Emergency Health Services, Medical Markets, and Asymmetries of Justice: An Argument Against Balance Billing

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Introduction

The Patient Protection and Affordable Care Act (ACA) mandated that US citizens purchase health insurance.[i] One of the major arguments for the legislation was that patients should be protected against the threat of bankruptcy as a result of medical bills they cannot pay.[ii] However, individuals and families who are commercially insured can find themselves in a situation where they are held financially liable for significant medical bills incurred in the context of a possibly life-threatening emergency situation.

Consider a thirty-year-old woman in Wisconsin who had a heart attack. She was taken to the "wrong hospital" by the EMTs operating the ambulance service, which was literally three blocks away from the contracted in-network hospital covered by her Blue Cross Blue Shield of Wisconsin health plan.[iii] While BCBS paid *their* entire standard in-network rate to the hospital, the hospital in turn billed the patient for the balance of their total chargemaster sticker price fee, rather than what they would receive from a contracted payer, leaving her responsible for $156,000 out of pocket. As a result of this medical encounter, the patient faces significant financial harm—even as a fully insured patient.

In this example, the EMTs are not morally at fault, as their remit is to seek the closest life-saving services for the patient. The patient is not at fault, as she could not choose where to suffer a medical emergency, and cannot be expected to request an in-network hospital under these circumstances. Perhaps she should have purchased a better insurance plan? This is a

possibility that will be discussed in greater detail later on. The hospital *is* at fault for its unjust billing practices that seek to gain additional profit from patients encountering accidents of fate. This additional charge is patently unjust, as it jeopardizes the economic security of the patient as a result of accidents of medical happenstance, for which she has paid money for the purpose of protection against that specific eventuality.[iv]

This circumstance is not simply a function of market-based supply and demand in healthcare operating the way markets do for commodities and services. Patients requiring emergency medical care, in particular, are not in a position to make an informed market-based provider choice, nor do they fully control their financial responsibility for medical services. Hospitals and healthcare providers, then, incur a moral responsibility to charge out-of-network and uninsured patients receiving emergency services reasonable rates that more closely resemble in-network contract pricing. In medical emergencies, informed consumer choice and consumer-directed action are not likely to be the operative forces in the selection of healthcare providers or institutions and therefore it is unethical to charge the full balance of the bill to these patients receiving emergency services.

The results are ethically problematic because bills to out-of-network and uninsured patients imply an expectation that these populations are responsible for compensating hospitals for providing discounted healthcare to others. This implication becomes a clear moral failure when aggressive collection tactics are employed and patients are asked to pay significantly higher medical bills through no fault of their own. Particularly in the case of emergency care, patients are not in a position to make an informed market-based provider choice, nor do they fully control their financial responsibility for medical services. Hospitals and healthcare

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providers, then, incur a moral responsibility to charge out-of-network and uninsured patients contracted prices, as billing for chargemaster rates is tantamount to price gouging.

The Chargemaster and Balance Billing

A lack of hospital pricing uniformity places patients at financial risk for out of pocket expenses. The greatest risk occurs when patients obtain care from an "out-of-network" hospital not contracted with or preferred by third party payers to provide services to their network of insured patients.[v] Not only are uninsured patients financially endangered by price differences, but commercially insured patients are similarly imperiled – including those receiving coverage through the ACA state healthcare exchanges. Individuals with high-deductible cost sharing plans or those receiving out-of-network services are especially vulnerable to "balance billing," a practice where the hospital and the contracted healthcare providers hold the patient responsible for the entire amount of the charge that insurance does not cover, not the *actual reasonable and customary charges* typically paid by commercial insurers.[vi]

The chargemaster, the internal and confidential hospital document listing the extensive customary fees billed for services rendered, represents the *undiscounted* amount that the hospital actually bills to any patient or third party payer for services rendered, and is typically 2.57 times the average amount that is actually paid by insurers via negotiated or government-set pricing.[vii] Hospitals agree to accept these discounted amounts through negotiation or legislative mandate as payment in full for services. Chargemasters can contain up to 25,000 line items. Because it is intended to anchor undiscounted fee expectations, hospital administrators use cost overruns in order to set the higher charges.[viii] Thompkins and Altman write, "The chargemaster sits at the vortex of government regulation, rapidly growing healthcare costs, growing segments of the

population lacking sufficient or any insurance, and an enduring philosophical legacy of 'optimizing reimbursement.'"[ix]

Exacerbating the inflation of the chargemaster, until the 1980s, Medicare payments had kept up with the costs of delivering care, but subsequently, the payment to cost ratio fell to less than 1:1 for both Medicare and Medicaid, and has not returned to overall profitability. [x] Hospitals responded to fixed Medicare underpayments by shifting costs to commercially insured patients in order to recoup the lost revenue. In general, the margin for commercially insured patients could be increased to offset treating unprofitable government-covered patients.[xi] Compounding this problem, the Medicare rules were at one time widely interpreted to imply that uninsured patients could not be billed at a discounted rate (for instance, similar to the accepted Medicare rates as opposed to the chargemaster rates) without risking prosecution for fraud, as the government has stipulated that it should receive the best pricing offered.[xii] Medicare reimbursement rates continue underpay actual costs at the present time.[xiii]

The Affordable Care Act does include a clause regarding out-of-network emergency services, but it applies *to insurers* requiring them to pay in their typical in-network rate to out-of-network hospitals, and bill the patient for no more "than the cost-sharing requirement (expressed as a copayment amount or coinsurance rate)… that would apply if such services were provided in-network."[xiv] However, the term "cost sharing" is interpreted to exclude the practice of hospital balance billing the patients themselves for out-of-network provider services.[xv] Rather than protecting patients and promoting affordable care, ACA explicitly safeguards a loophole to hospitals that exposes patients to considerable financial risk. Further, it has been noted that ACA effectively locks-in the use of chargemasters due to the requirement that Federal Assistance Program patients be billed less than the hospital's standard gross charges for services.[xvi]

The Role of Markets and Insurance in Setting Charges

Libertarian proponents of free-markets may argue that significant differences in charges and financial risk for consumers are acceptable within the bounds of a contract or an agreement for goods and services rendered, i.e. as a commodity. However, the widely-varied chargemaster pricing and billing is not truly a function of market-based supply and demand. Libertarian Robert Nozick promotes free markets as a "minimal state, limited to enforcing contracts, and protecting people against force, theft, and fraud…"[xvii] Richard Allen Epstein and David Hyman apply this libertarian market philosophy to healthcare, contending that "insurance contracts are devices for risk smoothing that leave all plan participants better off in expectation than by staying out," and that these contract arrangements should "produce joint gains or win/win outcomes."[xviii] If healthcare is analogous to a commodity within a market-based pricing structure, then one's obligation as a healthcare consumer is to purchase a better contract or pay the difference in cost on the backend of care. If this is the case, then the patient from Wisconsin suffering a heart attack in the example discussed above failed to meet her own obligation. Far from a government takeover of healthcare, the Affordable Care Act has taken this obligatory and mandatory third-party-payer approach, betting that healthcare costs are actually an insurance *coverage* problem rather than a market *efficiency* problem.[xix]

Libertarian free markets, though, are mutually agreed upon and not exploitative. Healthcare contracts within the context of third party payers introduce significant complication, as third party payers are, in fact, market distorting entities. When purchasing healthcare insurance through an insurer, one pays that organization to contract with care delivery organizations on one's behalf in order to reduce the risk to oneself. The actual terms of that

contract are written in such a way that both parties profit. The profit in other industries is determined by market forces that hold down those costs when the consumer determines that it is too high and chooses not to purchase. Apple and Ferrari may charge high prices relative to their competitors, but shoppers are free to go elsewhere if they find the value proposition more attractive.

The difference in the healthcare market vs. commodities is that insurance functions as a "health-insurance-as-payment" intermediary for *every* service rendered.[xx] The patient is insulated from the true cost of care, allowing fees to rise unchecked because the end consumer is not making choices based on pricing at all, with the exception of their premium.[xxi] If the aforementioned Ferrari were like healthcare, it would be perceived by the driver as a paid-for benefit. The driver is not looking at the bill to see if he can afford it as long as someone else is paying a substantial chunk of the lease. His perception of the cost of the Ferrari is the damage insurance premium, the cost of gas whenever he drives, and a small percentage of the total lease. In healthcare, this would be the monthly premium, the co-pay, and the co-insurance. If the monthly difference between a Kia and a Ferrari only looks like $100, the consumer will opt for the more expensive car given his insulation from the true cost. This fee may be automatically deducted from his paycheck, which means he may never directly pay those dollars. Of course, moving back to medical care, the total cost shows up in steadily increasing monthly premiums that must be continually subsidized by employers and government entities, narrower care networks, higher co-pays, increasing deductibles, denied non-covered services, and prior authorizations. Rather than a coverage problem, we have a market problem.

Market distortion of this kind drives up not just routine, scheduled, and anticipated healthcare, but also emergency services as well. After suffering a medical emergency, the well-

insured patient who receives in-network services will be relieved that she didn't have to pay for the whole bill, but will not compare the billed costs of care delivery between nearby hospitals afterward to make sure that the insurance company got the best deal available.

Adding an order of magnitude to the distortion within the healthcare market, the care contract is not only made between the patient and the third party payer, but also with those with whom the healthcare institution contracts. Many healthcare providers are not actually employed by the hospital in which they work, but have access privileges and carry their own payer contracts.[xxii] Because these charges are not transparent, deals are made in the best interest of the contracting organizations that may not be in the best interests of patients. This creates an environment where payer "interests do not necessarily coincide with the interests of the persons they insure. They act to maximize their own returns."[xxiii]

As discussed in the automobile example above, third-party-payers introduce a significant and material difference from consumer markets. "The health insurance system in the United States no longer protects persons only for aversion to risk associated with the low-probability/high-loss events."[xxiv] All associated healthcare costs, not just the catastrophic ones discussed above, are paid by insurance. The value proposition is obscured at all points in the care continuum. Rather than an instrument to spread risk, insurance is the vehicle of payment for every service and consumers expect to withdraw the full value and more of what they have paid in. If one insures one's car for $200 a month against unforeseen comprehensive damages, there is no expectation that one will in turn receive at least $2400 in benefits annually. Health insurance no longer operates in this way.

Insurance as comprehensive payer vehicle creates cost-inflation by distorting the perceived cost of care. Callahan and Wasunna write regarding the advent of employer-

subsidized plans, "third party insurance, mainly provided by employers, masked the true cost of healthcare to its recipients and insulated patients from feeling the impact of rising costs."[xxv] The price paid out of pocket becomes the perception of the total cost, allowing percentages of what is billed to run up into the range of what one would be willing to pay for cash services without insurance assistance. A deductible, co-pay, and 10-30% co-insurance allow healthcare providers and institutions to push the cost of care much higher than otherwise through invisible charges and lack of transparency. Consumers are shielded from the costs of care by these smaller out of pocket costs along with governmental and employer subsidization. "The employment-based, health insurance-payment system pool has become a 'contractual commons,' i.e., a commons that participants agree to create and fund in the belief that there is no practical limit on their right to draw upon it," says Kratzke.[xxvi]

Economist David Colander explains that in any third party payer market, and *especially* in the healthcare market, the consumer loses incentive to hold down costs, increasing demand.[xxvii] Increased demand drives costs. Again, the extreme inflation of hospital chargemaster fees can be attributed to the distortion of market forces. Patients feel they are entitled to the most expensive services and treatments because they have the means (insurance) to cover it. As a result, true catastrophic emergency care that requires a financial stop-loss is cost inflated right alongside voluntary and elective care that is paid by an insurance intermediator without attention to the bottom line, creating what Hall and Schneider term an "irrational market" producing "bizarre prices".[xxviii] A market subject to irrational pressures from influencers with ulterior profit interests is by definition a *distorted* one. The distortion has evolved to such a degree that the Virginia Mason Health System in Washington State has straightforwardly acknowledged that insurance companies and employer benefits managers are its customers

because they are "paying the bills".[xxix] In a market where the patient is not the only customer, whose interests are upheld?

Consent, Choice, and Coercion in Emergency Healthcare Services

Based on the discussion of markets above, chargemaster fee variance and balance billing for emergency services constitutes injustice. This injustice is similar to that of price gouging in natural disasters. Emergency healthcare, in particular, as a free market never gets off the ground because the consumer has no live option available to choose not seek life-saving services. It is simply not a voluntary choice. The price is agreed to without seeing the terms. A recent study shows that 40% of out-of-network care is involuntary, including a full 58% of inpatient out-of-network contacts, and that 68% of these non-network contacts were for medical emergencies. [xxx] Moreover, in over half of the cases the provider's out-of-network status was unknown at the point of service. [xxxi] While you may anticipate any particular emergent circumstance, if there is no reasonable and acceptable alternative, this effectively obliterates the market and the conditions under which it was accepted and is inconsistent with free choice and respect for patient autonomy. Put another way, this informational asymmetry results in an inability to make a truly informed purchasing decision.[xxxii]

Emergency healthcare for life-threatening conditions, then, becomes a bet or gamble that may be hedged by insurance (smoothed according to Epstein and Hyman)—or may not be, depending on accidents of fate, which hospital the ambulance drives to, and other arbitrary conditions outside the control of the patient. In these cases, consent to the financial cost of care is not possible and therefore the individual patient should not be responsible for paying any and all

demanded costs associated with that care if that amount is not reasonable or is financially harmful.

Moreover, medical relationships mediated through third parties are only partially contractual anyway because they are advising on what services you absolutely require.[xxxiii] They are operating in a life and death sphere where the patient, if asked in an acute situation, would literally *give anything* regardless of what may be written on a (hidden) price tag. Nation calls the "Authorization for Treatment" and "Statement of Financial Responsibility" documents patients are asked to sign at the point of service a "blank check" due to their basis on chargemaster prices that are intended to be discounted. [xxxiv] He writes that legally, "Contracts calling for payment of hospitals' chargemaster or list prices by the uninsured are unenforceable under the doctrine of unconscionability," and that courts and lawmakers are increasingly limiting the recovery of medical expenses to "the amount actually paid or incurred on behalf of the patient."[xxxv] This balance billing is unconscionable in the context of emergency health services because the medical market for emergency care is the very definition of a calamity, and that "the sick must engage with doctors in ways that unfit them for the market…the patient becomes a totally captive consumer."[xxxvi] For emergency care, the consumption of services is not desired (or maybe even not voluntary) so it resembles much less a commodity bought or service requested, as to a morally obligatory rescue. Musgrave observes succinctly, "Consumers do not have a per se demand for healthcare, but rather want healthcare as an alternative to pain."[xxxvii] This leads Hall and Schneider to liken emergency healthcare to *admiralty law,* which invalidates contracts made under circumstances where no other alternative exists.[xxxviii] Information asymmetry combined with a lack of real choice in what care one accepts in an emergency situation results in *asymmetries of justice* as evidenced by price disparities, aggressive collections, bankruptcies, and

insurance policies with insufficient network support that do not cover the actual costs of treatment.

Implications for Justice

Emergency healthcare requiring hospitalization is a different kind of service delivery that requires a different kind of approach to hold down costs and ultimately reduce the potential for financial exploitation of patients. Accordingly, emergency healthcare looks a lot less like a commodity and more like a kind of public utility that one cannot reasonably be expected to forgo. Electricity, water, and public roads are not entirely disconnected from supply and demand, but require oversight due to lack of true competition and the fact that we are dependent on the services to attain and maintain our interests. In other words, non-optional emergency medical care constitutes a primary good.

Although the argument for free markets is that they enhance welfare and respect freedom, the question is whether the results are virtuous when consumers are charged much higher fees during an emergent situation. The moral argument against price gouging in natural disasters makes clear that in these circumstances the market is not truly free, and welfare is not promoted. People (or institutions) are getting compensation they do not deserve – indicating a lack of virtue.[xxxix] We also have an intuitive sense that gouging is unjust, a kind of robbery that one is subjected to because one has no other option. It is inherently exploitative.

Based on this analysis, we have reason to question whether healthcare contracts with third party payers for emergency healthcare services even resemble a valid free market transaction or are in fact encourage price gouging. Market forces do not efficiently hold down

costs for healthcare in general via competition for quality services. This is not a free market deserving protection by the Nozik's minimal government nor does it produce Epstein's joint gains and win-wins. Charges for emergency medical care and where one is taken for that care are a species of force. Charging patients who are out-of-network, uninsured, or indigent the chargemaster rates is morally unjustifiable. Even on a libertarian philosophy of economics and markets, then, the state has an obligation to step in if hospitals and healthcare providers to not meet their moral obligation to provide care at reasonable rates to patients.

Transparency and Regulation for Emergency Healthcare Services

While the market is distorted and inefficient, market-based solutions can still be helpful if they are targeted toward reducing the source of that distortion. One way to protect consumers would be to make the current established fee schedule transparent, requiring publication of both the chargemaster sticker price (CMS billings could substitute), as well as the calculated actual cost of care delivery for the diagnosis code or DRG as an average of all accepted third party rates negotiated with commercial payers. Economist Uwe Reinhardt writes, "The high variance of healthcare prices in the United States can be explained in good part by the opacity of these prices. Both government and the private sector have done their best to maintain that opacity."[xl] This would track the actual cost of delivering care along with profit margins, but would be an admittedly difficult proposition affecting competitive contracting advantages. Legislation could start with non-profit institutions and make their continued non-profit status conditional on this kind of transparency. Unfortunately, the information, even if made available, would be subject to some translation difficulties, though, as patients typically do not understand DRGs, diagnosis

codes, and what services and supplies are associated with each other. Similar transparency laws have resulted in little interest from patients.[xli] This lack of interest is probably partially due to information asymmetry and partially due to third party payer distortions in the case of anticipated and scheduled care. In the case of emergency care, as discussed above, there is little incentive to ensure that the third party insurance payer got a good deal unless one finds oneself financially responsible for a large percentage of a bad deal on the backend of receiving care.

As an intermediate step to complete transparency in pricing, Kyanko and Bush suggest that insurers could be required to publish their out-of-network payment rates and providers to disclose list prices.[xlii] Any kind of pricing/billing transparency requirement, though, would necessarily be geared primarily toward elective and scheduled procedures as opposed to true emergencies. While it would not directly aid in consumer choices for particular emergency events, it could serve to exert pressure on hospitals that are egregious cost-outliers to bring their rates in line with their peer institutions for all services rendered or justify higher fees via clear quality and retrospective outcome measures. Healthcare watchdogs such as the Washington Health Association and the Colorado-based Center for Improving Value in Healthcare are providing this type of service by calling attention to the massive price variation that has been uncovered by the new CMS publication of billed fees.[xliii]

Another potential intermediate solution to out-of-network care for emergency services would be for EMTs operating ambulance services to have access to a database of in-network hospitals matched to the patient's name or insurance card. This workaround would be problematic, though, for a number of reasons. It would be difficult to maintain an up-to-date and accurate list for individuals taking into account insurance coverage changes, as well as work around privacy laws that may entail opt-in or opt-out permissions similar to health data

exchanges. More importantly, the time spent looking up the information and possibly additional time transporting the patient to a less expensive in-network hospital may not be in the best interest of a patient suffering a medical emergency. Also, as we have seen, even in-network hospitals subject patients to involuntary out-of-network care and the "right hospital" is no guarantee of financial risk mitigation. Asking EMS to take on the responsibility of taking the patient to a particular hospital misplaces the moral obligation and caters to the unjust existing system.

Because of the resemblance between emergency healthcare services and a public utility as social goods, hospitals and other healthcare delivery networks ought to be subject to regulation that protects patients from balance billing entirely. In inefficient and distorted markets, the legislative solution may become necessary when a market solution is not feasible. Currently, 13 states explicitly prohibit balance billing, including California and New York.[xliv] All 50 states should adopt this prohibition, and the Affordable Care Act should be amended at a federal level to require not only the reimbursement of out-of-network emergency department rates as in-network, but also inpatient DRG rates for admissions, prohibiting healthcare providers from balance billing to out-of-network patients. Aetna Inc., a large insurance company, explicitly supports this type of legislation.[xlv] In fact, Kyanko and Busch report that Aetna sued eight physicians in New Jersey on behalf of their insured customers for "unconscionable out-of-network fees at in-network hospitals, including a charge of more than $50,000 for an inpatient cardiology consultation."[xlvi]

Even if balance billing were prohibited in all states, it would still leave patients without insurance financially exposed to bills based on the full chargemaster amounts. For those lacking insurance, Hall and Schneider call it "ethically troubling for physicians to raise fees for

uninsured patients simply to make up for losses from better-protected patients."[xlvii] We agree. They recommend charging patients who are in economic danger the lowest rate accepted from a third party payer, citing the need for "clean hands and a clear conscience" rather than what "desperate patients would pay for life and limb". This could easily be the contracted rate paid to in-network patients who are insured. However, while the inflated chargemaster rates are unreasonable, something slightly higher than the in-network commercial rates for the uninsured may be defensible. Network contracting offers significant value to hospitals by essentially pre-screening for financial creditworthiness, steering additional business to their services, as well as easing the administrative burden of billing patients directly.[xlviii] Anderson suggests charging Medicare price, plus 25% in order to avoid interference with the market and to maintain administrative manageability.[xlix] However, with more services moving toward a fee for value type of an arrangement vs. fee for service; capitation, bonuses, and withholds become difficult to calculate. In cases like these, a historical look-back on average reimbursement, including incentives across all payers for a set of services or DRG, may suffice for billing purposes.[l]

Conclusion

Based on the above discussion, it is apparent that the practice of balance billing for emergency healthcare services is unjust, as is chargemaster pricing for emergency services that are not subject to market-based corrections in the same way as other commodities are. Consumption of emergency healthcare services is not based on transparent pricing and consumer perceptions of value. Therefore, corrective action is necessary, including legislation that prohibits balance billing for out-of-network patients and the uninsured, requires disclosure of list prices for services, and the adoption of billing policies by institutions to charge rates more

closely resembling the cost of care and/or contracted rates. These measures will protect patients from charges that constitute price gouging as a protective mechanism to ensure justice and underwrite societal freedom, welfare, and virtue.

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[xlv] Aetna Inc, "Balance Billing by Non-Par Physicians Under Involuntary Situations," web exclusive 2014, at: http://www.aetna.com/health-reform-connection/aetnas-vision/balance-billing-non-participating-physicians.html

[xlvi] Kyanko and Busch, "Out-of-network Benefit," 355.

[xlvii] The authors quote a text from 1882 that sates, ""When you are in doubt what to charge, look around you [to what other doctors charge], then upwards [toward God], then make out your bill at such figures as will show clean hands and a clear conscience."
M. Hall and C. Schneider, "Learning form the Legal History of Billing for Medical Fees," Journal of General Internal Medicine 23(8), (August 2008): 1260, at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2517971/

[xlviii] Nation, "Determining the Fair and Reasonable Value," 458.

[xlix] Anderson, "From Soak the Rich," 787.

[l] Charity care should discount on a sliding fee scale starting from the Medicare reimbursement, not the chargemaster, which could result in lucrative profitability for charity care despite discounts offered.

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