Frank Fedor

contracted payers
the latest challengers to hospital billed charges

AT A GLANCE

The latest challenges to billed charges come from an unexpected source—the hospital's contracted payers. Understanding these challenges, and their legal basis, is important to protecting your hospital's contracts.

Hospital billed charges are the focus of many critics. Advocates for the underinsured complain about the disproportionate impact of full charges on those least able to pay them. The Department of Health and Human Service's Office of Inspector General proposes a new definition of "usual charges" to include discount rates that hospitals offer their contracting payers. State health plan regulators substitute the elusive concept of "usual and customary" hospital charges for a hospital's billed charges when setting up a regulatory framework to identify unfair payment practices to noncontracting providers.

The latest challenge to billed charges comes from an unexpected source—the hospital's contracted payers. The same plan that at the time of contracting promises to pay on the basis of a percentage of the hospital's billed charges will later say at the time of payment that billed charges are "unreasonable." A plan will examine the prices of individual items and argue that those prices are more than the items are reasonably worth. A plan will focus on the amount by which overall prices increase in a given time period, perhaps in comparison with aggregate increases at other hospitals. A plan will hire a "cost management" company to use its proprietary database to "reprice" the hospital's charges.

Understanding these challenges, and their legal basis, is important to protecting the hospital's contracts.

False Premises

These approaches all have fundamental false premises. They seek to substitute the business judgment of the plan for that of the hospital, but only in discrete aspects of management's overall responsibilities and without addressing how the hospital should make up the resulting reduction in revenue. They also seek to impose a

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term on a contract that was never sought during its negotiation or included in its language. These approaches raise the question, "What is the point of having contracts if the plan can treat them as mere scraps of paper and do as it pleases?"

Implied Contracts: Carte Blanche for Rewriting Contracts?

Plans cite the implied covenant of good faith and fair dealing as the legal basis of their claimed ability to rewrite their contracts. This covenant is implied in all contracts as a matter of law by almost all states. The concept of the implied covenant is that neither party will do anything to deprive the other party of the contract's benefits. It is intended to cover acts that may not be included expressly in the language of the contract, but that the contract presupposes the contracting parties will perform to accomplish the contract's purpose or refrain from performing because they conflict with that purpose. However, the parameters of the implied covenant must be drawn from the express terms of the contract and may not contradict those express terms.

Health plans focus on a particular type of implied covenant that operates to save the validity of a contract when one party's discretionary power to set the contract's price would otherwise make the contract void. The law does not recognize the validity of a contract when there is no agreed-upon price, the underlying theory being that the parties have not really agreed to anything when one of them is allowed to set and then change the price whenever he or she wants. Such absolute discretion, however, can be removed by implying an obligation to exercise price discretion in an objectively reasonable way.[a] Plans thus argue that because the hospital has the right to change its chargemaster rates (by increasing prices or changing the structure of its rates), the implied covenant requires that these changes be objectively reasonable.

The logic of this theory limits the aspect of the hospital's charges that may be challenged as being "objectively unreasonable." During negotiations, both parties conduct financial estimates of what the cost of proposed rates would be based upon recent past performance, and have the freedom not to contract if the results of these estimates are unsatisfactory or either party is not given enough information to make its estimates. Consequently, there is no basis upon which to challenge the objective reasonableness of the chargemaster at the time of contracting. In other words, the hospital exercised no pricing discretion that the plan had the option to reject by not contracting.

The limit of this theory is thus restricted to the hospital's exercise of price discretion after the contract was made—for example, charge restructuring and price increases. Any restructuring of the chargemaster that has a revenue-neutral goal (though it may be combined with a price increase) is objectively reasonable. Hospital price increases that are tied to increases in costs and the need to make a reasonable margin are also objectively reasonable.

Price increases should also be viewed in the aggregate to take into account market forces that result in different markups for different items. If challenged, the hospital should present the testimony of a financial officer explaining the particular cost drivers of the hospital, the reasonable profit the hospital makes as a result of its charges, and the absence of any explanation by the plan as to how the hospital would keep its doors open with the reduction in its charges that the plan would impose.

Moreover, although a narrow focus on the percentage of the hospital's annual increase in chargemaster prices may at first glance seem to show exceptionally steep price increases, it ignores the unique role that percentage-of-charges rates play in allowing a

hospital to annually increase revenue to cover increased costs.

For example, if a hospital's costs rise 7 percent, if 80 percent of its revenue comes from non-charge-based sources (e.g., government payers or per diem commercial contract rates), and if those non-charge-based sources will agree to only a 4 percent increase, then the hospital would have to increase its chargemaster prices 19 percent to achieve additional revenue just to cover its 7 percent cost increase.[b] Indeed, the same plan that complains of the hospital's "high" annual price increases is often a cause of those increases by insisting on a rate structure that results in most claims being paid by a flat per diem rate. The rate stays the same year after year, and leaves only a relatively small percentage of claims to be paid by a stop-loss rate through which the hospital may, by raising its prices, annually increase revenue to cover higher costs. Flat per diem rates are of course as much of a negotiated benefit for the plan as is the right to raise prices to cover cost increases for the hospital.

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The hospital should also challenge whether the implied covenant of objective reasonableness in exercising price discretion can legally be applied in the context of the contract's express terms. The hospital should argue that its pricing discretion is already limited. The chargemaster rates must be uniformly billed to all payers and the hospital does not have discretion to increase its "billed charges" to only one health plan.

The hospital can also point out that because the percentage-of-charges rate is but one of a package of other fixed rates, there is no legal necessity to imply a covenant of objective reasonableness. In *Third Story Music Inc. v. Waits*,[c] musician Tom Waits argued that a contract wherein he gave the rights to his musical output to a promoter in return for the promoter's promise to promote *or not promote* it legally required the implication of a covenant that the promoter make reasonable efforts to promote the music. The court held that no such covenant could be implied because the contract was also supported by the adequate consideration of annual flat payments to Waits. The promise to promote his music was not the sole consideration for the contract.

In a typical managed care contract, a stop-loss rate of a percentage of charges will apply only after the stop-loss threshold is reached. Before the threshold is reached, per diem or other flat rates apply. As with the annual flat payments to Waits, these nondiscretionary rates should provide adequate consideration for the contract to prevent it from being illusory.[d]

A deal is still a deal. If a health plan wants to use doublespeak to breach its contract, the hospital need not retreat. It can use facts and the law to enforce its contract. ●

a. *California Lettuce Growers v. Union Sugar Co.*, 45 Cal.2d 474 (1955).
b. Eighty percent of fixed/negotiated non-charge-based payments times a 4 percent increase in revenue equals 3.2 percent of the 7 percent revenue increase needed to cover the 7 percent increase in cost. Twenty percent of charge-based payments must increase by 19 percent to achieve the remaining 3.8 percent of the 7 percent cost increase (20 X 19 percent price increase = 3.8 percent of increased revenue).
c. 41 Cal. App. 4th 798 (1996).
d. See also *Seaview Orthopaedics v. National Healthcare Resources, Inc.*, 841 A.2d 917 (Superior Court of New Jersey Appellate Division 2004), pointing out that whether a contract is illusory is determined by the totality of the exchange of promises and benefits. In this case, the healthcare provider could not be excused from the auto accident component of a preferred provider contract even if it received no benefit from that aspect of the contract because the provider received other valuable benefits from the remaining parts of the contract.

Frank Fedor, JD, is a partner with Murphy Austin Adams Schoenfeld, LLP, Sacramento, Calif., and a member of HFMA's Northern California Chapter. Questions or comments about this article may be sent to him at ffedor@murphyaustin.com.