemaster rates (sometimes a lot less) from HMOs, private insurers and government insurers as full payment on behalf of insured patients.[36][36] Overall in 2004, for every $257 that a hospital charged based on its chargemaster rates it actually collected $100.[37][37] In other words, patients such as the uninsured and other self-pay patients who are charged chargemaster rates are actually being asked to pay <u>at least</u> 2½ times the average amount paid by health insurers for the same exact care.[38][38] All of these discounts are well known in advance by the hospital and are planned for in budgeting.[39][39] Thus, with regard to medical services, different patients (or more accurately different insurers) pay dramatically different prices for the same medical care. In health care there is a huge difference between *the price charged* and *the price paid* (and accepted as full payment by providers) by or on behalf of most patients.[40][40] The most important factor in determining the amount the hospital or other

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[33][33] *Id*. at 58-60 (outlining payments to various insurers).
[34][34] *See e.g.*, Reindart, *supra* note 7 at 57 ("In 2004, for example, U.S. hospitals were actually paid only about 38 percent of their "charges" by patients or their insurers.")
[35][35] *See infra* notes 62-84 and accompanying text discussing *Nassau Anesthesia Association P.C. v. Chin* where the discounts among the various payers ranged from 20 percent to 91 percent.
[36][36] *See* Anderson *supra* note 10 at 781 ("In 2004, the overall ratio of gross to net revenues was 2.57, which means that for every $100 the hospital actually collected from all sources, it initially charged $257.")
[37][37] *Id.*
[38][38] *Id.*
[39][39] *See* Tompkins et al., supra note 11 at 48 ("Prototypically, pure pricing updates occur once a year, as a component of the budgeting process, which includes constructing an initial revenue model based on expected payer mix, services mix, and expected payer contract specifications, and an initial cost model based on current input costs, expected service volume, and so forth.") *id.*
[40][40] *Id.* at 47 ("The gap between charges and actual payments (net patient revenue) now averages 255 percent and is growing rapidly.")

provider will accept as payment in full for its medical care is the identity of the insurer.[41][41]

As noted, the usual premise in a free market is that a seller may set his price at any level he chooses, but buyers may refuse to buy. This premise is applicable to hospitals and other healthcare providers when they set prices with private insurers and HMO's. However, I argue that the special characteristics of healthcare render this premise inapplicable when a hospital or other provider is contracting directly with self-pay patients or when calculating the fair and reasonable value of necessary medical care as a component of damages for personal injury.[42][42] For example, when an uninsured patient receives treatment at a hospital she usually receives a bill that is priced at the hospitals chargemaster rate(s).[43][43] Since the patient is not insured, the huge discounts the hospital has negotiated with insurers (and factored into its inflated chargemaster rates) do not apply and the uninsured patient is faced with a bill that is 250 to 500 percent (or more) of the amount the hospital would accept as full payment from insurers.[44][44] The hospital bases it claim for this exorbitant amount on the contract entered into with the patient – for example, the "Statement of Financial Responsibility" usually signed by the patient upon admission to the hospital, pursuant to which the patient allegedly agrees to pay at "chargemaster" or "list" prices for all care received.[45][45] In addition, the hospital

[41][41] *Id*. at 47-50 (describing how prices are set for various payers); Reinhardt *supra* note 7 at 58-61 (similar).
[42][42] *See infra* notes 241-260 and accompanying text.
[43][43] *See supra* note 23.
[44][44] *See supra* notes 35 - 42 and accompanying text.
[45][45] *See e.g., supra* note 3.

claims that its list prices are "reasonable and customary" because all patients are billed at these rates before discounts are applied.[46][46]

Agreements such as the "Statement of Financial Responsibility" should not be used as justification to hold uninsured patients liable for unconscionably high chargemaster prices.[47][47] If patients were told the truth, no patient would ever freely agree to pay the hospitals list or chargemaster prices. For example, if a hypothetical patient entering the hospital for gall bladder surgery were told the truth the patient would be told that according to the chargemaster his bill would likely be about $14,000, but that the hospital has agreed to do the same exact procedure (with anesthesia and everything!) for HMO's at a price of $5,600, for Blue Cross/Blue Shield at a price of $4,700, for Aetna at a price of $5,000, for Medicare at a price of $2,590 and for Medicaid at a price of $1,260.[48][48] With this real and meaningful information no patient with capacity would freely agree to pay $14,000 for the gall bladder surgery. If the patient offered $6,000 the hospital would likely agree and the patient would save more than 50%. Of course, if the patient is in pain and needs the procedure he may agree to anything, or if he is stuck with the same "deal" at any other nearby hospital, he may agree, but in neither case is his agreement freely given as required under contact law.[49][49] Assuming no emergency, and no contract of adhesion, the real reason that patients "agree" to pay $14,000 for gall bladder surgery is that they are deceived by the "chargemaster" "list price" language in

[46][46] *See supra* note 23.
[47][47] *See generally*, Nation *supra* note 5.
[48][48] This example is hypothetical but the percentage differences in the prices expected to be paid by the various insurers are estimates based on actual discounts. *See infra* notes 63-147 and accompanying text.
[49][49] *See generally*, Nation *supra* note 5.

their Financial Responsibility Agreement and they are ignorant regarding the odd characteristics of hospital pricing.[50][50]

Contracting for Health Care

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

Hospitals and other health care providers argue that the parties have established a formula based on the hospital's chargemaster for arriving at the ultimate price that the patient will pay for the services provided, and therefore the court must use this formula to determine the amount the patient owes.[51][1] 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.[52][2] As I have noted elsewhere, the problem of inexact price information at the time of contracting is not unique to the sale of healthcare, but healthcare is the only area in which the parties purport to use a blank check as payment.[53][3] For example, many professionals such as lawyers base their charges on an hourly rate and it is often not possible to know at the time of engagement how many hours a matter will take. However, unlike the health care situation, the hourly rate is agreed to at the time of engagement and cannot be changed

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[50][50] *See e.g.,* Sanchez *supra* note 3 and quote at note 4.
[51][1] *See e.g.,* Allen v. Clarian *supra* note 2.
[52][2] *See e.g., supra* note 36 (Professor Melnick notes that hospitals may set chargemaster rates at any level they want and set them to maximize revenue). Nation, *Chargemaster Insanity supra* note 11 at 1-18 (similar).
[53][3] *See* Nation, *Determining supra* note 6 at 426-432.

unilaterally by the lawyer. In contrast, hospitals often do not provide any price information, not a copy of their chargemaster, or any other specific information to the patient at the time of contracting, and worse hospitals retain the right to change their chargemaster rates at any time.[54[4]]

This situation with the hospital more closely resembles that of an auto mechanic and a customer when the customer takes his car to the mechanic because it is having some unspecified problem and the mechanic refuses to give an exact price to repair the car because the mechanic does not yet know how much repair will be necessary. If the car owner and the mechanic agree that the mechanic will work on the car and then determine the price, an express contract has been entered into even though no specific price has been agreed upon. However, the law does not grant the mechanic the right to charge whatever price he will, rather the obligation of good faith discussed *supra* requires that the mechanic exercise his/her discretion to set the price in good faith;[55[5]] that is, the mechanic must set a commercially reasonable price.[56[6]] The mechanic cannot charge any more than the fair market value for the work the mechanic has performed. If the mechanic and customer cannot agree as what a reasonable price is then the court will set the price.[57[7]] Similarly, in the case of contracting for healthcare the court must step in and provide the price for the parties since it is clear, based on both the conduct and words of the patient and the hospital that they intend to have a contract, but they have failed to specify a clear price. The court should reject the hospital's claim that it should be free to

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[54[4]] *See* Anderson *supra* note 3 at 786 (noting that hospitals may change their chargemaster rates at any time).
[55[5]] *See supra* notes 220 - 222 and accompanying text.
[56[6]] *Id.*
[57[7]] *See* RESTATEMENT (SECOND) OF CONTRACTS § 204. (a term e.g., price] which is reasonable in the circumstances is supplied by the court).

calculate the price, based on its elusive and ever-changing chargemaster rates, and should, consistent with the common-law principles of contract, imply a term into the contract that requires the patient to pay a reasonable price, determined as discussed *infra*, for the services received.[58[8]]

2. Patients Required To Pay Prior To Treatment

Where the hospital requires an upfront payment of all or a certain percentage of the overall amount that the patient will be liable for, the parties have effectively established a specific price for the services that will be provided by the hospital. In this case, usually there is still a good argument to be made that under contract law principles the patient should be liable for no more than the reasonable value of the services received. This argument focuses on the common law requirement the contracts be knowingly and freely entered into.[59[9]] Chargemaster prices are simply unreasonable and no reasonable person would knowingly and freely agree to pay such exorbitant rates.[60[10]] That is, if the hospital had informed the patient that they were being asked to pay at least 2 ½ 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.[61[11]] As a result, there is a good argument to be made that an agreement to pay chargemaster prices is

[58[8]] *See infra* notes 237 - 259 and accompanying text.
[59[9]] *See supra* notes 147 - 189 and accompanying text.
[60[10]] *See supra* notes 42 - 47 and accompanying text.
[61[11]] *See supra* notes 42 - 47 and accompanying text; Bai and Anderson *supra* note 9 at 923 (noting that in 2012 on average U.S. hospital charges were 3.4 times the Medicare-allowable cost).

unconscionable.[62][12] That is, the patient either did not make an informed choice to pay these prices or the patient had no choice but to agree because he did not have the ability to acquire the services elsewhere and therefore the contract is procedurally unconscionable; and the chargemaster rates are grossly unfair and therefore the contract is also substantively unconscionable.[63][13] Thus, the contract should not be enforced.[64][14] 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.

[62][12] *See* Nation, *Obscene supra* note 3 (arguing that contracts with hospitals pursuant to which patients purportedly agreed to pay chargemaster rates are unconscionable).
[63][13] *Id.* at 124-128.
[64][14] *Id*. at 128-131.