

THE FLORIDA BAR

[ABOUT THE BAR](#)[NEWS & EVENTS](#)[FOR THE PUBLIC](#)[MEMBER SERVICES](#)[LOG IN](#)[FIND A LAWYER](#)[THE FLORIDA BAR / About the Bar](#)

The Florida Bar

www.floridabar.orgSearch:

The Florida Bar Journal

[Advertising Rates](#) • [Submission Guidelines](#) • [Archives](#) • [Subscribe](#) • [News](#)

February, 2016 Volume 90, No. 2

[Journal HOME](#)

Remedies for an Epidemic of Medical Provider Price Gouging

by **Steven I. Weissman**

Page 22

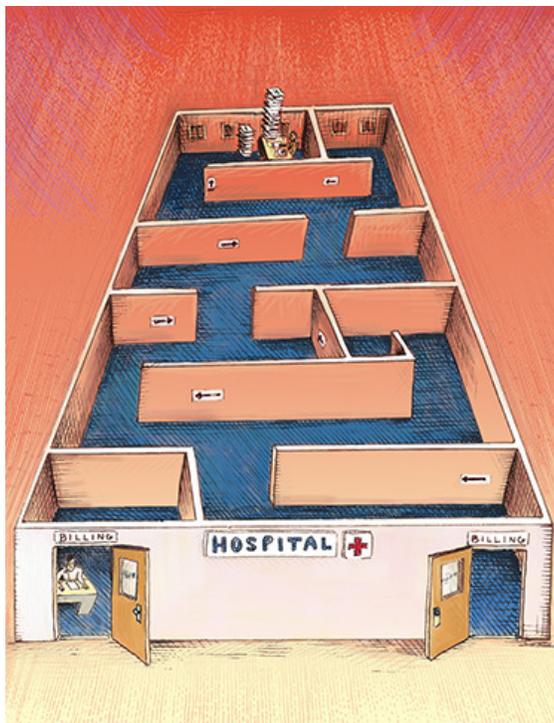


Illustration by Barbara Kelley

Share

Tweet

Share

Transparency is viewed as a self-evident good in Western society. The disinfectant quality of transparency is the essential ingredient to cure our healthcare system. Brandeis made his famous statement in a 1913 *Harper's Weekly* article: "Sunlight is said to be the best of disinfectants; electric light the most efficient policeman."¹ Hospital and laboratory prices are cloaked in secrecy. Insurers and hospitals include gag provisions, requiring the parties to maintain hospital pricing as a trade secret.² This article addresses the gaping absence of consumer protection with respect to these medical providers.

Hospital "list prices" are referred to in the industry as "charge master" prices. In Florida, charge master prices are three to four times the amounts negotiated as reasonable charges with insurers. As hereafter discussed, provider contracts stating that a patient agrees to pay charge master prices are overridden and controlled under Florida law by a reasonableness requirement.

Understanding healthcare pricing is a prerequisite to discussion of the Florida law and the proposed consumer protections considered below.

Healthcare Pricing

In 2008, the Center for American Progress reported that "America's economy is buckling under a broken healthcare system" and that healthcare spending in the U.S. had reached \$7,900 per person.³ By 2013, healthcare spending in the U.S. had grown to \$9,255 per person and accounted for 17.4 percent of the nation's gross domestic product.⁴ The majority of U.S. personal bankruptcies are due to medical expenses, despite the fact that 77.9 percent of those bankruptcy filers were insured.⁵ In 1985, total household food and beverage costs were roughly the same as total health expenditures; but, by 2012, health expenditures grew to 2.3 times food and beverage expenditures.⁶ In 1964, housing and utility costs were triple household healthcare costs; by 2012, healthcare costs roughly matched housing and utility costs.⁷

Healthcare pricing is generally determined by how much can be extracted from the patient on a case-by-case basis. Ask any hospital, lab, or physician the cost of any procedure or treatment and the response invariably is: "What insurance do you have?" Since the enactment of the Patient Protection and Affordable Care Act (ACA also known as "Obamacare"),⁸ debate has mistakenly focused on the cost of insurance as if it is synonymous with healthcare costs. The cost of insurance is merely a function of underlying medical costs. Sky high hospital, physician, and lab costs necessarily result in sky-high insurance premiums. Ironically, the more medical costs and premiums rise, the more the ACA allows insurers to profit.⁹

List prices (think car MSRP sticker prices) are billed only for the small minority of services performed when no insurance is involved.¹⁰ In the healthcare industry, list prices are phony, having no relationship to either costs or value. This fact has been widely reported in national media, reflecting public disgust and

List prices (think car MSRP sticker prices) are billed only for the small minority of services performed when no insurance is involved.¹⁰ In the healthcare industry, list prices are phony, having no relationship to either costs or value. This fact has been widely reported in national media, reflecting public disgust and

frustration with the system:

- *The Wall Street Journal* — “Many hospital executives dismiss those list prices — also known as charge master prices — as meaningless and misleading, since few patients ever pay them.”¹¹
- *Huffington Post*: “Medical providers set their prices in ways that seem arbitrary, with little oversight and practically no market incentive to reduce them, because almost no one actually pays the official rates.”¹²
- *The New York Times* — “There is little science to how hospitals determine the prices they print on hospital bills. ‘Charge master prices are basically arbitrary, not connected to underlying costs or market prices...[hospitals] can set them at any level they want. There are no market constraints.’”¹³
- *CBS News* — “Those prices represent what hospitals charge payers before discounts, which is often several times higher than what they actually get paid. The only people who pay the charge master price are the uninsured.”¹⁴
- *Time Magazine*:

The charge master, I learned, is every hospital's internal price list. Decades ago it was a document the size of a phone book; now it's a massive computer file, thousands of items long, maintained by every hospital....I quickly found that although every hospital has a charge master, officials treat it as if it were an eccentric uncle living in the attic. Whenever I asked, they deflected all conversation away from it. They even argued that it is irrelevant.¹⁵

The Medicare program recently released detailed studies regarding hospital list charges, comparing them to Medicare allowed amounts throughout the U.S.¹⁶ These studies are relevant in billing disputes, which, in Florida, boil down to the factual issue of reasonableness (discussed below).¹⁷

Florida is home to 20 of the nation's 50 highest priced hospitals with “[m]arkups of...9.2-12.6 times the Medicare-allowable costs.”¹⁸ A recent review of these statistics was published with the alarming title *Florida Is the Nation's Capital for Hospitals That Price Gouge Patients*.¹⁹

On average, commercial insurers pay hospitals 1.6 times Medicare rates.²⁰ When Florida hospitals charge 9.2 to 12.6 times Medicare reimbursement rates, that equates to 5.75 to 7.9 times more than their reasonable rates as negotiated with commercial health insurers. For example, for services having a Medicare reimbursement rate of \$9,460, a hospital would bill a commercial insurer 1.6 times that amount or \$15,000. If the bill is not covered by any insurance, the \$15,000 amount would jump to between \$87,032 and \$119,196, billed directly to the hospital patient.

Average charge master pricing at Florida hospitals is a minimum of 500 percent of Medicare allowable amounts (which amounts to roughly three to four times more than hospitals negotiate as reasonable rates with commercial health insurers). The chart below illustrates typical Medicare allowable rates verses average Florida hospital charge master rates.²¹

Diagnosis	Avg. Charge Master Price	Total Medicare Allowable
Transient Ischemia	\$30,192.00	\$4,724.00
Simple Pneumonia and Pleurisy	\$52,865.00	\$9,380.76
Major Cardiovascular Procedures	\$118,169.12	\$21,269.39
Perm. Cardiac Pacemaker Implant	\$86,717.42	\$16,268.58
Chest Pain	\$25,559.37	\$3,626.24
Laparoscopic Cholecystectomy	\$70,545.43	\$10,699.04
Back and Neck Proc. Exc. Fusion	\$51,584.65	\$6,881.58
Infectious and Parasitic Diseases W O.R. Procedure	\$180,708.87	\$35,452.36

List charges for clinical laboratory tests (such as blood and urine), whether performed at a hospital or independent lab, follow an even more extreme list pricing pattern than general hospital charges. Laboratory list prices are rarely published and there are no current industry-wide studies analyzing costs and charges. A comprehensive statewide study of hospital lab charges was, however, done in California. As *The Washington Post* reported:²² “The researchers weren't able to do a national analysis because the data are so difficult to find, and many states and hospitals don't make their charges publicly accessible. But the results . . . would likely be similar across the rest of the country.”

Researchers at the University of California analyzed prices at 160 to 180 California hospitals in 2011 for 10 common blood tests and found wild variations:

The median charge for a basic metabolic panel, which measures sodium, potassium and glucose levels, among other indicators, was \$214. But hospitals charged from \$35 to \$7,303, depending on the facility....The biggest range involved charges for a lipid panel, a test that measures cholesterol and triglycerides, a type of fat (lipid), in the blood. The median charge was \$220, but costs ranged from a minimum of \$10 to a maximum of \$10,169. Yes, more than \$10,000 for a blood test that doctors typically order to check the cholesterol levels of older adults.²³

Quest Diagnostics is a publicly traded commercial lab whose website states that it “[s]erves about half of the physicians and hospitals in the U.S.”²⁴ In California, a whistleblower lawsuit was filed against Quest in 2005, alleging it gave illegal kickbacks to doctors, hospitals, and clinics in the form of discounted or free testing in order to induce them to refer Medicaid patients to Quest. (California's Medicaid program is known as Medi-Cal). Medicaid rates are so profitable Quest apparently paid kickbacks to obtain the business and settled the lawsuit by agreeing to pay \$241 million to the State of California.²⁵ An

overcharge cited as an example in the settlement announcement is that “Quest charged Medi-Cal \$8.59 to perform a complete blood count test, while it charged some of its other customers \$1.43.” Theranos, a startup lab for self-pay patients currently operating in Walgreens locations in Arizona and California is offering the same test directly to consumers for \$5.35.²⁶ For comparison, as far as list price billing to an uninsured person, one of the few independent labs posting list prices online states that its list price for the same test is \$131.²⁷

A recent study by the Department of Health and Human Services compared Medicare allowable prices for lab charges to the negotiated prices paid for 20 high-volume and/or high-expense lab tests by other health insurers.²⁸ According to this study, the prices paid by Medicare are not paltry, but may in fact be above fair market value: “Medicare could have saved \$910 million, or 38 percent, on these lab tests if it had paid providers at the lowest established rate in each geographic area.”²⁹

Under Florida Law, Patients Are Only Obligated to Pay a Reasonable Amount for Services Provided

Florida has some of the best developed caselaw to the effect that regardless of the wording of an agreement signed by a patient upon hospital admission (whether the patient is admitted in emergency condition or otherwise), the patient is not obligated to pay more than a reasonable amount for the services provided. In *Mercy Hospital v. Carr*, 297 So. 2d 598 (Fla. 3d DCA 1974), *cert. denied*, 307 So. 2d 448 (Fla. 1974), upon admission the patient signed an agreement to pay the hospital: “all charges...in accordance with existing standard and current rates as set forth in regular schedules which are available for inspection and review.”

Carr reversed a summary judgment in favor of the patient, finding that the admission contract was “not unenforceable for uncertainty because the method of determining the amount of the bill was defined in the instruments.”³⁰ However, in remanding the case for trial on the issue of damages, without citation of any authority, the court held that the patient was not liable for the amounts billed per the hospital’s “standard” rates and was entitled to “question the reasonableness” of the hospital’s charges.

Two decades later, the First DCA expressly adopted the holding in *Carr* and held in *Payne v. Humana Hospital*, 661 So. 2d 1239, 1241 (Fla. 1st DCA 1995), that “[a] patient may not be bound by unreasonable charges in an agreement to pay charges in accordance with ‘standard and current rates....’ Humana thus is limited to reasonable compensation.” *Payne* rejected Humana’s argument that the express terms of the contract at issue incorporated the pricing set forth in Humana’s charge master and, therefore, the express pricing term in the contract cannot not be overridden to imply a reasonableness requirement. The court noted: “The charge master is reported at oral argument to be a document of hundreds of pages, in code.”³¹

In *Giacalone v. Helen Ellis Memorial Hospital*, 8 So. 3d 1233 (Fla. 1st DCA 2009), an uninsured patient was admitted to the hospital on an emergency basis in need of a pacemaker. He signed a standard admission form agreeing “to pay the account at the hospital in accordance with the regular rates and terms of the hospital.” Following a three-day hospitalization, the patient objected to the \$52,281 he was billed. The hospital filed suit to collect. Mr. Giacalone asserted the affirmative defenses of unconscionability (based on unreasonable pricing), lack of mutual assent, fraudulent nondisclosure, and undue influence. He also counterclaimed, alleging unfair or deceptive trade practices, breach of contract (implied covenants of good faith and fair dealing), and for declaratory relief. As the court observed: “The central theme of Mr. Giacalone’s defenses and counterclaims was that the [h]ospital’s charges for its services were unreasonable and unconscionable.”³²

Mr. Giacalone sought a writ of certiorari to quash the circuit court’s order denying his motion to compel responses to discovery requests. Mr. Giacalone sought discovery of the hospital’s charges to various categories of patients, including self-pay patients, Medicare patients, Medicaid patients, and privately insured patients, as well as the hospital’s cost structure. In granting the petition for writ of certiorari and quashing the circuit court’s protective order, the district court explained that denial of Mr. Giacalone’s motion to compel impaired his ability to obtain information relevant to the claim of unreasonable pricing, which includes “the usual and customary rate Mercy charges and receives for its hospital services; and Mercy’s internal cost structure....”³³

As a condition to participation in the Medicare program, federal law requires hospital emergency departments to provide emergency treatment to individuals regardless of ability to pay.³⁴ To protect Florida HMO subscribers when they find themselves in a hospital outside their HMO network, Florida law requires HMOs to pay for a subscriber’s emergency medical services to the extent of the lesser of F.S. §641.513(2): “(a) The provider’s charges...[or] (b) *the usual and customary provider charges* for similar services in the community where the services were provided....”³⁵

In *Baker County Medical Services d/b/a Ed Fraser Memorial Hospital v. Aetna Health, et al.*, 31 So. 3d 842 (Fla. 1st DCA 2010), the hospital commenced an action against Aetna and Humana HMOs for payment of bills due for emergency services rendered to their subscribers. The hospital was out of network and sought payment of its full list prices as set forth in its charge master. It argued that the statutory phrase “usual and customary provider charges” in the Florida Statute³⁶ mandates payment of its charge master rates.

Baker construes “usual and customary provider charges” as meaning the “fair market value” of the services rendered: “In the context of the statute, it is clear what is called for is the fair market value of the services provided. Fair market value is the price that a willing buyer will pay and a willing seller will accept in an arm’s-length transaction.”³⁷

The court’s analysis of the phrase “usual and customary provider charges” should govern the determination of the reasonable amount due from Florida patients who have no insurance coverage as well. This terminology, with immaterial variations, is the language used in standard hospital admission agreements signed by patients.

The district court in *Baker* was inescapably led to its holding by simply reviewing the definitions of the words. A hospital’s usual and customary charges are the amounts it actually negotiates and collects based upon experience determined on a community wide basis:

“Charge” is defined as a “price, cost, or expense.” Black’s Law Dictionary 248 (8th ed. 2004). In paragraph (5)(a), the term “charge” is modified by the terms

"usual and customary." "Usual" is defined as "ordinary; customary" and "expected based on previous experience...." "Customary" is defined as "a record of all of the established legal and quasi-legal practices in a community...."³⁸

Is "List Price" Billing Actionable Fraud?

Hospitals continue to assert that their regular, usual, standard, or customary charges are the list prices as set forth in their charge masters. However, in actuality, because those prices are infrequently billed to anyone, applying plain-English definitions as the district court did in *Baker*,³⁹ it is incorrect to characterize charge master prices as "usual," "customary," "regular," or any similar adjective.

The following hypothetical serves to illustrate this point: Assume a plumber advises prospective new customers that his regular, usual, standard, or customary charge for replacement of a toilet is \$2,000. However, in actuality, the plumber charges customers who negotiate the fee with him in advance, which is 86 percent of his customers, the "discounted" amount of \$400. In plain English, the \$2,000 pricing is "different," "abnormal," "uncommon," "exceptional," "anomalous," "divergent," "rare," and "atypical," all words that are antonyms of "regular," "usual," "customary," "ordinary," or "standard."⁴⁰

Healthcare providers invoice patients who do not negotiate a price in advance (*i.e.*, the roughly 14 percent of Floridians for whom no insurance coverage is applicable),⁴¹ exactly the same as the dishonest plumber — a significant multiple of charges billed to the vast majority of patients. What providers claim is the net "discounted" price to insurers is really their "standard" price.

When a provider represents that charge master list prices that it intends to bill are its regular, usual, standard, or customary charges, the provider is arguably making a false representation with the intent to mislead the patient. Florida law recognizes a cause of action for promissory fraud when a promise is made with no intention to perform.⁴² When such a promise is made, a cause of action arises for fraud in the inducement for which punitive damages may be awarded: "The overwhelming weight of authority in this state makes it clear that proof of fraud sufficient to support compensatory damages necessarily is sufficient to create a jury question regarding punitive damages."⁴³ Fraud in the inducement to make a contract is not barred by the economic loss rule. It is an independent tort that requires proof of facts that are distinct from the allegations of a breach of contract.⁴⁴ Stated differently, inducing a party to enter into a contract by misrepresenting a material fact on which the party justifiably relies to its detriment constitutes an independent tort.⁴⁵

As a result of the recently available hospital pricing information, the economics of hospital charge master billing is currently well known and infamous. The usual hospital list price or charge master billing fact pattern fits well within the elements required to plead fraud in the inducement, consisting of:

- (1) misrepresentation of a material fact (*i.e.*, the patient will be billed standard, regular rates and those rates are stated in the hospital's charge master);
- (2) the maker of the misrepresentation knew or should have known of the statement's falsities;
- (3) intent by the maker of the statement that the representation induce another to rely and act on it (*i.e.*, the patient agrees to be admitted or treated); and
- (4) resulting injury to the party acting in justifiable reliance on the representation (*i.e.*, the patient is billed a multiple of regular, standard rates charged to the vast majority of patients).⁴⁶

It should be noted that when approached in a nonemergency setting, a substantial portion of providers are willing to offer competitive cash prices to the uninsured, comparable to negotiated rates paid by commercial insurers.⁴⁷ When involved in a billing dispute, it is important to conduct discovery regarding provider pricing for uninsured patients who request a cash price in advance. The same hospital, which is pursuing a charge master price against an uninsured patient, likely has a policy of offering a legitimate market-based competitive rate if contacted in advance by a patient seeking to negotiate cash payment. Such a fact tends to establish that the provider is taking advantage of patient ignorance or medical emergency to impose unreasonable charges.

Consumer Protection for Patients

The lack of consumer protections for healthcare stands in stark contrast with consumer protection in other less important contexts, such as:

- *Motor Vehicle Repairs* — F.S. §§559.901-559.9221 regulates the billing of consumers by vehicle repair shops. The law includes the requirement of detailed written estimates containing, inter alia, a breakdown of all parts and labor and guarantees, procedure to be employed where a repair charge exceeds the estimate by more than 10 percent, including a right to cancel the work and civil remedies. The law also makes it unlawful for a repair shop, inter alia, to "[m]ake...any written or oral statement which is untrue, deceptive or misleading...." A state website publicizes a consumer's rights and a link to file a complaint.⁴⁸
- *Gas Prices* — Florida closely regulates the posting of gas prices, including the size of the numerals for fractions of pennies. F.S. §526.111. Florida counties have also passed ordinances mandating disclosure of cash versus credit gas prices.⁴⁹ The attorney general of the State of Florida has posted a notice regarding gasoline prices, stating: "It is the responsibility of the [a]ttorney [g]eneral to initiate inquiries into, or respond to citizen complaints of, unexplained price hikes which could be the result of anti-competitive behavior."⁵⁰
- *Truth in Lending* — The Truth in Lending Act is a federal law designed to promote the informed use of consumer credit.⁵¹ Among other things, the act requires disclosures and standardizes the manner in which costs are calculated. The act also gives consumers the right to cancel certain credit transactions, regulates credit card practices, and provides a means of resolution for credit billing disputes.
- *Prohibition of Price Gouging* — F.S. §501.160 prohibits "unconscionable" prices for any essential commodity during a state-declared emergency. An unconscionable price is defined as an amount that represents a "gross disparity" between the price of the commodity charged and the average price of the same item during the 30 days immediately prior to the declared emergency.

State and federal authorities universally acknowledge that billing by healthcare providers is riddled with fraud, yet the customary kinds of protections consumers have come to expect are glaring in their absence. The critical need to protect the government treasury from health fraud is acknowledged — but not the need to protect patients: “Those intent on abusing the system can cost taxpayers billions of dollars....”⁵² To combat Medicare fraud, the U.S. government created the Health Care Fraud Prevention Partnership, a public-private forum for the federal government and private and state organizations, including insurers, to prevent Medicare health fraud on a national scale.⁵³

While leaving this state’s citizens to fend for themselves, on June 18, 2015, Florida’s attorney general triumphantly announced the “Largest National Medicare Fraud Takedown in History Results in 73 Individuals Charged in South Florida,” stating,⁵⁴ “The charges in South Florida are part of a nationwide takedown by Medicare Fraud Strike Force operations in 17 cities that resulted in charges against 243 individuals, including more than 46 doctors, nurses, and other licensed medical professionals, involving approximately \$712 million in false billings.”

A cynical person might be forgiven for believing the lack of consumer protection for citizens is attributable to lobbying expenditures by doctors, hospitals, insurers, and the pharmaceutical industry, which dwarf the combined lobbying of the defense, aerospace, oil, and gas industries.⁵⁵

At the least, two steps must be taken to protect healthcare consumers. First and foremost, it should be unlawful for insurers and providers to include gag provisions in their contracts, prohibiting the disclosure of negotiated rates. Effective January 1, 2015, the State of California passed such legislation.⁵⁶ Florida, along with at least 44 other states have failed to require meaningful transparency for healthcare pricing.⁵⁷

The healthcare industry has relied on a number of arguments in resisting price transparency. One argument is that price transparency may actually increase costs by allowing providers with low insurance reimbursement rates to learn of higher rates negotiated by competitors, thereby aiding them in seeking rate increases.⁵⁸ It has also been asserted that patients may associate higher price with higher quality. Therefore, it is argued that price transparency may have the opposite of the intended effect by motivating individuals to obtain higher priced medical services in the belief that such services are of higher quality.⁵⁹ In this author’s opinion, these assertions irreconcilably conflict with the fundamental economic philosophy, which has generally proven effective in every other industry, to wit: free and transparent markets result in efficient pricing of goods and services.

With high-deductible plans, the patient may pay out of pocket 100 percent of their insurer’s allowed rates for a hospital bill. However, it is generally not possible for a patient to access any database to shop the allowed rates their insurer has contracted to pay all in-network providers in a given geographic area. Likewise, in shopping for insurance, the confidentiality clauses in provider contracts prevent the patient from considering the different reimbursement rates alternate insurance plans have negotiated with providers.

An insurance policy providing low reimbursement rates to providers may offer the best value because the insured will have lower medical bills to pay before deductibles are satisfied.

Florida, similar to other states, has an extensive regulatory scheme for all aspects of the insurance business and has adopted a Policyholders’ Bill of Rights.⁶⁰ Contracting to maintain reimbursement rates as nonpublic is in direct conflict with the first item in the Policyholders’ Bill of Rights: “*Policyholders shall have the right to competitive pricing practices and marketing methods that enable them to determine the best value among comparable policies.*”⁶¹

To determine the best value “among comparable policies,” citizens must be able to compare the reimbursement rates for which they, as the insured, would be liable to in-network providers under alternative policies.

Requiring publication of reimbursement rates would also have the benefit of empowering patients to learn market rates so that they are empowered to protect themselves from price gouging by shopping. Such transparency would impair the ability of providers to charge uninsured patients, or those who obtain out-of-network services, a multiple of the rates they have negotiated to accept from insurers. The patient, or a court, would be able to easily determine the fair market, reasonable value of the services from publicly available information.

The second essential action to protect patients is to require written cost estimates (in the absence of legitimate critical urgency). Providers must be required to disclose prominently a cost estimate on treatment and/or the admission forms, analogous to the requirements for vehicle repair shops, credit transactions, or gas purchases. The patient would then have reasonable disclosure and an opportunity to check prices elsewhere. If the actual provider invoice exceeds the estimate, in any subsequent litigation, the burden of proof should fall upon the provider to establish that the total charge does not exceed fair market value based upon negotiated prevailing rates actually charged in the community. If there are charges that were not anticipated by a provider at the time of estimate and approved by the patient, fairness dictates that the burden of establishing reasonableness should be placed upon the provider. In an emergency situation, when neither provider nor patient has an opportunity to estimate cost, the approach of existing Florida caselaw obligating the patient to pay a reasonable amount is satisfactory, particularly once negotiated rates are publicly available.

Conclusion

Healthcare is unaffordable because providers are lawfully permitted to shield themselves from price transparency and, hence, price competition. Transparency is essential to foster a healthy, efficient, free-enterprise marketplace for healthcare. Because healthcare is essential and citizens routinely encounter excessive charges, consumer protections must be enacted. Since health insurance rates are merely a function of underlying medical costs, the way to ameliorate rising insurance rates is to focus on underlying healthcare provider charges and to take the legislative action necessary to create a free and competitive market for healthcare services.

¹ Louis D. Brandeis, *Other People’s Money, What Publicity Can Do*, Ch. 5 at 92 (1932). First published in Harper’s Weekly, Dec. 20, 1913.

² For example, Mount Sinai Hospital in Miami Beach stated that it was unable to fulfill a promise to publish the amounts commercial insurers contracted to pay the hospital: “. . . confidential terms within the contracts — what he calls a ‘gag clause’ — have prevented his institution from doing so. Mount Sinai officials contacted all of their insurance carriers to release the information, but the insurers refused to grant Mount Sinai permission to disseminate the rates.” Bob Herman, *Post Your Price: It's Not So Simple for Hospital Executives*, Becker's Hospital Review, Mar. 3, 2014, available at <http://www.beckershospitalreview.com/finance/post-your-price-it-s-not-so-simple-for-hospital-executives.html>. See also Marlene Harris-Taylor, *Medical Fees Shrouded In Mystery*, The Blade, Apr. 5, 2015, available at <http://www.toledoblade.com/Medical/2015/04/05/Medical-fees-shrouded-in-mystery.html> (“The reimbursement contracts with medical providers are considered private, and all of the Toledo hospital systems said they cannot reveal to the public the terms of those contracts.”). Both insurers and medical providers have equivalent business interests in maintaining the secrecy of pricing. Both argue that the prices they pay and charge, respectively, are business secrets and that publicly disclosing those rates would hurt their bargaining positions and jeopardize their finances. For example, insurers do not want relatively low-paid medical providers to learn the higher rates they have negotiated with some medical providers. Likewise, hospitals do not want to disclose the rates, which they have agreed to accept for their services from the low paying insurers.

³ James Knvaal, Center For American Progress, *The Economic Imperative for Health Reform* at 1 (2008), available at https://cdn.americanprogress.org/wp-content/uploads/issues/2008/12/pdf/health_imperative.pdf.

⁴ Centers for Medicare and Medicaid Services, <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/nationalHealthAccountsHistorical.html>.

⁵ David U. Himmelstein, M.D., et al, *Medical Bankruptcy in the United States, 2007: Results of a National Study*, 20 The American J. of Medicine (No. 10 2009).

⁶ Department of Commerce (Bureau of Economic Analysis), <http://www.gpo.gov/fdsys/pkg/ERP-2013/pdf/ERP-2013-table16.pdf>.

⁷ *Id.*

⁸ Patient Protection and Affordable Care Act, 42 U.S.C. §18001, et seq. (2010).

⁹ The Affordable Care Act (ACA) requires health insurers to spend 80 percent of their premiums (after subtracting taxes and regulatory fees) on medical costs (for large groups it is 85 percent of premiums). 45 C.F.R. §158. A doubling of underlying medical costs leads to a doubling of premiums and, therefore, a doubling of the dollar amount of potential insurer profits under the ACA. The ACA, thus, aligns the financial interests of health insurers with the financial interests of providers in higher prices for medical care.

¹⁰ See, e.g., Medicare Payment Advisory Commission, *A Data Book: Health Care Spending and the Medicare Program* 79 (June 2014), available at <http://www.medpac.gov/documents/publications/jun14databookentirereport.pdf?sfvrsn=1> (“Rapid growth in charges may have little impact on hospital financial performance because few patients pay full charges.”).

¹¹ Melinda Beck, *How to Bring the Price of Health Care into the Open*, Wall Street J., Feb. 23, 2014, available at <http://www.wsj.com/articles/SB10001424052702303650204579375242842086688>.

¹² Jeffrey Young & Chris Kirkham, *Hospital Prices No Longer Secret As New Data Reveals Bewildering System, Staggering Cost Differences*, Huffington Post (May 8, 2013), available at http://www.huffingtonpost.com/2013/05/08/hospital-prices-cost-differences_n_3232678.html.

¹³ Elisabeth Rosenthal, *As Hospital Prices Soar, a Stitch Tops \$500*, The New York Times, Dec. 2, 2013, available at <http://www.nytimes.com/2013/12/03/health/as-hospital-costs-soar-single-stitch-tops-500.html?pagewanted=all>.

¹⁴ Ken Terry, *What Do Hospitals Really Charge? No One Knows, Even With Posted Prices*, CBS News, Money Watch, May 14, 2011, available at <http://www.cbsnews.com/news/what-do-hospitals-really-charge-no-one-knows-even-with-posted-prices/>.

¹⁵ Steven Brill, *Bitter Pill: Why Medical Bills Are Killing Us*, Time Magazine (Feb. 20, 2013).

¹⁶ E.g., Centers for Medicare and Medicaid Services, *New Medicare Data Available To Increase Transparency On Hospital Utilization*, June 1, 2015, available at <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-06-01.html>.

¹⁷ Courts routinely take judicial notice of government compiled statistics and official reports and publications of agencies of the United States. See *United States v. Orozco Acosta*, 607 F.3d 1156, 1164 n.5 (9th Cir. 2010). See also Fla. Evid. Code §90.803(8), which states an exception from hearsay for data compilations of public offices observed pursuant to a duty to report.

¹⁸ Ge Bai & Gerard F. Anderson, *Extreme Markup: The 50 U.S. Hospitals with the Highest Charge-to-Cost Ratios*, Health Affairs at 922-928 (2015).

¹⁹ Kyle Munzenrieder, *Florida Is The Nation's Capital for Hospitals that Price Gouge Patients*, Miami New Times, June 9, 2015, available at <http://www.miaminewtimes.com/news/florida-is-the-nations-capital-for-hospitals-that-price-gouge-patients-7672333>.

²⁰ On average nationwide, commercial insurance companies pay hospitals approximately 160 percent (i.e., 1.6 times) allowable Medicare reimbursement

rates, which is equivalent to approximately 150 percent of hospital costs. MedPAC Report to Congress: Medicare Payment Policy Ch. 3, *Hospital Inpatient and Outpatient Services* 67 (Mar. 2015), available at <http://www.medpac.gov/documents/reports/chapter-3-hospital-inpatient-and-outpatient-services-%28march-2015-report%29.pdf?sfvrsn=0>.

²¹ In 2015, the Center for Medicare and Medicaid Services announced the release of data, including hospital list prices (*i.e.*, charges) and Medicare actual payments for the 100 most common inpatient services by state averages and specific hospitals, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/>.

²² Lena H. Sun, *A Blood Test Can Cost from \$10 to \$10,000 In Calif. Hospitals, According To A Study*, The Washington Post, Aug. 16, 2014, available at http://www.washingtonpost.com/national/health-science/a-blood-test-can-cost-from-10-to-10000-in-calif-hospitals-according-to-a-study/2014/08/16/aba02472-24ae-11e4-8593-da634b334390_story.html.

²³ *Id.*

²⁴ Quest Diagnostics, Company Overview, <http://www.questdiagnostics.com/home/about/facts.html>.

²⁵ State of California Department of Justice, *Attorney General Kamala D. Harris Announces \$241 Million Settlement with Quest Diagnostics* (May 19, 2011), available at <https://oag.ca.gov/news/press-releases/attorney-general-kamala-d-harris-announces-241-million-settlement-quest>; Roxanne Palmer, *LabCorp Reaches \$49.5M Deal To End Medi-Cal Fraud Suit*, Law360, Aug. 30, 2011, available at <http://www.law360.com/articles/268518/labcorp-reaches-49-5m-deal-to-end-medi-cal-fraud-suit> (California entered into a settlement with Labcorp for \$49.5 million as well).

²⁶ Theranos, <https://www.theranos.com/test-menu>.

²⁷ HonorHealth, Average Prices for Laboratory Procedures at HonorHealth Facilities in Phoenix, <https://www.honorhealth.com/patients-visitors/average-pricing/laboratory-procedures-phoenix>.

²⁸ Department of Health and Human Services, Office of Inspector General, *Comparing Lab Test Payment Rates: Medicare Could Achieve Substantial Savings*, June 2013, available at <http://oig.hhs.gov/oei/reports/oei-07-11-00010.pdf>.

²⁹ *Id.*

³⁰ *Carr*, 297 So. 2d at 599.

³¹ *Payne*, 661 So. 2d at 1239, n. 3.

³² *Giacalone*, 8 So. 3d at 1234.

³³ *Id.* at 1235.

³⁴ 42 U.S.C. §1395dd.

³⁵ Emphasis added.

³⁶ Fla. Stat. §641.513(2).

³⁷ *Baker*, 31 So. 3d at 845.

³⁸ *Id.*

³⁹ *Id.*

⁴⁰ Antonyms for “standard” listed at Thesaurus.Com, <http://www.thesaurus.com/browse/standard?s=t>.

⁴¹ Fourteen percent of Florida’s citizens are uninsured. See Michael E. Martinez & Robin A. Cohen, National Center for Health Statistics, *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, Jan.-Sep. 2014* at 26, table 15 (Mar. 2015), available at <http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201503.pdf>.

⁴² *Connecticut General Life Ins. Co. v. Jones*, 764 So. 2d 677 (Fla. 1st DCA 2000).

⁴³ See *First Interstate Dev. Corp. v. Ablanedo*, 511 So. 2d 536 (Fla. 1987).

⁴⁴ *HTP, Ltd., v. Lineas Aereas Costarricenses, S.A.*, 685 So. 2d 1238 (Fla. 1996).

⁴⁵ *Poag v. Haring*, 696 So. 2d 1363 (Fla. 2d DCA 1997).

⁴⁶ *Palumbo v. Moore, et al.*, 777 So. 2d 1177 (Fla. 5th DCA 2001). To establish the element of damage, it may be necessary to pay the disputed hospital bill. See, e.g., *Colomar v. Mercy Hosp., Inc.*, 461 F. Supp. 2d 1265, 1273 (S.D. Fla. 2006): "If [p]laintiff has not yet paid any more than she alleges the services cost, then this will likely have a bearing on what damages, if any, she can ultimately recover."

⁴⁷ Tenet Health, a public company operating 11 hospitals in Florida (following a class action settlement for price gouging the uninsured), currently limits charges to "...rates equivalent to the hospital's current managed care rates, which are substantially discounted from retail or gross charges." See Tenet Health, Compact with Uninsured Patients, <https://www.tenethealth.com/docs/default-source/documents/compact-with-uninsured-patients.pdf?sfvrsn=2>. Hospitals generally offer deep discounts to patients proposing to pay cash up front. This is a logical strategy for hospitals to obtain profitable business, particularly considering that the average census (occupancy) of hospitals is approximately 60 percent. See Chad Terhune, *Many Hospitals, Doctors Offer Cash Discount For Medical Bills*, Los Angeles Times, May 27, 2012, available at <http://articles.latimes.com/2012/may/27/business/la-fi-medical-prices-20120527>.

⁴⁸ Florida Department of Agriculture and Consumer Services, Motor Vehicle Repair, <http://www.freshfromflorida.com/Divisions-Offices/Consumer-Services/Consumer-Resources/Consumer-Protection/Motor-Vehicle-Repair>.

⁴⁹ E.g., The Association for Convenience and Fuel Retailing, *Palm Beach County Requires Clarity for Gas Prices* (Apr. 23, 2014), <http://www.nacsonline.com/News/Daily/Pages/ND0423143.aspx#.VZ7tDvmbm4>.

⁵⁰ Attorney General Pam Bondi, Gasoline Prices — The Attorney General's Role, <http://myfloridalegal.com/pages.nsf/main/20199E8403864C6485256D02005BA9BF?OpenDocument>.

⁵¹ 15 U.S.C. §1601, *et seq.*

⁵² Department of Health and Human Services, *Medicare Fraud & Abuse*, ICN 006827 (Aug. 2014), available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Fraud_and_Abuse.pdf.

⁵³ *Id.*

⁵⁴ Attorney General Pam Bondi News Release, *Largest National Medicare Fraud Takedown in History Results in 73 Individuals Charged in South Florida* (June 18, 2015), available at <http://www.myfloridalegal.com/newsrel.nsf/newsreleases/4783A2FF14D0C4AC85257E6800616A53>.

⁵⁵ Steven Brill, *Bitter Pill: Why Medical Bills Are Killing Us*, Time Magazine, Feb. 20, 2013: "According to the Center for Responsive Politics, the pharmaceutical and healthcare-product industries, combined with organizations representing doctors, hospitals, nursing homes, health services and HMOs, have spent \$5.36 billion since 1998 on lobbying in Washington. That dwarfs the \$1.53 billion spent by the defense and aerospace industries and the \$1.3 billion spent by oil and gas interests over the same period. That's right: the healthcare-industrial complex spends more than three times what the military-industrial complex spends in Washington."

⁵⁶ California Legislative Information, California Health and Safety Code §1367.49, available at http://leginfo.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC§ionNum=1367.49.

⁵⁷ Bruce Japson, *Health Care Prices remain A Secret In Most States*, Forbes, July 8, 2015.

⁵⁸ See Morgan A. Muir, Stephanie A. Alessi & Jaime S. King, *Clarifying Costs: Can Increased Price Transparency Reduce Healthcare Spending?* 4 William & Mary Policy Review 319, 330 (2013), available at https://www.wm.edu/as/publicpolicy/wm_policy_review/Archives/Volume%204%20Issue%202/MuirAlessiKing_s13f.pdf.

⁵⁹ Peter Ubel, *How Price Transparency Could End Up Increasing Healthcare Costs*, The Atlantic, Apr. 9, 2013, available at <http://www.theatlantic.com/health/archive/2013/04/how-price-transparency-could-end-up-increasing-health-care-costs/274534/>.

⁶⁰ Fla. Stat. §626.9641.

⁶¹ Fla. Stat. §626.9641(1)(a) (emphasis added).

Steven I. Weissman served as president of an acute care hospital during 2013-14 and practices law in Cooper City. He has written articles appearing in *The Florida Bar Journal*, *Journal of State Taxation*, and *Trusts & Estates*, and served as an adjunct professor at both the University of Miami School of Law and Nova University Graduate Management Program. Weissman handles commercial matters and is of counsel to the Miami law firm Sinclair, Louis & Zaverntnik, P.A.

About the Bar

[President's Page](#)
[Board of Governors](#)
[Committees](#)
[Sections & Divisions](#)
[What We Do](#)
[Past Presidents](#)
[Frequently Asked Questions](#)
[History](#)
[Strategic Plan & Research](#)
[Working at the Bar](#)
[Contact Us](#)
[Diversity](#)
[Leadership Academy](#)

News, Events & Publications

[Daily News Summary](#)
[The Florida Bar News](#)
[The Florida Bar Journal](#)
[News Releases](#)
[Calendars](#)
[Meetings](#)
[Media Resources](#)
[Reporter's Handbook](#)
[Issue Papers](#)
[Publications](#)

For the Public

[Attorney Discipline](#)
[Consumer Information](#)
[Speakers Bureau](#)
[Courts](#)
[The Vote's in Your Court](#)
[Fair & Impartial Courts](#)
[Clients' Security Fund](#)
[Prepaid Legal Services](#)
[Pro Bono/Legal Aid](#)
[Unlicensed Practice of Law](#)
[Lawyer Referral Service](#)

Member Services

[Continuing Legal Education](#)
[Board Certification](#)
[Benefits and Discounts](#)
[Employment Opportunities](#)
[Lawyers Advising Lawyers](#)
[Florida Lawyers Assistance](#)
[E-filing Resources](#)
[Practice Resource Institute](#)
[Pro Bono Information](#)
[Legislative Activity](#)
[Lawyer Referral Service](#)
[Voluntary Bar Center](#)

Directories

[Lawyers](#)
[Authorized House Counsel](#)
[Certified Foreign Legal Consultants](#)
[Law Faculty Affiliates](#)
[Florida Registered Paralegals](#)
[Section Membership](#)
[Board Certified Lawyers](#)
[Florida Bar Staff](#)
[Courts and Judges](#)
[Legal Groups and Law Schools](#)
[Judicial Nominating Commission](#)

Research & Professionalism

[Ethics Opinions](#)
[Rules Regulating the Bar](#)
[Fastcase Legal Research](#)
[PRI - Practice Resource Institute](#)
[Henry Latimer Center for Professionalism](#)