Battling the Chargemaster: A Simple Remedy to Balance Billing for Unavoidable Out-of-Network Care

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ABSTRACT

OBJECTIVES: To develop an effective legal mechanism to combat chargemaster abuses and to facilitate price transparency.

STUDY DESIGN: Applying legal doctrines to out-of-network (OON) billing disputes.

METHODS: We reviewed rudimentary contract law and examined the law's handling of contracts where prices have not been specified in advance. These cases are the controlling authority to guide courts, handling of surprise and OON billing problems. We then compared legal remedies that correct OON billing abuses to prevailing legislative and regulatory approaches.

RESULTS: Our analysis suggests that providers have no legal authority to collect chargemaster rates from surprise and OON billing abuses. A proper application of contract law can end such abuses and would facilitate superior pricing incentives to other strategies designed to end balance billing disputes.

CONCLUSIONS: Chargemaster rates on uninsured and OON patients impose significant financial burdens on the vulnerable, distort medical prices, and inflate healthcare costs. Applying rudimentary contract law to these practices offers a solution that is simpler and more effective than other administrative and legislative schemes recently adopted in several states. It will prevent providers from hiding behind a convoluted hospital pricing system, encourage the development of attractive narrow-network insurance products, and shield urgently sick individuals from the dread of medical predation. Patients and payers should know that they are under no obligation to pay surprise bills containing chargemaster rates, and state attorneys general can use the law to prevent providers from pursuing chargemaster-related collection efforts against patients.

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Over the last several years, numerous articles in the lay press have documented one of the most disturbing practices in the healthcare system: providers billing exorbitant charges to the nation's most vulnerable patients. These patients are those who either lack insurance or who have the misfortune of requiring services rendered by an out-of-network (OON) provider, usually in emergent circumstances, and the prices charged are neither approved nor seen by patients in advance. The resulting medical bills—euphemistically described as "surprise bills"—place significant and sometimes ruinous burdens on patients' lives.[1]

These patients are more than just collateral damage to skyrocketing healthcare costs. Recent examinations of OON billing reveal that inflated charges are often part of a deliberate strategy by providers to apply negotiation leverage against insurers. The primary tool in this strategy is the notorious "chargemaster," a master file built within hospital information systems that contains a comprehensive listing of prices for all billable services. Inflated chargemaster charges have been used tactically both to secure higher payments from Medicare and private payers and to threaten insurers seeking to create affordable insurance offerings through narrow networks. The viability of narrow networks, which are one of the few health insurance innovations associated with gains in affordability and quality of care, depends on successfully battling the chargemaster.

Within the past 2 years, several state policy makers have taken notice and enacted legislation designed to curtail chargemaster collection efforts. A handful of states have protected healthcare consumers by enacting "balance billing" legislation that prohibits providers from charging patients for deficiencies between chargemaster prices and an insurer's reimbursement, while others have required insurance companies to shelter plan members from these deficiencies. Some states have gone further to set payment rates for certain OON charges either by statute or special administrative mechanism, and some states have approached the problem more gingerly by introducing efforts to bring transparency to provider pricing.

However, these state solutions—to use a medical analogy—treat the symptoms of chargemaster abuses without addressing the underlying problem. They prohibit the worst abuses, but they neither recognize that the root cause is unilateral price setting nor do they empower consumers to counteract unilateralism with a market response. We propose a simpler and better approach to stemming the growing role and distortive power of the chargemaster, one that requires neither additional legislation nor regulatory changes and yet preserves market incentives to craft more affordable insurance products. We illustrate how payers and patients can invoke rudimentary common law principles to challenge inflated chargemaster charges, replace inflated charges with amounts that instead reflect prevailing market prices, and correct some of the health sector's worst market failures.

TAKEAWAY POINTS

- Many healthcare providers seek to collect exorbitant chargemaster rates from uninsured and insured out-of-network patients. These efforts impose significant burdens on financially vulnerable patients and hinder efforts to create affordable narrow-network insurance plans.
- Contract law does not support the collection of chargemaster rates, which have little relation to either actual costs or market prices. Instead, proper contract law supports imputing market-negotiated rates.
- Applying these well-recognized legal principles to the complex world of out-of-network billing provides a simpler and less costly approach than those recently adopted in some states to combat the distortive effects of chargemaster billing.

The Problem: The Chargemaster and OON Bills

Most Americans use insurers as intermediaries to negotiate rates for healthcare services in advance with providers, and when an insured patient receives care, the provider is paid rates that are fully detailed in a contract between the provider and the patient's insurer. This arrangement benefits from the opportunity for providers and payers to negotiate deliberately, without emergency conditions and with the knowledge of prevailing market prices and costs of service.

When patients require or unknowingly receive care from providers who have not entered into a contract with their insurers (so-called OON care), or when patients are uninsured, providers typically charge rates in accordance with their chargemaster. The chargemaster and similar charge strategies are responsible for exorbitant prices for emergency care (eg, the $500 stitch),[2] for OON physicians serving as consultants and "drive-by" doctors (eg, the $117,000 medical bill from an unknown doctor),[3,4] and for charging more to the uninsured than to the rest of the population. "The rules are completely crazy," concedes one provider.[5]

The chargemaster has been described as the "central mechanism for the revenue cycle" of hospitals, but its defining feature is that it is "devoid of any calculation related to cost" and is not based on market transactions.[6] It lies in stark contrast to alternative billing and accounting systems that take cost into consideration, such as accounting systems that assimilate multiple factors in determining the cost of providing medical services and generating prices that reflect those costs.[7]

Because chargemaster prices are calculated without regard to costs, and because of the underlying complexity of hospital pricing and billing practices, hospitals have resorted to chargemaster price inflations to meet financial demands. Hospital accounting experts agree that hospital billing practices "encourage manipulation of the [chargemaster] to maximize revenue"[8] and have created a "legal fiction" that now serves as the basis of billing uninsured and OON patients.[9] In determining the amount that providers accept from third-party payers, "[c]hargemaster rates, in reality, serve as nothing more than the [hospital's] starting point for negotiations."[10] A hospital spokesperson, when speaking about the hospital's chargemaster rates, said "[t]hose are not our real rates . . . most people never pay those prices."[6] In addition to inflating prices paid by private insurance, higher hospital chargemaster rates also manipulate Medicare reimbursements. By using chargemaster prices to charge substantially more for Medical Severity–Diagnosis Related Groups, even when patients have similar lengths of stay as those in all other hospitals, hospitals can generate higher outlier payments under Medicare's inpatient prospective payment system.[11]

For these reasons, hospitals typically set chargemaster prices several times higher than prices in negotiated contracts. One study found that chargemaster prices are 2.5 times what most health insurers pay and more than 3 times hospitals' actual costs.[12] Another study found that the first 30 to 74 minutes of critical care delivered by a California provider could cost an OON patient as much as 2897% of what Medicare would have paid for the same services,[13] and a new survey shows that health plans and patients routinely receive charges from OON physicians that range from 118% to 1382% of amounts paid by Medicare.[14] An influential series of articles in *The New York Times* highlighted these abusive billing practices, such as charging $2200 for 3 stitches on a patient's knee, $1700 for a dab of skin glue to close a cut on a child's head, and more than $36 for a single Tylenol pill with codeine.[1-3]

Current State Responses

Although federal law offers few remedies against surprise balance billing and similar chargemaster strategies, many state policy makers have appropriately recognized that surprise OON bills cause genuine hardship to patients, impose unnecessary complexity to an already burdensome world of hospital billing, and pose a major threat to the availability of affordable narrow-network insurance plans.[15] The state approaches have varied, but their assorted elements can be categorized into 4 distinct strategies—although some state efforts have pursued several elements simultaneously.[16]

The least interventionist approach has been to bring transparency to healthcare prices and the consequences of obtaining OON 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. 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 OON providers.[17] 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 certain providers.[18] However, while greater transparency is desperately needed in the health sector, these efforts will stem surprise bills in only the most avoidable circumstances and do little to stop the most harmful abuses, including surprise bills from emergency care or from OON physicians consulting for in-network hospitals.

Other states have passed what have been called "balance billing laws," which prohibit OON providers from directly billing patients for certain deficiencies between their insurer's reimbursement and their provider's chargemaster rates.[19] These laws hold neither patients nor their insurers responsible for the surprise charges and refuse to reward providers for certain chargemaster abuses. However, unlike the objective behind transparency initiatives, they do not encourage patients to be price-sensitive nor do they induce providers to compete on price. Moreover, these balance billing prohibitions tend to restrict only specific conduct—Maryland's balance billing prohibition, for example, only applies to certain services and is triggered only if certain disclosures are not made.[17] Because they are targeted prohibitions, providers will continue to find pathways to implementing the chargemaster strategy. Finally, because they dilute providers' ability to distinguish in-network from OON prices, they remove providers' incentives to participate in and offer competitive prices for narrow network plans. Thus, balance billing prohibitions are neither likely to categorically prevent surprise bills nor likely to incentivize market-oriented behavior toward affordable care.

An increasingly common approach by states has been a "hold harmless" policy that requires insurance companies to shelter plan members from surprise bills. For example, Colorado law prohibits insurers from passing along to members the costs of treatment from certain non-network providers. Thus, insurers are required to pay the chargemaster prices, negotiate a lower price with the provider, or fight the bill in court.[20] Although this approach might incentivize insurers to anticipate and preempt surprise bills—either by negotiating agreements with more providers or actively steering subscribers in-network—it places a significant cost burden on payers, which will more likely pass along costs to consumers and through increased insurance premiums.

The most comprehensive approaches to solving surprise bills have come from New York and California. The New York law, which came into effect on April 1, 2015, bans balance billing from OON emergency services and establishes an independent dispute resolution for providers and health plans to settle on a fee for OON services performed.[21] California is similar and also establishes a default charge of 125% of Medicare reimbursement for surprise physician charges for in-network care.[22] This administrated negotiation approach is comparable to surprise billing laws in Illinois and Florida, and other states have used similar approaches to resolve OON bills in other contexts. In Michigan, for example, state statutes limit automobile insurers' responsibility to pay only "reasonable" and "customary" charges for healthcare expenses required of insureds.[23,24] Similar regulatory schemes have also been established in the worker's compensation context, requiring insurers to reimburse providers only a "fair and reasonable reimbursement amount [to] . . . ensure that similar procedures provided in similar circumstances receive similar reimbursement."[25] This administrative solution, however, imposes significant transaction costs to achieving solutions. Patients with surprise bills must be aware of the regulatory remedies and submit substantial paperwork before triggering protections. These bureaucratic hurdles not only prevent many consumers from receiving adequate protection, but they also dull providers' exposure to price competition. Alternative dispute resolution might offer effective mechanisms for finding compromise prices to resolve particular disputes, but those prices are not felt in the marketplace.

The seriousness and pervasiveness of surprise bills encouraged the National Association of Insurance Commissioners in November 2015 to update its Model Act to institute additional consumer protections. The new Model Act, which is represented as a "compromise among all of the participating stakeholders," reflects New York's effort to increase transparency and sponsor provider-payer mediation.[26] It requires health carriers to offer accurate network directories to warn patients before they seek OON care and provides a mediation process for providers and payers to resolve disputes over OON remittances. In addition, influential think tanks have focused on problems from surprise bills, with one recently recommending (in what amounts to a full frontal attack) a combination of federal, state, and private interventions.[27] The Model Act has not yet been passed by any state, nor have federal policy makers responded to the call to action, but these recent efforts reveal the pressing need to find a solution to surprise bills. Meanwhile, the diversity of legislative activity reveals that legislators have not yet arrived at an adequate policy.

A Better Solution: Rudimentary Contract Law

Despite this legislative activity in many states, protecting consumers from surprise OON bills requires neither new legislation nor new regulatory mechanisms. To the contrary, consumers are

already protected by current law—bedrock, rudimentary contract law—and require only its proper application to end harmful chargemaster practices.

Contract law offers not only a promising solution, but a better one. It 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 avoids the imposition of a new regulatory apparatus. And perhaps best of all, it triggers market solutions to address healthcare costs. A contract law solution empowers the very parties who currently are being exploited by OON charges.[28]

In the accompanying eAppendix, we detail our legal analysis, which concludes that providers do not have a legitimate legal claim to collect chargemaster charges. This analysis is in line with a growing chorus of legal scholars seeking to end chargemaster abuses.[29-31] The key motivation is that mutual assent is at the core of commercial transactions. Chargemaster prices, in contrast, are prices that neither patients nor payers accepted in advance nor are they prices to which payers would *ever* assent. Instead, the law entitles providers, as one court ruled, 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."[32] The law therefore entitles providers to collect no more than prevailing negotiated market prices for any OON services.

This leads to a stark conclusion: providers have no legal authority to collect chargemaster charges that exceed market prices for OON services, and thus neither patients nor payers are under any obligation to pay such chargemaster prices. Consistent efforts to enforce this interpretation of contract law would go far in addressing abuses. Moreover, judges, public law enforcement officials, and private attorneys can use this interpretation to combat abusive or harassing efforts that providers pursue to collect such charges. And, perhaps most important, payers that form narrow provider networks can be confident that they will not have to pay extortive chargemaster prices if their insureds require emergency OON care.

A Comparative Assessment

Contract law sets a clear baseline for what may be collected, and prevailing data resources can enable courts to calculate appropriate market prices with little difficulty (see eAppendix). A common law solution therefore lucidly demarks what patients and payers owe providers for OON care without costly litigation or cumbersome administrative procedures. It also encourages providers to be transparent with their prices, for higher prices are attainable only if providers obtain assent from payers in advance.

For these reasons, empowering courts to resolve surprise billing disputes—and to set the rules that govern surprise billing—is preferable to relying on new legislation. Although state policy makers are to be lauded for addressing chargemaster abuses, none of the 4 prevailing strategies—increasing transparency, prohibiting balance billing, requiring insurers to cover OON costs, and providing mediation—offer specific advantages from relying on courts applying contract law. This is because chargemaster and OON charges are pernicious not just because they allow providers to exploit a moment of vulnerability or a temporary information failure, but because they impose enormous dynamic costs as well.

An effective policy response to OON billing will not just protect patients from surprises, but is also how patients can benefit from the market. Laws that place a simple ban on balance bills from providers do not incentivize efficient providers to price competitively, join narrow networks, or encourage patients toward efficient care. Reciprocally, laws that obligate insurers to cover their patients' bills might provide patients with temporary salvation, but because they retain the potential for extortive billing, patients are likely to pay the inflated bills indirectly through higher insurance premiums. Thus, regulatory bans, whether they impose residual costs on insurers or on providers, fail to harness market forces that encourage price competition and quality improvements.

Administrative efforts to define reasonable reimbursement rates, whether through administrative fiat or through dispute resolution mechanisms, aim to mimic what a court would do in imputing 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 that court proceedings do not. More significant, administrative structures introduce the significant risk of enshrining the sentiments of entrenched stakeholders, whereas courts are much less prone to capture by special interests. For these reasons, administrative solutions would fail to address the dynamic costs of surprise bill strategies, and if used in conjunction with court solutions, they would interfere with and thereby undermine the many benefits of invoking contract law remedies.

The **Table** summarizes our comparative assessment of these alternative strategies.

CONCLUSIONS

Chargemaster abuses from OON and emergency care inflict serious financial harm to the most vulnerable while undercutting the functioning of healthcare markets and the creation of valuable insurance products. At the same time, they present straightforward questions of contract law and lead to a simple conclusion: providers are entitled only to collect prevailing negotiated prices for OON services, and patients and payers are under no legal obligation to pay higher chargemaster charges.

Applying this interpretation of contract law will prevent providers from hiding behind a convoluted hospital pricing system, will encourage the development of attractive narrow network insurance offerings, and will shield urgently sick people from the dread of

TABLE. Comparative Assessment of Responses to Surprise Out-of-Network Bills

	Protects Patients From Chargemaster Rates	Encourages Patients to Be Price Sensitive When Shopping for Healthcare Services	Encourages Providers to Provide Efficient Care; Discourages Abuse of Chargemaster Accounting	Protects Patients in Emergency Situations	Easy to Administer
Increasing Price Transparency for Healthcare Services	Unlikely	Yes, if done right	Yes, if done right	No	Not immediately; requires standardized accounting and states' boards to administer
Prohibiting Providers From Balance Billing	Yes, for insured patients, but costs will translate to higher premiums	No	No	Yes	Yes
Requiring Insurance Companies to Shelter Members from Out-of-Network Costs	Yes, initially, but costs will translate to higher premiums	No	No	Yes	Yes
Administrative Determination of Out-of-Network Rates	Yes, if done accurately	No	Yes	Yes	Unlikely; could entail a heavily politicized and bureaucratic process
Applying Rudimentary Contract Law	Yes	Yes	Yes	Yes	Yes

medical predation. State legislators are to be congratulated for recognizing that chargemaster abuses require attention. But rather than seeking legislative solutions, they should pursue court remedies that correct both the immediate and the long-term dynamic harms caused by chargemaster strategies.

Creators of narrow-network plans should be emboldened by our conclusions, and we particularly urge the legal community to take our conclusion to heart. Public law enforcement officials have an opportunity to give immediate relief to constituents who are routinely injured by chargemaster abuses. For example, a state attorney general who announces a commitment to enforcing contract law in chargemaster disputes would both protect vulnerable patients and bring some clarity to healthcare prices. Providers will know that subversive pricing strategies will be ineffective, and that they instead must forthrightly disseminate and obtain assent to their prices in a transparent market. ■

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eAppendix

This eAppendix briefly outlines our analysis of how contract law would resolve disputes over surprise bills. Operationalizing contract law—and understanding its role in governing chargemaster charges—requires considering how providers use courts to collect their bills. Although providers rarely take their patients to court, the few times that they do establish the rules that determine the validity of their charges and claims

Providers are in the position to collect their charges under two basic strategies. One strategy is to sue patients based on hospital admissions contracts. Healthcare providers, so long as they are not precluded by emergency circumstances, typically have their patients sign standardized contracts prior to receiving medical care. These admission contracts are detailed, drafted by the provider, and specify that the patient must pay for the medical services they are about to receive. They typically do not, however, explicitly specify the price for those services. Instead, they include boilerplate language in which the patient agrees "to guarantee payment of the account," "to pay all charges not covered by insurance," or to pay the "usual and customary charges of the hospital." Providers commonly argue that any reference in these form contracts to "payment," "charges," or similar language refers to chargemaster prices, and thus when patients sign these contracts, they commit to paying what they are subsequently billed.

The second strategy is invoked when there is no admissions contract. This is common when patients are admitted in emergency settings or when circumstances preclude a patient from signing a consent form. In these situations, providers argue that it was impossible to obtain meaningful assent prior to providing care, and thus the chargemaster rates are the only way to quantify the value of services provided. To allow patients to escape paying chargemaster charges, providers argue, would allow them to receive healthcare services without assuming financial responsibility.

Both of these arguments are examples of faulty reasoning to obtain chargemaster prices. The legal analysis begins with recognizing that mutual assent lies at the heart of contract law. The leading contracts treatise, for example, teaches that "the formation of a contract requires a bargain in which there is a manifestation of mutual assent to the exchange."[1] Chargemaster charges, in contrast, are not products of assent. Not only do chargemasters contain prices to which neither patients nor insurers consent, but they contain prices to which patients and payers

never would consent were they offered under conditions that afford deliberate and informed consideration. Chargemaster rates and surprise bills instead represent a provider's unilateral assertions, constrained neither by the prices customers are willing to accept in bargaining nor the market's prevailing prices.

The foundational principle of mutual assent is reflected in how contract law handles difficult contracting situations, including when patients are unable to provide consent, when providers are prohibited under the Emergency Medical Treatment and Labor Act (EMTALA) or other regulatory provisions to deny care, and when the complexity of providing healthcare overwhelms any rational deliberation. A proper application of rudimentary contract law, guided by the principle of mutual assent, illustrates why providers should fail to obtain chargemaster prices. To the contrary, the law instead protects patients and their payers.

Incomplete Contracts and Imputed Prices

Most contracts are like hospital admissions contracts: they provide a basic framework for a transaction (eg, the patient consents to receiving medical care and in return promises, perhaps on behalf of the insurer, to compensate the provider) but they lack key elements of the agreement (eg, what care is to be provided and what prices are to be paid). Contract law is familiar with incomplete contracts—indeed, all contracts to some degree are incomplete—and thus offers a body of default rules that are used to fill in those gaps.

Therefore, interpreting hospital admissions contracts—including deciding what financial obligations they trigger—involves a familiar process and well-known rules. The paramount objective is to fulfill the parties' intentions despite their failure to state definite and unambiguous price terms,[2] and the law instructs courts to fill price gaps by imputing reasonable prices—market prices—into the contract. 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."[3] An 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."[4]

Courts have applied these principles to disputes in admissions contracts by awarding reasonable market prices, not chargemaster rates, to providers. For example, a Pennsylvania

court adjudicating a payment dispute between a hospital and managed care organization concluded, "the Hospital is entitled to the reasonable value of its services, ie, what people pay for those services, not what the Hospital receives in one to three percent of its cases."[5] And in *Nassau Anesthesia Assocs. PC v. Chin*,[6] 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."

Chargemaster rates, by definition, are neither reasonable nor objective. As Gerald Anderson has testified, for "a price list to be reasonable it needs to reflect what is actually being charged in the market place" and since "virtually no public or private insurer actually pays full charges, charges are an unrealistic standard for comparison."[7] Chargemaster rates, imposed unilaterally to pursue accounting strategies and not to meet the demands of the marketplace, are poor proxies for prices that would be negotiated between a willing buyer and seller. Providers instead are entitled to a price "that would be agreed upon by a willing buyer and a willing seller negotiating at arm's length."[8]

Implied Contracts and Imputed Prices

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.[9] The Nebraska Supreme Court put it succinctly: "Even in the absence of an express contract, the rendering of medical services creates an implied contract between the provider and the person being given the medical care."[10] Other courts similarly and routinely articulate this same principle when patients refuse to pay for medical services they willingly received, finding that patients have consented to an implied contract.[11, 12]

But just as the law prevents patients from avoiding any obligation to pay, it similarly prohibits providers from charging whatever price they choose. While requiring patients to pay despite the absence of an explicit promise in advance, the law entitles providers to receive only a

reasonable market price, a price "that would be agreed upon by a willing buyer and a willing seller negotiating at arm's length."[8]

The law awards a reasonable market price through a legal creation called "quantum meruit," or literally "as much as he has deserved."[13] 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. Accordingly, the quantum meruit claim has been described as a "contract-like" or quasi-contract remedy, in that it shadows contractual logic and mimics the standard remedy when a party fails to pay for contracted services. One court offered a classic description of quantum meruit, noting that "the law prescribes the rights and liabilities of persons who have not in reality entered into any contract at all with one another, but between whom circumstances have arisen which make it just that one should have a right, and the other should be subject to a liability similar to the rights and liabilities in certain cases of express contract."[14] For these reasons, quantum meruit is the appropriate remedy for medical providers who deliver care without their patients explicitly assenting to pay.

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,"[15] an Ohio court defined quantum meruit recovery as "reasonable value of services rendered in the absence of an express contract,"[16] and a Montana court ruled that quantum meruit recovery is the "market value of the services rendered."[17] 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*."[18]

Imputing Prices and Contract Remedies—Making It Happen

The law of incomplete contracts and the law of implied contracts provide an opportunity to escape from the distorting burden of the chargemaster. Through these doctrines, contract law entitles providers to recover average negotiated prices, or the average of all prices to which payers and providers have agreed through negotiated contracts.

However, in large part because of the complexity of determining average negotiated prices, courts have only sporadically invoked this remedy. Courts generally recognize that chargemaster rates are not products of mutual assent, but several have been hesitant to calculate market prices as an alternative. In some cases, hospitals have convinced courts that the chargemaster rate is a reasonable proxy for negotiated prices.[19] In other cases, courts have determined that assigning a market price in the face of a lack of price transparency is too complex an undertaking, a task that belongs to legislative and regulatory bodies.[20] These experiences teach that even though the law is clear, courts might need assistance applying it in practice.

A number of mechanisms can assist courts in determining market prices. The first is to encourage courts to rely on recent efforts to bring more price transparency to healthcare markets. Both public and private actors have initiated health information technology (IT) projects designed to clarify opaque pricing mechanisms and allow patients to compare price and quality data across a range of providers. Independent entities, such as Castlight Health Inc., Healthcare Bluebook, FAIR Health, and the Health Care Cost Institute, are compiling vast amounts of healthcare price data, primarily to enable employees and consumers to compare the prices and quality of providers, and these firms could easily assist courts in calculating average negotiated prices.[21, 22, 23] Some insurers, like Blue Cross and Blue Shield of North Carolina, offer their members a database to compare provider prices.[24] States themselves have also taken an active role in promoting price transparency, with 14 states implementing (and at least 5 more now constructing) public All-Payer Claims Databases to allow comparisons between the prices accepted by various providers across a range of payers.[25, 26] These data sources can reveal to courts the prices to which willing payers and providers have agreed, and they can allow for calculations of average negotiated prices, the best proxy for market prices. As price transparency initiatives continue to proliferate, the information to make reasonable rate determinations will be more widely available, rate calculations will be simplified, and courts will find greater ease in calculating average negotiated for medical services.

Should courts still find difficulty in calculating average negotiated prices, we encourage providing judges with administrative assistance. Each administrative jurisdiction could retain a special master—a midcareer empirical health economist is all that should be required—to issue determinations of negotiated market prices for health services that local courts can use in their

assessments. Judges can be informed of the need for this determination through continuing education efforts and then can defer to this administrative process in assessing market prices. Given the economic importance of imputing market prices, the urgency of protecting patients from chargemaster rates, and the relatively minimal costs of obtaining and evaluating the required data, court systems should consider investing in such a special master.

As a last resort, courts could instead use a multiple of Medicare prices as a proxy for negotiated market prices. Although Medicare is a government monopsony, its reimbursement rates are offered by the government and accepted by providers (who are permitted to refuse) and approximate the lower end of the range of prices that a reasonably informed negotiation would produce.[27] Imputing 125% or 150% of Medicare rates into implied or incomplete contracts would offer providers reasonable compensation while drastically reducing the costs of out-of-network care.[28]

In short, courts should be encouraged—and required—to apply the law of quantum meruit and impute market prices to resolve and preempt surprise billing disputes. Because courts, like most institutions, are hesitant to engage in unfamiliar tasks, they have been hesitant in the past to make these calculations, but certain market and IT developments have made that task easier. There is little question what contract law requires, so policymakers, litigants, consumer advocates, and academics should ensure that courts are capable and determined to apply the law properly.

Conclusion

Because mutual assent lies at the heart of a contract, the doctrines of implied contracts and contract interpretation 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 resolving disputes over surprise charges, courts should 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. If judges are daunted by calculating these prices, court administrators should provide access to a standardized set of market prices for these cases .

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