

Frank P. Fedor

## reasonable value of noncontracted emergency services 3 health plan myths

### AT A GLANCE

The market sets the "reasonable value" of noncontracted emergency services. In the market for hospital services, payers obtain a discount from full charges only when they purchase one by offering volume or other economic value in a contract.

**One of the most hotly disputed issues in managed care today is what should be paid for noncontracted emergency services.** A hospital has an obligation to provide, and a plan has an obligation to pay for, emergency services to all subscribers who present at the hospital with an emergency medical condition. When there is no contract to cover the encounter, hospitals expect their full charges. However, an increasing number of plans are looking for ways to pay less.

The common law of *quantum meruit* provides the answer to this issue. When a service is furnished without a contract, the law requires the recipient to pay the provider the reasonable value of the service to prevent the unjust enrichment of the recipient.

Although this law, which has existed for decades, was not developed for the healthcare industry, the application of *quantum meruit* to hospital charges has led to much confusion about how it should be applied to health care.

### **Myth No. 1: Reasonable Value of a Service Should Be Based Solely on Its Cost**

In an industry in which the market is allowed to set the price of goods and services, an examination of the direct and indirect costs, volume, and prices is all that is necessary to identify breakeven points of an enterprise and from there to calculate varying levels of profitability.

The U.S. healthcare industry has unique attributes that do not allow the use of this conventional analysis. Government payers and the uninsured make up over 60 percent of the "customers," all of whom pay at varying levels below the cost—not the price—of the goods and services they consume. Moreover, the distribution of customers who receive services at varying levels below cost varies greatly from hospital to hospital. Thus, the payer mix of varying government payers, uninsured,

and commercial payers, as well as a hospital's bad debt, must be added to the cost of the goods and services to analyze the reasonable value of a service.

If retail stores in the United States had to give free food, clothes, and camping equipment to the hungry, naked, and homeless who presented at their front door; offered a 21.5 percent discount from cost for those on welfare and in other "special categories"; offered a 16.7 percent discount from cost to those over 65; and had the additional charity care and bad debt experience of hospitals, the population that did not fall into these categories would pay much more than it currently does for a loaf of bread, a pair of socks, or a toothbrush.

**Myth No. 2: Payers Who Are Asked to Pay Full Charges for Noncontracted Emergency Services Are Being Asked to Pay More than Their Reasonable Value**

The law is clear that the *quantum meruit* reasonable value of a service is its value in the relevant market. "[T]he reasonable value of the [physician] services is ... the reasonable value of the services in the community where they were rendered, by the person who rendered them." (*Citron v. Fields* [emphasis added]). An approved jury instruction of reasonable value in a leading case is "the reasonable value of what it would have cost Defendant to obtain the services Plaintiff provided from another person" (*Maglica v. Maglica* [emphasis added]).

It is critical to understand that for the less than 40 percent of payers who are commercial payers, there is a market for hospital services. Emergency services are part of this market and also have a market value. Plans that contribute a volume of patients requiring a range of services obtain those services, including emergency services, at contract rates that are less than full charges. Such plans are "buying" these discounted rates by "paying" with a volume of patients that contributes to the hospital's profit margin through a larger number of patient days or patient encounters at a lower margin. Plans that choose not to contribute a larger volume of patients (either because they think they can obtain the services elsewhere for less or they want to provide the services themselves) pay full charges for noncontracted

emergency services and contribute at a lower number of days or encounters, but at a higher margin. This market has existed for decades.

The market value of emergency services is the hospital's full charges. When a plan pays less than full charges for emergency services, it is because the hospital and the plan, in an arm's-length negotiation, traded values (e.g., volume of patients for discounted prices) to reach a mutually acceptable contract. Fundamental tenets of a market economy are that the seller sets the price of what it sells, and that the only buyers who get the benefit of a contract rate are those who bargain and trade fair value for that discount. Under *Citron* and *Maglica*, the reasonable value of what it would have cost a plan to obtain emergency services "in the community where they were rendered" ... "from another person" is either the discounted price purchased by a contract that delivered volume, or the full-charges price chosen by the plan when it chose not to contract.

The California Department of Managed Health Care published a regulation effective Jan. 1, 2004, that identified factors a health plan should use to determine the value of noncontracted emergency services (Title 28, California Code of Regulations, Section 1300.71(a)(3)(B)). These factors are derived from the California case *Gould v. Worker's Compensation Appeals Board*, and are consistent, on their face, with California *quantum meruit* law. Indeed, five of the six factors listed in the regulation reflect that the reasonable value of a service is measured by its value in the market: "(ii) the nature of the services provided; (iii) the fees usually charged by the provider; (iv) prevailing provider rates charged in the general geographic area in which the services were rendered; (v) other aspects of the economics of the medical provider's practice that are relevant; and (vi) any unusual circumstances in the case." The only factor that does not apply is "(i) the provider's training, qualifications, and length of time in practice," and then only because it applies to physicians instead of hospitals. Applied to a physician, it also reflects a measure of market value.

The historical behavior of payers in paying full charges for noncontracted emergency services is the best evidence of this market value. To illustrate this

point, we can look at a closely related myth that because the law does not make a hospital's full charges presumptively reasonable, the "reasonable" value of the services must be something less. It certainly is true that there is no statutory or common law exemption from the law of *quantum meruit* for hospitals or anyone else. Indeed, for decades, plans always had a right to ask a court to apply principles of *quantum meruit* to the full charges that hospitals billed for noncontracted emergency services.

However, the truism that a hospital's billed charges for noncontracted emergency services are not presumptively the reasonable value of these services is not a reason to jump to the opposite conclusion that full charges are presumptively unreasonable. Throughout the history of the Knox-Keene Act in California, health plans had the right, under *quantum meruit* case law, to file a court action and prove that the hospital's full charges for noncontracted emergency services were more than the reasonable value of these services. Health plans, however, did not file these actions because they correctly understood that the law required the plan to show that it could purchase noncontracted hospital emergency services for less in the same community—that is, that the market price of noncontracted emergency services was less than the billed charges.

**Myth No. 3: The Plan Has No Choice but to Pay the Hospital's Full Charges**

A common plan argument is that it is an "unwilling" or "captive" party that has no choice but to pay full charges. Nothing could be further from the truth. A plan finds itself with an obligation to pay full charges for noncontracted emergency services solely as a result of the choices it made—for example, to expand

market share in the area where the services were furnished, or to not establish or contract with emergency clinics that can service the less acute emergency needs of its members. A plan is faced with a bill of full charges for noncontracted emergency services for one reason only: It has rationally decided that not to contract with that hospital for discounted rates was in the plan's financial interest.

Of course, health plans want to have their cake and eat it, too, by promoting the notion that discounted rates found in contracts negotiated between Hospital and Plan A should also be applied to Plan B—a non-party to the Hospital-Plan A contract—when Plan B wants the same service. When this argument is made, it is soundly rejected (*Huntington Hospital v. Abrandt*). The law is equally clear that a discount that Plan A (or any other buyer in any industry) negotiates with Hospital (or any other seller in any industry) is not required to be made available to other plans or persons (or other sellers in any industry) who have not paid their own consideration to purchase such a discount.

In sum, the law of *quantum meruit* reasonable value allows the health plan to make its own market-driven choice of whether to purchase a discount or pay full charges for emergency services with any particular hospital. This eliminates the issue of balance billing while still leaving the plan with its legal right to challenge the *quantum meruit* value of full charges in those cases in which the plan believes that this is cost-effective. Even when health plans comply with *quantum meruit*, too many hospitals lose money from operations and do not make enough of a profit to adequately fund maintenance and growth in the rapidly growing communities they serve. On the other hand, health plans continue to report higher profits than hospitals. ●

**CASES CITED**

Following are the citations for the cases referred to in this article:

- > *Citron v. Fields*, 30 Cal. App.2d 51, 62 (1938)
- > *Gould v. Worker's Compensation Appeals Board*, 4 Cal. App.4th 1059 (1992)
- > *Huntington Hospital v. Abrandt*, 4 Misc.3d 1, 779 N.Y.S.2d 891 (2004)
- > *Maglica v. Maglica*, 66 Cal. App.4th 442, 450 (1998) (approved jury instruction at fn 6)

Frank P. Fedor, JD, is a partner, Murphy Austin Adams Schoenfeld, LLP, Sacramento, Calif., and a member of HFMA's Northern California Chapter (ffedor@murphyaustin.com).