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Limiting Overall Hospital Costs by Capping Out-of-Network Rates

David Orentlicher*, Kyra Morgan⁺, and Barak Richman**

I. INTRODUCTION

As the United States struggles with health care cost inflation, it is especially important to address the high costs of hospital care. According to a RAND Research Report, hospital services “account for 44 percent of health care spending, and the prices that private insurers pay hospitals have been growing faster than the prices of hospital inputs and the prices paid by private insurers for physician services”.¹ To illustrate, and as noted in the Health Care Cost Institute’s 2017 Health Care Cost and Utilization Report, “average payments for emergency room services per privately insured person were more than four times greater for hospitals (\$378) than physicians (\$88).”²

In this paper, we consider an important strategy for containing hospital charges: limits on charges for out-of-network care. While out-of-network charges have attracted considerable and deserved attention for their impact on the financial liability of patients who are billed for out-of-network care, they also have an important impact on the prices that hospitals and insurers negotiate for in-network care.³ As a RAND Research Report notes, hospitals “derive leverage from the threat of not contracting with insurers.”⁴ Ordinarily, a non-contracting hospital can charge patients inflated out-of-network rates, so its willingness to reduce its in-network rates for an insurer diminishes as its out-of-network rates rise.⁵ Limits on what a hospital can charge for out-of-network patients correspondingly reduce its leverage when negotiating in-network rates with insurers⁶. Notably, this effect is well

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¹ ERIN L. DUFFY ET AL., THE PRICE AND SPENDING IMPACTS OF LIMITS ON PAYMENTS TO HOSPITALS FOR OUT-OF-NETWORK CARE 1 (2020).

² *Id.*

³ *Id.* at 2.

⁴ *Id.*

⁵ *See id.* (explaining if a hospital and insurer do not reach a contract, the hospital may charge insured patients the higher price tag of full billed charges).

⁶ Duffy et al., *supra* note 1, at 2.

illustrated by the Medicare Advantage program.⁷ Because “Medicare Advantage caps out-of-network payments at Medicare fee-for-service prices . . . negotiated in-network prices paid by Medicare Advantage plans closely track traditional Medicare prices rather than payments by private plans.”⁸

Although most approaches to limiting out-of-network charges involve direct price regulation, we offer an alternative approach: applying common law contract principles to impute market prices, rather than unchecked mark-ups, to hospital charges for out-of-network care.⁹

When patients seek hospital care, they enter into either an explicit or implied contract with the hospital for their needed care, but that contract does not specify the agreed-upon price.¹⁰ Contract law readily governs such contracts with open price terms. It does not allow the provider of goods or services to simply name a price, as hospitals often do when issuing a bill for out-of-network care. Rather, the provider may charge no more than the reasonable value of the goods and services provided.¹¹ This basic principle was recently applied by the Colorado Supreme Court when it considered a challenge to a hospital’s out-of-network rates.¹² According to the Court, the jury properly decided that an out-of-network patient should be charged the reasonable value of goods and services provided by the hospital rather than the hospital’s much higher chargemaster rates.¹³

Individual patients could enforce common law contract principles on a case-by-case basis, perhaps as a defense against any hospital action seeking to collect chargemaster amounts. More important, however, is establishing market rates prospectively, and thus preventing hospitals from ever initiating attempts to collect inflated amounts. Accordingly, we propose that state attorneys general issue an official opinion that articulates how state courts should handle any price dispute for out-of-network care. The opinion would specify that hospitals may charge no more than the reasonable value of the goods and services provided for its out-of-network care. Calculating a reasonable value would involve an assessment of market-based factors, such

⁷ See *id.* (discussing how Medicare Advantage plans indicate that out-of-network payment limits influence negotiated rates).

⁸ *Id.*

⁹ *Id.* at 1 (discussing how several states implemented policies to address surprise billing and legislation has been proposed to employ federal limits on out-of-network payments).

¹⁰ George A. Nation III, *Contracting for Healthcare: Price Terms in Hospital Admission Agreements*, 124 DICK. L. REV. 91, 126-127 (2019).

¹¹ See generally Barak Richman et al., *Overbilling and Informed Financial Consent – A Contractual Solution*, NEJM (2012).

¹² See generally *French v. Centura Health Corp.*, 509 P.3d 443, 452 (Colo. 2022) (considering whether a hospital’s chargemaster was incorporated by reference into hospital services agreements that a patient had signed).

¹³ *French v. Centura Health Corp.*, 509 P.3d 443, 452 (Colo. 2022).

as the hospital's actual costs plus a small markup¹⁴ or an average of the hospital's in-network rates.¹⁵

Starting in January 2022, we began implementing this strategy with Nevada state officials. We have assisted the Nevada Department of Health and Human Services (DHHS) in requesting from the state attorney general an official opinion concerning the treatment of hospital bills for out-of-network care. Part of that request involved DHHS staff analysis of hospital charge data that documented the extent to which hospitals bill out-of-network patients well above their in-network rates. The DHHS analysis confirmed that Nevada hospitals charge inflated amounts for out-of-network care, demonstrated the potential utility of an attorney general opinion, and suggested how contract law principles could compel hospitals to bring their out-of-network rates in line with market rates.

In this paper, we first consider the problem of excessive hospital charges and how current contract law can and should adjudicate disputes over out-of-network hospital charges. We then present the empirical analysis we pursued in conjunction with the Nevada DHHS. We conclude by discussing how clarifying contract law statewide could impose meaningful and needed reductions in out-of-network hospital charges, which in turn should help contain the rise of all hospital charges.

II. THE PROBLEM OF EXCESSIVE HOSPITAL CHARGES

As mentioned, hospital charges are the major driver of health care cost inflation, accounting for 44 percent of all health care spending.¹⁶ Moreover, payments for hospital care far exceed the costs that hospitals incur to provide care.¹⁷ In 2018, for example, across all services provided, private insurers paid hospitals 247 percent of what Medicare would have paid for the same services.¹⁸ In some states, including Florida and Tennessee, the insurers paid more than 325 percent of Medicare rates.¹⁹

¹⁴ See generally *2023 Medicare Parts A & B Premiums and Deductibles 2023 Medicare Part D Income-Related Monthly Adjustment Amounts*, CMS (Sept. 27, 2022), <https://www.cms.gov/newsroom/fact-sheets/2023-medicare-parts-b-premiums-and-deductibles-2023-medicare-part-d-income-related-monthly> (providing a background for existing Medicare cost calculations).

¹⁵ See *infra* text accompanying note 45.

¹⁶ Duffy et al., *supra* note 1.

¹⁷ *Id.*

¹⁸ CHRISTOPHER M. WHALEY ET AL., *NATIONWIDE EVALUATION OF HEALTH CARE PRICES PAID BY PRIVATE HEALTH PLANS: FINDINGS FROM ROUND 3 OF AN EMPLOYER-LED TRANSPARENCY INITIATIVE 13* (RAND Corp. 2020).

¹⁹ *Id.* at 12. For some services, Medicare pays less than costs, but the level of underpayment is far less than the degree to which private insurers pay over Medicare rates.

Nevada illustrates the extent to which hospital charges dwarf physician charges in driving up health care costs. While private insurers pay about 210 percent of Medicare rates for hospital services in Nevada,²⁰ statewide they pay 108 percent of Medicare rates for clinician services, and only 102 percent in Las Vegas.²¹

One reason hospitals can extract these high reimbursement rates is because they have accumulated market power through mergers and consolidation in the hospital sector.²² While consolidation drives up the cost of care, it does not improve the quality of care.²³ Hence, there is ample economic justification for government intervention to prevent hospital profiteering that is derived from excessive market concentration.

Another reason for high hospital prices involves hospital pricing strategies that exploit vulnerable patients who receive out-of-network (OON) care, especially in emergency settings where patients are not able to shop for a lower-cost provider.²⁴ As was noted above, hospitals often charge patients inflated prices for OON care to exert leverage on insurers to accede to their in-network demands.²⁵ This strategy, which can lead to what has been described as “surprise bills,” rests on questionable legal grounds and—as we demonstrate in the following section—can be challenged under current law.²⁶

Government intervention to reduce hospital charges might take the form of reversing the consolidation that has already taken place. Most health policy experts have argued that antitrust enforcers should not have been as permissive as they have been when hospitals consolidated over the past several decades.²⁷ However, much of the consolidation is the product of mergers which policymakers have already approved. Trying to reverse hospital consolidation requires the heavy and uncertain task of undoing past mergers.²⁸

²⁰ *Id.* at 13.

²¹ Bill Johnson et al., *Comparing Commercial and Medicare Professional Service Prices*, HEALTH CARE COST INST. (Aug. 13, 2020), <https://healthcostinstitute.org/hcci-research/comparing-commercial-and-medicare-professional-service-prices>. The clinician figures are based on 2017 data.

²² Whaley et al., *supra* note 18.

²³ *Id.*

²⁴ Duffy et al., *supra* note 1.

²⁵ *Id.* at 2.

²⁶ *Id.* at 1.

²⁷ Barak D. Richman, *Antitrust and Nonprofit Hospital Mergers: A Return to Basics*, 156 UNIV. OF PA. L. REV. 121, 122 (2007) (discussing antitrust policymakers concern over antitrust enforcers' ability to challenge proposed mergers).

²⁸ See generally Clark C. Havighurst & Barak D. Richman, *The Provider Monopoly Problem in Health Care*, 89 OR. L. REV. 847 (2011) (arguing that antitrust enforcers should scrutinize future health care mergers to prevent market consolidation).

Alternatively, the government might reduce hospital charges through rate regulation, as is done in the U.S. Medicare program and in some healthcare systems in other countries.²⁹ However, there are strong political headwinds to doing so, as opposition by hospitals—who enjoy substantial political clout—and philosophical objections to price regulation promise rabid resistance.³⁰ Moreover, rate regulation is complicated both to design and administer, and rate-setting agencies can be overly influenced by the special interests that they are regulating (the problem of “regulatory capture”).³¹

Accordingly, there are important advantages to using common law contract principles to prevent excessive hospital charges. There is no need for a new regulatory regime—the government only needs to enforce laws already in force—and contract law can supply a readily applied standard for courts to employ. Plus, as indicated, limiting excessive out-of-network rates as a way to lower in-network rates offers additional administrative and market-wide benefits.³²

III. THE LAW OF CONTRACTS AND IMPUTED PRICES

Even though hospitals and other healthcare providers have been engaging in surprise billing strategies for years,³³ current law does not permit hospitals to collect their inflated bills for out-of-network care. This section illustrates how rudimentary contract law would scrutinize any such claim.

A. *Incomplete Hospital Contracts*

Contracts commonly mirror typical contracts for hospital care: they provide a basic framework for a transaction, but also lack key elements of the agreement.³⁴ Thus, while the patient consents to receiving medical care, and in return promises to compensate the provider, the contract often does not specify either the care to be provided or the prices to be paid.³⁵ Contract law is familiar with incomplete contracts—indeed, all contracts are

²⁹ See Jonathan Oberlander & Joseph White, *Systemwide Cost Control — The Missing Link in Health Care Reform*, 361 NEJM 1131-1133 (Sept. 2, 2009); Robert Murray & Robert A. Berenson, *Hospital Rate Setting Revisited*, URBAN INST. 12 (Nov. 2015), <https://www.urban.org/sites/default/files/publication/73841/2000516-Hospital-Rate-Setting-Revisited.pdf>.

³⁰ See generally *id.* (discussing the opposition to increased health care regulation).

³¹ See Murray & Berenson, *supra* note 29, at 64-65.

³² See generally *id.* (discussing hospital strategy of opting out of a network to collect higher out-of-network rates).

³³ See Zack Cooper et al., *Surprise! Out-of-Network Billing for Emergency Care in the United States*, 128 J. POL. ECON. 3626 (2020).

³⁴ Oliver Williamson, *Transaction-cost Economics: The Governance of Contractual Relations*, 22 J. L. & ECON. 233, 238 (1979).

³⁵ Nation III, *supra* note 11, at 128.

incomplete to some degree—and thus courts have developed a body of default rules that are used to fill in the gaps.³⁶

Therefore, interpreting contracts for hospital care—including deciding what financial obligations they trigger—involves a familiar process and a well-known set of rules. The paramount objective is to fulfill the parties' intentions despite their failure to state definite and unambiguous price terms, and the law instructs courts to fill price gaps by imputing reasonable prices into the contract.³⁷ Quoting a leading contracts treatise, a Texas court ruled that “[w]here parties have entered into an agreement containing all essential terms except price, courts have been willing to presume a reasonable price was intended.”³⁸ A Mississippi court similarly concluded that “[i]f ‘no statement as to the wages or price to be paid’ is listed, the court will ‘invoke a standard of reasonableness so that the fair value of the services or property is recoverable.’”³⁹

Chargemaster rates, by definition, are neither reasonable nor representative of typical market prices.⁴⁰ As Dr. Gerald Anderson has observed, for “a price list to be reasonable it needs to reflect what is actually being charged in the market place [sic]” and since “virtually no public or private insurer actually pays full charges, charges are an unrealistic standard for comparison.”⁴¹

Accordingly, courts have applied the principle of a reasonable price to disputes in contracts for hospital care by awarding typical in-network prices, not chargemaster rates, to providers.⁴² For example, a Pennsylvania court adjudicating a payment dispute between a hospital and managed care

³⁶ Ian Ayres & Robert Gertner, *Filling Gaps in Incomplete Contracts: An Economic Theory of Default Rules*, 99 YALE L.J. 87, 87 (1989).

³⁷ See *Oglebay Norton, Co. v. Armco, Inc.*, 556 N.E.2d 515, 520-21 (Ohio 1990) (holding when parties have manifested an intention to be bound by a contract, a court can fill price gaps with reasonable rates under the circumstances).

³⁸ *Am.’s Favorite Chicken Co. v. Samaras*, 929 S.W.2d 617, 624 (Tex. App. 1996) (citing *Bendalin v. Delgado*, 406 S.W.2d 897, 900 (Tex. 1966) & *Pennington v. Gurkoff*, 899 S.W.2d 767, 770 (Tex. App. 1995)).

³⁹ *Denbury Onshore, LLC v. Precision Welding, Inc.*, 98 So. 3d 449, 454 n.21 (Miss. 2012) (quoting RICHARD A. LORD, *WILLISTON ON CONTRACTS* § 4:25 (4th ed. 2000)).

⁴⁰ *What Is a Chargemaster and What Do Hospital Administrators Need to Know About It?*, GEORGE WASHINGTON UNIV. (Nov. 5, 2020), <https://healthcaremba.gwu.edu/blog/chargemaster-hospital-administrators-need-know/> (“Chargemaster rates serve as baselines when negotiating the rates at which these payers will reimburse hospitals, which is why they’re often much higher than actual costs.”).

⁴¹ *What’s the Cost?: Proposals to Provide Consumers with Better Information About Healthcare Service Costs: Hearing Before the Subcomm. on Health of the Comm. on Energy & Com.*, 109th Cong. 55, 58 (2006) (statement of Dr. Gerald F. Anderson, Johns Hopkins Bloomberg School of Public Health, Health Policy and Management), <https://www.gpo.gov/fdsys/pkg/CHRG-109hrg27590/html/CHRG-109hrg27590.html>.

⁴² *Temple Univ. Hosp. v. Healthcare Mgmt. Alternatives, Inc.*, 832 A.2d 501, 509 (Pa. Super. Ct. 2003).

organization concluded, “the [h]ospital is entitled to the reasonable value of its services, i.e., what people pay for those services, not what the [h]ospital receives in one to three percent of its cases.”⁴³ Additionally, in *Nassau Anesthesia Associates P.C. v. Chin*, the court limited a provider’s payment to “the average amount that [the provider] would have accepted as full payment from third-party payers such as private insurers and federal healthcare programs.”⁴⁴

Calculating an average negotiated price is a simple exercise in math—by definition, this is the weighted average of all prices paid to a particular provider for a particular service by private or public insurers. Variations of this calculation could include or exclude Medicare and/or Medicaid payments, which are almost universally lower than commercially negotiated rates. There is a good argument for including Medicare and Medicaid rates: both Medicare and Medicaid prices are products of voluntary agreements (after all, providers voluntarily accept those rates and certainly are permitted to decline them) and therefore should be incorporated into the calculation of market rates, as the court did in the *Nassau Anesthesia Associates* case.⁴⁵

B. Implied Contracts and the Healthcare Setting

For the same reasons that contract law is proficient at enforcing incomplete contracts, it is similarly adept at handling situations where parties were unable to craft a contract at all. The law’s ability to adapt to such circumstances is especially critical in supporting the delivery of healthcare, which routinely involves circumstances in which rational and deliberate negotiations are impossible. Medical settings, especially emergency medical settings, rarely afford parties the opportunity to reach any agreement about the terms and conditions of exchange, so contract law does not demand formally fulfilling the elements of contract formation. In such cases, courts will imply a contract.⁴⁶ The Nebraska Supreme Court put it succinctly:

⁴³ *Id.*

⁴⁴ *Nassau Anesthesia Assocs. P.C. v. Chin*, 924 N.Y.S.2d 252, 255 (N.Y. Dist. Ct. 2011); To be sure, some courts have allowed chargemaster rates. For example, in one case, the court observed that deciding a reasonable price was too complex a task in a judicial setting and are addressed more appropriately by “state and federal executives, legislatures, and regulatory agencies.” *DiCarlo v. St. Mary Hosp.*, 530 F.3d 255, 264 (3d Cir. 2008).

⁴⁵ See *Nassau Anesthesia Assocs. P.C.*, 924 N.Y.S.2d at 254-55 (holding the plaintiff’s damages should be equivalent to the market rate, which was calculated using price data from both third-party private payors and the federal government under Medicaid and Medicare).

⁴⁶ Patient-provider agreements rest especially heavily on the structure of contract law. Even when parties are able to discuss the parameters of scheduled care, the complexities of healthcare billing frequently preclude genuine mutual understanding and assent between patients and providers. CARL E. SCHNEIDER, *THE PRACTICE OF AUTONOMY: PATIENTS, DOCTORS, AND MEDICAL DECISIONS* (1st ed. 1998).

“Even in the absence of an express contract, the rendering of medical services creates an implied contract between the pro-vider [sic] and the person being given the medical care.”⁴⁷

The law implies a contractual price through a legal creation called “quantum meruit,” or literally “as much as he has deserved.”⁴⁸ Quantum meruit is the law’s solution to the mechanical problem that often arises when parties fail to formally enshrine a contract yet proceed as if a contract had been formed—in other words, when mutual assent is not formally expressed but when parties would reasonably have done so had they had the opportunity.

According to common law principles, a quantum meruit recovery amounts to the financial equivalent of a market price. A North Carolina court called quantum meruit the “reasonable value of services rendered,” an Ohio court defined quantum meruit recovery as “reasonable value of services rendered in the absence of an express contract,” and a Montana court ruled that quantum meruit recovery is the “market value of the services rendered.”⁴⁹ Quantum meruit is decidedly not simply what the charging party claims it to be: “[q]uantum meruit is not a completely free-wheeling approach that allows a plaintiff as much compensation as the plaintiff subjectively believes is appropriate. . . rather, it is based on the concept of an objective and customary market for services.”⁵⁰ Nevada courts come to the same conclusion. As the Nevada Supreme Court observed, “[t]he proper measure of damages under a quantum meruit theory of recovery is the reasonable value of [the] services,” and “recovery in quantum meruit 'is usually the lesser of (i) market value and (ii) a price the defendant has expressed a willingness to pay.’”⁵¹

In sum, mutual assent lies at the heart of a contract, and thus the doctrines of incomplete and implied contracts instruct courts to impute obligations that reflect what parties would have agreed to. By imposing reasonable obligations on both buyers and sellers, courts are able to manage difficult contracting situations where contracts are absent or vague while preserving both parties’ intentions. In protecting patients from excessive out-of-network charges, courts impute an obligation on the patient to pay the average negotiated price for the care they receive, not the extortive chargemaster price that is too often billed. These doctrines allow courts and other

⁴⁷ *Midwest Neurosurgery, P.C. v. State Farm Ins. Co.*, 686 N.W.2d 572, 578 (Neb. 2004).

⁴⁸ *Quantum Meruit*, BLACK’S LAW DICTIONARY (10th ed. 2014).

⁴⁹ *Robertson v. Steris Corp.*, 760 S.E.2d 313, 318 n.4 (N.C. Ct. App. 2014); *Donald Harris Law Firm v. Dwight-Killian*, 853 N.E.2d 364, 367 (Ohio Ct. App. 2006); *Kenneth D. Collins Agency v. Hagerott*, 684 P.2d 487, 489 (Mont. 1984).

⁵⁰ *Kinetic Energy Dev. Corp. v. Trigen Energy Corp.*, 107 S.W.3d 301, 304 (Mo. Ct. App. 2003).

⁵¹ *Las Vegas Land Partners LLC v. Nype*, No. 68819, No. 70520, 2017 WL 548439, at *4 (Nev. Nov. 14, 2017) (citations omitted).

instruments of law enforcement to protect consumers from excessive hospital prices and to sustain the underlying principles of a free and fair market.

IV. ON THE SUPERIORITY OF CONTRACT REMEDIES OVER REGULATED PRICES

The economic and social costs of inflated out-of-network charges are well known, and policymakers have devised a number of possible policy solutions. As noted above, the prevailing recommendation is to administer regulated prices. In contrast, the use of contract law has garnered little attention. In this section, we review the assorted responses and indicate why our common law approach is superior.

A. *Current State and Federal Responses*

Inflated out-of-network charges by hospitals have provoked particular concern in the setting of “surprise billing”—situations in which patients are unable to choose their hospital and therefore receive no warning that they will be expected to pay substantial fees out of pocket.⁵²

Emergency care is a paradigmatic context for surprise bills. Since patients generally do not choose where they will be taken in an emergency, they cannot ensure that the hospital is in their health plan’s network.⁵³ *The New Republic* reported on a case involving a patient who suffered a heart attack, received treatment at an out-of-network hospital, and later received a bill for just under \$109,000.⁵⁴ Another example of surprise billing involves the practices of out-of-network providers at an in-network facility, where patients might find out only after a procedure that an ancillary provider chosen by the hospital was out-of-network for their plan.⁵⁵

After years of haunting stories documenting inflated “surprise bills,” many policymakers appropriately devised policy solutions. These approaches have varied—and some policies have pursued several elements simultaneously—but general responses can be categorized first by whether they mandate disclosure or limit charges, and second by the range of the protections when out-of-network charges are limited.

⁵² *No Surprises: Understand your rights against surprise medical bills*, CMS, (Jan. 3, 2022), <https://www.cms.gov/newsroom/fact-sheets/no-surprises-understand-your-rights-against-surprise-medical-bills>. Surprise billing can also occur when a patient is treated at an in-network hospital by an out-of-network doctor.

⁵³ There are similar concerns with out-of-network charges for emergency care by air and ground ambulance services.

⁵⁴ Libby Watson, *The Grim Lottery of Surprise Medical Bill Stories*, THE NEW REPUBLIC (Oct. 10, 2019), <https://newrepublic.com/article/155334/grim-lottery-surprise-medical-bill-stories>.

⁵⁵ *See id.*

The least interventionist approach has been to bring transparency to hospital prices and the consequences of obtaining out-of-network care. Although insurers are generally obligated to inform their subscribers of the financial consequences of going out of network, some states additionally require insurers to provide accurate network directories, publicize both summary and specific information on the costs of receiving care out of network, and alert consumers at the point of service of network participation.⁵⁶ These policies go in hand with other state efforts to bring transparency to healthcare costs, including the growing effort to assemble all-payer claims databases that will allow patients to compare prices for common services between in-network and out-of-network providers.⁵⁷ Some insurers have also established their own independent systems to inform both plan members and the general public of the costs associated with medical care by hospitals and other providers.⁵⁸ However, while greater transparency is desperately needed in the health sector, it is unlikely that these efforts will have much of an effect on patient bills.⁵⁹ Studies on transparency policies have been disappointing to date, largely due to low use by patients.⁶⁰

Accordingly, some states and the federal government have gone beyond disclosure to place limits on out-of-network charges, and there are three important elements of these laws: which services are covered, how much the patient has to pay, and how much the insurer has to pay the provider.⁶¹ The laws tend to overlap on the services covered and the patient's financial

⁵⁶ See, e.g., *Healthcare Price Transparency Across America*, PIONEER INST. PUB. POL'Y RSCH. (May 7, 2020), <https://pioneerinstitute.org/transparency/national-study-finds-most-states-lack-healthcare-price-transparency-laws/>; In 2021, federal price transparency rules took effect. Nisha Kurani, et al., *Price Transparency and Variation in U.S. Health Services*, PETERSON-KFF HEALTH TRACKER SYSTEM (Jan. 13, 2021), <http://www.healthsystemtracker.org/brief/price-transparency-and-variation-in-u-s-health-services/>

⁵⁷ See, e.g., HA TU & REBECCA GOUREVITCH, CAL. HEALTHCARE FOUND., *MOVING MARKETS: LESSONS FROM NEW HAMPSHIRE'S HEALTH CARE PRICE TRANSPARENCY EXPERIMENT 3* (Apr. 2014) <http://www.nh.gov/insurance/reports/documents/moving-markets.pdf> (explaining how New Hampshire implemented "one of the nation's first all-payer claims databases to collect provider pricing information").

⁵⁸ See, e.g., BLUE CROSS BLUE SHIELD, *Consumers Save Money with Cost Transparency Tools* (July 5, 2022), <https://www.bcbs.com/the-health-of-america/articles/consumers-save-money-cost-transparency-tools> (describing the various price transparency services which Blue Cross Blue Shield offers to members in different states).

⁵⁹ See, e.g., Barak Richman & Katherine T. Bartlett, *Shopping for Healthcare: Can We Be Good Consumers?*, HEALTH MGMT. POL'Y & INNOVATION (Apr. 22, 2022), <https://hmpi.org/2022/04/29/shopping-for-healthcare-can-we-be-good-consumers/> (identifying the successful effects of market transparency and its impact on consumers).

⁶⁰ See Angela Zhang et al., *The Impact of Price Transparency on Consumers and Providers: A Scoping Review*, 124 HEALTH POL'Y 819, 821 (2020) (examining six studies which all reported low price transparency tool usage rates).

⁶¹ See *infra* note 63 (describing state laws that protect consumers against balance billing).

liability, with more variation on how much the insurer will have to pay the provider.⁶²

B. Services Covered

As mentioned, concerns about out-of-network hospital charges have arisen especially for surprise billing, and that's where state legislators have targeted their fee caps. In states such as California, Michigan, and Texas, the laws limit fees for emergency care provided by out-of-network hospitals.⁶³

But there are important gaps in state law. A significant minority of states have no surprise billing protections, and the Employee Retirement Income Security Act (ERISA) precludes application of the state laws to self-funded employer health plans.⁶⁴ Importantly, the state statutes apply in the emergency setting and not to out-of-network hospital charges for non-emergency care.⁶⁵

Congress did much to address the first two gaps in state laws by passing the No Surprises Act in December 2020.⁶⁶ Under the Act, patients are protected when they receive emergency and post-stabilization care at an out-of-network hospital, and the protections apply to all health plans.⁶⁷ But the Act does not apply to out-of-network charges by hospitals for non-emergent care.⁶⁸

⁶² *Id.*

⁶³ Maanasa Kona, *State Balance-Billing Protections*, THE COMMONWEALTH FUND (Feb. 5, 2021), <https://www.commonwealthfund.org/node/27021>. These statutes also limit fees for out-of-network emergency care by professionals and other facilities. Other states, including New York and Ohio, also apply their surprise billing laws to ground ambulance services.

⁶⁴ *Id.*; Elizabeth Y. McCuskey, *Reforming ERISA to Help States Control Health Care Costs*, THE COMMONWEALTH FUND (Feb. 9, 2023), <https://www.commonwealthfund.org/publications/issue-briefs/2023/feb/reforming-erisa-help-states-control-health-care-costs>.

⁶⁵ *See generally Your Rights and Protections Against Surprise Medical Bills*, UCHICAGOMEDICINE (last visited May 14, 2023), <https://www.uchicagomedicine.org/patients-visitors/patient-information/billing/no-surprises-act>. However, surprise billing statutes typically apply to out-of-network charges by professionals for non-emergency care when the care is provided at an in-network hospital or other facility.

⁶⁶ Jack Hoadley et al., *No Surprises Act: A Federal–State Partnership to Protect Consumers from Surprise Medical Bills*, THE COMMONWEALTH FUND (Oct. 20, 2022), <https://www.commonwealthfund.org/publications/fund-reports/2022/oct/no-surprises-act-federal-state-partnership-protect-consumers>; No Surprises Act, H.R. 3630, 116th Congress, (2019-2020).

⁶⁷ *Id.* The No Surprises Act also applies to out-of-network professionals providing emergency care, air ambulance services, and non-emergency care provided by out-of-network professionals at in-network facilities.

⁶⁸ *Id.*

C. Patient Financial Responsibility

Surprise billing laws typically limit the patient's financial responsibility for out-of-network care to what the patient would have paid for in-network care.⁶⁹ There are two ways in which the laws provide this protection—balance billing bans and hold harmless provisions.⁷⁰ Some states have one of these protections (e.g., Ohio, Oregon, and Washington), other states have both (e.g., California, New York, and Texas), and the federal No Surprises Act also has both protections.⁷¹

While surprise billing laws prevent patients from receiving inflated bills, hospitals may still be able to impose inflated costs by shifting costs from health care bills to health insurance premiums. For while the different laws prohibit the patient's bill from exceeding in-network prices, they often leave room for hospitals to receive additional reimbursement from health insurers, and the costs of the additional reimbursement can be passed along to plan members when they pay for their coverage. Accordingly, the insurer's financial obligation to hospitals is a critical element of surprise billing laws.

D. Insurer Financial Obligation for Out-of-Network Care

While all surprise billing laws limit patient cost sharing responsibility to in-network cost sharing amounts, they vary in how they set the insurer's obligation to hospitals.⁷² In one approach, pursued in Illinois and New York, the law establishes an independent dispute resolution process for hospitals and health plans to settle on a fee for out-of-network services provided.⁷³ Other states are more prescriptive and employ a payment standard.⁷⁴ In California, the statute establishes a payment amount for emergency care based on the reasonable and customary value of the services.⁷⁵ In a third,

⁶⁹ Karen Pollitz, *No Surprises Act Implementation: What to Expect in 2022*, KAISER FAMILY FOUND. (Dec. 10, 2021), <https://www.kff.org/health-reform/issue-brief/no-surprises-act-implementation-what-to-expect-in-2022/>.

⁷⁰ Karen Pollitz, *Surprise Medical Bills*, KAISER FAMILY FOUND. (Mar. 17, 2016), <https://www.kff.org/private-insurance/issue-brief/surprise-medical-bills/> (explaining balance billing bans prohibit the out-of-network hospital from charging patients more than their in-network level of cost sharing and noting that hold harmless provisions require insurers to hold patients harmless for charges above their in-network level of cost sharing).

⁷¹ *Id.*; Hoadley et al., *supra* note 66.

⁷² Hoadley et al., *supra* note 66.

⁷³ Kona, *supra* note 63.

⁷⁴ Jack Hoadley & Kevin Lucia, *Hybrid Approach to Resolving Payment Disputes Breaks Legislative Stalemates Over Balance Billing, How Will the No Surprises Act Affect These New State Laws?*, CTR. ON HEALTH INS. REFORMS (Apr. 13, 2021), <http://chirblog.org/hybrid-approach-to-resolving-payment-disputes/>.

⁷⁵ Kona, *supra* note 63 (“For non-emergency services, the insurer pays the greater of 125% of Medicare or the average in-network rate.”).

hybrid approach, the state offers a payment standard and allows insurers or hospitals to request arbitration if they are not satisfied with their payment.⁷⁶ In Virginia, for example, insurers are obligated to pay a “commercially reasonable amount” based on payments for the same or similar services, with hospitals able to request arbitration if they are not satisfied with their payment.⁷⁷

In the No Surprises Act, Congress opted for an independent dispute resolution process.⁷⁸ The Act requires an initial payment by the insurer, but there is no payment standard.⁷⁹ If the hospital is dissatisfied with the payment, the hospital and insurer enter negotiations, and if those fail, arbitration is the final step.⁸⁰ The Act identifies factors for the arbitrator to consider or not to consider.⁸¹ For example, arbitrators should take into account the insurer’s median in-network rate, the quality of the hospital, and other factors, and should not consider the hospital’s chargemaster rate or the reimbursement paid by public insurers such as Medicare or Medicaid.⁸² With these arbitration factors, the Act’s drafters hoped to curtail the prevalence of tortive hospital prices that drive up health insurance premiums.

There are significant disadvantages to an independent dispute resolution process. While a payment standard provides a relatively simple measure that can be readily applied across providers and services, the resolution process requires a complicated administrative procedure that has to be applied on a case-by-case basis.⁸³ In the first three-quarters of 2022, according to estimates, more than 275,000 claims were submitted nationwide for the No Surprises Act’s independent dispute resolution process.⁸⁴ Sadly, there is little

⁷⁶ Hoadley et al., *supra* note 66.

⁷⁷ Kona, *supra* note 63; *Virginia’s Balance Billing Law: Frequently Asked Questions*, VA. C. EMERGENCY PHYSICIANS (Dec. 10, 2020), <https://www.vacep.org/news-blog/frequently-asked-questions-about-surprise-billing>.

⁷⁸ Hoadley et al., *supra* note 66; see Katie Keith et al., *Recent Guidance to Implement the No Surprises Act*, HEALTH AFF. (Feb. 18, 2022), <https://www.healthaffairs.org/doi/10.1377/forefront.20220218.568825/>.

⁷⁹ *Id.*

⁸⁰ Hoadley et al., *supra* note 66.

⁸¹ Katie Keith, *Health Care Providers Fight Arbitration Rule in No Surprises Act*, COMMONWEALTH FUND (Mar. 17, 2022), <https://www.commonwealthfund.org/blog/2022/health-care-providers-fight-arbitration-rule-no-surprises-act>.

⁸² Katie Keith et al., *Federal Officials Revise Approach To Arbitration Under No Surprises Act*, HEALTH AFF. (Aug. 22, 2022), <https://www.healthaffairs.org/content/forefront/federal-officials-revise-approach-arbitration-under-no-surprises-act>. These would include claims by other providers, as well as hospitals.

⁸³ Keith et al., *supra* note 78.

⁸⁴ *No Surprises Act Prevents More than 9 Million Surprise Bills Since January 2022*, AM. HEALTH INS. PLANS (Nov. 2022), 202211_1P_Surprise_Billing.pdf (ahip.org).

reason to be confident that the Act will meaningfully mitigate the scourge of surprise bills.

In sum, existing statutory responses to high hospital charges suffer from two of their core elements—they apply only in the setting of emergency care rather than to all out-of-network care, and they often rely on an independent resolution process rather than a payment standard to determine the financial responsibility of insurers.

V. A COMPARATIVE ASSESSMENT

A comparison of the efficacies of the independent resolution process and contract law reveals the superiority of the latter. Contract law has the virtue of simplicity. It does not create a new fiduciary duty or consumer protection. It neither expands the reach of a federal statute nor limits the reach of state regulatory power. It requires no additional legislation, regulatory apparatus, or regulatory bodies. And perhaps most importantly, it triggers market solutions to address hospital costs. A contract law solution empowers the very parties who are currently being exploited by out-of-network charges.⁸⁵

Our contract law analysis leads to a stark conclusion: hospitals have no legal authority to collect chargemaster charges that exceed market prices for out-of-network services, and thus neither patients nor payers are under any obligation to pay such chargemaster prices.⁸⁶ Accordingly, payers that form narrow provider networks can be confident that they will not have to pay extortionate chargemaster prices if their beneficiaries require out-of-network care.⁸⁷

Consistent efforts to enforce contract law principles would go far in addressing abuses. Judges, public law enforcement officials, and private attorneys can use contract law to combat abusive or harassing efforts that providers pursue to collect such charges.⁸⁸ The role of public law enforcement officials is especially important, and the issuance of opinion letters by state attorneys general could compel all out-of-network charges to be based on prevailing in-network rates.

Contract law sets a clear baseline for what may be collected, and prevailing data resources can enable law enforcement officials and courts to calculate appropriate market prices with little difficulty. A common law solution therefore lucidly demarks what patients and payers owe hospitals for

⁸⁵ Barak D. Richman et al., *Battling the Chargemaster: A Simple Remedy to Balance Billing for Unavoidable Out-of-Network Care*, 23 AM. J. MANAGED CARE e100, e103 (2017), <https://www.ajmc.com/view/battling-the-chargemaster-a-simple-remedy-to-balance-billing-for-unavoidable-out-of-network-care>.

⁸⁶ *Id.* at e103.

⁸⁷ *Id.*

⁸⁸ *Id.*

out-of-network care without costly litigation or cumbersome administrative procedures. It also encourages hospitals to be transparent with their prices, for higher prices are attainable only if hospitals obtain assent from payers in advance.

For these reasons, invoking contract law to resolve out-of-network billing disputes—and to set the rules that govern out-of-network billing—is preferable to relying on new legislation. Although Congress and state policy makers are to be lauded for addressing chargemaster abuses, independent resolution processes do not offer any advantage over relying on the application of contract law principles. This is because chargemaster and out-of-network charges are pernicious not just because they allow hospitals to exploit a moment of vulnerability or a temporary information failure, but because they impose enormous dynamic costs as well.

Administrative efforts to define reasonable reimbursement rates, whether through administrative fiat or through dispute resolution mechanisms, aim to mimic how contract law would impute market prices. If designed properly and executed efficiently, they could reflect what reasonable parties would have agreed to had there been an opportunity for meaningful bargaining. But administrative procedures are subject to due process safeguards and introduce transaction costs and delays. In addition, administrative structures introduce the significant risk of enshrining the sentiments of entrenched stakeholders. For these reasons, administrative solutions would fail to address the dynamic costs of out-of-network bill strategies, and if used in conjunction with contract law solutions, they would interfere with and thereby undermine the many benefits of invoking contract law remedies.

VI. OUT-OF-NETWORK HOSPITAL PRICES IN NEVADA

Nevada state law, like all other states, follows the standard rule that market prices are imputed into open price terms in incomplete and implied contracts.⁸⁹ Nonetheless, Nevada, like all other states, features abundant instances of excessive billing for out-of-network care.⁹⁰ This section documents an accounting of out-of-network charges for assorted codes for emergency care, gathered in conjunction with the Nevada Department of Health and Human Services.

⁸⁹ Charles J. Goetz & Robert E. Scott, *The Limits of Expanded Choice: An Analysis of the Interactions Between Express and Implied Contract Terms*, 73 CAL. L. REV. 261, 277 (1985), https://scholarship.law.columbia.edu/cgi/viewcontent.cgi?article=1407&context=faculty_scholarship.

⁹⁰ See Whaley et al., *supra* note 18, at 30.

A. Methodology

Hospital reimbursement rates by payer class were pulled from Turquoise Health datasets specific to the Emergency Department billing codes 99281-99285.⁹¹ These codes range from no/low complexity to high complexity in ascending order, meaning that 99281 corresponds to the lowest level of care and 99285 corresponds to the highest complexity and level of care.⁹²

Records with outlier values in the reimbursement rate were excluded based on interquartile ranges, to remove the impact of rare events and data entry errors. Then, average self-pay rates were compared to commercial rates, 150% of Medicare rates, and an all-payer weighted average to determine if there is inequity across payer classes, and specifically for self-pay.

Commercial rates are defined as rates paid by private insurance plans and self-pay rates represent the cash price of the service. In this analysis, self-pay rates are used as a proxy for out-of-network rates.

B. Results

Overpayments are estimated to be present across all comparison markets for all CPT codes, except for 99285, when comparing self-pay to commercial rates. The estimated overpayment increases as the level of care increases, except for 99285 which estimates less overpayment than 99284 for all comparison markets. When considering the percent estimated overpayment, calculated as the Self Pay rate divided by the comparison market, we find that the estimated overpayment, as a percent, is highest among the lowest level of care (99281) and decreases with increasing severity.

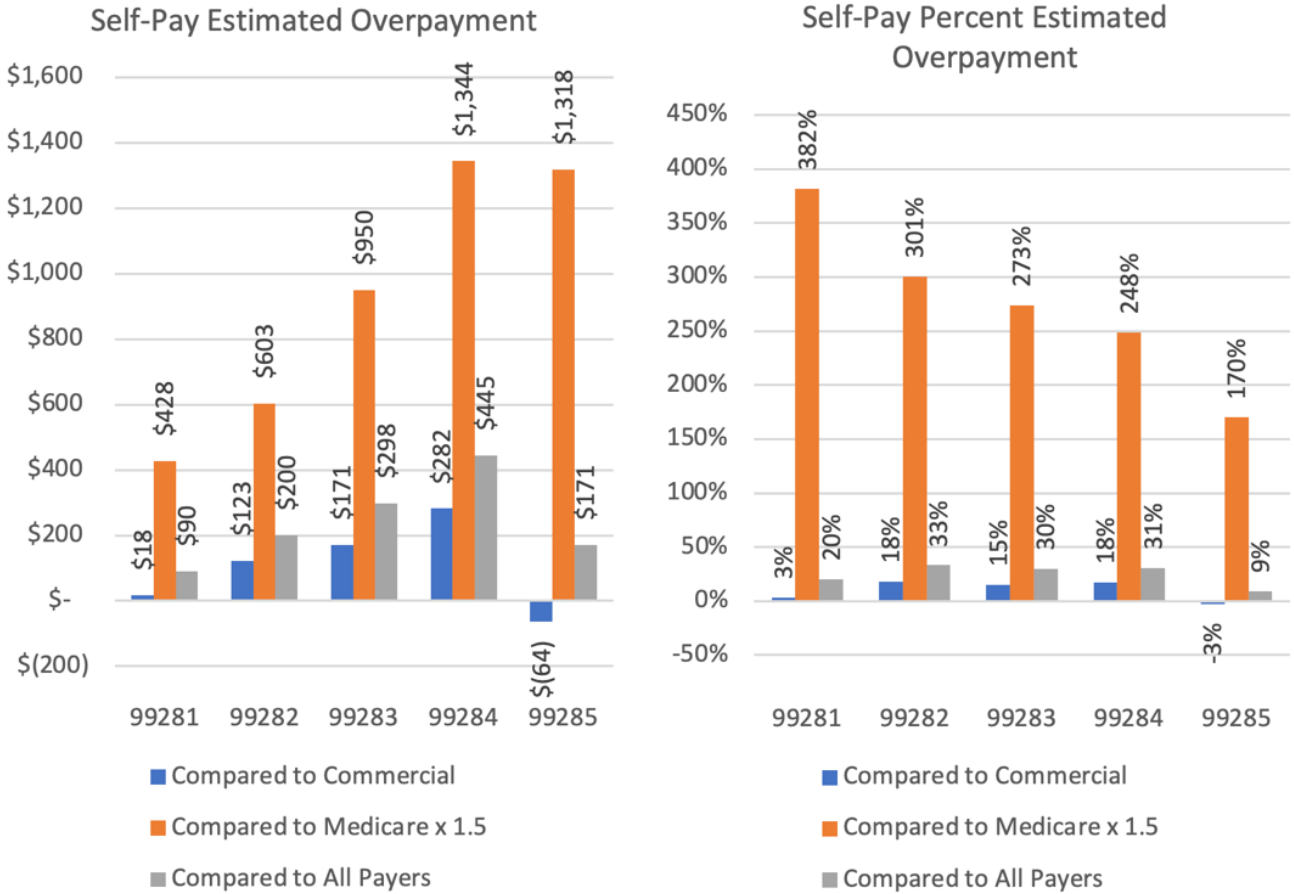
Although we compared to several markets in this analysis, we believe that actual cost would fall between 100-150% of Medicare rates. Under this premise, we estimate that self-pay rates are inflated by as much as:

- 382%, or \$42, above cost for CPT code 99281 (emergency department visit for minor problem),
- 301%, or \$603, above cost for CPT code 99282 (emergency department visit for low to moderate severity problem),
- 273%, or \$950, above cost for CPT code 99283 (emergency department visit for moderate severity problem),

⁹¹ *Price Transparency Data for Researchers*, TURQUOISE HEALTH, <https://turquoise.health/researchers> (last visited Feb. 24, 2023).

⁹² *Coding and Billing Guidelines for Emergency Department*, BLUECROSS BLUESHIELD N.D., <https://www.bcbsnd.com/providers/policies-precertification/reimbursement-policy/coding-and-billing-guidelines-for-emergency-department> (last visited Feb. 24, 2023).

- 248%, or \$1,344, above cost for CPT code 99284 (emergency department visit for high severity problem),
- 170%, or 1,318, above cost for CPT code 99285 (emergency department visit for high severity problem that poses an immediate significant risk to life or physiologic function).⁹³



⁹³ *CPT® Overview and Code Approval*, AM. MED. ASS'N (last visited Apr. 22, 2023) <https://www.ama-assn.org/practice-management/cpt/cpt-overview-and-code-approval>.

VII. CONCLUSION

Inflated out-of-network bills cause genuine hardship to patients, impose unnecessary complexity to an already burdensome world of hospital billing, pose a major threat to the availability of affordable insurance plans, and inject inflationary forces on healthcare prices writ large.

As the data indicates, Nevada hospitals charge well above the amount permitted by basic contract law principles. While hospitals are entitled to recover the reasonable value of their services, their out-of-network charges are much higher and severely burden the patients who must pay them. They also elevate costs of hospital care for all commercial payers. As previously discussed, the higher the out-of-pocket rates Nevada hospitals can charge, the higher the in-network rates they can negotiate.

Accordingly, if Nevada hospitals were prevented from overcharging for out-of-network care, the state would achieve both efficacious application of contract law and remove an important cause of hospital price inflation. More simply, as a matter of principle, it would ensure that hospitals charge no more than a reasonable amount for the services they provide. This is what current contract law dictates and it is what is required to make markets work efficiently. We therefore have been working with the Nevada Department of Health and Human Services to elicit an opinion letter from the Nevada Attorney General advising hospitals of their legal duty to limit their out-of-network rates to the reasonable value of the care they provide, as reflected in an average of their in-network rates. We are hopeful that similar efforts in other states could both yield meaningful benefits to healthcare markets and, finally, stop the exploitive epidemic of surprise bills.