I. Background: The Problem

In a recent newspaper article a journalist recounted the story of a 50-year-old construction worker who experienced chest pains and was admitted to St. Francis Hospital in Bartlett Tennessee in 2014.[1] 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.[2] The couple received a bill from the hospital for $22,945.[3] 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.[4] However, this limitation under the ACA does not apply to non-emergency room charges provided by an out-of-network hospital.[5] That is, the limitation does not protect patients from balance billing, and thus the family received a bill for $22,945. In this case, as discussed in the article, the family was lucky because they appealed the charges and the hospital eventually reduced them to $600, but only after the bill had been sent to a collection agency, which the family worries will hurt their credit rating.[6]

A. Narrow Networks

In 2015, under the ACA, out-of-pocket costs are capped at $6,600 dollars for an individual and $13,200 for a family.[7] But again these caps do not apply to out-of-network providers who charge patients for the portion of their bills that their insurance

[1] *See* Stephanie Armour, *Surprises in Health-Law Bills*, WALL STREET JOURNAL; June 12, 2015 at A3.
[2] *Id.*
[3] *Id.*
[4] *Id.*
[5] *Id.*
[6] *Id.*
[7] *Id.*

does not pay.[8] Moreover, this balance-billing problem is getting worse because networks are becoming narrower.[9] A network consists of the hospitals with which an insurer has contracted.[10] Pursuant to those contracts hospitals agree to dramatically discount their list prices.[11] If a provider is not in-network, that means that the insurance company has no contract with the hospital and patients who are insured by that company are not entitled to the huge discounts and instead are, according to the hospital, responsible for the full undiscounted, obscenely high, list price for the services they receive. A network is narrow if it only includes a few hospitals.[12] A wide network includes many hospitals. Wide networks give patients more choice as to where to seek care. A poll conducted by the Kaiser Family Foundation found that more than half of Americans believe that it is important to make sure that health plans have sufficient networks to provide a wide choice of doctors and hospitals.[13] However, according to a 2015 report by McKinsey &

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[8] *Id.*

[9] *Id.* (noting that plans with narrow networks make up about half of all health law exchange networks and about two-thirds of the networks in large cities); *See*, Abelson *supra* note 7 (balance-billing becoming more frequent).

[10] *See*, "Unexpected Charges" *supra* note 4 at 3-5.

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

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

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

[13] *Id.*

Company, plans with narrow networks make up half of all of the insurance networks offered through the ACA, and narrow networks make up about two-thirds of the insurance networks offered through the ACA in the largest cities.[14] As insurance networks become narrower more patients are burdened with exorbitant hospital debt pursuant to balance billing.[15]

The reason that networks are becoming narrower is the desire on the part of hospital systems to increase profits.[16] For example, in some cases insurance companies cannot afford the reimbursement levels being demanded by hospital systems in order to become in-network.[17] 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

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[14] *Id.*

[15] *Id.*

[16] *See* Murray *supra* note 9 at 3 where he states:

> More importantly, the already astronomical and rapidly escalating hospital charge levels also have a less obvious impact on the rise in overall health care costs. High and increasing charges fundamentally undermine the negotiating leverage of private payers relative to hospitals, both big and small. This dynamic, which has been playing out in negotiations between private insurers and hospitals for years, goes something like this:
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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.
>
> However, even under Scenario 1, with markups at 320 percent or higher, the hospital has relatively little incentive to negotiate with a health plan that cannot promise substantial volumes. The bottom line conclusion, then, is that high markups and heavy and growing use of the ED as a source of admission act to substantially reduce insurer market power, even for providers with relatively small market share. Those who negotiate on behalf of commercial insurers are well aware of how the ability of hospitals to raise charges completely undermines their own negotiating leverage. [Table 1 omitted]

[17] *Id.*

to recoup higher payments from insurers and patients.[18] An important cause of this is the increased concentration that has occurred on the provider side of the market.[19] 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.[20]

B. No Notice, No Control & Unfair Surprise

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[18] *Id.*

[19] *Id.* at 5-6 stating:

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

[20] *Id.*; Elizabeth Rosenthal, *As Hospital Prices Soar, A Stitch Tops $500*, N.Y. TIMES, Dec. 2, 2013 citing Glen Melnick, a professor of health economics at the University of Southern California, regarding California Pacific Medical Center, which is owned by Sutter Health Inc., whose chargemaster rates are 5 ½ to over 10 times the Medicare reimbursement rate. According to Professor Melnick, Sutter is a leader – a pioneer – in figuring out how to amass market power to raise prices and decrease competition. *Id.* Research shows that today's hospital mergers tend to drive up prices. For example in the case of Sutter, it operates the only hospital in some California cities. As a result employers have limited ability to fight back against Sutter's high fees. Professor Melnick notes that hospital's sent prices to maximize revenue and they raise prices as much as they can. In addition, Professor Melnick notes that chargemaster prices are basically arbitrary, not connected to underlying cost or market prices; hospitals can set them at any level they want. There are no market constraints. Hospitals are the most powerful players in the healthcare system and there is little or no price regulation in the private market.); Martin Gaynor and Robert Town, *The Impact of Hospital Consolidation – Update*, Robert Wood Johnson Foundation 2 (June 2012), (hospital bargaining leverage main determinant of relative expensiveness within the same hospital market).

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.[21] 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.[22] 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.[23] That is, it is very common for in-network hospitals to employ physicians who are not in that network.[24] As a result, patients treated at an in-network hospital may receive balance bills from the out-of-network physicians who treated them.[25] 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.[26] 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.[27] 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

[21] *See e.g.,* Chen *supra* note 4; Armour *supra* note 17. *See generally, Unexpected Charges, supra* note 3.
[22] *See* Chen *supra* note 4 (quoting Karen Pollitz, a senior fellow at the Menlo Park, California-based Kasier Foundation as follows: "It's a pretty good bet that if you're hospitalized or having any kind of surgery, somebody along the way who touches you or your slides or films, will not be in network").
[23] *Id.*
[24] *Id.*
[25] *Id.*
[26] *See e.g.,* Nation, *Determining*, *supra* note 6 at 427.
[27] *Id.*

often be zero or a minimal amount. Unfortunately this does not represent the current reality the hospital billing as illustrated by the fact that in the case cited above once the hospital reduced it charges the bill went from $22,945 down to $600![28]

What makes the problem of balance billing so pernicious is that the bills not only surprise patients, but the amount of the bills is often financially devastating to patients.[29] I have written before about outrageously high charge master prices that hospitals insist are usual and customary and I do not wish to repeat that work here.[30] It is sufficient to note here that the amounts reflected on balance bills, when based on chargemaster prices, are outrageously high, bear no relationship to the hospital's cost, are set to discounted and not paid, and if they are paid yield truly enormous profits to the hospital.[31]

D. Balance Billing Increases The Overall Cost Of Health Care

Because the profit maximizing conduct of hospitals, both for-profit and not-for-profit, are unrestrained by competitive market forces the overall cost of healthcare in the United States is inflated.[32] The lethal combination of exorbitantly high chargemaster

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[28] *See supra* notes 17 - 22 and accompanying text.
[29] *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), (medical debt makes it difficult to get further healthcare); Christopher Tarver Robertson et al., *Get Sick, Get Out: The Medical Causes of Home Mortgage Foreclosures*, 18 HEALTH MATRIX 65, 66-68 (2008) (23% of home foreclosures were caused by unmanageable medical bills); Melissa B. Jacoby & Elisabeth Warren, *Beyond Hospital Misbehavior: An Alternative Account of Medical-Related Financial Distress*, 100 NORTHWESTERN U.L. REV. 535, 548 (2006) about 46% - 56% of personal bankruptcies were caused by a medical reason for their bankruptcy).
[30] *See generally*, Nation, *Obscene Contracts supra* note 3; Nation, *Determining*, *supra* note 6; Nation, *Wolves* supra note 13, Nation, *Chargemaster Insanity*, supra note 11.
[31] *See e.g.,* Reinhardt, *U.S. Hospital Services*, *supra* note 3 at 63 (chargemaster prices if paid would yield truly enormous profits).
[32] *See* Nation, *Chargemaster Insanity, supra*, note 11 at 26-30 (high chargemaster prices lead to overall higher prices for healthcare); Nation, *Wolves*, supra note 13 at 154 (primary reason that the non-profit business model has dominated the hospital industry is that it provides camouflage and autonomy for the real profit seeking motives and/or elitist weak transfer motives of these in de-facto control and affords a tax deduction that enhances profits).

prices and the practice of balance billing combine to put upward pressure on prices for health care across the board.[33] 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.[34] While government insures whom pay for more than half of the healthcare provided in the U.S. no longer set reimbursement rates based directly on chargemaster rates; higher chargemaster rates do indirectly put upward pressure on government reimbursement amounts.[35] However, more importantly and the focus of this article, is the fact that the combination of obscenely high charge- master rates and the practice of balance billing increase the cost of healthcare for both uninsured and privately insured patients.[36]

It is obvious why uninsured and out-of-network patients pay more because the dysfunctional market for health care allows hospitals' to set unreasonably high chargemaster rates and insist on balance billing out-of-network, uninsured and other self-pay patients.[37] 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. [38] 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,

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[33] *See supra* note 9.
[34] *See supra* note 9.
[35] *See* Nation, *Determining supra* note 6 at 454 (main reason chargemaster prices are so high is that the higher chargemaster prices lead to higher revenues, though not dollar for dollar, for hospitals from government and private insurers as well as from self-pay patients); Nation, *Chargemaster Insanity* supra note 11 at 26-30 (exorbitant chargemaster prices case higher overall prices for healthcare).
[36] *See supra* note 9.
[37] *See supra* notes 23 - 47 and accompanying text.
[38] *See supra* notes 4 - 10 and accompanying text.

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, that is the insured patients, will be charged the provider's exorbitant chargemaster rates and balance billed for the difference between these ridiculously high rates and the amount the insurance company pays for the services provided to the patient.[39] This threat: "agree to our reimbursement rates or your insureds' will face huge charges for health care" is strengthened each time the hospital raises its chargemaster rates.[40] This threat based bargaining power is irresistible in the case of a hospital or hospital system that is dominant in its' market.[41] Insurers simply cannot sell health insurance policies if those who buy them will be punished with exorbitant balance bills if they receive care from the dominant provider in the market.[42] As a result, many insurers have no option but to agree to the high reimbursement rates requested by the hospital system and pass these costs along to their customers/insureds in the form of higher prices for health insurance.[43] As a result, the price of insurance (what insured patients pay for health care) goes up.[44]

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[39] *See* Bai and Anderson *supra* note 9 at 3 (noting that high chargemaster rates motivate insurers to include hospitals in their networks to reduce the likelihood of having subscribers pay high out-of-network prices); Murray *supra* note 9 at 3 (high chargemaster rates undermine the negotiating leverage of private insurers relative to hospitals).
[40] *See* Murray *supra* note 9 at 3.
[41] *See, e.g.,* Nation *Chargemaster Insanity supra* note 11 at 22 (discussing California Pacific Medical Center owned by Sutter Health and the fact that its amassed market power allows it to charge 5 ½ to over 10 times the Medicare reimbursed rate).
[42] *See* Nation *Chargemaster Insanity supra* note 11 at 28 (private insurers, even these with significant market power are forced to agree to high contractual reimbursement rates with must have hospitals in their market).
[43] *Id.*
[44] *Id.*

An alternative for insurance companies is to simply sell very narrow network policies to uninformed customers and let these patients be shocked and surprised by the balance bills they receive. Narrow network policies are, of course, cheaper and the low price often attracts customers who do not fully understand the risks posed by narrow network policies.[45] As noted *supra*, the majority of policies sold on ACA exchanges are narrow network policies.[46] In addition, several newspaper articles have focused on the frustration, shock and surprise of patients who receive huge balance bills.[47]

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.[48] I have written before about the very uncharitable conduct of so-called charitable hospitals and there is no need to repeat that work here; it is sufficient to note here that there is no meaningful difference between the conduct of non-profit and for-profit hospitals when it comes to conducting their financial affairs, except of course that the non-profits make more money because they pay no taxes.[49] Moreover, while the pricing and collection limitations included in the ACA apply only to non-profit hospitals these provisions do not solve the balance-billing problem even in the context of non-profit hospitals as discussed at the next section.[50]

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[45] *See* Armour *supra* note 17 (customers who purchased coverage through the ACA are surprised by balance bills).
[46] *Id.*
[47] *See supra* note 4.
[48] *See* Nation, *Wolves supra* note 13 at 174-179 ("The many instances in which non-profit hospitals seem to place the pursuit of profit over charity care has led the Commissioner of the IRS to observe that there is now very little difference between for-profit and not-for-profit hospitals") [notes omitted] *Id*. at 179. *Cf.* Bai and Anderson *supra* note 9 (finding that 98% of the top 50 hospitals with the highest chargemaster rates were for-profit). These findings are misleading with respect to the difference between for and non-profit hospitals. The sample is small at 50, most of the top 50 were owned by just two for-profit systems, but most importantly the average chargemaster rate for *all* hospitals was 3.4 times Medicare allowable cost. *Id* at 923.
[49] *See generally*, Nation, *Wolves supra* note 13.
[50] *See infra* note ____ - ____ and accompanying text.

Thus, there is very little to be gained from simply applying the ACA's ineffective price and collection limitations to for-profit hospitals.

E. The ACA Actually Encourages Balance Billing

The ACA started out with laudable goals, however much got lost in the translation into legislation. As noted above, the ACA contains limits on what patients may be asked to pay out-of-pocket if they are covered by a qualified health insurance policy, but these limits do not apply to non-emergency charges of out-of-network providers.[51] In other words, the out-of-pocket limits established by the ACA do not apply to balance billing.[52] The ACA also establishes limits on the amount that indigent uninsured patients may be charged for health care, and also limits the type of collection techniques that may be used to recover health care debt.[53] 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.[54] 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.[55]

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[51] *See*, Patient Protection and Affordable Care Act, Pub. L. 111-148; 124 Stat. 119, 855-858 (2010), as amended by the Health Care and Educational Reconciliation Act of 2010, Pub. L. 111-152 (2010) § 9007(a)(codified at 26 U.S.C. § 501 (r), (5)(6). Emergency out of network charges are covered to some extent under the ACA. See ACA, §§ 1001, 10101(h), 42 U.S.C. 300 gg-19a (amending § 2719A of the Public Health Service Act): 29 C.F.R. § 2590.715-2719A; 45 C.F.R. § 147.138(b).

[52] *See* ACA § 1302 (c), codified at 42 U.S.C. § 18022 (c); Bai and Anderson *supra* note 9 at 923 (ACA requires nonprofit hospitals to provide discounts to eligible uninsured patients. However, the same provision lets individual non-profit hospitals determine their own eligibility standards does not address the levels of the markup faced by out-of-network patients and casualty and workers' compensation insurers, and does not apply to for-profit hospitals [notes omitted]).

[53] *See supra* note 66.

[54] *See supra* note 66.

[55] *See generally*, Nation, *Wolvers supra* note 13.

In any event, an indigent patient eligible for a (not-for-profit, tax-exempt) hospital's financial assistance policy or FAP may not be charged more than the hospital's generally billed amount (GBA).[56] 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 on the perspective Medicare reimbursement rate alone.[57] Moreover, these hospitals and their collection agencies are forbidden from using extraordinary collection techniques to collect hospital debt from FAP-eligible patients.[58]

However, these provisions fail to solve the balance-billing problem even for not-for–profit, tax-exempt hospitals for several reasons. First, these hospitals are free to define who is eligible for their financial assistance programs.[59] Many hospitals define FAP eligibility according to income levels based on the Federal Poverty Guidelines. The problem is that in addition to the FPG limits most of these hospitals also limit eligibility for their FAP's to those who are uninsured.[60] 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

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[56] I.R.C. § 501(r)(5)(A)(West 2011).
[57] *Id.*
[58] I.R.C. § 501 (r)(6).
[59] I.R.C. § 501 (r)(4)(A). Additional Requirements for Charitable Hospitals, 26 C.F.R. § 1.501 (r) ("Neither the (ACA) nor these regulations establish specific eligibility criteria that a FAP (financial assistance policy) must contain").
[60] *See, e.g.,* Cleveland Clinic Foundation Summary of Financial Assistance available at my.clevelandclinic.org/ccf/media/files/patients/financial-assistance-app.pdf (stating: we provide financial assistance … if you are a resident of the state in which you are seeking care, *do not have insurance*, and your family income does not exceed four times the FPG).

who qualify for financial assistance.[61] 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.[62] That is, 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![63]

Finally, the ACA specifically refers to a hospital's "gross" charges[64] clearly indicating their chargemaster rates. While the ACA does this with good intentions, specifically requiring not-for-profit tax-exempt hospitals to charge less than their list prices two FAP-eligible patients (the ACA does not say how much less), nevertheless the effect of these references to chargemaster rates is to effectively require that charge-masters with their exorbitant prices stay in existence. In addition, hospitals continue to have the same incentives to continually right raise their chargemaster rates.[65] As noted above, high chargemaster rates contribute significantly to the severity of the balance-billing problem. [66]

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[61] *See*, 26 C.F.R. § 1.501(r)-5(b)(2) (it is no violation of the Regulations if the total amount paid by the individual and the health insurer exceeds the AGB so long as the individual's portion including co-payments, co-insurance and deductibles, does not exceed the AGR).
[62] *Id*.
[63] *Id*.
[64] *See,* 26 C.F.R. § 1.501(r)-1(b)(16). ("Gross Charges" is defined as the chargemaster rate ("a hospital facility's full, established price for medical care that the hospital facility consistently and uniformly charges patient before applying any contractual allowances, discount, or deductions). *Id*.
[65] Higher chargemaster rates mean greater revenue though not dollar for dollar. *See supra* note 48.
[66] *See supra* notes 42 - 47 and accompanying text.