Health Care Reform: Presumptively Reasonable Rates for Necessary Medical Services

David Stahl*
HEALTH CARE REFORM: PRESUMPTIVELY REASONABLE RATES FOR NECESSARY MEDICAL SERVICES

DAVID STAHL*

I. INTRODUCTION ........................................................................................................... 175

II. BACKGROUND ........................................................................................................... 177
   A. Private Insurance ..................................................................................................... 177
      1. Health Maintenance Organizations ....................................................................... 177
      2. Preferred Provider Organizations ....................................................................... 178
   B. Personal Injury Protection ...................................................................................... 179
   C. Uninsured ................................................................................................................. 180

III. USUAL, CUSTOMARY, AND REASONABLE (UCR) CHARGES .................................. 181
   A. What Is a “Charge”? ............................................................................................... 182
   B. What Is “Usual and Customary”? .......................................................................... 183
      1. “Veil of Secrecy” .................................................................................................... 183
      2. Problems with Private Databases ........................................................................ 185
      3. A New Hope? ......................................................................................................... 187

IV. POTENTIAL SOURCES FOR ESTABLISHING REASONABLE CHARGES .................... 187
   A. Medicare Fee Schedules ....................................................................................... 188
   B. Workers’ Compensation ......................................................................................... 189

V. JUDICIAL DETERMINATION OF UCR ......................................................................... 190
   A. Lessons from Temple ............................................................................................. 190
   B. New Jersey PIP Case .............................................................................................. 191
   C. Florida HMO Cases .............................................................................................. 194

VI. UCR AND HIGHER HEALTH CARE COSTS ................................................................ 199

VII. CONCLUSION ............................................................................................................ 201

I. INTRODUCTION

A major medical emergency forces a person to seek care at the nearest hospital. Fortunately, or at least so the person believes, he or she has health insurance and will only have to pay a deductible and copay. But the insured may soon find out that he or she may be receiving bills from the medical

* David Stahl is a judicial clerk for the Honorable Cory J. Ciklin at Florida’s Fourth District Court of Appeal. He received his J.D. summa cum laude from Nova Southeastern University Shepard Broad Law Center in 2010, where he served as Editor-in-Chief of the Nova Law Review from 2009–2010. He also has a B.A in Biochemistry from Harvard University and an M.B.A from Florida Atlantic University. An earlier version of this article was written for Professor Kathy L. Cerminara’s Law and Medicine seminar, and he thanks her for her critical advice with this article.
providers far in excess of those amounts. The reason is not just that his or her insurance plan may require a higher copay and deductible when using out-of-network providers, but also because of a common provision in the insurance contract to only reimburse bills from out-of-network providers at a rate which the insurer deems to be "usual and customary." When a bill arrives a few months later, the insured will soon learn that there is a significant difference between what the insurer considers to be usual and customary and what the provider is charging the insured—sometimes the provider's charge will be more than twice what the insurer has determined to be usual and customary and the insured may be responsible for this difference.¹ The practice by providers of charging the insured for this difference is known as balance billing.² This article will examine ways that courts have dealt with disputes regarding "usual and customary" charges and explore ways that courts can help to make the determination more predictable for all of the interested parties—including the insured, the insurers, and the healthcare providers.

The difficulty in determining what is a "usual and customary" rate not only affects those whose insurance policies are limited to such coverage, but even those who have insurance which protects them from balance billing to the extent that this uncertainty is a contributing factor to the high premiums of their policies. State legislatures have in many cases left it to the courts to determine what the "usual and customary" rates for necessary medical services are, and this has inevitably led to litigation between insurers and providers. To resolve both the issue of balance-billing and inevitable disputes between providers and insurers, courts should establish a presumptive rate based on a measurable standard to ensure that patients, providers, and insurers all have reasonable expectations of what rates should be.

Part II of this article provides background information with regard to the types of situations where "usual, customary, and reasonable" charges remain uncertain. Part III explores the reasons courts have had difficulty in construing the meaning of "usual, and customary charges." Part IV discusses government insurance programs that limit reimbursement to maximum fee schedules as a potential reference point for courts in other contexts. Part V analyzes how courts have dealt with the uncertainty through a review of appellate cases. Finally, the article proposes that courts, unless prohibited by other statutory mandates, should recognize presumptively reasonable rates


https://nsuworks.nova.edu/nlr/vol35/iss1/7
ideally based on a government-run database, or alternatively based on Medicare rates.

II. BACKGROUND

There are several different contexts in which a dispute is likely to arise over the amount due for healthcare services that a provider has rendered. The first situation is in the context of private health insurance where the insurer and provider have not pre-negotiated a rate in advance of treatment. The second circumstance arises where an individual seeks medical attention following an automobile accident and the automobile insurer is responsible to pay for a portion of the services that have been rendered. Another circumstance is where an uninsured person seeks medical treatment.

A. Private Insurance

Over half the country is covered by private health insurance. The majority of these people are covered by either a health maintenance organization or a preferred provider organization. This article will limit its analysis of usual and customary charges to these two types of health insurance products.

1. Health Maintenance Organizations

A health maintenance organization (HMO) is a type of managed care insurance where the insured is limited to a closed network of doctors. Usually, the insured must have a primary care physician and usually must obtain a referral from that physician prior to seeing a specialist or seeking non-emergency care in a hospital. The HMO usually has contractual discounts with all of its network providers. An HMO member will not be reimbursed for seeking treatment outside the network of doctors or if he or

4. Id.
7. See id.
she does not follow the procedural requirements. There are two instances where a member may have no choice but to go out of network. The first is when the insured goes to a non-network facility in an emergency—or is brought to such a facility if unconscious or severely injured at the time. The second is when the insured has gone to a network facility, but a hospital-based physician—such as an emergency room doctor, an anesthesiologist, pathologist, or radiologist—who treats the insured is not part of the HMO network. Many states have either express statutory restrictions on balance billing HMO members or have determined that it is unlawful to do so through judicial construction of a state’s statutes. Although the HMO member is protected, the issue of usual and customary charges still exists as the provider and insurer must settle between them what the insured should reimburse the provider for the treatment.

2. Preferred Provider Organizations

A preferred provider organization (PPO) is a type of managed care that also consists of a network of contracted providers, similar to an HMO. The insurance company will have usually contracted significant discounted rates with the providers in its network. The insurance contract, however, will usually not require any referrals to see specialists or for extensive procedures. Furthermore, the plan will often cover the insured even if he or she chooses to visit an out-of-network provider—that is, one that has not con-
tracted with the insurance company.\textsuperscript{16} A plan may try to discourage members from visiting out-of-network providers by imposing higher out-of-pocket costs—via higher deductibles, copays, and out-of-pocket maximums or a combination thereof.\textsuperscript{17} The insurer will often also limit the amount that it will reimburse out-of-network providers to what the insurer deems to be the usual and customary charge for that service in a specific geographic area.\textsuperscript{18} The insured and the provider often are unaware of how this maximum fee is calculated by the insurance company.\textsuperscript{19} Where the insured has knowingly selected an out-of-network provider, the insured will have the opportunity to work with his or her insurance company to determine the reimbursement rate and to negotiate a rate with the out-of-network provider.\textsuperscript{20} The insured has no choice, however, when he or she goes to an out-of-network facility in an emergency situation, or where the insured goes to an in-network facility but is seen by a hospital-based physician who has not contracted with the insurer.\textsuperscript{21} The hospital-based physicians, such as emergency room doctors, anesthesiologists, pathologists, radiologists, and on-call specialists are often not hospital employees and will bill separately for their services.\textsuperscript{22} During his or her hospital stay, the insured has no choice as to which doctors will see him or her and may not learn until months after leaving the hospital that such providers were not part of his or her insurance network.\textsuperscript{23} As such, not only will he or she be surprised at the higher out-of-pocket responsibility, but may also be shocked to learn that the provider is also asking for the difference between what the insurance company called usual and customary and what the provider claims to be his or her usual charge.

\section*{B. \textit{Personal Injury Protection}}

States that have no-fault automobile insurance may require automobile drivers to carry Personal Injury Protection (PIP) to cover some portion of the

\begin{thebibliography}{99}

\bibitem{16} See \textit{Furrow et al.}, \textit{supra} note 5, at 564.
\bibitem{17} See \textit{id.}
\bibitem{19} See \textit{id.} at 4–5.
\bibitem{20} See \textit{Hoadley et al.}, \textit{supra} note 8, at 13.
\bibitem{21} See \textit{id.}
\bibitem{22} See \textit{id.} at 5.
\bibitem{23} See \textit{LaMendola}, \textit{supra} note 1.
\end{thebibliography}
medical fees for the driver and his or her passengers resulting from an automobile accident regardless of fault. 24 As automobile insurers are often not primarily health insurance companies, they may not have the resources to pre-negotiate rates with a significant number of providers in their coverage area. State legislatures, in their attempt to ensure that automobile insurance rates are affordable, will often specify the maximum fees that providers can charge when treating patients covered under the PIP schedule of an automobile insurance policy. 25 PIP statutory schemes without fixed schedules have produced litigation between automobile insurers and providers. 26 In New Jersey, for example, the statutory scheme required that a government agency establish the 75th percentile of usual and customary charges. 27 Originally, the agency only established such fees for a small number of services. 28 This led to extensive litigation and, according to the New Jersey Department of Banking and Insurance (Department), higher automobile insurance fees. 29 To resolve this uncertainty, the Department then established a fee schedule based on what it deemed to meet the statutory requirements for more than one thousand services. 30 Many providers challenged the Department’s fee schedule claiming that the schedules did not represent the statutory required fees. 31 The state appellate court, however, upheld the department’s fee schedule. 32

C. Uninsured

Another situation where a person seeks treatment without a pre-negotiated contractual fee with the provider is where a person does not have health insurance—that is, the person is uninsured. 33 State protection for the

27. N.J. Stat. Ann. § 39:6A–4.6(a). The statute actually requires the fees to represent “the reasonable and prevailing fees of 75% of the practitioners within the region.” Id.
29. Id.
30. Id.
32. Id.
33. If the estimates by the Congressional Budget Office prove accurate, the number of uninsured Americans will drop from approximately 50 million today to about 23 million by 2019 as a result of the Patient Protection and Affordable Care Act. See Letter from Douglas
uninsured varies. Some states will require that the patient only pay a reasonable fee for the services. Other states will allow hospitals and physicians to bill the rates they list as their standard prices—lists which are sometimes referred to as “charge masters”—even if few people ever pay these actual rates and even if the lists contain tens of thousands of items. Court decisions in states where the uninsured are only responsible for a reasonable fee could provide guidance with regard to usual and customary or market rates. Courts, however, might distinguish reasonable rates from customary rates on the theory that the highest contract rate might be reasonable even if it is not the usual and customary rate for that service.

III. USUAL, CUSTOMARY, AND REASONABLE (UCR) CHARGES

Legislatures have left it to the courts to determine what the “usual, customary, and reasonable” rate for medical services are in particular circumstances. This might be because, traditionally, plaintiffs and defendants have come to courts for a factual determination on matters such as how much to award an injured plaintiff in a negligence case, what the fair market value of a closely held corporation is, or what is a reasonable fee for an attorney or other fiduciary. Nevertheless, a factual determination of the “usual and customary” charge in the context of medical services is distinct from these other situations and courts have not been able to effectively resolve these differences.

In making a determination as to what is a usual and customary medi-
ical charge, a court faces at least two initial challenges. First, in light of the modern reality of medical billing, the courts must construe the meaning of a word like “charges” to determine if this refers to the amount the provider bills for services in the absence of any contract, or the amount that the provider accepts as full payment. Next, assuming a court accepts that “charges” refers to the payments that providers accept as full payment, a court must still determine how to calculate what these “usual and customary” amounts actually are.

A. What Is a “Charge”?

Before determining what “usual and customary charges” are, a court must first construe the meaning of the word “charges.” Medical providers may argue that the word “charges” means a provider’s standard charges before applying any contractual discounts. The providers argue this based on the use of the word “charges” rather than “amounts accepted.” When interpreting statutory language regarding compensation for healthcare services, several courts have looked at the legislative intent and determined that “usual and customary” language is generally used to ensure that the insurers are required to compensate the providers at fair market prices for their services. The fair market value reflects the legislative intent to balance the desire to provide fair compensation to the providers so that qualified people will choose to become healthcare providers with the need to keep insurance costs affordable. As such, the fair market value would be based on what the providers have agreed to accept as full payment. Whether the value should include only private contracted amounts or should also include payment from all sources is another issue courts must resolve.

40. See, e.g., id. at 844–45.
41. Id. at 845.
43. See In re Adoption of N.J.A.C., 11:3–29, 979 A.2d at 789 (noting that the purpose of the statute in question was to contain “insurance costs ‘while providing a fair level of reimbursement for services based on what providers received in the market’” (quoting Coal. for Quality Health Care v. N.J. Dep’t of Banking & Ins., 817 A.2d 347, 350 (N.J. Super. Ct. App. Div. 2003))).
44. See id. (citing Coal. for Quality Health Care, 817 A.2d at 350).
The recently enacted federal healthcare legislation, the Patient Protection and Affordable Care Act (Act), could offer some support for the proposition that "charges" should refer to the discounted amounts. 45 Under the Act, to maintain their tax exempt status, charitable hospitals must implement certain charge policies with respect to financial assistance for uninsured patients. 46 The Act prohibits the use of "gross charges," and as originally written, required the charitable hospitals to charge no more than "the lowest amounts charged to individuals who have insurance covering such care." 47 The implication from this language is that when unmodified, a "charge" is the amount that a patient or insurer is ultimately responsible to pay. In the Act, the legislature adds modifiers such as "gross" or "standard" when referring to the non-discounted charges. 48

B. **What Is “Usual and Customary”?**

If a court has construed "charges" to mean the amounts that providers in the community are willing to accept as full payment for similar services, the court still faces a daunting task of determining what those rates actually are. This section discusses why the rates are difficult to determine, analyzes the problems that the private market has had in making reliable data publicly available, and explores the possibility of a government sponsored database of fee information.

1. **“Veil of Secrecy”** 49

The difficulty in determining the actual prices paid for medical services in the United States is twofold. First, most contracts between insurers and

46. See id. § 9007(a), (c), 124 Stat. at 855, 857.
47. See id. § 9007(a), 124 Stat. at 857. Section 10903 changes the language from "lowest amounts charged" to "amounts generally billed." See id. at § 10903(a), 124 Stat. at 1016. The logical implication of this change is that the legislature considers the amount charged (as well as the amount billed) to be the discounted amount and not the full list price which the legislature refers to as "gross charges" in the next paragraph. The use of the modifier "to individuals who have insurance covering such care" indicates that Congress recognized that those with and those without insurance are billed/charged different amounts. The use of "gross charges" also shows that Congress recognizes that hospitals have a policy of setting list prices that do not represent the amount that most pay.
48. See Public Health Service Act § 2718(c) (as amended by Patient Protection and Affordable Care Act § 1001).
providers contain confidentiality agreements that prevent either the insurer or the provider from disclosing the information to third parties.\textsuperscript{50} One scholar refers to this lack of transparency as a "veil that has been draped for so long over the actual prices paid in the U.S. health system."\textsuperscript{51} Second, there is no standard billing practice for all providers, so it is difficult to compare charges from different providers.\textsuperscript{52}

Even without contractual confidentiality agreements, antitrust concerns would also play a part in making such data difficult to obtain. For example, the U.S. Department of Justice and the Federal Trade Commission have warned that disclosure of a provider's fees which may become available to competing providers could violate federal antitrust laws.\textsuperscript{53} The federal authorities have issued guidelines to medical providers regarding the type of fee information they can safely disclose to third party data collectors without violating any of the federal antitrust regulations.\textsuperscript{54} These guidelines require that all disclosures be made to third parties—that is, not directly to any competing providers—the disclosed data must be at least three months old if it may become available to competitors, and "the information must be collected from enough sources so that no individual provider's price may be identified."\textsuperscript{55}

The antitrust concerns create a tension because they may preclude an insurance company involved in litigation from producing, pursuant to a discovery request, documents that include detailed information about contractual relationships with competing providers in the area. While the insurer could provide data that would meet the federal antitrust guidelines—by including only data that is at least three months old and by removing any information regarding individual provider's prices—the provider would likely object to its reliability on three grounds. First, the provider would not be able to investigate the calculations in detail. Second, the data would be at least three months old. Finally, the data would only be collected from one insurer and therefore would not be reflective of the entire marketplace.

\textsuperscript{50} See id. at 61–62.
\textsuperscript{51} Id. at 62.
\textsuperscript{52} See id. at 59, 62–63.
\textsuperscript{54} See id.
\textsuperscript{55} Id.
2. Problems with Private Databases

One potential solution to the difficulty in determining the "usual and customary" amounts paid for medical services would be for a third-party to maintain a reliable database which could be used by the industry to determine how rates compare. For many years, the medical insurance industry relied on databases provided by Ingenix, Inc. for such information. The industry primarily used this database to establish the amount the insurers were willing to pay out-of-network providers based on the insurers' contractual obligations with their customers to pay a usual and customary amount. The Ingenix database was maintained by a wholly owned subsidiary of UnitedHealth Group, Inc. (UnitedHealth), one of the largest health insurers in the United States.

Although the Ingenix database was used by insurers to calculate the usual, customary, and reasonable rate that they were willing to reimburse out-of-network providers in PPOs, its reliability often did not hold up in court. For example, one federal district judge, in ruling that a class settlement agreement between a health insurance company and its subscribers was fair, reported that there were "serious flaws" in the way the Ingenix data was collected and processed. Similarly, a Massachusetts appellate court found that the database could not be introduced as evidence in a dispute between an automobile insurer and a chiropractor over a "reasonable fee" because the data lacked the "requisite indicia of reliability to be admissible." Furthermore, a New Jersey appellate court stayed a state agency's ruling that allowed insurers to use the Ingenix database to determine reasonable and prevailing fees for services which the agency had not established fee schedules. The court criticized the agency for not having investigated fully whether the database was reliable.

The use of the Ingenix database to determine usual and customary rates ended after a settlement between UnitedHealth and the New York Attorney

56. UNDERPAYMENTS TO CONSUMERS, supra note 18, at 4. In testimony before a Senate Committee, a healthcare executive said, "We know of no alternative sources of national health care charge databases." Id. (citing Letter from William Marino, President and CEO, Horizon Blue Cross Blue Shield of N.J., to Sen. John D. Rockefeller IV (Apr. 23, 2009)).
57. Id. at 7–8.
58. Id. at 3.
62. Id. at 790.
In February 2008, the New York Attorney General announced that his office was conducting "an industry-wide investigation into a scheme by health insurers to defraud consumers by manipulating reimbursement rates." Based on this investigation, the New York Attorney General filed a lawsuit against UnitedHealth and its subsidiaries alleging that due to a conflict of interest, Ingenix was intentionally reporting fees below the true market values. This was done because other UnitedHealth subsidiaries were using the data to determine their own liability for reimbursement to out-of-network providers. UnitedHealth eventually settled with the State by agreeing to close the Ingenix database, to contribute $50 million for the creation of a nonprofit organization to run a new database, and to transfer its existing data to the new organization. The New York Attorney General also entered into settlement agreements with other insurance companies where they also agreed to contribute to the creation of this independent nonprofit organization.

The creation of the independent nonprofit organization to maintain a database of paid medical claims is promising; however, this organization will likely face some of the same challenges Ingenix experienced as described in a United State Senate Commerce Committee report. One main problem that the Senate report found was that the insurance companies that would eventually use the same data to determine their own liability were responsible for reporting their own unaudited claims data. As such, these insurers would "scrub" the data before submitting it to Ingenix by excluding high payouts. The insurers would also average some claims together which would distort the method used of finding modal data—such as a price at which 75% of providers charge less. Another criticism by the Senate

64. Lucas & Williams, supra note 6, at 156 (quoting New York Attorney General Cuomo).
65. Id. at 156–57.
66. Id. at 158–59.
68. See Lucas & Williams, supra note 6, at 161.
69. See UNDERPAYMENTS TO CONSUMERS, supra note 18, at i–ii.
70. See id. at 8–9.
71. Id. at 17–18.
72. See id. at 17.
Commerce Committee was that the Ingenix database did not provide transparency to consumers and medical providers.  

3. A New Hope?

In addition to the New York settlement agreement, there is another hope for the compilation of transparent data with regard to the payment of claims. Section 10101 of the Patient Protection and Affordable Care Act (Act) amends section 2794 of the Public Health Service Act and provides funding for the creation of “Medical Reimbursement Data Centers.” A data center created under this provision must, among other things, “develop fee schedules and other database tools that fairly and accurately reflect market rates for medical services and the geographic differences in those rates.” Also, the centers must “make health care cost information readily available to the public through an Internet website that allows consumers to understand the amounts that health care providers in their area charge for particular medical services.” Furthermore, the Act entitles qualifying states to receive between $1 million and $5 million a year for up to five years for creating these centers. The amendment to the original bill seems to correspond with many of the findings of the earlier Senate Commerce Committee report. Only time will tell if states will take advantage of this potential federal grant and whether such data can be implemented to make the elusive “market rates for medical services” easier to determine.

IV. POTENTIAL SOURCES FOR ESTABLISHING REASONABLE CHARGES

In the absence of hard data on the customary rates that providers are actually “charging,” courts could look to government established fee schedules such as those used by Medicare and state worker’s compensation statutes for guidance on prevailing rates.

73. See id. at 14–16.
75. Public Health Service Act, § 2794(d)(1)(A) (as amended by Patient Protection and Affordable Care Act § 10101(i)).
76. Id.
77. Id. § 1003, 124 Stat. at 140.
A. Medicare Fee Schedules

Medicare is a federal health insurance program administered by the Centers for Medicare and Medicaid Services (CMS) and primarily covers people who are at least sixty-five years old. The government pays physicians who treat Medicare members based on fee schedules and federal law generally prevents the providers from balance-billing Medicare members. Although Medicare participants do not need protection from balance-billing and their premiums are unaffected by the determination of usual and customary fees, understanding how Medicare fees are determined is important in analyzing whether courts should consider these fees when trying to ascertain the usual and customary charge for a medical procedure.

When Medicare was first started in 1965, the government needed to encourage medical providers to accept patients covered by the program. Accordingly, Medicare initially reimbursed doctors the same way that private insurers were reimbursing them at the time. This was based on the prevailing amount that doctors in a geographic area actually billed. Where the Medicare rate was less than a physician’s full charges, the doctors could bill beneficiaries for the balance. This led to a rapid rise in the providers’ charges as Medicare reimbursements would increase with any rise in prices. As a result, starting in 1975, the federal government would only increase Medicare reimbursements for fee increases that did not exceed the increase in the Medicare economic index.

Because these changes were not enough to stop total payments from rising more rapidly than Congress anticipated, in 1992, Congress implemented a new payment system that was based on a fee schedule rather than on physi-

78. H.B. 13C Staff Analysis, supra note 25, at 8. The program also covers some disabled people under sixty-five and people with End-Stage Renal Disease (“permanent kidney failure treated with dialysis or a transplant”). Id.
79. See id. at 9, 12; Hoadley, et al., supra note 8, at 17.
81. Id.
82. See Hoadley, et al., supra note 8, at 10.
83. Medicare’s Physician Fee Schedule, supra note 80, at 3.
84. See id.
85. Cong. Budget Office, Econ. & Budget Issue Brief, The Sustainable Growth Rate Formula for Setting Medicare’s Physician Payment Rates 1 (2006), available at http://www.cbo.gov/ftpdocs/75xx/doc7542/09-07-SGR-brief.pdf [hereinafter Sustainable Growth Rate Formula]. The Medicare economic index measured both changes in the cost of a physician’s time (i.e. inflation) and discounted for expected improvements in productivity. See id. at 1 n.1.
cians' actual charges. This fee schedule calculated fees based on the relative resources required for each service. This scale currently includes factors that consider the amount of training and time required by the physician to perform the work, the physician's practice expenses, and the physician's professional liability insurance. This scaled value is then multiplied by a geographic factor and a monetary conversion factor to arrive at a fee for a particular service. Although the Centers for Medicare and Medicaid Services (CMS) is ultimately responsible for setting and reviewing the factors used for every service, CMS relies on input from the American Medical Association and national medical specialty societies. The monetary conversion factors were originally established such that the total reimbursement to all physicians, after converting to the fee schedule, would be the same as when the fees were based on usual and customary charges. As a result, in 1991, the allowed reimbursement for a particular service based on the fee schedule did not necessarily correlate with the usual and customary charge for that same service, but over the years, the use of this formula by Medicare and other private insurers is likely to have influenced the usual and customary charges in general.

B. Workers' Compensation

Workers' compensation insurance statutes may also provide guidance to courts as to what constitutes a usual and customary rate for medical services in the absence of a contract. State law will often require employers to carry

86. Id. at 1.
87. Id.
89. See id.
90. See id.
91. SUSTAINABLE GROWTH RATE FORMULA, supra note 85, at 1. The federal government has made several changes since implementing this fee schedule in order to keep overall expenditures within the projected budget. Id. Originally, this was to be done by basing the conversion value for particular services on the total volume of those services used. Id. at 1–2. This method, however, required using volumes from past years and did not restrain the overall costs as expected. Id. at 2. Thus, in 1998, Congress shifted to a Sustainable Growth Rate model. Id. The current impact of this switch is that physician payouts are scheduled to be reduced by more than 20% in the next few years. SUSTAINABLE GROWTH RATE FORMULA, supra note 85, at 2. If this reduction goes into effect, then the proposed relationship between Medicare fees and usual and customary charges will be distorted. See id.
92. See HOADLEY ET AL., supra note 8, at 10.
insurance to fully compensate workers for work related injuries—including medical costs.93 The intent is to get the worker back to being productive as soon as possible “at a reasonable cost to the employer.”94 An injured employee may choose a provider whose standard rate is much higher than what other providers in the area charge. Typically, in cases involving workers’ compensation, the provider and the insurer do not have a pre-negotiated contract on fees.95 To ensure that workers’ compensation insurance remains affordable, many legislatures have adopted maximum fee schedules that providers can charge when treating patients for work related injuries that are covered by workers’ compensation insurance.96 Except where fee schedules continue to be based on reasonable and customary charges, the providers and insurers should also be able to determine the maximum fee without litigation. Courts could use the workers’ compensation fee schedules as evidence of market value because under most circumstances providers do not have to take workers’ compensation patients unless they choose to do so, and because such patients are not likely to be such a huge portion of a practice that it would be commercially impracticable for a provider to refuse to participate.97 Thus, provider’s acceptance of the worker’s compensation rates suggests that the compensation they receive represents a fair market value.

V. JUDICIAL DETERMINATION OF UCR

Analyzing how courts have dealt with determining the usual, customary, and reasonable charges where there is no contract between the payor and the service provider helps to understand where the courts are and where they should be headed.

A. Lessons from Temple

In *Temple University Hospital, Inc. v. Healthcare Management Alternatives, Inc.*,98 a Pennsylvania appellate court held that the “reasonable value” for a hospital’s services should be determined based on the value actually paid by the relevant community.99 *Temple* involved a dispute between a Me-

93. See e.g., FLA. STAT. § 440.09(1) (2010).
94. Id. § 440.015 (2010).
95. See H.B. 13C Staff Analysis, supra note 25, at 10; Lucas & Williams, supra note 6, at 138.
96. H.B. 13C Staff Analysis, supra note 25, at 9–12.
97. Hall & Schneider, supra note 38, at 660–63.
99. Id. at 510.
icaid HMO and a hospital after a contract between the two expired. The hospital had told the insurer that it would not enter into a new contract at the old rates. As the hospital was required to take emergency room patients and the insurer, as a Medicaid HMO, could not prevent its subscribers from visiting any particular hospital, the hospital continued treating the HMO members for a four year period while trying to negotiate with the insurer. During much of that time, the hospital billed at its published rates, but the HMO only paid what it deemed its standard rate—a rate that was lower than the original contract amount between the two parties. The trial court eventually found that the HMO had to pay the hospital the reasonable value for its services under a quasi-contract theory. The trial court determined that the "reasonable value" was the hospital’s published rate as long as the court was "not shocked by the amount." The appellate court reversed, holding that the "reasonable value" should be the average charge the hospital received based on its contracts with governmental agencies and private insurance companies. The court reasoned that for the hospital to recover anymore than its average compensation would amount to a windfall for the hospital.

B. New Jersey PIP Case

Section 39:6A-4.6 of the New Jersey Statutes requires the Department of Banking and Insurance (the Department) to establish medical fee schedules for medical expenses paid by automobile insurers pursuant to no-fault personal injury protection. The statute requires that the fee schedule “shall incorporate the reasonable and prevailing fees of 75% of the practitioners within the region.” Originally, the Department had established a fee sche-

100. Id. at 505.
101. Id.
102. See id. at 509.
103. Temple Univ. Hosp., 832 A.2d at 505.
104. Id. at 506.
105. Id.
106. See id. at 509–10.
107. See id. at 509. The persuasiveness of this quasi-contract reasonableness argument in cases where the insurer is required to pay a “usual and customary charge” is not clear. Even if “usual and customary” charges are based on payments received, the “usual and customary” charge could be much higher than the average payment which the court proposed in this case. For example, if the provider’s paid fee was $100 for just more than half of the patients he or she saw and $50 in the rest of the case, then the “average” charge would be $75, even though the provider never charged that amount.
108. N.J. STAT. ANN. § 39:6A-4.6(a) (West 2010).
109. Id. Although the statute referred to “reasonable and prevailing fees,” the agency also used the term “usual, customary, and reasonable” fee in determining how parties are to deter-
After years of using a formula based on billed fees, the Department, in December 2000, proposed changing its fee schedule to reflect the realities of medical billing in the state. The Department noted that in the nine-years since the fee schedules had been in effect, there had been "an increasing difference between fees billed by health care providers and the fees actually accepted by them as payment for services rendered." As a result, the majority of payments accepted were below the seventy-fifth percentile of billed fees. Because the purpose of the statute was to contain costs for automobile insurance while ensuring a fair level of compensation for services provided, the Department proposed setting its schedule based on the paid fees accepted by 75% of the providers.

The Department eventually calculated a revised fee schedule by collecting data of all medical fees actually paid for medical care under PIP claims. The Department noticed a high correlation between the seventy-fifth percentile of the fees actually paid and 130% of the Medicare reimbursement rate. Because the Department found the Medicare participating provider fee schedule to be both "comprehensive" and "resource based," the Department decided that for most of the services for which it was providing a fee schedule, the 130% of the Medicare participating provider fee reflected the reasonable and prevailing fees of 75% of the practitioners in the area. For services where the Department found that the rate from the collected data was much higher than the rate based on Medicare, the Department calculated the seventy-fifth percentile of the fees actually paid based on the collected data.

mine fees for services not in the schedule. See McCoy v. Health Net, Inc., 569 F. Supp. 2d 448, 450–51 (D.N.J. 2008). The New Jersey appellate court, in upholding the agencies fee schedule, distinguished a previous federal case based on New Jersey law where the contractual language had been "charges" rather than fees. In re Adoption of N.J.A.C. 11:3-29, 979 A.2d 770, 783 (N.J. Super. Ct. App. Div. 2009). In McCoy v. Health Net Inc., the federal district court had determined that the insurer had breached its contract with providers when it started paying them the usual and customary payments they received rather than the usual and customary amounts they billed. McCoy, 569 F. Supp. at 464–65. The court emphasized that the contract had used the word "charge" rather than "fee." Id. at 464–68.

110. In re Adoption of N.J.A.C. 11:3-29, 979 A.2d at 775–76.
111. Id. at 776.
112. Id.
113. Id.
114. See id.
115. In re Adoption of N.J.A.C. 11:3-29, 979 A.2d at 778.
116. Id.
117. See id. at 777.
118. Id. at 778.
Several coalitions of healthcare providers challenged the fee schedule as violating the statutory requirement that the fee schedule represents “the reasonable and prevailing fees of 75%.” They argued that the statute required the Department to look at the billed fees rather than the paid fees and that the use of a multiplier of the Medicare participating provider fee schedule did not reflect the “reasonable and prevailing fees of 75% of the practitioners within the region.”

Although a New Jersey appellate court initially granted a stay preventing the implementation of the new fee schedule, the appellate court eventually ruled that “the rules, regulations and fee schedule” were valid. In coming to its conclusion, the court noted that the Department’s reliance on the Medicare data was based on two factors. The first factor was the close correlation with data that it had already collected. The other factor was that the Department had analyzed how the Medicare fees were determined. The court acknowledged that the Department had described in detail the methodology used to determine Medicare rates. Further, the court noted that the Department had considered that the Centers for Medicare and Medicaid Services used input from the provider community in determining the relative value units for the physician’s work, practice expenses and malpractice premium expenses.

Perhaps the aspect of this case which provides the most helpful guidance with respect to resolving what constitutes a charge or fee in the context of medical services is the court’s rationale for rejecting the appellants’ claim that the Department violated the statute’s requirements by using “billed fees” rather than “paid fees.” First, the court pointed out “that the purpose of the [PIP] statute was to contain automobile insurance costs ‘while providing a fair level of reimbursement for services based on what providers received in the market.’” Next, the court, citing its earlier precedent, noted that “paid fees have diverged significantly from billed fees, making paid fees a much more accurate measure of ‘reasonable and prevailing fees.’” The findings of this case should not be limited to Personal Injury Protections. Courts that

119. Id. at 773.
120. In re Adoption of N.J.A.C. 11:3-29, 979 A.2d at 773 (quoting N.J. STAT. ANN. § 39:6A-4.6 (West 2002)).
121. Id. at 774.
122. See id. at 785–86.
123. Id. at 786.
124. See id. at 785–86.
125. In re Adoption of N.J.A.C. 11:3-29, 979 A.2d at 785–86.
126. See id. at 785.
128. Id. (quoting Coal. for Quality Health Care, 817 A.2d at 350).
are making factual findings with regard to "usual and customary" charges, whether the court is construing a statute or a contract, should acknowledge this divergence between "paid fees" and "billed fees" and try to find the "usual and customary" value based on "paid fees."

C. Florida HMO Cases

This section examines how Florida courts have dealt with disputes between health insurance providers and out-of-network providers over reasonable charges in the absence of a pre-existing contract.

One situation where the courts have had to determine the proper compensation for medical services in the absence of a contract is where HMO subscribers have used non-contracting providers for emergency services. In Florida, HMO contracts must include coverage for emergency care and services. The HMO is not permitted to deny coverage for such care even if the provider that has treated the subscriber does not have a contract with the insurer. Section 641.513 of the Florida Statutes also dictates how the HMO must compensate the provider of emergency services. In such a case, the HMO must reimburse the medical provider the lesser of:

(a) The provider’s charges;

(b) The usual and customary provider charges for similar services in the community where the services were provided; or

(c) The charge mutually agreed to by the health maintenance organization and the provider within 60 days of the submittal of the claim.

If the HMO pays the amount the provider initially bills or if the HMO and the provider come to a mutual agreement, there are no issues. Where the parties cannot agree on what the reimbursement should be, providers have

130. FLA. STAT. §§ 641.31(12), .513(3) (2010).
131. See id. § 641.513(5).
132. Id.
133. Id. (emphasis added).
134. The insurers have no reason to seek redress because the provider, as required by law, has already performed the services. An insurer could seek a declaratory judgment in court of law, but there would be little reason for doing so.
two options: they can file lawsuits to resolve the disputes, or they can seek voluntary alternate dispute resolution processes. The alternate dispute resolution process, however, is nonbinding. As such, the process is not well-suited for resolving the legal question of how to calculate “usual and customary provider charges.”

Although section 641.513 of the Florida Statutes does not specifically indicate that a provider has a private cause of action, Florida courts have determined that providers can sue to establish the appropriate reimbursement under the statutory scheme. Until recently, the Florida appellate decisions had not provided much guidance, however, as to how to calculate the “usual and customary provider charges for similar services.” For example, in Peter F. Merkle, M.D., P.A. v. Health Options, Inc., the Fourth District Court of Appeal provided that the statute requires “HMOs to reimburse non-participating providers according to the statute’s dictates, not based on Medicare reimbursement rates.”

The court, however, was ruling on a motion to dismiss based on the defendant’s claim that the statute required the providers to use the alternate dispute resolution process, and, therefore, never provided binding guidance on how a finder of fact should calculate the “usual and customary provider charges.” The court noted that the insurer was not following the statute’s requirement to compensate based on the “usual and customary provider charges” where the insurer was adhering to a strict formula based on a multi-

---

135. See Adventist Health Sys./Sunbelt, Inc. v. Blue Cross & Blue Shield, 934 So. 2d 602, 604 (Fla. 5th Dist. Ct. App. 2006).
137. Baycare Health Sys., Inc., 940 So. 2d at 568 n.5.
138. See id. at 568 (“This case demonstrates that the process created by section 408.7057 is not an adequate method to resolve legal issues of first impression that involve the payment of millions of dollars.”). In one case, the claim-dispute-resolution entity found that “reimbursement of 120% of the Medicare fee schedule would fall within an appropriate range to be considered reasonable,” and thus was the equivalent of the “usual and customary” rates. Id. at 566. If this were binding, then the issue of what constitutes a usual and customary rate in Florida would be resolved.
139. Adventist Health Sys./Sunbelt, Inc., 934 So. 2d 602, 604 (Fla. 5th Dist. Ct. App. 2006).
140. 940 So. 2d 1190 (Fla. 4th Dist. Ct. App. 2006).
141. Id. at 1196.
142. Id. at 1193. Apparently, in 2003, many insurers were paying non-participating providers 120% of the Medicare reimbursement rate. See Adventist Health Sys./Sunbelt, Inc., 934 So. 2d at 603; Baycare Health Sys. Inc., 940 So. 2d at 566.
143. See Health Options, Inc., 940 So. 2d at 1198.
tiplier of the Medicare reimbursement rate.\textsuperscript{144} Nevertheless, this statement was not relevant to the court's resolution of the case and thus, as non-binding dicta, may have little precedential value.

In \textit{Baker County Medical Services, Inc. v. Aetna Health Management, LLC,}\textsuperscript{145} the First District Court of Appeal finally provided some guidance on how courts should construe the term "usual and customary provider charges."\textsuperscript{146} In this case, Baker County Medical Services, a rural hospital, provided emergency care for subscribers to two HMOs.\textsuperscript{147} The insurer did not have contracts with the hospital.\textsuperscript{148} The hospital would bill the HMOs at its "charge master" rate.\textsuperscript{149} The HMOs, however, would send the providers checks for a lesser amount and marked as "payment in full."\textsuperscript{150} Accordingly, the hospital filed suit for declaratory relief seeking a judicial interpretation of the meaning of "usual and customary provider charges."\textsuperscript{151}

At a bench trial, the trial court determined that the "usual and customary provider charges for similar services" was a question of fact "to be determined from the consideration of different factors, including but not limited to amounts billed and amounts received by the provider for payment of the similar services."\textsuperscript{152} The trial court further explained that this calculation should include Medicare and Medicaid reimbursement rates.\textsuperscript{153}

On appeal, the First District Court, noting that the statute did not include any definition of "charges," looked to \textit{Black's Law Dictionary} and concluded that "ordinary and customary provider charges" was the equivalent of fair market value.\textsuperscript{154} The court defined fair market value as "the price that a willing buyer will pay and a willing seller will accept in an arm's-length transaction."\textsuperscript{155} The court then held that Medicare and Medicaid reimbursement rates had to be excluded from the calculation because these rates were not indicative of what a "willing seller" would accept because medical providers are required by law to provide emergency care to the Med-

\textsuperscript{144.} \textit{Id.} at 1197.
\textsuperscript{145.} 31 So. 3d 842 (Fla. 1st Dist. Ct. App. 2010).
\textsuperscript{146.} \textit{See id.} at 844.
\textsuperscript{147.} \textit{Id.} at 843.
\textsuperscript{148.} \textit{Id.} at 844.
\textsuperscript{149.} \textit{Id.} The Court defined the "charge master" rate as the maximum charges which the hospital had a statutory duty to report to the Agency for Health Care Administration (AHCA) in accord with section 408.061 of the \textit{Florida Statutes}. \textit{Baker Cnty. Med. Servs., Inc.}, 31 So. 3d at 843–44.
\textsuperscript{150.} \textit{Id.} at 844.
\textsuperscript{151.} \textit{Id.}
\textsuperscript{152.} \textit{Id.} at 845.
\textsuperscript{153.} \textit{Id.}
\textsuperscript{154.} \textit{Baker Cnty. Med. Servs., Inc.}, 31 So. 3d at 845.
\textsuperscript{155.} \textit{Id.}
icare and Medicare patients. And, in such cases, the government agencies will only reimburse the providers the rates the agencies have established unilaterally. The exclusion of Medicare and Medicaid rates should only apply when dealing with providers which do not have the right to refuse to treat patients covered by these programs, such as hospitals providing emergency care. The court also did not indicate whether a trier of fact could consider workers' compensation fee schedules in evaluating fair market value.

The appellate court, in excluding Medicare and Medicaid reimbursement rates, ignored the fact, however, that the government must reimburse unwilling providers at a fair rate. Otherwise, accepting the court's finding that participation in Medicare and Medicaid was involuntary in this case, the providers could challenge the government's actions under the Takings Clause if the compensation were not just. In fact, this is why the finder of fact should consider the governmental reimbursement rates in determining the fair market value in non-contract cases. The court should give deference, in the absence of evidence to the contrary, that the government will act in accord with the constitution and compensate the health care providers at a reasonable rate. Thus, the government rate should at least be presumed to be a reasonable rate. Whether it represents a "usual and customary charge" is another issue for the finder of fact to decide.

A presumption that the usual and customary provider charge can be calculated based on government reimbursement rates that providers accept would not infringe upon the legislature's statutory scheme. The legislature has given the courts the responsibility of making a factual determination of what the "usual and customary provider charges" are. The legislature has not defined these terms in the statutes, thus leaving it to the courts to interpret the meaning of this phrase. In the absence of a statutory definition, the courts have great latitude in construing the meaning of these terms. A court should not be able to establish an absolute value for such charges, such as equating the "reasonable and customary charge" to always be 125% of the Medicare reimbursable rate. That is a decision for the legislative branch. But by establishing a presumptively reasonable rate, the court would merely be shift-

156. Id. at 845-46.
157. Id. at 845.
158. See id. at 846. Although the court did not specifically state that in non-emergency cases the Medicare rates might be evidence of fair market value, the court implied this by indicating that the fees were only being excluded in this case because the court determined the hospital had no choice but to treat such patients because of state and federal law.
ing the burden to the party that disputes the presumptive rate. If the provider were to consider the presumptive rate too low, the provider could produce evidence that the provider has contracted for higher rates with other insurers. An insurer that believes the presumptive rate is too high can produce evidence of contracts that it has with other providers in the area for similar services. The Medicare rate should at least in some way correlate to actual cost. Rather than presuming a set percentage of Medicare as the reasonable rate, a court could allow the insurer—or the patient if the patient is self-paying—to offer general evidence of how much more private payers on average pay in comparison to Medicare reimbursement rates in that area.\(^{160}\) A provider could challenge these findings by showing that its actual costs were higher than Medicare allows. The provider could also proffer evidence that the particular procedure was more complicated than the “similar” procedures used by the trier of fact for comparison.

The court in *Baker County Medical Services* equated the “usual and customary provider charges” with fair market value.\(^ {161}\) The court defined “fair market value” as “the price that a willing buyer will pay and a willing seller will accept in an arm’s-length transaction.”\(^ {162}\) Providers are likely to argue that the “fair market value” for their services should be higher because of their experience or special training. This argument, however, should have little weight in the case of an HMO subscriber seeking emergency medical services unless the provider could show that the patient chose that provider because of the provider’s training. In the case of an HMO subscriber, however, the insurance policy does not permit the patient to choose out-of-network providers.\(^ {163}\) Section 641.513 of the *Florida Statutes*, however, only applies where the patient is seeking emergency services and care.\(^ {164}\) In such situations, the patient will likely be choosing a facility because of its proximity, or someone else may have selected the facility because of the patient’s condition, preventing him or her from making such a determination. Thus, while a provider’s level of experience may play a factor in justifying a higher rate for non-emergency situations, the same rationale should not apply to section 641.513 of the *Florida Statutes*.

---

162. *Id.* (citing U.S. v. Cartwright, 411 U.S. 546, 551 (1973)).
163. HOADLEY ET AL., *supra* note 8, at 5.
164. FLA. STAT. § 641.513 (2010).
VI. UCR AND HIGHER HEALTH CARE COSTS

The uncertain nature of "usual and customary" charges not only affects those who face uncertain balance billing as a result of such uncertainty, but also affects the overall cost of health care by increasing insurance premiums. This uncertainty affects insurance costs because insurers set their premiums based in part on their expected payouts. If an insurer cannot predict the amount that it will have to payout to cover medical claims, then it will increase premiums to cover this uncertainty. Furthermore, the uncertainty creates litigation costs that must also be covered by the insurance premiums.

The cost to a single insurer is not the only reason that this uncertainty leads to higher costs. Another reason is that this uncertainty creates barriers to entry for new insurers. According to the American Medical Association (AMA), "Competition in the health insurance industry is disappearing . . .." The AMA reports that in twenty-four states, two insurers had a combined market share of seventy percent or more. Furthermore, in more than half of the markets, one insurer controlled at least fifty percent of the market. The AMA recommends that the Department of Justice should investigate if there are any antitrust implications of this consolidation. Although the AMA cites the rising premiums as the reason for its concern, the AMA is probably more concerned that dominant insurers will be able to dictate the prices that its members must accept for their services in a given market. Actually, however, the presence of a dominant insurer does not necessarily lead to lower fees for medical providers. In fact, under the Patient Protection and Affordable Care Act, insurers may have little incentive to negotiate for lower fees. A group insurer will have to return any premiums in excess of eighty-five percent of the amounts it paid out to reimburse medical costs during a particular year. This combination of a market dominated by a few

165. Id. at 7.
167. Id.
168. Id.
169. Id.
170. See INCREASING TRANSPARENCY, supra note 53, at 7.
173. See id.
insurers and a requirement that the insurers must payout certain amounts for actual medical coverage could lead to uncontrolled increases in both insurance premiums and medical fees.

The reason that making the amounts insurers are required to pay out-of-network providers clearer could help with overall insurance premiums is because this uncertainty creates barriers to entry for potential new insurers.\textsuperscript{174} To compete in a new medical market, the insurer would have to negotiate discount rates similar to those of its established competitors.\textsuperscript{175} Considering that the published rates and discounted rates can differ by such large factors, the risk of having to pay non-discounted rates could make entry into new markets commercially unfeasible.\textsuperscript{176} On the other hand, insurers could enter markets slowly by building up small local networks knowing that in emergency situations, they would only be required to pay a market rate similar to what the more dominant insurers are paying. The courts would be instrumental in making this possible by establishing that usual and customary rates are determined by the amounts providers are accepting as payment, and by establishing a measurable presumptive value in the absence of further data. This could also create an incentive for providers to negotiate contract rates with these new insurers, again increasing the ability for the new insurers to compete in the market.

Some people argue that increased competition among insurers will actually cause overall healthcare costs to increase because medical providers would have more leverage in negotiating with each insurer.\textsuperscript{177} Further, some people have expressed concern that increased price transparency may also lead to higher costs as the providers who currently agree to costs that are below usual and customary amounts would demand more.\textsuperscript{178} Although those at the high end of the scale could be pressured to lower costs to some extent, this lowering might not offset the increases demanded by the lower-cost providers.\textsuperscript{179} Although no one can predict the true effect of increased transparency in actual medical costs and/or increased competition among insurers, the increased transparency would allow policymakers to closely monitor the effects. If costs did rise as a result of transparency, state legislatures could implement maximum fee schedules based on the new data that would be available to them in making their policy decisions.

\textsuperscript{174} See \textit{Increasing Transparency}, supra note 53, at 7.
\textsuperscript{175} See id.
\textsuperscript{176} See id. at 4.
\textsuperscript{177} See id. at 4–6.
\textsuperscript{178} See \textit{Increasing Transparency}, supra note 53, at 4–6.
\textsuperscript{179} See id. at 8.
VII. CONCLUSION

Statutes that require courts to calculate "usual, customary, and reasonable" values for medical services using traditional discovery principles have contributed to both to the problem of a lack of consumer protection from balance billing as well as increased uncertainty (and likely price increases) in health insurance markets. The difficulty is unique to the nature of the health care industry and the third-party payment system that has evolved around the healthcare market. In particular, the problem relates to the confidential agreements between insurers and providers that has evolved as the method of reimbursement in most cases. Combined with these confidential pricing relationships is the public policy that our legislatures want the healthcare market to be somewhat market driven in the sense that our policymakers have wanted the compensation of medical providers to be based on market rates, rather than on a government established fee schedule. The problem, however, is that because of the lack of transparency as to what providers are actually paid, insurers and providers often cannot agree what the fair market value should be when they are in situations where they have not pre-negotiated a rate and statutory or common law requires reimbursement based on some market rate.

The courts have also been an inefficient place to set guidelines for two reasons. First, determining the true market rate has proven to be elusive due to the unavailability of reliable data regarding the true "usual and customary" value for medical services in a given area. Many courts have been unwilling to use other statutory fee schedules to substitute for the indeterminable "usual and customary" value absent some clear direction from the legislature. The greatest hope for the future may be with the creation of a truly independent non-profit organization which will manage a database of all medical fee payments across the country. Perhaps the funds that several large insurers have agreed to contribute as part of a settlement with the State of New York, combined with the availability of federal grant money to create Data Reimbursement Centers pursuant to the Patient Protection and Affordable Care Act will make such a database a reality.

Nevertheless, in the interim, until such a database is operational and courts have had an opportunity to rule on the reliability of its data collection methods, a solution is still needed. While the best solution would come from the legislature in terms of either a maximum fee schedule or a presumptively reasonable fee schedule, in the absence of such legislation, state courts should consider imposing their own presumptions on reasonable rates based on a multiplier of the Medicare reimbursement fee schedules or a State’s own workers’ compensation fee schedules. By creating a presumption, the courts would only be shifting the burden of producing evidence that the pre-
sumptive rate is not the true market rate to the parties that would most likely have evidence to the contrary. For example, if a medical provider truly collects more than the presumptive rate from most other private insurers, the provider could easily produce this evidence to the court—or possibly even the other party before any litigation begins—to rebut the presumptive rate. Thus, there would be no overreaching by the court and when a major medical emergency forces a person to seek care at the nearest hospital, he or she will have a better understanding of what to expect.