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IRRATIONAL HOSPITAL PRICING

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ABSTRACT

Hospital prices are almost completely irrational. They bear no relationship to the cost of providing the services, they are opaque, and the prices vary wildly among hospitals and payers. The craziness of hospital pricing was laid bare when the federal government released data on hospital charges in May 2013. In response to public shock and outrage, hospitals maintained that their chargemasters, or list of retail prices, are harmless because no one actually pays these prices. Hospitals have a variety of incentives to inflate their charges, including increasing their bargaining leverage against health insurance companies. This article posits that irrational hospital pricing harms many who do pay these inflated prices, including middle class uninsured patients and those insured with high deductible health plans or who receive out-of-network care. Irrational hospital prices also further distort the health care market and undermine efforts to keep costs under control, leading to higher prices overall. The harms of irrational hospital prices fall heavily upon many more individuals than we typically think of, perpetuate a great deal of inequity and uncertainty among health care consumers, and reverberate through the health care system in ways that harm us all.

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TABLE OF CONTENTS

I. INTRODUCTION

A joint replacement, the most common hospital procedure that Medicare pays for, is a routine procedure that nearly every hospital performs dozens, even hundreds, of times per year. Getting a sense

of what a joint replacement costs, however, is no simple matter. The charge for a joint replacement at Kaiser Hospital in West Los Angeles is $36,308, while the same procedure at Centinela Hospital, a for-profit hospital less than eight miles away, is $220,881.[1] For this procedure, Medicare paid these hospitals $13,221 and $18,011, respectively.[2] Centinela's high prices cannot necessarily be attributed to being in a high-cost region—Mt. Sinai Hospital in New York City charged $41,486.[3] Nor do high prices necessarily reflect quality. Top-ranked hospitals in orthopedics like the Mayo Clinic charged just $27,703 and Johns Hopkins charged $36,059.[4] Finally, price variations are not unique to Los Angeles; the Regional Hospital of Jackson in Tennessee charged $161,699 for joint replacement while the only other hospital in Jackson charged $29,860.[5]

Public shock greeted the government's release of data on May 8, 2013, of what hospitals charge for their one hundred most common inpatient procedures.[6] Known within the health care industry as a

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[1] *Medicare Provider Charge Data: Inpatient*, CTRS. FOR MEDICARE & MEDICAID SERVS., http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Inpatient.html (last visited Aug. 20, 2013) [hereinafter *Medicare Provider Charge Data*]. The data posted on May 8, 2013 are hospital-specific charges for more than 3,000 U.S. hospitals that participate in Medicare from Fiscal Year 2011.

[2] *Id.*

[3] *Id.*

[4] *Id. See also*, *Top-Ranked Hospitals for Orthopedics*, U.S. NEWS & WORLD REP., http://health.usnews.com/best-hospitals/rankings/orthopedics (last visited Aug. 20, 2013) (ranking the Mayo Clinic second and Johns Hopkins Hospital sixth for orthopedics); Jordan Rau, *Hospital Charges Bear Little Relationship to the Quality of Care, Study Says*, WASH. POST, Jul. 22, 2013, *available at* http://www.washingtonpost.com/national/health-science/hospital-charges-bear-little-relationship-to-the-quality-of-the-care-study-says/2013/07/22/a3a2a8fc-efd1-11e2-9008-61e94a7ea20d_story.html.

[5] *Medicare Provider Charge Data, supra* note 1.

[6] *Id.*; *see also* Barry Meier et al., *Hospital Billing Varies Wildly, Government Data Shows*, N.Y. TIMES, May 8, 2013, *available at* http://www.nytimes.com/2013/05/08/business/hospital-billing-varies-wildly-us-data-shows.html?pagewanted=all&_r=0. On June 2, 2014, the government released hospital charge data for 2012. The updated data showed that charges increased for nearly all procedures and the variations between hospitals seen in the 2011 data persisted in 2012. *See* Julie Creswell et al., *Hospital Charges Surge for Common Ailments, Data Shows*, N.Y. Times, June 3, 2014, *available at* http://www.nytimes.com/2014/06/03/business/Medicare-Hospital-Billing-Data-Is-Released.html?_r=0.

hospital's "chargemaster," revelation of these list prices drew criticism over their wide variation as well as their dizzying heights. Hospitals were quick to point out that these chargemaster figures are, in fact, quite harmless because no one really pays full charges.[7] Private insurance plans typically negotiate deep discounts off charges, and increasingly the poorest of the uninsured are receiving discounted or free charity care.[8]

The hospital's chargemaster is a bloated symptom of a larger systemic problem of irrational hospital prices.[9] Hospital prices are characterized by mind-boggling complexity, opacity, unfair and inefficient price discrimination, and wide variations. The price variations apparent in the chargemaster data carry through to the prices charged to health insurance companies. Not only do different hospitals charge vastly different prices for the same service, but the same hospital charges different prices to different payers, a phenomenon known as price discrimination. The highest prices are charged to those with the least ability to pay and weakest bargaining power, such as self-pay patients. Each hospital has dozens of payers and each payer has its own payment methodology and price list, which are often kept secret by contractual confidentiality obligations. Whether due to complexity or gag clauses, most hospitals cannot tell a patient what a procedure will cost before the patient incurs the bill.[10] There is no one price, rather the price depends on who is

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[7] *See e.g.*, Sarah Kliff & Dan Keating, *One Hospital Charges $8,000 – Another, $38,000*, WASH. POST, May 8, 2013, 12:01 A.M. *available at* http://www.washingtonpost.com/blogs/wonkblog/wp/2013/05/08/one-hospital-charges-8000-another-38000/; M.B. PELL, *Huge Hospital Markups Burden Patients*, ATLANTA J. CONST., Apr. 20, 2011, *available at* http://www.ajc.com/news/business/huge-hospital-markups-burden-patients/nQsmJ/.

[8] Meier et al., *supra* note 6.

[9] With respect to hospital prices, I am using the term "irrational" to mean unreasonable, senseless, groundless, incoherent, and unjustifiable. This usage is distinct from the economic notion of irrationality, which is the inverse of rationality—a set of mathematical assumptions economists use to describe our preferences and how they lead to actions. As I discuss in Part II, hospitals have a variety of incentives to price their services the way they do from an economic standpoint. Thus, the pricing behavior of hospitals as economic actors may be a rational response to existing incentives, but the result is a crazy, variable, complex, opaque, and often harmful system that I describe as "irrational" in a more colloquial sense.

[10] Jaime Rosenthal et al., *Availability of Consumer Prices from U.S. Hospitals for Common Surgical Procedure*,173 JAMA INTERNAL MED. 427 (2013) (finding that only 16% of hospitals studied

paying. Despite the enormous administrative costs exacted by this complicated pricing system, hospitals have incentives to inflate the chargemaster to increase bargaining leverage over health plans and maximize profit.

Irrational hospital prices are not harmless. First, several categories of patients do pay inflated chargemaster prices (or significant portions of these prices), including middle-class uninsured patients who do not qualify for financial assistance, patients with high-deductible plans, patients who receive care out-of-network, and patients whose care is not covered by insurance. These individuals suffer significant financial and health–related harms from their unaffordable medical bills and the debt collection practices used to recover unpaid bills. Second, irrational hospital prices drive up health care costs for everyone by distorting the health care market and undermining efforts to coordinate care and control health care costs.

This article proceeds in three parts. Part I describes the irrationality of hospital prices, characterized by complexity, opacity, price discrimination, and wide price variations. Part II explores hospitals' incentives to inflate their chargemaster rates. Part III analyzes the various ways irrational hospital prices harm particular groups of individuals and distort the market for health care services.

II. THE IRRATIONALITY OF HOSPITAL PRICES

A bill for a hospital stay may be among the most expensive a person will incur in a lifetime, and the prices are uniquely irrational—they bear little relation to the hospital's costs of producing the service or its quality, and they vary wildly from one hospital to another even in the same geographic region.[11] Prices also vary within the same hospital for the same service depending on who is paying for the services, a phenomenon known as price discrimination.[12]

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could provide a full price quote for a total hip replacement for a fictitious 62 year-old uninsured grandmother).

[11] Paul B. Ginsburg, *Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power*, 16 RES. BRIEF (Ctr. for Studying Health Sys. Change), Nov. 2010, at 2-4.

[12] *See* MICHAEL E. PORTER & ELIZABETH OLMSTED TEISBERG, REDEFINING HEALTH CARE 65 (2006)

Despite efforts to increase transparency, hospital prices remain almost completely opaque and undiscoverable by a patient until he or she has received the bill for services already rendered.[13] Even if hospitals disclose their price lists, they are written in cryptic code, contain thousands of items, and are unintelligible to most patients.[14]

In May of 2013, the Centers for Medicare and Medicaid Services (CMS) released data for the first time on hospital charges for every Medicare-participating hospital for the one hundred most common inpatient procedures and thirty most common outpatient procedures.[15] The public and news media were appalled over the wide and inexplicable price variation between hospitals.[16] For

("[T]he current system has resulted in pervasive price discrimination, in which different patients pay widely different charges for the same treatment, with no economic justification in terms of cost"); *see also* Uwe E. Reinhardt, *Chaos Behind the Veil of Secrecy*, 25 HEALTH AFF. 57, 63 (2006) [hereinafter *Veil of Secrecy*] ("The reality is that hospitals accept different payments from different payers for identical services, and that can properly be called price discrimination.").

[13] *See Veil of Secrecy*, *supra* note 12, at 59; *see also* Gina Kolata, *What Does Birth Cost? Hard to Tell*, N.Y. TIMES WELL BLOG, Jul. 8, 2013, 2:22 P.M., http://well.blogs.nytimes.com/2013/07/08/what-does-birth-cost-hard-to-tell/?nl=health&emc=edit_hh_20130709 (describing the difficulty for an uninsured, self-pay patient to receive price estimates on childbirth from hospitals in New Jersey); Rosenthal et al., *supra* note 10 (finding that 90% of non-ranked hospitals and 55% of top-ranked hospitals in study could not provide price estimates for common hip replacement).

[14] Gerard F. Anderson, *From 'Soak the Rich' To 'Soak the Poor': Recent Trends in Hospital Pricing*, 26 HEALTH AFF. 780, 786 (2007) [hereinafter *Soak the Poor*].

[15] *Medicare Provider Charge Data*, *supra* note 1; *see* Meier et al., *supra* note 6. The release of data accompanied an announcement by the Department of Health & Human Services of grants for states to form "data centers" to analyze and publish information in an effort to promote price transparency. Press Release, Dep't of Health & Human Servs., Administration Offers Consumers an Unprecedented Look at Hospital Charges (May 8, 2013), *available at* http://www.hhs.gov/news/press/2013pres/05/20130508a.html.

[16] *See, e.g.*, Meier et al., *supra* note 6; Kliff & Keating, *supra* note 7; Peyton M. Sturges & Nathaniel Weixel, *Release of Hospital Pricing Data by CMS Could Spur Calls for Greater Accountability*, 22 HEALTH L. REP. 739 (May 16, 2013); KYLE BROWN & EMILY WATTMAN-TURNER, COLO. CTR ON LAW & POLICY, CHARGES VARY DRAMATICALLY AMONG COLORADO HOSPITALS, EVEN WITHIN THE SAME CITY (2013) *available at* http://cclponline.org/wp-content/uploads/2014/01/Our-Dollars-Our-Health-Part_1_Charges-var-drmatically-among-Colorado-hospitals-even-within-the-same-city_DOC-6.13.131.pdf; David Wenner, *Central Pennsylvania Hospital Charges Are All Over the Map*, PENNLIVE.COM, June 9, 2013, http://www.pennlive.com/midstate/index.ssf/2013/06/healthcare_costs_medicare_medi.html; Alex Wayne, *Hospital Charges Vary Across U.S. for Same Procedures*, BLOOMBERG, May 8, 2013, http://www.bloomberg.com/news/2013-05-

example, charges for a joint replacement ranged from $5,300 in Ada, Oklahoma to $223,000 in Monterey Park, California.[17] The amounts published represent the amounts that hospitals charge Medicare, although Medicare sets its own payment rates at levels one-third to one-fifth of the retail charge.[18] To deflect criticism, hospitals responded that these lists of charges are merely starting points for negotiations with payers, and that no one really pays these prices.[19]

This Part describes the complicated and convoluted world of hospital pricing and examines some of its distinguishing features: its complexity and opacity, price discrimination, extreme price variation, and the market failure resulting from collusion between hospitals and health insurance companies.

a. Chargemasters, Complexity, and Opacity

Understanding hospital pricing requires an understanding of the hospital's "chargemaster." A chargemaster (also called the charge description master) is a master list of the hospital's charges, akin to retail list prices, for each of the tens of thousands of items, services, and procedures it provides.[20] Hospitals may make changes to their chargemasters at any time. Most hospitals update their chargemasters at least annually with across-the-board increases to reflect medical inflation plus more frequent updates for certain items or services.[21] Hospitals have complete discretion over the process of

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08/hospital-charges-vary-across-u-s-for-same-procedures.html.

[17] *See* Dep't of Health & Human Servs., *supra* note 15.

[18] *See* Meier et al., *supra* note 6.

[19] *See e.g.*, Kliff & Keating, *supra* note 7 (quoting Carol Steinberg, vice president of the American Hospital Association: "The chargemaster can be confusing because it's highly variable and generally not what a consumer will pay. Even an uninsured person isn't always paying the chargemaster rate."); PELL, *supra* note 7 (quoting Deborah Keel, president and CEO of Tenet Healthcare's North Fulton Regional Hospital as saying: "No North Fulton Regional patients pay the full markup.").

[20] ALLEN DOBSON ET AL., LEWIN GROUP, A STUDY OF HOSPITAL CHARGE SETTING PRACTICES, MEDPAC i (Dec. 2005), *available at* http://www.medpac.gov/documents/Dec05_Charge_setting.pdf (noting that chargemasters reviewed contained between 12,000 and 45,000 items). Hospital chargemasters do not depict the entire bill for a patient's medical care because physicians' charges are typically billed separately and make up a significant additional cost.

[21] *See Veil of Secrecy supra* note 12, at 59.

setting charges, which lacks any discernable methodology and has been described variously as "ad hoc,"[22] "bewildering,"[23] "arbitrary,"[24] and "cockamamie."[25]

The chargemaster originated in the 1930s along with the advent of health insurance, which routinely paid a hospital's charges—then calculated as the hospital's cost of providing the service plus about ten percent.[26] Everyone, whether insured or not, paid the same chargemaster rates.[27] This system persisted for over 30 years until Medicare was established and started paying hospitals on the basis of costs, rather than charges.[28] Medicare required that hospitals have a uniform set of charges for all payers, and because private payers and self-pay individuals continued to pay charges, market forces maintained the relation between charges and costs.[29] In the 1980s and

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[22] *Id.* ("In general, the process [of updating the chargemaster] appears to be ad hoc, without any external constraints.").

[23] *See* Sturges & Weixel, *supra* note 16 (quoting Rich Umbdenstock, Chief Executive Officer of the American Hospital Association as saying: "The complex and bewildering interplay among 'charges,' 'rates,' 'bills' and 'payments' across dozens of payers, public and private, does not serve any stakeholder well, including hospitals.").

[24] Elizabeth Rosenthal, *As Hospital Prices Soar, A Single Stitch Tops $500*, N.Y. TIMES, Dec. 2, 2012, http://www.nytimes.com/2013/12/03/health/as-hospital-costs-soar-single-stitch-tops-500.html?hp (quoting health economist Glenn Melnick: "Chargemaster prices are basically arbitrary, not connected to underlying costs or market prices . . . [hospitals] can set them at any level they want. There are no market constraints.").

[25] Lucette Lagnado, *California Hospitals Open Books, Showing Huge Price Differences*, WALL STREET J., Dec. 27, 2004, http://online.wsj.com/article/ SB110410465492809649.html (quoting William McGowan, chief financial officer of the UC Davis Health System: "There is no method to this madness. As we went through the years, we had these cockamamie formulas. We multiplied our costs to set our charges.").

[26] *A Review of Hospital Billing and Collection Practices: Hearing Before the Subcomm. on Oversight and Investigations of the H. Comm. on Energy and Commerce*, 108th Cong. 18 (2004) (written testimony of Gerard Anderson, Professor, Department of Health Policy & Management and International Health, Johns Hopkins Bloomberg School of Public Health) [hereinafter *2004 House Hearing on Hospital Billing Transcript*].

[27] Christopher P. Tompkins, et al., *The Precarious Pricing System For Hospital Services*, 25 HEALTH AFF. 45, 46 (2006).

[28] *Id.*

[29] *2004 House Hearing on Hospital Billing Transcript*, *supra* note 26, at 20 (statement of Gerard Anderson, Professor, Department of Health Policy & Management and International Health, Johns Hopkins Bloomberg School of Public Health) (noting that in the mid-1980s, charges were typically 25% above costs, compared to 2004 when charges were 200%-400%

1990s, with the advent of managed care, health insurers began negotiating discounts off of charges and using different mechanisms to calculate hospital fees, removing what little remaining effect market forces had on hospital charges.[30]

Today, chargemaster prices bear almost no relationship to the hospital's actual costs of providing the service, except insofar as they are almost always significantly higher than a hospital's costs.[31] Even the process of calculating the cost of a particular service is fraught with complexity and variation, with hospitals using different accounting systems to allocate operating costs across departments or service lines and some hospitals struggling to calculate their costs at a procedure level.[32] Hospital administrators themselves cannot explain where their chargemaster prices come from. One hospital administrator is quoted as saying, "There is no rationality to the charge master and costs still do not have much relevance."[33] Today's chargemaster rates are the product of decades of arbitrary choices, based on rates set by some process long in the past that nobody can remember and raised automatically on a periodic basis.[34] For new procedures, hospitals estimate a price based on the price for similar services, and these charges get incorporated into the chargemaster, rarely to be revisited or lowered if the cost of providing the service goes down.[35]

The chargemaster also bears little relationship to the prices Medicare pays hospitals. Medicare gathers extensive data on hospitals' financial data, including costs, charges, payments,

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higher than costs).

[30] *See id.* at 19; Tompkins et al., *supra* note 27, at 47.

[31] *See* DOBSON ET AL., *supra* note 20, at v.

[32] *See* Tompkins et al., *supra* note 27, at 49; Health Care Fin. Mgmt. Ass'n, *Reconstructing Hospital Pricing Systems: A Call to Action for Hospital Financial Leaders*, at 17 (2007), http://www.hfma.org/hospitalpricing/.

[33] DOBSON ET AL., *supra* note 20, at 7 (quoting a respondent to the Lewin Group's interviews with hospital chargemaster administrators on hospital charge setting practices).

[34] Peter Ubel, *Hospital Prices and Irrational Thinking*, FORBES (Aug. 24, 2012, 12:52 PM) http://www.forbes.com/sites/peterubel/2012/08/24/hospital-pricing-and-irrational-thinking/.

[35] *See* DOBSON ET AL., *supra* note 20, at v.

utilization, and staffing to calculate its reimbursement rates.[36] For hospital inpatient services, Medicare pays a flat, bundled rate for the entire case on the basis of diagnosis, which is broken out into 746 "Medicare severity-adjusted diagnosis-related groups" or MS-DRGs.[37] Each DRG is weighted according to how resource-intensive treatment for the diagnosis tends to be compared to the average admission.[38] The DRG weight is multiplied by an annually determined, standardized base payment rate for labor and other operating costs, adjusted for geographic variations in wages.[39] Additional amounts may be added on to the DRG-adjusted base payment rate to reflect the extent to which a hospital provides a disproportionate share of unreimbursed indigent care, expenses for providing graduate medical education, and outlier payments for unusually expensive cases.[40] Medicare outpatient fees are calculated according to groupings of major procedures under the ambulatory payment classification (APC).[41] Like the DRG system, the APC amounts are weighted and multiplied by a monetary conversion factor and further adjusted for regional variations in input costs.[42]

Historically, when Medicare paid hospitals on the basis of their costs, Medicare used charge data from hospitals to make sure that Medicare was allocated the appropriate costs.[43] Medicare still collects

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[36] *Cost Reports*, CTRS. FOR MEDICARE & MEDICAID SERVS., COST REPORTS, http://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/CostReports/index.html?redirect=/costreports/ (last visited May 24, 2014).

[37] *Acute Inpatient PPS*, CTRS. FOR MEDICARE & MEDICAID SERVS., ACUTE INPATIENT PPS, http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html (last visited May 24, 2014) [hereinafter *Acute Inpatient PPS*]; *see also* Uwe E. Reinhardt, *How Medicare Sets Hospital Prices: A Primer*, N.Y. TIMES ECONOMIX BLOG (Nov. 26, 2010, 6:00 AM), http://economix.blogs.nytimes.com/2010/11/26/how-medicare-sets-hospital-prices-a-primer/.

[38] *Acute Inpatient PPS*, *supra* note 37.

[39] *Id.* For hospitals in Hawaii and Alaska, cost of living adjustments are also applied to the non-labor component of the base case rate.

[40] *Id.*

[41] *See Veil of Secrecy*, *supra* note 12, at 60.

[42] *Id.* at 60-61; CTRS. FOR MEDICARE & MEDICAID SERVS., HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (Jan. 2014), http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/ hospitaloutpaysysfctsht.pdf.

[43] *2004 House Hearing on Hospital Billing Transcript*, *supra* note 26, at 18-19 (written testimony

data on charges (the subject of its data release on May 8, 2013), although it does not directly base its payment rates to a hospital on that particular hospital's charge data.[44] Nevertheless, Medicare uses aggregate hospital charge data as a proxy for resource-intensity to calculate the DRG weights.[45] Medicare rates are a popular point of reference because of their ubiquity and relation to cost. Critics of Medicare prices say that they do not represent a market price because Medicare unilaterally sets the prices without negotiation,[46] and according to one estimate, Medicare fees cover only ninety-four percent of the average hospital's costs of providing the service.[47]

Private insurance companies contract with hospitals and other providers to provide services to their enrollees at discounted prices.[48] Providers accept the discounted rates in exchange for the increased volume of patients they will receive as a result of being a contracted (in-network) provider.[49] Payers pay hospitals on a variety of bases: (1) a percentage discount off of a hospital's chargemaster rates; (2) per diem payments for an inpatient stay categorized by the case's level of complexity; or (3) a flat charge for the entire episode of care (a DRG or case-rate).[50] Each insurance company separately negotiates its rates with each of the hospitals, which creates great price variation among

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of Gerard Anderson, Professor, Department of Health Policy & Management and International Health, Johns Hopkins Bloomberg School of Public Health)

[44] *See id.* at 18.

[45] *See* DOBSON ET AL., *supra* note 20, at vi-1 ("The fact that charges are often not closely tied to costs implies that the current Medicare payment systems may not be closely tied to resource utilization. The findings from this study suggest that in certain instances, relative charges may not accurately proxy relative costs. Therefore, the impact of using charges to set payment rates in Medicare should be investigated more closely.").

[46] Uwe Reinhardt, *Determining the Level of Payments in U.S. Health Care*, N.Y. TIMES ECONOMIX BLOG (Mar. 2, 2012, 6:00 A.M.), http://economix.blogs.nytimes.com/2012/03/02/determining-the-level-of-payments-in-health-care/.

[47] MEDPAC, REPORT TO CONGRESS: MEDICARE PAYMENT POLICY 42 (Mar. 2013), *available at* http://www.medpac.gov/chapters/Mar13_Ch03.pdf. Although it is a common refrain that Medicare pays below the hospital's costs of providing the service, MedPAC also noted that hospitals with greater efficiency have demonstrated the ability to profit from Medicare, with a 2% positive Medicare margin.

[48] *See* PORTER & TEISBERG, *supra* note 12, at 38.

[49] *See id.*

[50] *See Veil of Secrecy*, *supra* note 12, at 61.

hospitals and insurance plans.[51] Negotiating with and managing the bills for each payer's rates and bases for payment is extremely labor-intensive and drives up the administrative costs for the hospital and health plans alike.[52] Typically the negotiated prices are subject to contractual confidentiality requirements and treated as trade secrets.[53] This not only limits the degree to which competitors can access a health plan's negotiated rates with a hospital, but also results in insuperable price opacity for patients.[54]

None of the health insurance plans that contract with the hospital pay anything close to full charges—most receive steep discounts exceeding fifty percent off charges.[55] But, as discussed further below, a private insurance plan that does not have a contract with a particular hospital will generally be billed full charges.[56] Perversely, the hassle of re-negotiating existing contracts on a different payment basis (per diem or case-rate instead of a percentage of charges) is a major reason hospitals say they cannot jettison their chargemasters.[57] Even if a hospital administrator insists that the chargemaster is an anachronism and bemoans the administrative complexity of updating it, the reality is the chargemaster has become locked in through path-dependence.[58]

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[51] N.J. DEP'T OF HEALTH, N.J. COMM'N ON RATIONALIZING HEALTH CARE RES. 98 (2008).

[52] *Id.*

[53] Morgan A. Muir et al., *Clarifying Costs: Can Increased Price Transparency Reduce Healthcare Spending?* 4 WM. & MARY POL'Y REV. 319, 327 (2013) (discussing the legal arguments for and against treating hospitals' contractual prices as trade secrets and concluding that the question remains unresolved by courts).

[54] *Id.* at 327-29, 331.

[55] *Veil of Secrecy*, *supra* note 12, at 61.

[56] *See infra*, Part II.A.2.

[57] *2004 House Hearing on Hospital Billing Transcript*, *supra* note 26, at 114 (statement of Jack O. Bovender Jr., Chairman and CEO of Hospital Corporation of America) (stating that one of the barriers to lowering chargemaster rates is that "many of our contracts—and at HCA we have over 5,000 contracts with managed care providers across the country. Many of those contracts are not on a per diem basis or case rate basis, but are really based on a discount off of charges. It will take us probably two to two and a half years to renegotiate all of those contracts because many of them are multiple year contracts.").

[58] *See* Steven Brill, *Bitter Pill: How Outrageous Pricing and Egregious Profits Are Destroying Our Health Care*, TIME, Mar. 4, 2013, at 22 (quoting a hospital executive's statement on chargemasters: "They were set in cement a long time ago and just keep going up almost

The hospital bill that an individual receives may be indecipherable, written in cryptic codes and contain dozens of items that run pages long.[59] Most individuals do not realize they will receive a bill from the hospital for the facility component of their care and then separate bills from the physicians who treated them. Especially if the patient is a self-pay patient, the bill may be unbundled, with a separate charge assigned to every procedure, piece of equipment, supply, medication, or item used in her care. Medicare prohibits hospitals from unbundling their bills—it is a form of Medicare fraud because Medicare pays in a lump sum per episode of care.[60] There is no legal prohibition against unbundling for non-Medicare patients, though private insurers may also negotiate for bundled payments, especially if paying on a per diem or case-rate.[61] By unbundling the bills for self-pay patients, hospitals can charge inflated prices for every item, further driving up the total bill.[62]

In sum, any given hospital has dozens of price lists for dozens of payers, each of whom may pay on a different basis, and only those with the least clout are billed full charges.[63] The enormous complexity of hospital pricing is just one aspect of the puzzle. Hospital price irrationality is also evident from three characteristics that reveal the dysfunctional market for hospital services: price discrimination, extreme variability, and in some cases, anticompetitive collusion between dominant hospitals and health insurers.

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automatically.").

[59] *Soak the Poor*, *supra* note 14, at 786.

[60] Social Security Act, 42 U.S.C. § 1395y(a)(14) (1935); Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99–509, 100 Stat. 1874 § 9343(c) (1986) (extending prohibition to unbundling of hospital outpatient services); 65 Fed. Reg. 18434, 18439-40 (2000).

[61] Frank Fedor, *Unbundling the Confusion About "Unbundling" of Charges*, 60 HEALTHCARE FIN. MGMT. 40, 40-43 (2006).

[62] *See* Elizabeth Rosenthal, *American Way of Birth, Costliest in the World*, N.Y. TIMES, June 30, 2013, http://www.nytimes.com/2013/07/01/health/american-way-of-birth-costliest-in-the-world.html?emc=eta1 (quoting Gerard Anderson, health economist at the Johns Hopkins Bloomberg School of Public Health: "It's not primarily that we get a different bundle of services when we have a baby. It's that we pay individually for each service and pay more for the services we receive.").

[63] Mark A. Hall & Carl E. Schneider, *Patients as Consumers: Courts, Contracts, and the New Medical Marketplace*, 106 MICH. L. REV. 643, 663 (2008).

b. Price Discrimination

One characteristic of hospital pricing is significant price discrimination, the practice of accepting different fees from different payers for identical services.[64] Price discrimination is not itself necessarily insidious or inefficient; there are several industries where price discrimination exists and reflects the varying price sensitivity of purchasers and an inability to resell the product.[65] Airlines, for example, routinely charge widely varying prices for seats on the same flight depending on the timing of when the seat is sold, how empty the flight is, where the seat is located on the plane, and other indicia of willingness to pay.[66] In health care, however, the groups that pay the most are those with the least bargaining power: the uninsured and those insured whose plans do not have a contract with the hospital.[67] Hospital price discrimination is inefficient and unfair because the different prices are inversely correlated with ability to pay.[68]

Hospitals explain their discriminatory prices through the theory of cost shifting.[69] Hospitals claim that because government payers (Medicare and Medicaid) pay below costs, the hospital needs to make up the loss by shifting the costs to private payers, including self-pay patients.[70] There are two problems with the cost shifting explanation for hospital price discrimination. First, the economic evidence suggests hospitals do less cost shifting than they claim.[71] Health

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[64] *See Veil of Secrecy*, *supra* note 12, at 63.

[65] *Id.*

[66] *See* N.J. DEP'T OF HEALTH, *supra* note 51, at 92-93.

[67] Uwe 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, 2128-29 (2011).

[68] *Id.* at 2129.

[69] Austin B. Frakt, *How Much Do Hospitals Cost Shift? A Review of the Evidence*, 89 MILBANK Q. 90, 90 (2011).

[70] AM. HOSP. ASS'N, *Hospital Billing and Collection Practices: Statement of Principles and Guidelines*, at 1 (May 5, 2012) http://www.aha.org/presscenter/pressrel/2012/120530-pr-BillingPractices.pdf; *see* Frakt, *supra* note 69.

[71] *See e.g.*, Frakt, *supra* note 69, at 123 (observing hospitals engage in modest cost-shifting and that changes in market power can significantly affect prices charged to private payers); Chapin White, *Contrary to Cost-Shift Theory, Lower Medicare Hospital Payment Rates for Inpatient Care Lead to Lower Private Payment Rates*, 32 HEALTH AFF. 935, 941 (2013) (finding

economists studying the issue have concluded that the degree to which hospitals are able to extract higher fees from private health plans is driven by the hospital's market power rather than a need to make up shortfalls from government payers.[72] In addition, when faced with Medicare reimbursement cuts, hospitals reduce their costs or output rather than shift more costs to private payers.[73] The second problem with the cost-shifting explanation is that the need to make up losses from government payers does not explain why self-pay patients would be charged several times what private insurance companies pay, because in most cases self-pay patients would not be able to afford their bills.[74] Shallow-pocketed self-pay patients are a poor source from which to make up losses from government payers, which make up approximately 57% of all care provided by hospitals.[75] The extent of price discrimination, where self-pay patients are charged far higher prices than even privately insured patients, simply cannot be explained by the cost-shift theory.

Coupled with the enormous complexity of hospital billing and payment practices, price discrimination serves no beneficial purpose and instead raises costs and results in unjust distributions of benefits and burdens.[76]

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that lower Medicare rates resulted in lower private payer rates, contrary to cost-shift theory).

[72] *See* White, *supra* note 71, at 939-40; Frakt, *supra* note 69, at 123.

[73] David Dranove et al., *How Do Hospitals Respond to Negative Financial Shocks? The Impact of the 2008 Stock Market Crash* (Nat'l Bureau of Econ. Research Working Paper No. 18853, 2013) (concluding that hospitals cut costs, rather than cost-shift in response to reductions in Medicare or Medicaid payments); Chapin White & Tracy Yee, *When Medicare Cuts Hospital Prices, Seniors Use Less Inpatient Care*, 32 HEALTH AFF. 1789, 1794 (2013) (concluding that Medicare price cuts lead hospitals to reduce capacity and provide fewer services to the elderly, reducing output rather than cost-shifting).

[74] *Veil of Secrecy*, *supra* note 12, at 62 ("Because uninsured patients often are members of low-income families, many of them ultimately paid only a fraction of the vastly inflated charges they were originally billed by the hospital, but only after intensive and morally troubling collection efforts by the hospital.").

[75] AM. HOSP. ASS'N, *Underpayment by Medicare and Medicaid Fact Sheet* (2012), http://www.aha.org/content/12/2012medunderpayment.pdf.

[76] PORTER & TEISBERG, *supra* note 12, at 66 ("The administrative complexity of dealing with multiple prices adds costs with no value benefit. The dysfunctional competition that has been created by price discrimination far outweighs any short-term advantages individual system participants gain from it, even for those participants who currently enjoy the biggest

c. Variability of Hospital Charges

What was striking about the hospital chargemaster data released by CMS in 2013 was the degree of variability in hospital prices for the same services, even within the same geographic area.[77] In Jackson, Mississippi, charges for treating patients for heart failure ranged from $9,000 to $51,000 and in Richmond, Virginia, treatment for esophagitis ranged from $8,100 to $38,000.[78] This variation cannot be explained entirely by the causes usually cited by hospitals: higher labor costs, extra resources spent on medical training and research, or a sicker patient-population.[79] The variation occurs not just between geographic regions, but also among hospitals within the same geographic region, which likely face similar costs for wages, real estate, and energy.[80] In addition, within-hospital markups on charges, which can be measured as a percentage above Medicare prices, vary significantly from procedure to procedure.[81]

As discussed in Part II, *infra*, hospitals have a variety of incentives to inflate their chargemasters. One question is why all hospitals in a given region do not mark up their charges to a similar extent. The answer appears to be tied to the relative market power of the hospitals.[82] Hospitals with more market power inflate their

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discounts.").

[77] *See Medicare Provider Charge Data*, *supra* note 1.

[78] N.Y. Times Editorial Board, *The Murky World of Hospital Prices*, N.Y.TIMES, May 16, 2013, http://www.nytimes.com/2013/05/17/opinion/the-murky-world-of-hospital-prices.html; Kliff & Keating, *supra* note 7.

[79] *See* Office of the Attorney General Martha Coakley, *Examination of Health Care Cost Trends and Cost Divers Pursuant to G.L. c. 118G, § 61/2(B): Report for Annual Public Hearing* 3, 16-27 (Mar. 16, 2010), http://www.mass.gov/ago/docs/healthcare/2010-hcctd-full.pdf [hereinafter *Massachusetts AG 2010 Report*].

[80] Ginsburg, *supra* note 11, at 2-4.

[81] James C. Robinson, *Price Transparency Begins at Home*, 23 FRONTIERS OF HEALTH SVCS. MGMT. 25, 27 (2007); *see also Soak the Poor*, *supra* note 14, at 781; DOBSON ET AL., *supra* note 20, at iv.

[82] *See* Martin Gaynor & Robert Town, *The Impact of Hospital Consolidation—Update*, ROBERT WOOD JOHNSON FOUNDATION 2 (June 2012), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261 ("The evidence points to differences in hospital bargaining leverage as a principal driver of the difference between relatively expensive and inexpensive hospital systems within the same hospital market.").

charges more than those with less power.[83] Hospital markets with greater concentration (fewer big players that control a greater share the market) have higher prices and greater variability than less concentrated markets.[84]

Put another way, the reason charges are so high for some hospitals is that there is no countervailing market force to push prices down. "Must-have" hospitals (hospitals that an insurance plan needs in its network to attract and maintain enrollees) use their strong bargaining power to extract higher prices from payers. Patients whose insurance pays their hospital bill are generally ignorant of and insensitive to price differences among hospitals, but they may be very attuned to reputation or other proxies for quality when choosing a hospital.[85] Although health plans typically seek to negotiate hospital prices down, their ability to do so is often limited by their relative lack of bargaining power against a powerful, "must-have" hospital.[86]

That concentrated markets have higher prices and more variation is troubling given that increases in health care costs are driven more by rising prices than increased utilization.[87] Additionally, hospital price increases account for a significant portion of overall rising health care costs.[88] Price increases that result from hospital mergers in concentrated markets are significant, often in excess of twenty percent, and there is some evidence that reduced competition may lead to reductions in quality.[89] The problem of concentration in

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[83] *Id.*

[84] *Id.* at 1.

[85] Anna D. Sinaiko & Meredith B. Rosenthal, *Increased Price Transparency in Health Care – Challenges and Potential Effects*, 364 N. ENGL. J. MED. 891, 892 (2013).

[86] Gerard F. Anderson et al., *It's The Prices, Stupid: Why The United States Is So Different From Other Countries*, 22 HEALTH AFF. 89, 102 (2003) (noting that the bargaining power of highly fragmented payer-side of the market is relatively weak compared to that of providers, and this is one factor contributing the high prices paid for health care in the U.S.).

[87] *See Massachusetts AG 2010 Report*, *supra* note 79, at 35-37 (finding that price increases, not utilization, caused most of the increase in health care costs over the study period).

[88] Hamilton Moses III, et al. *The Anatomy of Health Care in the United States*, 310 JAMA 1947, 1949 (2013) ("Between 2000 and 2011, increase in price (particularly of drugs, medical devices, and hospital care), not intensity of service or demographic change, produced most of the increase in health's share of GDP.").

[89] *See* Gaynor & Town, *supra* note 82, at 2, 6.

hospital markets is getting worse, not better.[90] In 2010, nearly half of all hospital markets in the U.S. were considered "highly concentrated," about a third were "moderately concentrated," and none were considered "highly competitive."[91] The Affordable Care Act (ACA) contains provisions for reducing provider fragmentation and spurring clinical and financial integration, which has accelerated the ongoing wave of concentration and consolidation of the provider markets.[92]

Although market power generally fuels the heights and wide variation in hospital prices, there may be an ethic against inflationary rates based on the ownership characteristics of the provider. For-profit hospitals tend to have higher markups (the ratio of charges to Medicare-allowable costs) than nonprofit hospitals or public hospitals.[93] An ethos of fairness or charity may exert some downward pressure on prices at nonprofit hospitals compared to their proprietary counterparts. The constraining effect of nonprofit status is slight, however, as hospitals of all stripes appear to behave as

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[90] *See The Patient Protection and Affordable Care Act, Consolidation, and the Consequent Impact on Competition in Health Care: Hearing Before the Subcomm. On Regulatory Reform, Commercial and Antitrust Law of the H. Comm. on the Judiciary*, 113th Cong. 4 (2013) (statement of Thomas L. Greaney, Chester A. Myers Professor of Law and Director of the Center for Health Law Studies at Saint Louis University School of Law), http://judiciary.house.gov/hearings/113th/09192013_2/ Greaney%20Testimony.pdf.

[91] *See* David Cutler & Fiona Scott Morton, *Hospitals, Market Share, and Consolidation*, 310 JAMA 1964, 1966 (2013). Cutler and Scott Morton evaluated data from the American Hospital Association on 306 U.S. hospital referral regions, calculating hospital market concentration using the Herfindahl-Hirschman Index (HHI). They noted that, "[t]he extent of hospital concentration has increased over time. The hospital HHI has increased by 40% since the mid-1980s, changing from a market with on average 5 independent firms (there were >5 independent hospitals, but approximately 5 major ones) to a market with approximately 3 independent firms."

[92] *See* Gaynor & Town, *supra* note 82, at 1 (noting that the ACA's promotion of accountable care organizations and bundled payments that encourage coordination of care, have in fact accelerated hospital and physician practice consolidation); Frakt, *supra* note 69, at 90-1; Ginsburg, *supra* note 11, at 2 (advising caution when implementing the ACA's provisions that encourage provider integration and consolidation, such as accountable care organizations).

[93] *See Soak the Poor*, *supra* note 14, at 781; Meier et al., *supra* note 6 ("[B]ills submitted by profit-making hospitals to Medicare are typically higher than those submitted by nonprofit centers. . . ."); Glenn Melnick & Katya Fonkych, *Fair Pricing Law Prompts Most California Hospitals To Adopt Policies To Protect Uninsured Patients from High Charges*, 32 HEALTH AFF. 1101, 1104 (2013).

profit-maximizers and increase prices when their market power allows it.[94]

d. Hospital-Insurer Cooperation

The balance of power between hospitals and payers, namely health insurers, is a large driver of hospital prices. As explained above, hospitals with more bargaining power relative to health plans raise their prices because of the lack of pressure to contain costs.[95] The converse scenario would appear to offer a solution: increase payers' bargaining power to lower hospital prices.[96] Unfortunately, however, price increases created by hospital market power may not be solved simply by increasing health insurer bargaining clout, especially when the increased insurer bargaining power is due to concentration on the health insurance side of the equation.[97] Markets with both a dominant hospital system and a dominant health insurer may experience increases in both hospital prices and insurance premiums.[98] In these markets, the dominant hospital and dominant insurance company may agree to limit competition to benefit both parties, with predictable harms to patient-consumers.[99]

Prominent examples of such hospital-insurer collusion include the unwritten agreement between Partners HealthCare, the dominant hospital system in Massachusetts that included Massachusetts General and Brigham and Women's Hospital, and the largest health

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[94] *See Veil of* Secrecy, *supra* note 12, at 64; White, *supra* note 71, at 939; Clark Havighurst & Barak Richman, *The Provider Monopoly Problem in Health Care*, 89 OR. L. REV. 847, 855 (2011).

[95] *See* Gaynor & Town, *supra* note 82, at 1 and text accompanying notes 82-86.

[96] There is evidence that when Medicare payment rates decline, hospitals respond by cutting their costs, which has a spillover effect of reducing rates for private payers. *See* Dranove et al., *supra* note ,73 at 4; White, *supra* note 71, at 940-41; Austin B. Frakt, *The End of Hospital Cost Shifting and the Quest for Hospital Productivity*, 49 HEALTH SERVS. RES. 1, 3 (2014).

[97] *See infra* text accompanying notes 229-232.

[98] Austin Frakt, *The Future of Health Care Costs: Hospital-Insurer Balance of Power*, NAT'L INST. FOR HEALTH CARE MGMT FOUND., EXPERT VOICES (Nov. 2010), *available at* http://nihcm.org/pdf/EV_Frakt_FINAL.pdf.

[99] Thomas L. Greaney, *Regulating to Promote Competition in Designing Health Insurance Exchanges*, 20 KAN. J.L. & PUB. POL'Y 237, 247-48 (2011) (noting that "where dominant insurers face dominant providers, the preferred strategic response may entail understandings that divide the gains of the parties' market power").

insurer in the state, Blue Cross Blue Shield of Massachusetts.[100] In that deal, Blue Cross agreed to a substantial increase in payments to Partners in return for Partners using its clout to demand even larger payment increases from other health insurance plans.[101] Another example is the case of *West Penn Allegheny Health System Inc. v. UPMC*, in which the largest hospital system in the Pittsburgh area and the dominant health insurer conspired to protect each other from competition.[102] The hospital, UPMC, agreed to use its market power to exclude health insurer Highmark's rivals from the health insurance market by refusing to contract with them.[103] In exchange, Highmark agreed to strengthen UPMC and weaken the competing hospital system by artificially depressing its reimbursement levels for the competitor.[104] In both of these cases, rather than counteract the market power of the "must-have" hospitals, the existence of a dominant health insurer simply invited collusion among the big players to ratchet up prices and exclude rivals. The results were supracompetitive prices and reduced choices for patients without any offsetting gains in efficiency or quality.[105]

Another example of coordination or vertical restraint between hospitals and insurers is the use of "most-favored-nations" (MFN) clauses in their hospital-payer contracts.[106] MFN clauses provide that the hospital will not accept any lower payment rates from a favored health insurer's competitor, or else it must offer the same discount to

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[100] *Id.*

[101] Scott Allen & Marcella Bombardieri, *A Handshake that Made Healthcare Hist*ory, BOS. GLOBE, Dec. 28, 2008, at A1.

[102] W. Penn Allegheny Health Sys., Inc. v. UPMC, 627 F.3d 85, 109-10 (3d Cir. 2010).

[103] *Id.* at 108-10.

[104] *Id.* at 109-110.

[105] *See* Greaney, *supra* note 99, at 248.

[106] *See e*.g., Complaint at 1, United States v. Blue Cross Blue Shield of Mich., 809 F. Supp. 2d 665 (E.D. Mich. 2010) (No. 2:10-CV-14155). The Justice Department dropped this antitrust lawsuit against Blue Cross Blue Shield of Michigan after the State of Michigan passed a law prohibiting health insurers from using MFN clauses in contracts with health care providers. Press Release, DEP'T OF JUSTICE, *Justice Department Files Motion to Dismiss Antitrust Lawsuit Against Blue Cross Blue Shield of Michigan After Michigan Passes Law to Prohibit Health Insurers from Using Most Favored Nation Clauses in Provider Contracts* (Mar. 25, 2013), http://www.justice.gov/atr/ public/press_releases/2013/295114.htm.

the favored health insurer.[107] These provisions are designed to give a "most-favored" payer the benefit of any price concessions that the hospital offers other payers.[108] The hospital benefits because it is able to collect higher price payments from the dominant insurance company than it otherwise would without the MFN agreement.[109] The federal antitrust enforcement agencies have criticized MFN clauses for harming consumers by raising hospital prices and preventing other health plans from entering local markets.[110] Thus, increasing the monopsony power of health insurers on the buy-side to counteract the monopoly power of hospitals may not solve the problem of inflated hospital prices. Indeed hospital prices can rise to supracompetitive levels when both the hospital and health insurance markets are concentrated and the dominant players collude to suppress competition.

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Many features of market failure explain the irrationality of hospital prices. There is information asymmetry that stems from the overwhelming complexity and opacity of the system of pricing hospital services. Hospital prices are also characterized by perverse and inefficient price discrimination that penalizes those self-pay patients with the least bargaining power and ability to pay. Wide price variations between hospitals are driven not by differences in quality, amenities, or costs, but by the market power the hospital commands. Finally, increasing insurer bargaining power to counteract hospital power may not curb prices where dominant hospitals and insurance companies collude to exclude competition.

III. HOSPITAL INCENTIVES TO INFLATE THE CHARGEMASTER

What drives hospitals to inflate their chargemaster rates so

[107] Complaint, *supra* note 106.

[108] *Id.*

[109] Havighurst & Richman, *supra* note 94, at 879 (noting that antitrust enforcement may not deter a "provider monopolist [from] agreeing to an MFN clause to induce a powerful insurer to pay its high prices.").

[110] FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION, Ch.6, at 23-25 (2004), *available at* www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf.

much? If nobody pays these prices, what purpose does the chargemaster serve? Hospitals respond that their chargemasters are starting points for negotiation.[111] This response reveals some of the hospital's inherent incentives to anchor their "starting point" as high as possible, so that the process of negotiating discounted rates for private payers results in higher rates overall. Thus, the first incentive for hospitals to inflate their charges is that high charges create greater leverage for health plan negotiation. Second, hospitals raise their charges because there are some patients who do pay the full list price for services. A third reason is that inflated charges were previously used to boost calculations of charity care provided. Finally, before changes in Medicare rules, hospitals that raised their charges more quickly were able to increase outlier payments from Medicare. Each of these incentives is discussed below.

a. Leverage for Health Plan Negotiation

High hospital charges give hospitals additional leverage when they negotiate their rates with health plans.[112] This is particularly true for health plans, typically small health plans with less bargaining power, that pay hospitals based on a percentage of their charges.[113] Even for health plans that pay on a case-rate or per diem basis, a significant portion of care may not be governed by the fee-schedule and is reimbursed based on a percentage of charges.[114] The hospital may be able to effectively raise its rates for these payers by raising its charges, even if it continues to grant steep discounts off the full price.

The chargemaster serves as an anchor in negotiations with health plans over prices. Behavioral economists have long demonstrated a phenomenon called the anchoring effect, under which the value of an initial starting point biases final determinations toward the initial

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[111] Melnick & Fonkych, *supra* note 93, at 1101.

[112] *See Soak the Poor*, *supra* note 14, at 785.

[113] *See* Brill, *supra* note 58, at 23 (noting that when the insurer needs the hospital more than the hospital needs the insurer, the price negotiation starts with the chargemaster and works down. "Getting a 50 percent or even 60 percent discount off the chargemaster price of an item that costs $13 and list for $199.50 is still no bargain.").

[114] *See* Tompkins et al., *supra* note 27, at 51 (noting that 20-30% of services may be billed according to discounted charges even for payers that use a per diem or case-rate methodology).

value.[115] Amos Tversky and Daniel Kahneman studied anchoring by asking study participants to estimate the percentage of African countries in the United Nations.[116] The experimenters then spun a wheel appearing to generate a random number between 1-100, but it was rigged to stop at either the number 10 or 65.[117] This number served as an "anchor," which affected the subjects' estimates.[118] When the wheel stopped at 10, the participants guessed 25%, but when the wheel stopped at 65, the participants estimated 45%.[119] Anchoring effects have been demonstrated in the courtroom regarding sentencing and damage awards, settlement agreements, and in negotiations between buyers and sellers over price.[120] Hospitals have incentives to anchor price negotiations as high as possible with inflated chargemaster rates. Even if everyone knows the health plan will receive a significant discount, the higher the starting point of negotiations, the higher the ultimate price will be.

The higher a hospital's charges, the less a given health plan can afford not to contract with the hospital. Out-of-network hospitals usually bill a non-contracted health plan full charges.[121] The higher charges rise, the greater a health plan's incentive to sign a contract with the hospital.[122] Even if the health plan is able to limit its payment to a rate less than full charges, hospitals may bill the patient directly for the remainder of its charges, a practice known as "balance-billing."[123] Hospitals are usually prohibited (by contract or state law)

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115 *See* Amos Tversky & Daniel Kahneman, *Judgment Under Uncertainty: Heuristics and Biases*, 185 SCI. 1124, 1128 (1974).

116 *Id.*

117 *Id.*

118 *Id.*

119 *Id.*

120 Dan Orr & Chris Guthrie, *Anchoring, Information, Expertise, and Negotiation: New Insights from Meta-Analysis*, 21 OHIO ST. J. ON DISP. RESOL. 597, 607-09, 611 (2006).

121 *See* AM. HEALTH INS. PLANS, SURVEY OF CHARGES BILLED BY OUT-OF-NETWORK PROVIDERS: A HIDDEN THREAT TO AFFORDABILITY, (Jan. 2013), http://www.ahip.org/Workarea/DownloadAsset.aspx?id=2147489872.

122 *See Soak the Poor*, *supra* note 14, at 785.

123 Carol K. Lucas & Michelle A. Williams, *The Rights of Nonparticipating Providers in a Managed Care World: Navigating the Minefields of Balance Billing and Reasonable and Customary Payments*, 3 J. HEALTH & LIFE SCI. L. 132, 147 (2009) ("The term 'balance billing' refers to the practice of

from balance-billing patients whose insurance plans have a contract with the hospital and must accept the insurance plan's payment as payment in full.[124] Once a health plan signs a contract with a hospital and establishes its own rate schedule, its motivation to press the hospital to lower its chargemaster rates wanes because the higher the chargemaster, the greater the negotiated discount the health plan has won for its members appears.

Laws that were passed to protect insured patients who receive emergency medical care out-of-network may create additional incentives for hospitals to raise their charges. Historically, many managed care plans did not cover any service provided by a non-network provider, including emergency care. This policy had the effect of deterring people from seeking needed emergency care, so states and the federal government passed laws that require health plans to cover some portion of the out-of-network emergency care.[125] Some states and the ACA require that patients' cost-sharing amount for receiving emergency care in an out-of-network hospital must be limited to the amount they would owe if they received the care in-

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out-of-network medical providers billing a patient the difference between the reimbursement made by an enrollee's health plan and the amount the provider contends it is owed for the services rendered.")

[124] *See* Kaiser Family Foundation, *State Restriction Against Providers Billing Managed Care Enrollees* (2013) *available at* http://kff.org/private-insurance/state-indicator/state-restriction-against-providers-balance-billing-managed-care-enrollees/.

[125] COLO. REV. STAT. ANN § 10-16-704 (West 2013); DEL. CODE ANN. tit. 18 § 3565 (West 1999 & Supp. 2012); FLA. STAT. § 627.6472 (2011); GA. CODE ANN. § 33-30-24 (West 2013); 215 Ill.. Comp. Stat. ANN. 5/370o (West 2014); IND. CODE ANN. § 27-13-36-9 (West 2008); MASS. GEN. LAWS ANN. ch. 176I, § 3(b) (West 2007); N.M. STAT. ANN. § 59A-22A-5 (West 2000); N.Y. INS. LAW § 4303 (McKinney 2007 & Supp. 2014); N.D. CENT. CODE ANN. § 26.1-47-03 (West 2010); TEX. INS. CODE ANN. § 1301.155 (West 2009 & Supp. 2013). The ACA requires health plans to pay for out-of-network emergency services according to one of three formulations. Patient Protection and Affordable Care Act ("PPACA") §§ 1001, 10101(h), 42 U.S.C. 300gg-19a; 29 C.F.R. § 2590.715-2719A; 45 C.F.R. § 147.138(b). The provision requires non-grandfathered health plans to pay for out-of-network emergency services in an amount equal to the greatest of: (1) The amount negotiated with in-network providers for the emergency service furnished; (2) The amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary, and reasonable charges) but substituting the in-network cost-sharing provisions for the out-of-network cost-sharing provisions; or (3) The amount that would be paid under Medicare for the emergency service. Usually the highest amount of the three will be second option, usual customary and reasonable charges (UCR), but calculating UCR raises a whole host of other issues, discussed *infra* in notes 185-191 and accompanying text.

network.[126] However, these laws generally permit the provider to balance-bill the patient for the difference between the amount paid by the insurance company and the provider's charges.[127]

Without these laws requiring insurance companies to cover out-of-network emergency care, the hospital had no recourse against the insurance company and could only bill the patient, usually for full charges. Patients have much shallower pockets than their insurance companies. With legal requirements for the health plan to pay for the care, hospitals can raise their charges for emergency services knowing they will get paid a substantial portion of their charges by the non-contracted health plan and balance-bill the patient for the rest.

The hospital may have the perverse incentive to raise its charges and simultaneously refuse to contract with health plans because the hospital can get more from the plan by billing high out-of-network rates for emergency care rather than negotiating discounts needed to be in-network.[128] New Jersey's Bayonne Medical Center, reported to be the most expensive hospital in the country, utilized a strategy of

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[126] COLO. REV. STAT. ANN § 10-16-704 (West 2013); DEL. CODE ANN. tit. 18 § 3565 (199 & Supp. 2012); FLA. STAT. § 627.6472 (West 2011); GA. CODE ANN. § 33-30-24 (West 2013); 215 ILL. COMP. STAT. ANN. 5/370o (West 2014); IND. CODE ANN. § 27-13-36-9 (West 2008); MASS. GEN. LAWS ANN. ch. 176i, § 3(b) (West 2007); N.M. STAT. ANN. § 59A-22A-5 (West 2000); N.Y. INS. LAW § 4303 (McKinney 2007 & Supp. 2014); N.D. CENT. CODE ANN. § 26.1-47-03 (West 2010); TEX. INS. CODE ANN. § 1301.155 (West 2009 & Supp. 2013).

[127] Although this article is focused on hospital billing practices, the balance-billing phenomenon is particularly acute with physician bills. Even if a hospital is in-network, the various physicians who provide services at the hospital, such as emergency physicians, surgeons, anesthesiologists, radiologists, or pathologists, may not be in-network and may bill the patient or health insurance provider at rates that are marked up 10-100 times what Medicare pays. The patient often has no choice of physician when receiving care in the hospital, and hospitals are not able to require their independent medical staff physicians to contract with all of the health insurance companies that the hospital does. *See, e.g.*, AM. HEALTH INS. PLANS, *supra* note 121, at 2; Ginsburg, *supra* note 11, at 6; Roni Caryn Rabin, *Out-of-Network Bills for In-Network Health Care*, N.Y. TIMES WELL BLOG (Nov. 19, 2012, 4:23 PM), http://well.blogs.nytimes.com/2012/11/19/out-of-network-bills-for-in-network-health-care/; Tara Siegel Bernard, *Out of Network, Not by Choice, and Facing Huge Health Bills*, N.Y. TIMES, (Oct. 18, 2013), http://www.nytimes.com/2013/10/19/your-money/out-of-network-not-by-choice-and-facing-huge-health-bills.html.

[128] *See* Julie Creswell et al., *New Jersey Hospital Has Highest Billing Rates in the Nation*, N.Y. TIMES, May 16, 2013, http://www.nytimes.com/2013/05/17/business/bayonne-medical-center-has-highest-us-billing-rates.html?pagewanted=all.

going out-of-network to turn it from a floundering hospital to an extremely profitable one, but the consequence has been sky-high prices.[129]

b. Some People Do Pay Full Price

Hospitals have an incentive to raise chargemaster rates because occasionally a self-pay patient who is charged the list price actually pays it. These patients include international visitors seeking care in the U.S. and wealthier self-pay individuals.[130] Although some of those who pay full price are truly wealthy, others in the middle class can barely afford their hospital bills yet may earn too much to qualify for financial assistance, the burdens of which are discussed more in Part III.A, below.[131] Some of these self-pay patients have high-deductible insurance, but they are responsible for paying for the full price of care up to their deductible.[132] Although self-pay patients make up a very small fraction of the hospital's total revenue (typically about three percent), hospitals concerned about their profit margins seek to maximize profit wherever they can.[133] As one hospital CEO put it, "You don't really want to change your charges if you have a Saudi sheikh come in with a suitcase full of cash who's going to pay full charges."[134] Without any market force to keep charges down, the possibility of getting paid full charges in a few cases provides additional incentive to keep raising charges.

c. Boosting Charity Care Calculations

Another historical incentive for hospitals to raise chargemaster rates was that the amount of charity care hospitals could claim to

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[129] *Id*.

[130] *See 2004 House Hearing on Hospital Billing Transcript*, *supra* note 26, at 16, 20 (statement of Gerard Anderson, Professor, Johns Hopkins Bloomberg School of Public Health).

[131] *See id*. at 16.

[132] *See id*. at 13.

[133] *Id*. at 20, 119 (statement of Herbert Pardes, President and CEO, New York Presbyterian Hospital) ("[T]here are some high income people and some international patients who do pay full charges, and as a result of that, there is a certain amount of cost optimization.").

[134] Rosenthal, *supra* note 24.

have provided was based on full charges.[135] This was good for hospitals' public relations[136] and for meeting state requirements for charity care for tax-exemption or licensure.[137] By calculating the value of charity care provided based on inflated charges, hospitals could meet their requirements faster without providing nearly as much free or discounted care.[138]

In 2008, the IRS finalized new requirements for Form 990, which tax-exempt organizations are required to file with the IRS.[139] The new Form 990 includes a Schedule H for tax-exempt hospitals on which the hospital must report its community benefit activities, including a calculation of the amount of charity care provided.[140] Schedule H was designed to standardize and make accessible the calculation of community benefits for all nonprofit hospitals.[141] The IRS instructs hospitals to calculate charity care "at cost," which is the product of the amount of gross charity care charges and the hospital's cost-to-charge ratio.[142] Because the hospital must calculate its charity care in terms of cost and not charges, the hospital can no longer inflate its charity care calculation by raising charges.

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135 *See Soak the Poor*, *supra* note 14, at 784-85.

136 *See* N.J. DEP'T OF HEALTH, *supra* note 51, at 93 ("[W]hen hospitals proudly boast in the media that they have separated this or that pair of Siamese twins free of charge, and 'at a cost of several million dollars,' the laity is made to believe that the 'several million dollars' represents true costs that the hospital had to absorb, that is, for which it had to write checks. In fact, those amounts almost always represent merely the hospital's total charges, at charge-master levels.").

137 Some states require hospitals to provide a certain amount of charity care (calculated as a percentage of revenues) to maintain tax-exemption from state and local taxes or to qualify for a certificate of need, required in some states for licensure and operations. *See* Sara Rosenbaum et al., *Hospital Tax-Exempt Policy: A Comparison of Schedule H and State Community Benefit Reporting Systems*, 2 FRONTIERS IN PUB. HEALTH SERVS. & SYS. RES. (2013) *available at* http://uknowledge.uky.edu/frontiersinphssr/vol2/iss1/3.

138 *See* N.J. DEP'T OF HEALTH, *supra* note 51, at 93.

139 Bonnie M. Wyllie, *The Redesigned Form 990*, J. ACCOUNTANCY, March 2009, *available at* http://www.journalofaccountancy.com/issues/2009/mar/ redesignedform990.htm.

140 *See* IRS, SCHEDULE H (FORM 990): HOSPITALS, *available at* http://www.irs.gov/uac/About-Schedule-H-Form-990.

141 *See* Rosenbaum et al., *supra* note 137, at 1.

142 IRS, 2012 INSTRUCTIONS FOR SCHEDULE H (FORM 990), *available at* http://www.irs.gov/file_source/pub/irs-pdf/i990sh.pdf.

d. Medicare Outlier Payments

A different historical reason for bloated chargemasters was the way Medicare calculated extra hospital payments called "outlier payments." For high-cost cases, Medicare pays hospitals an outlier payment in addition to the standard DRG rate.[143] Historically, hospitals could game the methodology Medicare used to determine their outlier payments by increasing charges.[144] Outlier payments were calculated using the hospital's cost-to-charge ratio, and by increasing charges more rapidly than costs, hospitals could increase the spread between costs to charge, resulting in greater outlier payments.[145] For-profit hospital giant Tenet Healthcare took advantage of the outlier loophole and in 2006 agreed to pay the government $788 million in a settlement agreement for overbilling Medicare for outlier overpayments.[146] In 2003, CMS changed its calculation for outlier payments, closing the loophole for hospitals to rapidly raise charges to increase outlier payments.[147] Nevertheless, as recently as 2013, the Office of Inspector General has continued to express concern that a few hospitals may be using high charges to earn greater and more frequent outlier payments.[148]

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[143] Tompkins et al., *supra* note 27, at 53.

[144] *2004 House Hearing on Hospital Billing Transcript*, *supra* note 26,, at 127-28, 145 (Exchange between Rep. Greenwood, Chair of the Subcommittee of Oversight and Investigations, and Trevor Fetter, President and CEO of Tenet Healthcare, and the statement of Herb Kuhn, Director, Center for Medicare Management, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services).

[145] *Id.* at 142-45 (Statement of Herb Kuhn, Director, Center for Medicare Management, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services).

[146] Press Release, U.S. Dep't of Justice, *Tenet Healthcare Corporation to Pay U.S.More than $900 Million to Resolve False Claims Act Allegations*, Jun. 29, 2006, *available at* http://www.justice.gov/opa/pr/2006/June/06_civ_406.html; *see also* Margaret K. Kyle & David B. Ridley, *Would Greater Transparency and Uniformity Of Health Care Prices Benefit Poor Patients?*, 26 HEALTH AFF. 1384, 1388 (2007).

[147] *See* Proposed Change in Methodology for Determining Payment for Extraordinarily High-Cost Cases (Cost Outliers) Under the Acute Care Hospital Inpatient Prospective Payment System, 68 Fed. Reg. 10420, 10420-10429 (Mar. 5, 2003) (codified at 42 C.F.R. § 412.84).

[148] Department of Health & Human Service, Office of Inspector General, Medicare Hospital Outlier Payments Warrant Increased Scrutiny, 3 (Nov. 2013), http://oig.hhs.gov/oei/reports/oei-06-10-00520.pdf ("Although hospital charges do not affect the Medicare payment amount on most IPPS claims, hospital charges directly affect whether a hospital receives an outlier payment and, if so, the amount of payment.").

A similar incentive continues to apply to hospitals that are paid by commercial payers on a per diem or case rate basis. Usually such contracts contain stop-loss provisions, where the hospital will get paid additional amounts, usually based on discounted charges, if a patient's expenses exceed the stop-loss threshold.[149] In that situation, the hospital has an incentive to inflate charges so that it gets paid more after the stop-loss threshold and also to bring the patient across the threshold sooner.[150]

Although changes to the regulations addressing calculations of charity care for tax-exempt hospitals and Medicare outlier payments have largely eliminated ongoing incentives to inflate charges for these reasons, the fact is that once elevated, charges do not come back down. Due to the bloated, gargantuan chargemaster's entrenchment and inertia, chargemaster prices move in only one direction—up.

IV. THE HARMS OF IRRATIONAL HOSPITAL PRICING

Although hospitals concede that chargemaster prices are irrational, the common response to public reprobation over these prices is that almost nobody actually pays chargemaster prices. It is the equivalent of a "no harm no foul" argument: chargemasters are financial abstractions that simply serve as the starting point for real negotiations on price.[151] The problem with this argument is that there are people who are billed for full charges, including self-pay patients who have to pay out-of-pocket for their medical care either because they lack insurance or because their insurance does not cover their care.[152] The common refrain that chargemaster prices are harmless overlooks the harms that irrational hospital prices visit upon those who are obliged to pay them. Beyond the individual effects, irrational hospital prices distort the health care market, which is already

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[149] Robinson, *supra* note 81, at 23.

[150] *See* Kyle & Ridley, *supra* note146, at 1388.

[151] *See* Brill, *supra* note 58, at 23 (quoting a hospital spokesperson as saying that chargemaster rates "are not our real rates . . . I don't think a bill like this is relevant. Very few people actually pay those rates.").

[152] *2004 House Hearing on Hospital Billing Transcript*, *supra* note 26, at 10 (statement of Rep. Janice D. Schakowsky (D-IL), member, H. Comm. on Energy & Commerce).

plagued by features of market failure, and impede efforts to increase competition and contain costs.

a. Individual Harms

Medical bills impose significant financial and health-related harms on patients and families who struggle to pay them, even if the hospital ultimately writes off most of the unpaid bill.[153] Hospitals pursue medical debt aggressively, often assigning the bills to collection agencies that use wage-garnishment, liens on homes or foreclosure, seizure of property, high interest rates, and even arrest or body attachment to collect from these patients.[154] Medical debt is a contributing cause of approximately half of personal bankruptcies and nearly a quarter of home foreclosures.[155] Even for those who do not file for bankruptcy or lose their home, unpaid medical debt damages a family's credit score, which affects the ability to finance or re-finance a home, pay for college, and secure favorable interest rates on other consumer debt.[156] Many of those who suffer these financial hardships were not poor to begin with, but rather were middle-class

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[153] *2004 House Hearing on Hospital Billing Transcript*, *supra* note 26,, at 28 (statement of Melissa Jacoby, Associate Professor, University of North Carolina at Chapel Hill, School of Law). *But see*, Melissa B. Jacoby & Elizabeth Warren, *Beyond Hospital Misbehavior: An Alternative Account of Medical-Related Financial Distress*, 100 NW. U. L. REV. 535 (2006) (arguing that hospital billing and collection practices are only one contributor to the relationship between financial distress and medical debt, which also includes use of consumer debt to finance medical bills and lost income due to medical conditions).

[154] *2004 House Hearing on Hospital Billing Transcript*, *supra* note 26, at 34 (statement of Mark Rukavina, Executive Director of the Access Project); Lucette Lagnado, *Medical Seizures: Hospitals Try Extreme Measures To Collect Their Overdue Debt--Patients Who Skip Hearings on Bills Are Arrested*, WALL ST. J., Oct. 30, 2003, at A1; Lucette Lagnado, *Call it Yale v. Yale - Law School Clinic Is Taking Affiliated Hospital to Court Over Debt-Collection Tactics*, WALL ST. J., Nov. 14, 2003, at B1.

[155] *See* Jacoby & Warren, *supra* note 153, at 548 (estimating that between 46% and 56% of personal bankruptcy filers had self-identified a medical reason for their bankruptcy); Christopher Tarver Robertson et al., *Get Sick, Get Out: The Medical Causes of Home Mortgage Foreclosures*, 18 HEALTH MATRIX 65, 66-68 (2008) (concluding from survey data that 49% of home foreclosures were caused in part by a medical problem, and 23% were caused by unmanageable medical bills).

[156] *2004 House Hearing on Hospital Billing Transcript*, *supra* note 26, at 26-27 (statement of Melissa Jacoby, Associate Professor, University of North Carolina at Chapel Hill, School of Law).

homeowners.[157] These harsh collection tactics used by hospitals, though legal and even customary, create a significant amount of stress for the debtor, which contributes to further declines in health status and even risks of suicide.[158] Those suffering under the burden of medical debt find it difficult to obtain medical care because providers may refuse to see patients with unpaid medical bills.[159] They ration their own care by foregoing necessary medical attention or medications and cut back on other necessities such as food or shelter.[160]

The burdens imposed on individuals by high and unaffordable hospital bills are experienced by both the uninsured and the insured. Traditionally, most of the attention focused on the uninsured who suffered from unmitigated and undiscounted hospital bills. Although more help is increasingly available for the neediest uninsured, the burden persists for those uninsured with more means as well as those with insurance.

1. Many Uninsured Continue to Pay Full Charges

Despite mounting pressure to change their billing practices for the poorest uninsured patients, hospitals still charge many uninsured patients full prices for hospital services.[161] These middle-class, working-class or self-employed uninsured have little bargaining power to negotiate discounts and lack the wherewithal in most cases to do so.[162] Historically, hospitals defended the practice of charging uninsured patients the highest amounts citing confusion about

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[157] *See* Jacoby & Warren, *supra* note 153, at 545 (noting that bankruptcy filers are largely middle class); Robertson et al. *supra* note 155, at 97 (noting that foreclosure filers are largely middle class).

[158] Melissa B. Jacoby, *The Debtor-Patient: In Search of Non-Debt-Based Alternatives*, 69 BROOK. L. REV. 453, 477 (2004); *see also* Katherine Porter, *The Damage of Debt*, 69 WASH. & LEE L. REV. 979, 1006-08 (2012).

[159] *See* Jacoby, *supra* note 158, at 477.

[160] Melissa B. Jacoby & Mirya Holman, *Managing Medical Bills on the Brink of Bankruptcy*, 10 YALE J. HEALTH POL'Y L. & ETHICS 239, 247 (2010).

[161] *See Soak the Poor*, *supra* note 14, at 780-81.

[162] Reinhardt, *supra* note 67, at 2129; Uwe Reinhardt, *Shocked, Shocked, Over Hospital Bills*, NY TIMES ECONOMIX BLOG (Mar. 1, 2013, 6:00AM), http://economix.blogs.nytimes.com/2013/03/01/shocked-shocked-over-hospital-bills/.

whether Medicare fraud and abuse rules permit discounts to uninsured patients and concerns that discounts offered to uninsured patients will adversely affect negotiations with health plans that insist on paying the lowest prices offered to any customer.[163] In 2004, CMS and the Office of Inspector General confirmed that hospitals may offer discounts or free care to uninsured patients without running afoul of Medicare rules or the federal anti-kickback statute,[164] and yet the practice of billing self-pay patients full charges continues.

In his 36-page Time magazine special report in 2013, Steven Brill described how an uninsured patient, Janice S., received a $21,000 bill for a trip to the ER for chest pains that turned out to be heartburn and how Emilia Gilbert was charged $9,418 for a trip to the ER when she slipped and fell.[165] Both women lacked insurance but were charged full price because they exceeded the modest income levels required for hospital financial assistance.[166] If Janice had been 65 rather than 64 when she went to the hospital, Medicare would have paid less than one-tenth the price she paid for some of the items on her bill.[167] Emilia's hospital unbundled her bill, charging her separately for items like bandages and intravenous tubing that would have been included in Medicare's bundled payment.[168] Regardless of whether these patients remit the full amount they are charged, they suffer the effects of being charged for services beyond what they can afford.

The ACA provides some help for the uninsured facing hospital bills. The Act reduces the overall number of uninsured and requires tax-exempt hospitals to limit prices charged to uninsured patients who qualify for financial assistance.

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163 *See* Tompkins et al., *supra* note 27, at 53.

164 *See Questions on Charges for The Uninsured*, CTRS. FOR MEDICARE & MEDICAID SERVS. (2004), http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/downloads/FAQ_Uninsured.pdf; *Hospital Discounts Offered to Patients Who Cannot Afford to Pay Their Hospital Bills*, DEPT. HEALTH & HUMAN SERVS., OFFICE OF INSPECTOR GEN., (Feb. 2, 2004) https://oig.hhs.gov/fraud/docs/alertsandbulletins/2004/FA021904hospitaldiscounts.pdf.

165 *Brill*, *supra* note 58, at 22, 28.

166 *Id.*

167 *Id.* at 22.

168 *Id.* at 28.

i) ACA impact on total number of uninsured

The group most often cited as being billed full charges is the uninsured, and so one way to protect this population from irrational hospital prices is to cover them. Under the ACA, the number of uninsured persons in the U.S. is projected to decline by 26 million.[169] Most of the coverage gains are accomplished by the reforms to the private individual and small group markets making everyone insurable, the individual mandate requiring nearly everyone to obtain coverage, and the expansion of Medicaid in states that elect to undertake it.[170]

Even after the ACA's coverage provisions fully take effect, approximately 31 million nonelderly people will continue to be uninsured.[171] These include undocumented immigrants, persons for whom coverage will remain unaffordable, those under 100% of the federal poverty level in states that do not expand Medicaid, those who elect to pay the penalty rather than comply with the individual mandate, and those with religious exemptions.[172]

Expanded coverage under the ACA is an inadequate solution to the problem of irrational hospital prices. Many millions will remain uninsured, and some of those who remain uninsured will not be eligible for hospital financial assistance. In addition, as discussed below, having insurance does not completely protect individuals from being charged full price.

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[169] CONG. BUDGET OFFICE, UPDATED ESTIMATES OF THE EFFECTS OF THE INSURANCE COVERAGE PROVISIONS OF THE AFFORDABLE CARE ACT, APRIL 2014 4 (April 2014), http://www.cbo.gov/sites/default/files/cbofiles/attachments/45231-ACA_Estimates.pdf.

[170] PPACA §§ 1201, 1311, 42 U.S.C. §§ 300gg (2010) (setting forth health insurance market reforms and creating health insurance exchanges); PPACA § 1401, 26 U.S.C. § 36 (2010) (providing premium subsidies for individuals to purchase health insurance); PPACA § 1001, 42 U.S.C. § 1936a (2010) (expanding the Medicaid program to cover those whose income is below 133% of federal poverty levels); *see* Erin C. Fuse Brown, *Developing a Durable Right to Health Care*, 14 MINN. J.L. SCI. & TECH. 439, 455-460 (2013). Additional private market reforms such as allowing young adults to remain on their parents' plans until the age of 26 add to the numbers newly covered under the ACA. PPACA §§ 1004, 2301, 42 U.S.C. 300gg (2010) (expanding coverage for dependents up to age 26).

[171] CONG. BUDGET OFFICE, *supra* note 169, at 4.

[172] *See* Fuse Brown, *supra* note 170, at 460 n. 72.

ii) Rules for tax-exempt hospitals

A new set of rules directed at tax-exempt hospitals by the IRS softens the financial impact of a hospital stay for those who are eligible under the hospital's financial assistance policies. The ACA contains new requirements that charitable hospitals must meet as a condition of maintaining their tax-exempt status. First, tax-exempt hospitals must have a written financial assistance policy, widely publicized, that sets forth eligibility criteria for free or discounted care for low-income patients, as well as how charges to patients are calculated.[173] Second, such hospitals may not charge such patients "gross charges"[174] and must limit the amounts charged to patients who are eligible for financial assistance to "amounts generally billed" to insured patients for emergency or medically necessary care.[175] The "amounts generally billed" (AGB) are the maximum amount the hospital may charge a patient eligible for financial assistance under its policy.[176] The ACA also bars tax-exempt hospitals from using "extraordinary collection actions" unless it has made "reasonable efforts" to determine whether the patient is eligible for financial assistance.[177]

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[173] PPACA §§ 9007(a), 10903(a), 124 Stat. at 855-858, (codified at 26 U.S.C. § 501(r)).

[174] PPACA §§ 9007(a), 124 Stat. at 857 (codified at 26 U.S.C. § 501(r)(5)). The ACA does not define "gross charges", but the term generally refers to undiscounted chargemaster rates. *See* MINORITY STAFF OF S. FINANCE COMM., TAX EXEMPT HOSP.: DISCUSSION DRAFT 5, at 12 (2007), *available at* http://grassley.senate.gov/releases/2007/07182007.pdf.

[175] Additional Requirements for Charitable Hospitals, 77 Fed. Reg. 38148 (Jun. 26, 2012). In proposed regulations, the IRS provides two alternate methods of calculating AGB. The first method calculates AGB as the amount that would be paid by Medicare, including Medicare beneficiary co-insurance. Under the second method, AGB takes into account the amounts received for patients insured by both Medicare and private insurers. 77 Fed. Reg. at 38165-66 (to be codified at 26 C.F.R. § 1.501(r)-5) (proposing methodologies for calculating "amounts generally billed").

[176] Additional Requirements for Charitable Hospitals, 77 Fed. Reg. at 38149, 38165-66.

[177] PPACA § 9007(a)(r)(6), 124 Stat. at 857 (codified at 26 U.S.C. § 501(r)(6)). The IRS proposed rules define extraordinary collection actions to include placing a lien on an individual's property; foreclosure on an individual's real property; attaching or seizing an individual's bank account or any other personal property; commencing a civil action against an individual; causing an individual's arrest; causing an individual to be subject to a writ of body attachment; garnishing an individual's wages; reporting an individual to a credit agency; and selling an individual's debt to another party. To have made "reasonable efforts," a hospital must determine whether an individual is eligible for financial assistance

Although these IRS rules will help the most vulnerable patients avoid being billed for full or gross charges, the rules do not cover the entire landscape of self-pay patients. Specifically, the rules do not apply to patients who are ineligible for the hospital's financial assistance policy, such as the middle-class.[178] Hospitals are free to set their own income limits for their financial assistance policies and may leave many patients who cannot afford to pay undiscounted charges ineligible for financial assistance. These ACA requirements also do not apply to patients at for-profit hospitals.[179]

In response to ongoing pressure from Congress, the news media, and patient advocates, some hospitals have undertaken voluntary efforts to limit prices charged to the uninsured. The American Hospital Association issued updated guidelines in 2012 setting forth principles for hospital billing and collections.[180] These voluntary guidelines are largely consistent with the ACA requirements, but would apply to all hospitals that adopt them, not just tax-exempt hospitals. Though laudable, the voluntary guidelines for hospital billing and collection practices have been seen by economists as inadequate to fully address the problem of discriminatory pricing.[181]

2. The Insured Also Pay Inflated Charges

Most discussions of the harms of irrational hospital pricing

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or provide notices about the availability of financial assistance during a notification period that ends 120 days after the date of the first bill. Additional Requirements for Charitable Hospitals, 77 Fed. Reg. at 38156, 38166 (to be codified at 26 C.F.R. § 1.501(r)(6)).

[178] Although there is no agreement on the definition of "middle class," in 2012 nearly a quarter of the 47 million uninsured earned household incomes over 250% of FPL. *Key Facts About Americans Without Health Insurance*, KAISER COMMISSION ON MEDICAID AND THE UNINSURED, at 4, fig. 3, Sept. 2012, fig. 3, http://www.kaiserfamilyfoundation.files.wordpress.com/2013/09/8488-key-facts-about-the-uninsured-population.pdf.

[179] *Summary of Proposed Rules for Non-profit Hospitals' Financial Assistance, Billing and Collection Practices*, CMTY. CATALYST 1 (Aug. 2012), http://www.communitycatalyst.org/doc-store/publications/Summary_Notice_of_Proposed_Rules_Financial_Assistance_Debt_Collection.pdf.

[180] AM. HOSP. ASS'N, *supra* note 70.

[181] *See, e.g.*, Uwe Reinhardt, *What Hospitals Charge the Uninsured*, N.Y. TIMES ECONOMIX BLOG (Mar. 15, 2013, 6:00 AM), http://economix.blogs.nytimes.com/2013/03/ 15/what-hospitals-charge-the-uninsured/.

center on the uninsured, but those with insurance are also subject to significant burdens from inflated hospital charges. Patients with insurance may be charged full or inflated prices under certain circumstances: they receive care from an out-of-network provider, they have a high deductible plan, their care is not covered by insurance, or their type of insurance does not receive negotiated discounts.

i) Out-of-Network Care

As noted above, even insured patients may be billed for full charges when they receive out-of-network hospital care, typically in an emergency.[182] The Emergency Medical Treatment and Labor Act (EMTALA) requires Medicare-participating hospitals to screen and provide stabilizing treatment to all patients with an emergency medical condition without regard for ability to pay, but the law does not limit the price a hospital may charge for those services.[183] Even if the patient's insurance plan pays for a portion of the bill, the hospital often balance-bills the patient for the rest—sometimes half or more of the hospital's full chargemaster price for the service.[184] The IRS's new limits on charges to amounts generally billed may not apply because an out-of-network patient with insurance may not qualify for financial assistance or because the hospital is for-profit.

Non-network hospitals do not have a contract with the patient's insurance plan and thus there are no negotiated rates for the patient's care. Under the ACA and some state laws, the health plan is obligated to pay for non-network emergency care according to its

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[182] *See supra* text accompanying note 56. Emergencies are not the only reason insured individuals seek out-of-network care. Patients may also seek specialty care, such as treatment for cancer or a rare disease, at hospitals that are known for their expertise on that particular treatment. *See, e.g.*, Nina Bernstein, *Insurers Alter Cost Formula, and Patients Pay More*, N.Y. TIMES, Apr. 23, 2012, http://www.nytimes.com/2012/04/24/nyregion/ health-insurers-switch-baseline-for-out-of-network-charges.html?pagewanted=all&_r=0 (describing the Glaser family who sought out-of-network care for son's rare liver disease); Brill, *supra* note 58, at 18 (describing how Sean Recchi sought treatment for his non-Hodgkin's lymphoma at MD Anderson Cancer Center, an out-of-network hospital).

[183] 42 U.S.C. § 1395dd(b)-(c) (2006); *see also* Lucas & Williams, *supra* note 123, at 137-38.

[184] *See* Bernstein, *supra* note 182.

"usual, customary and reasonable" (UCR) rate for those services.[185] When it pays UCR, the insurance plan ends up paying inflated prices, even if it does not pay full charges, and the plan often resorts to expensive litigation to determine what the UCR price should be.[186]

The problem with UCR rates is that they are indeterminate and controversial.[187] UCR falls somewhere below full charges and above what a negotiated in-network rate would be (which is itself higher than what Medicare or Medicaid pays). However, there is a large amount of play in that gap, and health plans and hospitals often cannot agree upon how to calculate UCR. Contractual provisions often do not define UCR in any concrete manner, and judicial intervention may be required to assign a value to UCR.[188] Courts struggle with this highly fact-intensive task, which at first blush seems to be a fairly straightforward matter of figuring out the fair market value for those services in the geographic market. The irrationality of hospital prices—the price discrimination, wide variations, different methodologies for calculating payment, and opacity—complicates the court's effort to determine UCR. UCR may be determined according to a variety of methodologies: *quantum meruit*, a measure of what the recipient of the services would have paid to avoid unjust enrichment;[189] the amount the hospital has accepted as payment from other payers (including or excluding

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185 *See* Lucas & Williams, *supra* note 123, at 138.

186 *See id*.

187 Troy J. Oechsner & Magda Schaler-Haynes, *Keeping It Simple: Health Plan Benefit Standardization and Regulatory Choice Under the Affordable Care Act*, 74 ALB. L. REV. 241, 274 (2010).

188 David Stahl, *Health Care Reform: Presumptively Reasonable Rates for Necessary Medical Services*, 35 NOVA L. REV. 175, 181 (2010).

189 *See, e.g.*, Prospect Med. Group, Inc. v. Northridge Emergency Med. Group, 198 P.3d 86, 88-89 (Cal. 2009); Bell v. Blue Cross of Cal., 31 Cal. Rptr. 3d 688 (2005); Anticaglia v. Lynch, No. 90C-11-175, 1992 WL 138983 at *4, *9 (Del. Super. Ct. Mar. 16, 1992); Yellowitz v. J.H. Marshall & Assocs., Inc., 284 A.2d 665, 666 (D.C. 1971); Nursing Care Servs., Inc. v. Dobos, 380 So. 2d 516, 518 (Fla. Dist. Ct. App. 1980); Moncrief v. Hall, 63 So. 2d 640, 642 (Fla. 1953); Payne v. Humana Hosp. Orange Park, 661 So. 2d 1239, 1241 (Fla. Dist. Ct. App. 1995); Culverhouse v. Jackson, 194 S.E.2d 585, 586 (Ga. Ct. App. 1972); Majid v. Stubblefield, 589 N.E.2d 1045, 1048 (Ill. App. Ct. 1992); Poulson v. Foster, 293 N.W. 361 (S.D. 1940); Miracle v. Barker, 136 P.2d 678, 683-84 (Wyo. 1943).

Medicare and Medicaid);[190] the value calculated by third-party databases;[191] or a multiplier of Medicare rates.[192] All of these methods have been criticized or disapproved at some point, illustrating that there is no clear methodology for arriving at UCR. The one method that most courts seem to reject for calculating UCR is equating UCR with full, billed charges.[193]

Even if the patient does not pay the entire bill for out-of-network emergency care out of his or her own pocket, the reality is that when the health plan pays for care at inflated prices and spends resources litigating the calculation of UCR, these costs are passed on to consumers in the form of higher premiums or reduced benefits. Meanwhile, the individual patient is burdened with a bill for the balance, the difference between what her health plan paid the hospital and the hospital's billed charges.

ii) High Deductible Plans

Patients with high deductible health plans may also be billed full

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[190] *See, e.g.*, Baker Cnty. Med. Servs., Inc. v. Aetna Health Mgmt, LLC, 31 So. 3d 842, 845 (Fla. Dist. Ct. App. 2010) (excluding Medicare and Medicaid rates); Temple Univ. Hosp., Inc. v. Healthcare Mgmt Alts., Inc., 832 A.2d 501, 509-10 (Pa. Super. Ct. 2003) (including Medicare and Medicaid rates).

[191] One prominent database used to calculate UCR was operated by Ingenix, Inc., a company owned by health insurance giant United Healthcare. Ingenix was the target of class action litigation and investigation by then-State Attorney General of New York, Andrew Cuomo, for conflicts of interest and biased data that resulted in inaccurate, lower UCR calculations owed by insurance companies to providers for out-of-network care. The litigation and investigation resulted in a 2009 settlement with health insurers that called for the creation of an independent, not-for-profit database to be established called FAIR Health. For more discussions of the Ingenix controversy, *see* Lucas & Williams, *supra* note 123, at 155-162; Oechsner & Schaler-Haynes, *supra* note 187, at 275-279; Stahl, *supra* note 188, 185-187.

[192] *See* In re Adoption of N.J.A.C., 979 A.2d 770, 774 (N.J. Super. Ct. App. Div. 2009); *cf.* Bernstein, *supra* note 182 (observing an increasing trend toward insurance companies paying 140-250% of Medicare for out-of-network care, instead of 80% of UCR, resulting in lower payments by the insurance plan and large balance-bills for the patient).

[193] *See, e.g.*, In re Adoption of N.J.A.C., 979 A.2d at 785; Doe v. HCA Health Servs. of Tenn. Inc., 46 S.W.3d 191 (Tenn. 2001); Payne, 661 So. 2d at 1239; Victory Mem'l Hosp. v. Rice, 493 N.E.2d 117, 119 (Ill. App. Ct. 1986); Greenfield v. Manor Care, Inc., 705 So. 2d 926, 930-31 (Fla. Dist. Ct. App. 1997). *But see* Holland v. Trinity Health Care Corp., 791 N.W.2d 724, 728 (Mich. Ct. App. 2010) (finding that "usual and customary charges" referred to the hospital's chargemaster prices because Black's Law Dictionary defines charge as "to demand a fee; to bill.").

charges for care that is not covered by their plan because the patient has not reached his annual deductible.[194] Purchasers of high deductible health plans may pay lower premiums, but coverage does not begin until the individual has spent a certain sum out-of-pocket toward health care costs, ranging, for example, from $2,000 to $10,000.[195] The individual may also have a tax-preferred health savings account to use for out-of-pocket expenses.[196] The prevalence of high-deductible health plans has been steadily increasing, growing from just four percent of those with employer-sponsored health insurance in 2006 to nineteen percent in 2012.[197]

Individuals with high-deductible health plans may be charged higher prices for the care they pay for themselves: either full or minimally discounted charges.[198] They may not get the benefit of the lower, negotiated rate that their insurance plan would pay.[199] Hospitals are reluctant to extend the health plan's negotiated discount to an individual with a high-deductible, citing the greater administrative burden of collecting from self-paying patients and the lack of guaranteed patient volume that drives many insurance discounts.[200]

Some have argued that individuals with high deductible plans are insensitive to prices for hospital care, because generally any hospital stay will be so expensive that they will exceed their deductible and insurance coverage will kick in.[201] Nevertheless, many

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194 Matthew Rae et al., *Snapshots: The Prevalence & Cost of Deductibles in Employer Sponsored Insurance*, HENRY J. KAISER FAMILY FOUND. (Nov. 2, 2012), http://kff.org/health-costs/issue-brief/snapshots-the-prevalence-and-cost-of-deductibles-in-employer-sponsored-insurance/.

195 *See Veil of Secrecy*, *supra* note 12, at 65; Muir et al., *supra* note 53, at 324.

196 Mark Hall, *The Legal and Historical Foundations of Patients as Medical Consumers*, 96 GEO. L.J. 583, 587 (2008).

197 *See* Rae et al., *supra* note 194.

198 *See Soak the Poor*, *supra* note 14, at 784.

199 Michele Melden, *Guarding Against the High Risk of High Deductible Health Plans: A Proposal for Regulatory Protections*, 18 LOY. CONSUMER L. REV. 403, 407 (2006).

200 *See* Tompkins et al., *supra* note 122, at 45, 53.

201 James C. Robinson & Kimberly MacPherson, *Payers Test Reference Pricing and Centers of Excellence to Steer Patients to Low-Price and High-Quality Providers*, 31 HEALTH AFF. 2028, 2029 (2012).

of those with high deductible plans will struggle to pay for their care up to their deductible, including the costs of brief visits to the hospital emergency room or outpatient procedures, so the difference between full charges and discounted charges is still significant to them. Individuals with high deductible plans are more likely to spend a higher percentage of their income on health care and are more likely to be burdened with medical debt and suffer from the effects of aggressive debt collection.[202] Moreover, individuals with high-deductible plans have been shown to cut back on both necessary and unnecessary care, and billing them the highest charges for their care may exacerbate avoidance of needed health care.[203]

iii) Services Not Covered by Insurance

Care that is not covered by health insurance will often be billed at full price. The individual pays as if they are essentially uninsured for those services. For example, prior to the ACA's rule changes in 2014, prenatal care and childbirth were often excluded by individual or small group insurance policies.[204] The individual is left to negotiate her own rates or face undiscounted retail prices.[205] Such patients may find it difficult to get hospitals to provide specific price quotes necessary to shop around and have little bargaining power to demand significant discounts.[206] The hospital may also unbundle the bill, and the long list of *a la carte* charges will result in a higher price-tag overall.[207] Although the ACA will require individual and small-group health plans to provide more comprehensive coverage as part of the essential health benefits, many plans may still contain gaps in coverage for which the individual may be billed full charges.[208]

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[202] *See* Melden, *supra* note 199, at 412; Timothy Stoltzfus Jost, *Is Health Insurance a Bad Idea? The Consumer-Driven Perspective*, 14 CONN. INS. L.J. 377, 387 (2008).

[203] *See id.*, at 384-85.

[204] *See* Rosenthal, *supra* note 62; Hall & Schneider, *supra* note 63, at 649.

[205] *See* Rosenthal, *supra* note 62.

[206] *Id.*; Hall & Schneider, *supra* note 63, at 650.

[207] *See* Rosenthal, *supra* note 62,*see supra* text accompanying note 62.

[208] As of January 1, 2014, the ACA requires non-grandfathered individual and small group plans, both inside and outside of the exchange, to cover the essential health benefits, which include certain types of care (such as maternity care or mental health and substance abuse

iv) Workers' Compensation and Automobile Insurance

Individuals whose hospital care is covered by workers' compensation or automobile insurance are typically charged full list prices.[209] These patients have insurance coverage, but the insurers generally do not have negotiated rates with most providers and have little bargaining clout because they represent such a small portion of any particular hospital's patients or revenue.[210] Several states have legislatively addressed this problem by establishing a regulated fee schedule that will apply to auto or workers' compensation insurance.[211] These regulatory fees are typically higher than the rates commercial health plans negotiate, but they protect the payer from the wild variability and unpredictability of the chargemaster. Not all states, however, have set fee schedules for these payers, and in those states, hospitals will likely bill the payer full charges.

The fact that a deeper pocket pays the charges rather than the individual does not erase the harm. Providers may balance bill the

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care) that were historically excluded by individual health plans. Employer-based plans may still contain gaps in coverage because employer-based and self-funded ERISA plans do not have to cover essential health benefits. PPACA § 1302, 42 U.S.C. § 18022 (2010). Nevertheless, in response to the public furor over cancellation of non-ACA compliant health plans, the Obama administration has implemented an option allowing health insurance companies to renew such non-compliant plans for an additional year. *See* Sarah Kliff, *This is How Obama Plans to Un-cancel Insurance Policies*, WASH. POST WONKBLOG (Nov. 14, 2013, 3:01 PM), http://www.washingtonpost.com/blogs/wonkblog/wp/2013/11/14/this-is-how-obama-plans-to-un-cancel-insurance-policies/.

209 *See Soak the Poor*, *supra* note 14, at 780-81; N.J. DEP'T OF HEALTH, *supra* note 51, at 97.

210 *See* Stahl, *supra* note 188, at 190.

211 For automobile insurance fee schedules, s*ee, e.g.*, N.J. STAT. ANN. § 39:6A-4.6 (West 2013); FLA. STAT. § 627.736 (2013); 31 PA. CODE § 69 (1991). For workers compensation fee schedules, *see, e.g.*, ALA. CODE § 25-5-293 (2013); ALASKA STAT. § 23.30.097 (2013); ARK. CODE ANN. § 11-9-517 (2013); CAL. LAB. CODE § 11-9-517 (West 2013); COLO. REV. STAT. § 8-42-101 (2013); CONN. GEN. STAT. § 31-280 (2013); DEL. CODE ANN. tit. 19 § 2322B (2013); FLA. STAT. § 440.13 (2013); GA. CODE ANN. § 34-9-205 (2013); HAW. REV. STAT. § 431:10C-308.5 (2013); 820 ILL. COMP. STAT. 305/8.2 (2013); KAN. STAT. ANN. § 44-510i (2013); KY. REV. STAT. ANN. § 342.035 (West 2013); LA. REV. STAT. ANN. § 23:1034.2 (2013); ME. REV. STAT. tit. 39-A § 209-A (2013); MD. CODE ANN., LAB. & EMPL. § 9-663 (West 2013); MICH. COMP. LAWS § 418.315 (2013); MINN. STAT. § 176.136 (2013); MISS. CODE ANN. § 71-3-15 (2013); MONT. CODE ANN. § 39-71-704 (2013); NEB. REV. STAT. § 48-120 (2013); NEV. REV. STAT. § 616C.260 (2013); N.M. STAT. ANN. § 52-4-5 (2013); N.C. GEN. STAT. § 97-26 (2013); OHIO REV. CODE ANN. § 4121.44 (West 2013); OKLA. STAT. tit. 85, § 327 (2013); OR. REV. STAT. § 656.248 (2013); 77 PA. CONS. STAT. § 531 (2013); TENN. CODE ANN. § 50-6-204 (2013); TEX. LAB. CODE ANN. § 413.011 (West 2013); VT. STAT. ANN. tit. 21, § 640 (2013).

patient if the insurance payment is deemed inadequate. The high prices borne by these payers reverberate through the market, ratcheting up the costs for the consumer or employer who funds the entity that pays for the care.

b. Harms to the Market for Health Care Services

Irrational hospital prices do not just harm the individuals who have to pay them; these prices distort the larger health care market. Our dysfunctional system of hospital pricing leads to higher health care costs across the economy, creates barriers to entry for new health insurance competitors, and thwarts efforts to reduce health care costs through better-coordinated and higher-quality care.

1. Irrational Prices Lead to Higher Prices Overall

The extreme variation that characterizes hospital prices comes with a cost. As noted above, price variation is explained almost entirely by the market share of the hospital and not by variations in the costs, quality, sickness of the patient population, the payer mix, the payment methodology, or whether the hospital is a teaching facility.[212] This means that higher prices do not buy better quality or more effective health care, and purchasers of health care—the individuals and employers who pay for health insurance or services directly—are getting little value for their money when they spend more on higher-priced care. The problem of hospital market power is getting worse. Hospitals with larger market share are draining patient volume from hospitals with less market power and lower prices.[213] As big hospitals get bigger, they are able to invest more in equipment and capital improvements than the smaller facilities, making the dominant hospital systems even more indispensible to health plans and further elevating their prices.[214] The ongoing wave of hospital mergers and consolidations has grown since the ACA was signed into law and shows no signs of slowing.[215]

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[212] *Massachusetts AG 2010 Report*, *supra* note 79, at 3-4. *See supra* discussion in Part I.C.

[213] *Massachusetts AG 2010 Report*, *supra* note 79, at 38-40.

[214] *Id.*

[215] Julie Creswell & Reed Abelson, *New Laws and Rising Costs Create a Surge of Supersizing*

The disparity between the strong leverage of hospitals and the relatively weak bargaining power of the private purchasers of health care is a major reason U.S. health care prices are so much higher than prices for similar services in other wealthy, developed countries.[216] These high prices, not higher utilization or better quality care, explain why per capita health care spending is so high in the U.S.[217] Americans pay more every time we touch the health care system for every item, supply, or service we receive.[218] Health care is consuming eighteen percent of the national GDP and an increasing amount of employees' paychecks.[219] The opaque, complex and discriminatory system of hospital pricing is on a never-ending feedback loop that continually drives those prices higher and widens variations in price.

Some may counter that hospitals use their monopoly profits to finance expansion or maintenance of their services, such as building a new hospital wing or subsidizing a money-losing service line, which benefit the patients and community. However, the benefits to ordinary individuals seem minimal in comparison to the wealth transferred to powerful health care providers. The costs of hospitals' monopoly profits fall to those paying for health insurance premiums, borne by all those who purchase health insurance, including those with lower and middle-incomes.[220] Clark Havighurst and Barak Richman note that this redistribution of wealth from consumers to

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Hospitals, N.Y. TIMES, Aug. 12, 2013, http://www.nytimes.com/2013/08/13/business/bigger-hospitals-may-lead-to-bigger-bills-for-patients.html?emc=eta1; Greaney, *supra* note 90, at 4.

216 *See* Anderson et al., *supra* note 86, at 102; Reinhardt, *supra* note 46.

217 Anderson et al., *supra* note 86, at 103; David A. Squires, *Explaining High Health Care Spending in the United States: An International Comparison of Supply, Utilization, Prices and Quality*, 10 THE COMMONWEALTH FUND 2, 5, 7, 9, 10 (May 2012), http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2012/May/1595_Squires_explaining_high_hlt_care_spending_intl_brief.pdf (citing high prices as the major cause, with possible other causes including more readily accessible technology and higher obesity rates).

218 Elisabeth Rosenthal, *The $2.7 Trillion Medical Bill*, N.Y. TIMES (Jun. 1, 2013), http://www.nytimes.com/2013/06/02/health/colonoscopies-explain-why-us-leads-the-world-in-health-expenditures.html.

219 *Id.* (noting that "[t]he United States spends about 18 percent of its gross domestic product on health care, nearly twice as much as most other developed countries.").

220 *See* Havighurst & Richman, *supra* note 94, at 860.

monopolistic health care providers is exacerbated by health insurance, which creates an economic buffer between the hospital and the ultimate consumer that allows the monopolist hospital to charge even more than the usual monopolist's price and earn more than the usual monopolist's profit.[221] This inflationary pressure further pushes health insurance premiums up, transferring wealth from lower and middle-income individual consumers to large, powerful health care providers and industry actors.[222]

2. *Barriers to Entry for New Insurance Plans*

The same incentives that push hospitals to go out-of-network and refuse to contract with health insurers can create barriers to entry for new health insurers.[223] Barriers to entry and reduced competition among health insurers mean higher premiums and fewer choices for consumers. For a new health insurer to compete in an existing health care market, it must contract with a sufficient number of providers and secure comparable discounts to offer competitive premiums. A new entrant may not have a lot of patient volume to bring to the negotiating table, and thus may be unable to get the same discounts of established large payers.[224] The hospital would have little reason to offer the plan at substantially discounted rates, especially if it knows it will be paid at least UCR for out-of-network emergency services.[225]

When hospitals refuse to deal in this way, new insurance companies have higher barriers to entry into the market, and

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[221] *Id.* at 862-64; *See also* Clark Havighurst & Barak Richman, *Distributive Injustice(s) in American Health Care*, 69 LAW & CONTEMP. PROBS. 7, 16 (2006) ("In the absence of insurer competition focused on giving subsets of consumers optimal value for their health care dollars . . . private health insurance enables providers and suppliers possessing advantageous market positions to parlay them into unusually large profits earned at premium payers' expense.").

[222] *See* Havighurst & Richman, *supra* note 94, at 862-64.

[223] Laws that require insurance plans to pay for out-of-network emergency care, for example, may cause the hospital to raise its charges and go out-of-network with most plans because the hospital makes more from billing high out-of-network rates for emergency care than negotiating discounts needed to be in-network. *See supra* text accompanying note 128.

[224] *See* Christine A. Varney, *Antitrust and Healthcare: Remarks as Prepared for the American Bar Association/American Health Lawyers Association Antitrust in Healthcare Conference*, DEP'T OF JUSTICE 9 (May 24, 2010), www.justice.gov/atr/public/speeches/258898.htm.

[225] *See supra* discussion in Part II.A.2.a.

competition among insurance plans declines. There is evidence that new health insurance companies are less able to secure competitive discounts from health care providers in health insurance markets dominated by one or two major plans than in less concentrated markets.[226] In many areas, the health insurance market is characterized by depleted competition and increasing concentration.[227] In a recent study by the American Medical Association, ninety-nine percent of metropolitan health insurance markets were "highly concentrated."[228] Although some degree of health insurance market power can counteract hospital monopolies, too much health insurance market concentration may result in higher premiums,[229] especially when the reason for concentration is barriers to entry.[230] One study found that increased insurer competition resulted in lower negotiated hospital prices for most hospitals, but resulted in higher prices for powerful "must-have" hospitals.[231] Although the findings are complicated and mixed, it appears that in at least some circumstances, barriers to entry for new health plan competitors may lead to higher costs for the consumer.[232]

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[226] *See* Varney, *supra* note 224, at 9.

[227] Press Release, Am. Med. Ass'n, AMA Study Shows Competition Disappearing in the Health Insurance Industry (Feb. 23, 2010), *available at* http://www.ama-assn.org/ama/pub/news/news/health-insurance-competition.shtml (reporting that 99% of metropolitan health insurance markets were "highly concentrated," and in 54% of metropolitan health insurance markets one health insurer had more than 50% market share).

[228] *Id.*

[229] Frakt, *supra* note 98.

[230] Austin Frakt, *Market Concentration and Entry*, THE INCIDENTAL ECONOMIST (Aug. 31, 2010, 4:00 AM), http://theincidentaleconomist.com/wordpress/market-concentration-and-entry/.

[231] Kate Ho & Robin S. Lee, *Insurer Competition and Negotiated Hospital Prices* 39 Nat'l Bureau of Econ. Research, Working Paper No. 19401, 2013).

[232] *See, e.g.*, Leemore Dafny et al., Paying a Premium on your Premium? Consolidation in the U.S. Health Insurance Industry 1 (Nat'l Bureau of Econ. Research, Working Paper No. 15434, 2009); James C. Robinson, *Consolidation and the Transformation of Competition in Health Insurance*, 23 HEALTH AFF. 6, 11 (2004).

3. Stymied Efforts to Increase Coordination and Reduce Costs of Care

The uncertainty that health insurers face over the costs of their enrollees' out-of-network care and battles over UCR raise costs for the insurance company, which are passed along to the consumer in the form of higher premiums.[233] These costs also deplete the savings otherwise achieved through tightly managed, efficient care among contracted providers who are increasingly being required to do more for their payments. Since the advent of managed care, health plans have assumed a greater role in controlling utilization and driving down health care prices.[234] The push for increased coordination is accelerating under the ACA with the creation of accountable care organizations (ACOs) for the Medicare program, which are intended to transform providers' financial incentives by rewarding them for reducing costs through better care coordination while meeting quality standards.[235] Also as intended, Medicare ACOs are spawning similar innovations in the private health care market.[236] When hospitals go out-of-network, they opt out of the increased coordination and efficiencies that come with a tightly managed network of providers, including shared electronic health records, channels of communication, and clinical protocols. The irrationality of hospital prices is driving some hospitals to go out-of-network as a profit-maximizing strategy, undermining efforts by managed care organizations and new entities such as ACOs to coordinate care and control costs.

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Irrational hospital prices harm many more individuals than are generally discussed. Even with increased protections for the poorest

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233 *See* Stahl, *supra* note 188, at 176.

234 *See* Carl E. Schneider & Mark A. Hall, *The Patient Life: Can Consumers Direct Health Care?* 35 AM. J. L. & MED. 7, 10-11 (2009).

235 Jessica L. Mantel, *Accountable Care Organizations: Can We Have Our Cake and Eat It Too?*, 42 SETON HALL L. REV. 1393, 1410-1411 (2012). Unfortunately, the push for more coordination of care and sharing of risks and rewards is also increasing consolidation among health care providers, which may drive hospital prices even higher in those markets. *See supra,* note 92.

236 *See* David Muhlestein, *Continued Growth of Public and Private Accountable Care Organizations*, HEALTH AFF. BLOG (Feb. 19, 2013), http://healthaffairs.org/blog/2013/02/19/continued-growth-of-public-and-private-accountable-care-organizations/.

of the uninsured, middle-class uninsured and a growing number of insured patients are billed inflated hospital charges. Unmanageable hospital bills exact a significant toll on the individual, ranging from financial ruin to declines in health. In addition, the perverse system of hospital pricing further distorts a broken health care market in a way that both raises costs and thwarts efforts to bring costs under control.

V. CONCLUSION

No one disputes that hospital prices are irrational. They bear no relation to cost or quality and are highest for those with the least bargaining power and ability to pay. We shop for hospital services blind: prices are shrouded in secrecy until after you have purchased the service and receive the bill, and then your bill is written in code, disaggregated into pages of individual items that may be marked up 100-1000% over the hospital's cost. If you are unable to pay for your care, the hospital may assign your bill to a collection agency that hounds you or goes after your home, your bank account, or your wages, a process that drives many into bankruptcy or home foreclosure.

Hospitals agree that the current pricing system is overly complex and bereft of meaning, weighing down their administrative staff to manage the chargemaster, negotiate with and bill dozens of payers, and chase down uncollected bills from their patients. But hospitals feel powerless to rationalize the system, locked in by its complexity and perceived market necessities. So hospitals respond to the incentives they have, inflating the chargemaster to gain leverage over payers, further consolidating their market power, and continuing to charge each purchaser a different price for the same service.

The public is shocked and appalled when confronted by the irrationality of hospital charges, to which hospitals respond that their charges are harmless because no one actually pays full prices. To the contrary, there are many who do, including middle-class uninsured and those with insurance who have high-deductible plans or receive care out-of-network. Even for those with insurance that pay lower prices, the irrationality of hospital prices results in higher prices overall, perpetuates a great deal of inequity and uncertainty, and gets

in the way of efforts to control health care costs. The harms of irrational hospital prices fall heavily upon many more individuals than we typically think of and reverberate through the health care system in ways that harm us all.