Fixing The Free Market For Healthcare:

Exposing the unfairness of chargemaster based pricing

George A. Nation III
Professor Law & Business Lehigh University

Key Takeaways From This Presentation

- **Chargemaster prices are exorbitant and no one should be forced to pay them!**
- **Chargemaster prices are set to be discounted and not paid**.
- The usual and customary prices set by hospitals are significantly higher than the **usual and customary amounts hospitals are actually paid**.
- Exorbitant chargemaster prices drive up the cost of healthcare for everyone!

INTRDUCTION

- Goal: The **Best** Healthcare In The World
- The Delivery Of Healthcare Is A Business
- Free-market competition is the best way to accomplish our goal.
- THE PROBLEM: MARKET FAILURE
- MACRO: Health systems are getting so large and in many markets have close to monopoly power; this threatens the overall market for healthcare.
- MICRO: knowledgeable, well-informed consumers with available **alternative suppliers** are necessary for the market to function.—THIS IS OUR FOCUS--

Healthcare Consumers Are Not Knowledgeable And Well-Informed With Respect To Healthcare Prices

- 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 and meaningful price information before a contract is created**.
- 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.

Characteristics that distinguish the business of healthcare #1

- 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.**
- 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.
- These are **"blank checks"** given to the hospital and the hospital may unilaterally fill in any amount it wishes.
- Hospitals abuse this discretion--THIS IS UNFAIR--

Chargemaster based list prices

- A chargemaster is an extensive price list created and maintained by hospitals and other providers. A hospital's chargemaster, lists a price for each good and service provided by the hospital (20,000 or more separate items may be included). Hospitals have complete control and update, that is increase these list prices frequently. 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%).
- Hospitals claim, **disingenuously** that all patients are billed at charge master rates.

Characteristics that distinguish the business of healthcare #2

- **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 pursuant to contracts with government and private insurers.
- Discounts from chargemaster prices given to insurers overall average about 62%, but in specific cases can be 80% or even more.
- Chargemaster prices would yield truly **enormous profits** if these prices were actually paid.
- **Only paid by 1-3% of patients**

Characteristics that distinguish the business of healthcare #3

Disingenuous because: Hospitals engage in extensive and significant **price discrimination**. Providers routinely and significantly discount their chargemaster prices pursuant to specific contracts with HMOs and private insurance companies.

Overall in 2004, for every $257 that a hospital charged based on its chargemaster rates it actually collected $100.

In other words, **patients such as the uninsured and other self-pay patients who are charged chargemaster rates are actually being asked to pay at least 2½ times the average amount paid by health insurers for the same exact care.**

Healthcare Consumers Are Not Knowledgeable And Well-Informed With Respect To Healthcare Prices

- Simply requiring hospitals to publish their charge- masters' or list prices is **not** the answer.
- **Publication of list prices does not increase meaningful price transparency for patients.**
- 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. A patient may know for instance that he needs a hernia repair procedure and he may have discussed the various procedures in detail with 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.

Limits should be set on hospitals' ability to set prices for self-pay patients

- 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 is true when hospitals and other healthcare providers contract with private insurers and HMO's.
- **But, the special characteristics of healthcare render this premise inapplicable when a hospital or other provider is contracting directly with self-pay patients**

Suggested limits on hospital pricing

- Hospital should be **encouraged** to publish a list of **all-inclusive procedure based prices** similar to those used by Medicare and private insurers which are based on DRG and APC classifications.
- **Comparable alternatives enhance competition.**
- **Hospitals who choose** to use à la carte pricing based on chargemaster rates, should be limited to charging self-pay patients no more than 115% of the average amount actually paid to the hospital by government and private insurers for the same services.
- **This is not price-fixing.**

Why chargemaster prices are so high; reasons are complex and rooted in history

- **Market failure**-excessive, exorbitant, and unconscionable prices are all symptoms of a **dysfunctional marketplace.**
- List prices are set in an arbitrary and capricious manner, have no consistent relationship to either costs or expected payments, and are virtually unrestrained by normal market forces. **Those with market power do not pay them directly.**
- Increases in chargemaster prices do not produce a dollar-for-dollar increase in hospital revenue. However, the relationship between chargemaster prices and revenues is in the aggregate positive. **Higher chargemaster rates are associated with higher profits.**
- Chargemaster rates serve as a **starting or anchoring point for negotiations** with third-party payers regarding the amount that they will actually pay for the services provided.

Reasons for exorbitant chargemaster rates continued; History

- Mid-1980s two hospital payment systems; private insurers paid a negotiated discount from **list prices** and government insurers paid rates they set (based to some extent on **list prices**)
- Both government and private insurers demanded **reimbursement models based on bundled or procedure based pricing.**
- Private insurers paid expenses not part of procedure based pricing at a percentage of **list prices,** e.g. 40%
- CMS significantly reduced hospital reimbursement rates, but provided outlier reimbursements based directly on **list prices**
- Few insurers or patient's paid chargemaster prices directly**, market forces that might have restrain there rise failed.**
- Allowed tax exempt hospitals to **overstate charity care and** bad debt expense.
- **The result was that chargemaster prices skyrocketed!**

Reasons for exorbitant charge master rates continued; Today

- High chargemaster rates provide **negotiating leverage with insurance companies**, leading to more expensive healthcare.
- Today, neither government nor private insurers pay based *directly* on chargemaster prices, but **higher chargmaster prices, for a variety of reasons, still indirectly produce higher net revenues** – though not dollar for dollar.
- Hospitals have **no incentive to reduce** either the absolute level nor the rate of increase of chargemaster prices; **in fact they have every incentive to continue to quickly increase list prices.**

High chargemaster rates increase the overall crost of healthcare!

- The relative level of a provider's chargemaster prices **bears no relationship to either the quality of the services provided or to the cost** of the services provided.
- Self-pay patients include the uninsured and the insured who often must pay **"balance bills"**.
- **If private insurers refuse to agree to the reimbursement rates demanded by large healthcare systems, their insureds will be OON and billed at exorbitant chargemaster prices.**

Contracting for healthcare

- Contracts are based on the **free, knowing, and voluntary agreement of the parties**.
- **No real contract exists for emergency care** such as that provided by ambulance services (MICU) and the Emergency Dept.
- The obligation to pay is based on **Quasi Contract**, and is limited to the reasonable value of the services provided.
- In the case of **nonemergency necessary medical care** the principles of contract may apply but only if the patient knowingly and freely agrees

Patients do not knowingly and freely agree to pay chargemaster based list prices

- 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.**
- **Thus, the contract should not be enforced!**

Determining the fair and reasonable value of healthcare

- The fair reasonable value of healthcare is the **usual & customary amount paid** for it and not the usual & customary amount billed for it.
- Start with the **average reimbursement amount that the hospital regularly accepts** as full payment for the services provided.
- Because self-pay patients do not provide the same benefits that private insurers provide, **some adjustment to this base is necessary.**
- This adjustment should be no greater than 10 to 15%.

Can the free market work for direct consumer purchase of healthcare?

- **If consumers are provided with meaningful price information the free-market can work** and will work much better than government price-fixing to accomplish the goal we started with: the best health care in the world.
- **I strongly support all of Governor Scott's Healthcare transparency proposals.**

Sources used for this presentation

- Non- Profit Charitable Tax Exempt Hospitals- Wolves In Sheep's Clothing: To Increase Fairness and Enhance Competition All Hospitals Should Be For Profit and Taxable (Rutgers Law Journal) http://works.bepress.com/cgi/viewcontent.cgi?article=1000&context=george_nation
- OBSCENE CONTRACTS*: THE DOCTRINE OF UNCONSCIONABILITY AND HOSPITAL BILLING OF THE UNINSURED (Kentucky Law Journal) http://works.bepress.com/cgi/viewcontent.cgi?article=1003&context=george_nation
- Determining the Fair and Reasonable Value of Medical Services: The Affordable Care Act, Government Insurers, Private Insurers and Uninsured Patients (Baylor Law Review) http://www.baylor.edu/content/services/document.php/206145.pdf
- Health Care and the Balance Billing Problem: The Solution is the Common Law of Contracts and Strengthening the Free Market for Health Care.(forthcoming Pepperdine Law Review) http://works.bepress.com/george_nation/7/
- Hospital Chargemaster Insanity: Heeling The Healers (forthcoming Villanova Law Review)) http://works.bepress.com/george_nation/6/