

**“DISINGENUOUS AND SOMEWHAT DEPLORABLE”
A LOOK AT HOSPITALS’ USE OF HEALTHCARE-
PROVIDER LIENS TO REAP A WINDFALL**

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I. INTRODUCTION

Nancy was riding her bike to work one morning when a car made an illegal turn and slammed into her, sending Nancy tumbling across the asphalt road. An ambulance rushed Nancy to the hospital where she was treated for her injuries. Luckily, Nancy only needed to stay a few days in the hospital, and she thought she could soon put the incident behind her. She had good health insurance through her job, and the driver's auto insurer had offered Nancy a \$50,000 settlement.

Shortly after Nancy's hospital stay, her health insurer paid the hospital in full based on the rate schedule the hospital had agreed to with Nancy's health insurer, less a \$200 co-pay which Nancy paid promptly. Nonetheless, a week later, Nancy received a letter from a law firm representing the hospital seeking \$80,000. This amount was the difference between what the insurance company already paid the hospital and the bill the hospital calculated for Nancy based on the hospital's much higher chargemaster rates,¹ a practice known as balance billing. Contracts between insurance companies and healthcare providers generally prohibit a provider from balance billing. The hospital's law firm, however, asserted that the state's hospital lien statute essentially overrides its contract with Nancy's health insurer and allows the hospital to balance bill up to the amount of any settlement or monetary judgment Nancy receives as a result of the accident.

Nancy consulted a lawyer who told her that balance billing is standard practice when an auto insurer is liable. She also learned from the lawyer that the hospital's law firm has likely sent a letter to the auto insurer informing it of a claim on her settlement. As a result, the auto insurer will not pay out the \$50,000 settlement to her, but instead, will directly pay out to the hospital. Further, there is a good chance that Nancy's health insurer will try to recoup from her what it paid the hospital, given the auto insurer is obligated for Nancy's medical costs associated with the accident.

The lawyer was correct, and in the end, Nancy received nothing. Her entire settlement went to the hospital, meaning Nancy got no compensation for her missed work, lingering pain, or destroyed bike, among other things. Rather, through reliance on a state statute, the

1. See Michael K. Beard & Dylan H. Marsh, *Arbitrary Healthcare Pricing and the Misuse of Hospital Lien Statutes by Healthcare Providers*, 38 AM. J. TRIAL ADVOC. 255, 276-77 (2014) (“[M]any courts have noted that the charge-master rates are significantly inflated and bear no meaningful relationship to the actual cost of goods or services, or their value in the marketplace.”); see also *infra* notes 29-42 and accompanying text.

hospital received a payment three times its normal rates² as well as the benefit of another customer—truly a windfall for the hospital.³

This is an all too common occurrence when someone who is injured by a third-party is treated by a healthcare provider. Statutes in many states allow hospitals to file liens against tort payouts to guard against nonpayment by those patients. But many hospitals file these liens for the chargemaster amount of their services even when they have or could have been paid by the patient's insurance. These liens apply to the whole of any tort recovery, not just the amount allocated to medical expenses.⁴ Patients are left with wholly inadequate recoveries that fail to cover incident expenses, let alone the premiums they have been paying for the benefits of health insurance.⁵ Where the hospital receives a windfall, the victim receives a punishment.⁶ This practice led at least one court to call these attempts “disingenuous and somewhat deplorable.”⁷

In recent years, healthcare spending in the United States has continued to increase, reaching a staggering \$3.5 trillion in 2017.⁸ This astronomical number accounts for almost 18% of the nation's gross domestic product (GDP).⁹ This puts US healthcare spending well above the entire GDPs of such countries as the United Kingdom (\$2.9 trillion), India (\$2.7 trillion), Canada (\$1.7 trillion), and South Korea (\$1.6 trillion).¹⁰ Relative to GDP and per capita, the

2. See Ge Bai & Gerard F. Anderson, *Extreme Markup: The Fifty US Hospitals with the Highest Charge-to-Cost Ratios*, 34 HEALTH AFFS. 922, 923 (2015), <https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.1414> [<https://perma.cc/ZW8U-2SWA>] (stating that the average charge-to-cost ratio among U.S. hospitals is 3.4); see also *infra* notes 34-39 and accompanying text.

3. See *infra* Part VI.

4. *Blankenbaker v. Jonovich*, 71 P.3d 910, 915 (Ariz. 2003) (“Under [the hospital lien statute], the lien extends to any amount that ‘has been or is to be collected by the injured person.’”).

5. In 2016, the average family paid \$833 per month for health insurance in addition to any deductible or other co-payments. That's just under \$10,000 a year. Ester Bloom, *Here's How Much the Average American Spends on Health Care*, CONSUMER NEWS AND BUS. CHANNEL (CNBC) (June 23, 2017), <https://www.cnbc.com/2017/06/23/heres-how-much-the-average-american-spends-on-health-care.html> [<https://perma.cc/4T2F-9J6B>].

6. See *infra* Part VI. Cf. *Allstate Ins. Co. v. Druke*, 576 P.2d 489, 492 (Ariz. 1978) (“[T]o require an injured policy holder to return to his insurer the benefits for which he has paid premiums is to deny him the benefits of his thrift and foresight.”).

7. *Rabun v. St. Francis Med. Ctr., Inc.*, 50, 849 (La. App. 2 Cir. 8/10/16); 206 So.3d 323, 328. See *infra* notes 57-59 and accompanying text.

8. See CENTERS FOR MEDICARE & MEDICAID SERVICES, NATIONAL HEALTH EXPENDITURES 2017 HIGHLIGHTS 1 (2017), <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf> [<https://perma.cc/NXM4-EWN9>] [hereinafter CMS]; see also Sean P. Keehan et al., *National Health Expenditure Projections, 2016-25: Price Increases, Aging Push Sector to 20 Percent of Economy*, 36 HEALTH AFFS. 553, 554-55 (2017), <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2016.1627> [<https://perma.cc/QCN7-JYZL>].

9. CMS, *supra* note 8, at 1.

10. THE WORLD BANK, GROSS DOMESTIC PRODUCT (GDP) (CURRENT US \$): ALL COUNTRIES AND ECONOMIES (2019), <https://data.worldbank.org/indicator/NY.GDP.MKTP.CD> [<https://perma.cc/FP8F-KDGT>].

United States significantly outpaces other wealthy countries.¹¹ In fact, it is predicted that between 2017 and 2026, national healthcare spending will increase 5.5% and will make this spending nearly one-fifth of the entire United States GDP.¹²

Most of our everyday experience with this \$3.3 trillion-dollar system happens through insurers such as Medicare or private insurance companies.¹³ We pay our premiums, go to the doctor, give our insurance information, and maybe see a portion of the bill on the other end. We may never see the behind-the-scenes workings between the healthcare providers and the insurance providers where they negotiate contracts, change charges, and plan your care. Rather, you pay for insurance¹⁴ so that those things are taken care of for you.

But what happens when you are injured by a third party and receive medical treatment for that injury? Who is obligated to pay? You have a contract with an insurance company that they will work with the healthcare provider to cover costs. But the third party who injured you may also be responsible. If the third party is at fault for your injury, he or she must cover your damages. These damages will likely include healthcare costs. But where does the money end up going? Does your insurance company have a duty to provide payment to the hospital for the treatment? Does the hospital have a duty to accept this payment under its contract with the insurer? As the Nancy scenario depicts, the answer all too often is that you do not receive the benefit of the insurance for which you have been paying, and you do not receive the damages the third party caused to you. Instead, the hospital gets a windfall.

This Article addresses hospital balance billing where a physical tort occurs, and a hospital provides treatment to the victim. But then by statute, the hospital may be able to force the tortfeasor to pay three or four times more for the victim's care than the hospital would normally charge and may leave the victim without any recovery. Such an arrangement frustrates contract law principles and contradicts public policy. Fortunately, a few states have addressed the problem and thus, serve as examples for other states to follow.

11. Bradley Sawyer & Cynthia Cox, *How Does Health Spending in the U.S. Compare to Other Countries?*, PETERSON-KFF HEALTH SYSTEM TRACKER (Dec. 7, 2018), <https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/#item-average-wealthy-countries-spend-half-much-per-person-health-u-s-spends> [<https://perma.cc/MFK3-YGGT>].

12. Jeff Byers, *Healthcare Spending to Reach 19.7% of GDP within a Decade*, HEALTH CARE DIVE (Feb. 14, 2018), <https://www.healthcaredive.com/news/cms-health-spending-projections-2017-2026/517097/> [<https://perma.cc/N9ML-UY4Y>].

13. Only 8.8% of the U.S. population were without health care insurance for 2016. JESSICA C. BARNETT & EDWARD R. BERCHICK, U.S. CENSUS BUREAU, HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2016 (Sept. 12, 2017), <https://www.census.gov/library/publications/2017/demo/p60-260.html> [<https://perma.cc/KJQ2-S3U5>].

14. Either you pay for insurance directly, your employer pays for it (which is simply another way of you paying for it with your labor), or we all as taxpayers pay for it.

Part II provides context by describing the basis of healthcare costs and insurance. Part III examines hospital lien statutes in detail. Part IV delves into contracts between hospitals and health insurance providers and what arguments patients could make to fight these liens. Part V considers how patients might receive recourse. And finally, Part VI considers in a broad sense how the legal system should address situations like Nancy's.

II. HEALTHCARE COSTS AND INSURANCE – THE BASICS

Healthcare providers, and especially hospitals, face a number of tough economic pressures. Healthcare services, for a variety of reasons, are exorbitantly high. Hospitals are often required to treat patients who have little or no ability to pay.¹⁵ Hospitals must take into account bad debts (amounts that have been charged but the hospital does not expect to receive)¹⁶ as well as charity care (instances where the hospital has agreed to charge less or nothing for its services).¹⁷ In Arizona, for example, the average amounts allotted for

15. See generally CENTERS FOR MEDICARE AND MEDICAID SERVICES, EMERGENCY MEDICAL TREATMENT & LABOR ACT (EMTALA), <https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/index.html?redirect=/EMTALA/> [https://perma.cc/72QG-BFBZ] (last modified Mar. 26, 2012).

16. Jayme Parmakian, *Contractual Allowance vs. Bad Debt for Healthcare Providers*, LBMC FAMILY OF COMPANIES RESOURCES & INSIGHTS BLOG (May 12, 2020), <https://www.lbmc.com/blog/contractual-allowance-for-healthcare-providers/> [https://perma.cc/L4AU-V7FD]. However, Medicare reimburses hospitals a majority of their bad debt for Medicare deductible and co-payments after the hospitals make a reasonable effort to collect. MEDICARE PAYMENT ADV. COMM'N., HOSPITAL ACUTE INPATIENT SERVICES PAYMENT SYSTEM 3 (Oct. 2018) [hereinafter MEDPAC], http://medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_18_hospital_final_v2_sec.pdf?sfvrsn=0 [https://perma.cc/4UCA-ADGT].

17. *Defining Charity Care at Hospitals*, VALUE HEALTHCARE SERVICES, <http://value-healthcareservices.com/education/defining-charity-care-at-hospitals/> [https://perma.cc/Z568-3MBP] (last visited July 22, 2020). However, states may provide other ways to help cover the costs of care that hospitals are required to give. Jennifer Preston, *As Revenues Drop, Hospitals Talk of Forsaking Charity Care*, N.Y. TIMES (Apr. 14, 1996), <https://www.nytimes.com/1996/04/14/us/as-revenues-drop-hospitals-talk-of-forsaking-charity-care.html> [https://perma.cc/VPR7-YE4X].

However, just because hospitals may provide some charity care does not mean that many of those who are unable to pay are offered reduced prices. One report stated that “[h]ospitals frequently charge uninsured patients two to four times what health insurers and public programs actually pay for hospital services. . . . Only about one quarter of low-income uninsured adults . . . report they have received care for free or at reduced rates in the past year.” HENRY J. KAISER FAMILY FOUNDATION, THE UNINSURED: A PRIMER, KEY FACTS ABOUT AMERICANS WITHOUT HEALTH INSURANCE 10, (Oct. 2007), <https://web.archive.org/web/20080602151746/http://www.kff.org/uninsured/upload/7451-03.pdf> [https://perma.cc/U9YC-D7V2]. Furthermore, the percentage of physicians offering charity care in hospitals has been trending downward. PETER J. CUNNINGHAM & JESSICA H. MAY, CTR. FOR STUDYING HEALTH SYS. CHANGE, NO. 13, A GROWING HOLE IN THE SAFETY NET: PHYSICIAN CHARITY CARE DECLINES AGAIN, TRACKING REPORT (2006), <http://www.hschange.org/CONTENT/826/826.pdf> [https://perma.cc/R9FY-4CWF].

bad debts and charity care in each Arizona general hospital were \$29.3 million in 2015, \$27.8 million in 2016, and \$28.8 million in 2017.¹⁸

However, how much pressure hospitals are really feeling from uncompensated care (bad debts plus charity care) is in question. The amount of uncompensated care has been decreasing dramatically,¹⁹ falling 39% between 2013 and 2015 in Medicaid-expansion states.²⁰ Meanwhile, hospital profits increased 43% since 2011, taking into account revenue and all expenses including uncompensated care.²¹

The vast majority of hospital revenue, however, comes through insurers. Approximately 91.2% of Americans are covered by some form of health insurance.²² Insurers contract with healthcare providers for the amount that will be charged to the insurance for each service or diagnosis.²³ In this way, health insurance is not usually simply a risk management tool where you pay premiums and the insurance company pays you *your costs* if a specified event happens like a doctor's visit or hospitalization.²⁴ Rather, the insurance company has

18. Using the Uniform Accounting Reports for each year available, I simply added the amounts listed for bad debts and charity care and averaged the amount for general hospitals. ARIZ. DEP'T. OF HEALTH SERVS., HEALTH FACILITY COST REPORTING, COST REPORTING & REVIEW - COMPILED HEALTH FACILITY FINANCIAL REPORTS, <https://www.azdhs.gov/preparedness/public-health-statistics/health-facility-cost-reporting/index.php#compiled-health-facility-financial-reporting> [https://perma.cc/GBX8-X6DA] (last visited July 22, 2020).

19. AMERICAN HOSPITAL ASSOCIATION, UNCOMPENSATED HOSPITAL CARE COST FACT SHEET 3 (2016), <https://www.aha.org/system/files/2018-09/uncompensatedcarefactsheet.pdf> [https://perma.cc/UV6Y-G2R3]. Although the total cost of uncompensated care increased slightly in 2016, uncompensated care as a percentage of total expenses stayed the same between 2015 and 2016, at 4.2%. Tara Bannow, *Hospital Profits, Uncompensated Care Climb*, MODERN HEALTHCARE (Jan. 6, 2018), <https://www.modernhealthcare.com/article/20180106/NEWS/180109940> [https://perma.cc/TJ9B-ALZZ].

20. MARIANNE UDOW-PHILLIPS ET AL., CTR. FOR HEALTH & RES. TRANSFORMATION, HOSPITAL UNCOMPENSATED CARE IN THE UNITED STATES, 2015 – COMPARISON OF MIDWEST STATES (July 25, 2017), <https://www.chrt.org/publication/hospital-uncompensated-care-united-states-2015-comparison-midwest-states/> [https://perma.cc/3E9N-H9JK].

21. Bannow, *supra* note 19. (referring to an American Hospital Association survey).

22. BARNETT & BERCHICK, *supra* note 13, at 1.

23. CareCloud Corp., *Healthcare 101: How Healthcare Reimbursement Works?*, CONTINUUM, <https://www.carecloud.com/continuum/how-healthcare-reimbursement-works/> [https://perma.cc/N2CU-HE3F] (last visited July 22, 2020). Individual physicians will usually charge per service provided while hospitals charge based on a diagnosis. The amount is fixed per hospital stay. *Id.* See generally Aaron Rinck, *Four Common Types of Health Insurance Plans*, PEOPLE KEEP (Jan. 29, 2013), https://www.peoplekeep.com/blog/bid/263380-four-common-types-of-health-insurance-plans?__hstc=69472015.d48e83ada7046d1abd9bf9755b84d78d.1548879273105.1548879273105.1548879273105.1&__hssc=69472015.2.1548879273105&__hsfp=2397204329 [https://perma.cc/LD87-H3FK]; JACK HOADLEY ET AL., CTR. ON HEALTH INS. REFORMS, GEO. U. HEALTH POLICY INST., BALANCE BILLING: HOW ARE STATES PROTECTING CONSUMERS FROM UNEXPECTED CHARGES? 3 (2015), http://www.statecoverage.org/files/Georgetown_Balance_Billing.pdf [https://perma.cc/4NNZ-WUEA].

24. Mark V. Pauly, *Insurance Reimbursement*, in HANDBOOK OF HEALTH ECONOMICS 538 (A.J. Culyer & J.P. Newhouse eds., vol. 1 2000) (“Most insurances other than health insurance do not ‘reimburse’; instead they pay cash to insureds conditional on the occurrence of a prespecified event. In contrast, health insurance ties the payment to medical expenditures or costs incurred in some fashion, often making payments directly to medical providers.”).

contracted with the healthcare provider that the provider will not hold you liable for costs if the insurance pays the agreed amount. Thus, the *cost* for your healthcare is not a charge to you but whatever is agreed upon between the provider and the insurance company. In the case of private insurance, there are sophisticated contract negotiations with each side weighing the benefits and costs of the agreement. With government funded insurance, the government sets the rates and providers choose whether to accept patients with these insurances.²⁵ While the rate set by the government is lower than what providers could obtain through private insurances, the providers weigh this against the benefit of many more potential customers.²⁶ In fact, the rate of non-pediatric physicians accepting Medicare is about the same as those physicians accepting any type of insurance (93% versus 94%).²⁷ Thus, competition for rates and customers results in reasonable²⁸ costs. Importantly for this Article, all the parties have freedom of contract to enter into these agreements and should have reasonable expectations of their binding nature.

But if the healthcare charges that the 91.2% of Americans with health insurance are seeing are negotiated by insurance companies, what is the normal price tag on these healthcare services? That is where *chargemasters* come in. Chargemasters are lists of procedures, drugs, tests and other services offered by the provider and their corresponding price.²⁹ In the case of hospitals, each hospital sets their own chargemaster with their own prices,³⁰ and the prices are generally

25. Medicaid and CHIP Payment and Access Comm'n, *Managed Care Rate Setting*, MACPAC, <https://www.macpac.gov/subtopic/managed-care-rate-setting/> [https://perma.cc/B8UR-BMU3] (last visited July 22, 2020).

26. DARIA PELECH, U.S. CONGRESSIONAL BUDGET OFFICE, AN ANALYSIS OF PRIVATE-SECTOR PRICES FOR PHYSICIAN SERVICES 22 (2017), <https://www.cbo.gov/system/files/115th-congress-2017-2018/presentation/52818-dp-presentation.pdf> [https://perma.cc/7JBP-KND7] (comparing a sample of service prices from three large insurance providers against the government fee rate for those same services and finding that “[c]ommercial prices are (sometimes substantially) higher than Medicare.”); Kaiser Family Foundation, *Health Insurance Coverage of the Total Population*, STATE HEALTH FACTS, <https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0> [https://perma.cc/CD6C-4JF5] (last visited July 22, 2020) (noting that roughly 34% of the U.S. population is insured through Medicare and Medicaid).

27. Cristina Boccuti et al., *Primary Care Physicians Accepting Medicare: A Snapshot*, KFF (Oct. 30, 2015), <https://www.kff.org/medicare/issue-brief/primary-care-physicians-accepting-medicare-a-snapshot/> [https://perma.cc/JEB3-A65V]. The share of all physicians accepting Medicaid is 71%. *Id.* A different source states that “less than 1% of physicians in clinical practice opted out of Medicare.” Mitchell Clark, *Balance Billing Would Allow Doctors to Bill Whatever They Choose*, MEDICARE RIGHTS CENTER (Feb. 16, 2017), <https://blog.medicarights.org/balance-billing-allow-doctors-bill-whatever-choose/> [https://perma.cc/7FXC-EUPD].

28. “Reasonable,” of course, being relative.

29. Jacqueline LaPointe, *The Role of the Hospital Chargemaster in Revenue Cycle Management*, REVCYCLE INTELLIGENCE (Feb. 9, 2018), <https://revcycleintelligence.com/features/the-role-of-the-hospital-chargemaster-in-revenue-cycle-management> [https://perma.cc/6FND-2UA8].

30. *Id.*; Bai & Anderson, *supra* note 2, at 922.

not subject to any limit.³¹ However, these lists are seldom seen by any patient and until just recently, were often considered proprietary information.³² Beginning in 2019, hospitals are required to list these charges on their websites, but the lists are still not comprehensible to the average person.³³ A main purpose of these lists is to set a high first bar when negotiating charges with insurance companies before the price is negotiated down to the reasonable, economically correct price.³⁴ One study found that for every additional dollar in the chargemaster rate for a service, hospitals were able to negotiate fifteen cents more from the privately insured for the service.³⁵ A different study stated that “[b]ecause it is difficult for patients to compare prices, market forces fail to constrain hospital charges.”³⁶ On average in the United States, chargemaster prices are a staggering 3.4 times the cost for services set by Medicare, with some hospitals “charging” as much as ten times the Medicare-allowable amount.³⁷ In Arizona, the average markdown for contractual allowances in 2017 was at least 77.7% in general hospitals.³⁸ This has only gotten worse over time – in 1984, the

31. Bai & Anderson, *supra* note 2, at 922.

32. LaPointe, *supra* note 29.

33. Sarah Kliff, *You Can Now Look Up Charges at Your Local Hospital. Good Luck Understanding Them*, VOX (Jan. 14, 2019), <https://www.vox.com/policy-and-politics/2019/1/14/18182450/hospital-prices-transparency-health-care> [<https://perma.cc/B77A-22Q8>].

34. LaPointe, *supra* note 29; Kliff, *supra* note 33. (The prices insurers pay “are negotiated in secret, and are not made available in this dataset. Some research has found that the actual prices insurers and patients pay *bear little relationship* to the published charges.”)

35. Michael Batty & Benedic Ippolito, *Mystery of the Chargemaster: Examining the Role of Hospital List Prices in What Patients Actually Pay*, 36 HEALTH AFFS. 689, 693 (2017).

36. Bai & Anderson, *supra* note 2, at 922.

37. *Id.* at 923.

38. ARIZ. DEP’T OF HEALTH SERVS., *supra* note 18. Using the Uniform Accounting Reports for each year available here: <https://www.azdhs.gov/preparedness/public-health-statistics/health-facility-cost-reporting/index.php#compiled-health-facility-financial-reporting> [<https://perma.cc/R77Z-S7ZP>], we estimated the contractual allowance percentage as follows: “Gross Patient Revenue” represents what the hospital should have been paid. “Net Patient Revenue” represents what the hospital was actually paid. The report also lists what “allowances” or deductions were made from the gross revenue. These include self-pay discount, charity care, bad debts, capitation, and “other contractual allowances.” These “allowances” represent all of the money that was supposed to be paid to the hospital but was not—that is, if you add up the allowances, you get the difference between gross and net revenue. While we know how much of an allowance was made for each of these categories, we do not know how much each category was originally supposed to pay, i.e., how much each category made up of the gross revenue. However, we will assume that each category except “other contractual allowances” was discounted at 100%, meaning the allowance listed in the report is equal to the original amount that category should have contributed to gross revenue. Thus, by taking gross revenue and subtracting each allowance except “other contractual allowances,” we know how much the transactions included in “other contractual allowances” should have contributed to gross revenue, i.e., the original bill amount. By taking the “other contractual allowance” amount and dividing it by this “original bill amount,” we end up with the percentage of the original bill that was deducted away for “other contractual allowances.” We performed this calculation for each hospital in the 2017 report labeled general hospital and averaged the result.

We assumed that the other allowances were discounts at 100%, although likely not true because this results in the lowest possible contractual allowance percentage. If those other categories of transactions were actually billed at more than the amount listed as the

average listed cost from the chargemaster was only 1.35 times the cost index listed by the federal government.³⁹ Although most patients will never see these amounts because of insurance, these astronomical charges are commonly used against the uninsured,⁴⁰ those getting services “out-of-network,” and against third-party insurers, like worker’s compensation and auto insurance.⁴¹ These are “the most vulnerable patients and those with the least market power.”⁴² Rather than be an amount tied to what the service costs the provider or what is an economically reasonable price, chargemasters are unrestrained prices that are strategically used to elicit more money from payers.

III. HOSPITAL LIEN STATUTES

Returning to our tort victim who was treated at a hospital, forty-two states in the United States have enacted some type of hospital lien statute that allows hospitals to attach a lien against any recovery the victim may have from the tortfeasor.⁴³ Many states have text similar to that of Arizona’s law:

Every individual, partnership, firm, association, corporation or institution or any governmental unit that maintains and operates a health care institution or provides health care services in this state . . . is entitled to a lien for the care and treatment or transportation of an injured person. The lien shall be for the claimant's customary charges for care and treatment or transportation of an injured person. A lien pursuant to this section extends to all claims of liability or indemnity . . . for damages accruing to the person to whom the services are rendered . . . on account of the injuries that gave rise to the claims and that required the services.⁴⁴

The crux of the problem, and the issue now facing victims and legislatures, is that many hospitals now use these statutes to place a lien for the full chargemaster price of the services they provided to the

allowance (a discount of less than 100%), those categories would have contributed more to the gross revenue. This would mean the amount we calculated as the original bill for the “other contractual allowances” transactions would be a lower number. This would make the percentage we calculated larger.

39. Bai and Anderson, *supra* note 2, at 924.

40. Batty and Ippolito found that “an extra dollar in list price was associated with a roughly 20-cent increase in payments from the uninsured.” Batty & Ippolito, *supra* note 35, at 693.

41. Jeff Legasse, *Study: Hospitals Still Using Chargemaster Markups to Maximize Revenue*, HEALTHCARE FINANCE NEWS (Sept. 9, 2016), <https://www.healthcarefinancenews.com/news/study-hospitals-still-using-chargemaster-markups-maximize-revenue> [<https://perma.cc/FBY6-2RJQ>]; Bai & Anderson, *supra* note 2, at 922.

42. Bai & Anderson, *supra* note 2, at 923.

43. See *infra* Part III(A); “Hospital lien statutes generally give the hospital a lien against any recovery from a tortfeasor by a ‘patient’ or the ‘injured party’ to whom services were necessarily rendered as a result of the tortfeasor’s conduct.” Carol A. Crocca, Annotation, *Construction, Operation, and Effect of Statute Giving Hospital Lien Against Recovery from Tortfeasor Causing Patient’s Injuries*, 16 A.L.R. 5th 262 Art. 1 § 2(a) (1993).

44. ARIZ. REV. STAT. ANN. § 33-931(A) (2020).

victim. So, while the hospital may have agreed with the insurer to receive \$5,000 to treat our victim's broken leg, the law gifts the hospital with a windfall of perhaps \$17,000 (\$5,000*3.4) based on an unregulated and artificially-high chargemaster.⁴⁵ Not only is the tortfeasor faced with this arbitrary punishment, but the victim is deprived of the benefit of the insurance for which he or she paid and loses much, if not all, of his or her recovery for the injury and damages caused.

The origin and purpose of hospital lien laws have been questioned. In 1940, when only seventeen states had hospital lien laws, M. Ann Joachim warned in relation to these laws, "Hospitals are definitely in politics and it is essential that careful study be continuous."⁴⁶ Joachim further noted that insurance companies and lawyers were against these laws.⁴⁷ In cases involving its hospital lien statute, Arizona courts have noted that these laws were adopted to "lessen the burden on hospitals and other medical providers imposed by non-paying accident cases."⁴⁸ However, this reasoning is suspect when considering the increasing use of these laws in instances where the hospital already could be or has been paid by insurance. Even the federal government has expressly forbidden this type of balance billing for Medicare and Medicaid recipients.⁴⁹

A. *What Different States Have Done*

Some states have enacted laws in attempts to address this issue with varying degrees of success. The following is a short summary of hospital lien statute language in all 50 states.

Many states put a cap on the total possible amount of the lien, either as a specific dollar amount or as a percentage of the victim's recovery.⁵⁰ The biggest block of states simply state that the lien is for

45. Some hospitals do this in lieu of billing the victim's insurance, see *infra* Part IV(B)(2), while others bill the insurance, receive payment, and then use the lien to cover the above and beyond part of their chargemaster rate. As will be seen below, both these situations are problematic.

46. M. Ann Joachim, *The Position of the Private Hospital in State Laws*, 15 NOTRE DAME L. REV. 91, 121 (1940).

47. *Id.* at 113.

48. *LaBombard v. Samaritan Health Servs.*, 991 P.2d 246, 251 (Ariz. Ct. App. 1998); Crocca, *supra* note 43, at Art. 2[a].

49. See *infra* Part III(B); 42 U.S.C § 1396a(a)(25)(C) (2018); 42 C.F.R. § 447.15 (2013).

50. See, e.g., CAL. CIV. CODE § 3045.4 (West 2019) (lien capped at 50% of recovery after attorney's liens); TENN. CODE ANN. § 29-22-101 (West 2019) (lien capped at one-third of recovery after attorney's liens); 770 ILL. COMP. STAT. 23/10 (2019) (hospital lien shall not exceed 40% of recovery); KAN. STAT. ANN. § 65-406 (West 2019) (full lien allowed up to \$5,000 and any amount above \$5,000 must meet "equitable distribution . . . under the circumstances"); N.C. GEN. STAT. § 44-50 (2019) (lien shall in no case exceed 50% of recovery); MD. CODE ANN., COM. LAW § 16-601 (West 2019) (lien allowed for reasonable and necessary charges, but not more than 50% of recovery); MO. REV. STAT. § 430.230 (2019) (lien not to exceed \$25 per day plus cost of necessary services); VA. CODE ANN. § 8.01-66.2 (2017) (hospital lien cannot exceed \$2,500); VT. STAT. ANN. tit. 18, § 2251 (2019) (lien shall not attach to one-third of the recovery or \$500, whichever is less); WASH. REV. CODE ANN. § 60.44.010 (West 2020) (hospital lien shall not exceed 25% of recovery).

reasonable charges involved in treating the patient for the injury.⁵¹ Some do not even require reasonableness.⁵² Two states, Arizona and Nebraska, use slightly different language that may or may not be significant: the lien is allowed for “customary” charges.⁵³ New Jersey limits hospital liens to “ward rates.”⁵⁴ Only the following few states have addressed our problem head-on.

Iowa:

Under Iowa Code § 582.1A, a hospital must submit a claim to the patient’s insurance if the patient provides proof of insurance within thirty days after being discharged from the hospital.⁵⁵ Even if the patient’s health plan denies payment for any reason, the health plan must provide the hospital and the patient with “a statement detailing the amount the health plan would have paid for the hospital services provided and the amount the patient would have been responsible for had the claim not been denied.”⁵⁶ The hospital’s lien is limited to the amount that the hospital would have received from the insurer. Even if the hospital only learns about the patient’s health insurance after the lien has been filed (presumably more than thirty days after the patient’s discharge), the hospital must submit the charges to the insurer and the amount is likewise limited.

Louisiana:

Louisiana courts have interpreted Louisiana statutes to practically have the same effect as Iowa’s law. Louisiana Revised Statutes § 9:4752 provides hospitals with a lien for reasonable charges, but the state’s Health Care Consumer Billing and Disclosure Protection Act prohibits a healthcare provider from collecting or attempting to collect from a health-plan enrollee “any amount in excess of the contracted reimbursement rate for covered health care services.”⁵⁷ The state appellate court has interpreted these two statutes to limit a hospital’s statutory lien to the amount the insurer would pay under the contract

51. ALA. CODE § 35-11-370 (West 2019); DEL. CODE ANN. tit. 25, § 4301 (2020); GA. CODE ANN. § 44-14-470 (2019); HAW. REV. STAT. ANN. § 507-4 (West 2019); IDAHO CODE ANN. § 45-701 (2019); ME. REV. STAT. tit. 10, § 3411 (2019); MASS. GEN. LAWS ch. 111, § 70A (2019); MINN. STAT. § 514.68 (2019); N.D. CENT. CODE § 35-18-01 (2020); N.H. REV. STAT. ANN. § 448-A:1 (2019); N.M. STAT. ANN. § 48-8-1 (West 2019); N.Y. LIEN LAW § 189 (McKinney 2019); OKLA. STAT. tit. 42, § 43 (2019); OR. REV. STAT. § 87.555 (2017); 9 R.I. GEN. LAWS § 9-3-4 (2019); S.D. CODIFIED LAWS § 44-12-1 (2019); TEX. PROP. CODE ANN. § 55.004 (West 2019); UTAH CODE ANN. § 38-7-1 (LexisNexis 2019); WIS. STAT. § 779.80 (2018).

52. See, e.g., ARK. CODE ANN. § 18-46-104 (2019) (allowing lien for “the value of the service rendered and to be rendered”); CONN. GEN. STAT. ANN. § 49-73 (2019), (allowing hospital lien for “the extent of the actual cost of such service and materials”); MONT. CODE ANN. § 71-3-1114 (2019) (allowing lien for “value of services”).

53. ARIZ. REV. STAT. ANN. § 33-931 (2020) (“The lien shall be for the claimant’s customary charges[.]”); NEB. REV. STAT. § 52-401 (2019) (allowing for “usual and customary charges”).

54. N.J. STAT. ANN. § 2A:44-38 (West 2019).

55. IOWA CODE § 582.1A (2019).

56. *Id.*

57. LA. STAT. ANN. § 9:4752 (2019); *id.* at § 22:1874.

if the patient had insurance.⁵⁸ In fact, the court called a hospital's attempt to use the lien to collect more than the insurance rate "disingenuous and somewhat deplorable."⁵⁹ Arizona, for one, has a statute like this, too, but *Andrews v. Samaritan Health System* held that because the statute says the hospital cannot charge the enrollee more and the lien is against the tort recovery instead of the enrollee themselves, the hospital's actions were okay.⁶⁰

Indiana:

Indiana requires that "the hospital has made all reasonable efforts to pursue the insurance claims in cooperation with the patient" and that the lien then be "reduced by the amount of any benefits to which the patient is entitled under the terms of any contract, health plan, or medical insurance."⁶¹

Alaska:

Alaska's hospital lien statute is very direct and simply states that if the patient has "a contract providing for indemnity or compensation" for the healthcare received, the amount of the hospital's lien is only for "the amount payable under the contract."⁶²

Colorado:

Under Colorado law, although a hospital is entitled to a lien, the hospital is required to submit the claim to the victim's insurance if he or she has insurance "in the same manner as used by the hospital for patients who are not injured as the result of the negligence or wrongful acts of another person."⁶³ The law was strengthened by an amendment in 2015 that grants the victim a claim against the hospital for twice the amount of the asserted lien if the hospital violates the statute, including not submitting to insurance.⁶⁴

Nevada:

In Nevada, a hospital is entitled to a lien for "the reasonable value of the hospitalization."⁶⁵ But the lien is only perfected with valid notice, and that notice is void unless the hospital submits the charges to the patient's insurer.⁶⁶ It is unclear whether the lien could be applied above the contracted amount if the insurer pays out.

58. *Rabun v. St. Francis Med. Ctr., Inc.*, 50, 849 (La. App. 2 Cir. 8/10/16); 206 So. 3d 323, 328.

59. *Id.*

60. *See Andrews v. Samaritan Health Sys.*, 36 P.3d 57, 61-62 (Ariz. Ct. App. 2001), disapproved of by *Blankenbaker v. Jonovich*, 71 P.3d 910 (Ariz. Ct. App. 2003).

61. IND. CODE § 32-33-4-3(b)(5) (2020).

62. ALASKA STAT. § 34.35.450(b) (2019).

63. COLO. REV. STAT. § 38-27-101 (2019).

64. *Id.* at § 38-27-101(7); *see also Marchant v. Boulder Cmty. Health, Inc.*, 436 P.3d 590, 591-92 (Colo. App.), *modified* (Colo. App. 2018), *cert. denied*, No. 18SC671, 2019 WL 922352 (Colo. Feb. 25, 2019).

65. NEV. REV. STAT. § 108.590 (2019).

66. *Id.* at § 108.605.

In all, forty-two states have some sort of hospital lien statute. The states that do not are Wyoming, West Virginia, South Carolina, Pennsylvania, Ohio, Mississippi, Michigan, and Kentucky.

B. Federal Medicare Preemption

In accepting Medicare and Medicaid, providers are required by federal law to accept the payments from the government agencies as “payment-in-full.”⁶⁷ This law seems to preempt any state lien law that would give the provider a lien against the patient’s tort claim recovery.⁶⁸

IV. PATIENTS’ OPTIONS TO FIGHT HOSPITAL LIENS

When a patient like Nancy finds herself in this situation, what options does she have? The patient may consider whether the hospital lien statute is even applicable, whether the hospital breached its contract, or whether the contract is valid or enforceable.

67. 42 U.S.C § 1396a(a)(25)(C) (2018); 42 C.F.R. § 447.15 (2013).

68. *Lizer v. Eagle Air Med. Corp.*, 308 F. Supp. 2d 1006, 1009 (D. Ariz. 2004) (rejecting argument that the law only prohibits using a lien after a Medicare payment if the lien is against the patient and not against the patient’s tort recovery). *See also* *Olszewski v. Scripps Health*, 69 P.3d 927, 945 (Cal. 2003) (“[A] provider that treats a Medicaid beneficiary may not recover from that beneficiary an amount exceeding the Medicaid payment by asserting a lien against the beneficiary’s entire recovery from a third party tortfeasor. . . . [V]irtually every case addressing the federal Medicaid statutes and regulations governing provider reimbursement holds that ‘[u]nder federal law, medical service providers must accept the state-approved Medicaid payment as payment-in-full, and may not require that patients pay anything beyond that amount.’ ”); *Ansley v. Banner Health Network*, 419 P.3d 552, 559 (Ariz. Ct. App. 2018) (“The regulation plainly bars a hospital that has contracted with AHCCCS from billing a patient for the balance between what AHCCCS has paid and the hospital’s customary rates. We hold this regulation likewise bars a hospital from imposing a lien on the patient’s tort recovery for the balance.”).

The District Court in *Lizer* explained:

First, the pertinent regulation clearly mandates that states must require providers to accept Medicaid payments as payment in full. See 42 C.F.R. § 447.15. This language prevents providers from billing *any* entity for the difference between their customary charge and the amount paid by Medicaid. Providers are not merely prevented from balance billing patients themselves. Furthermore, this case demonstrates the necessity of the payment in full provision in order to carry out the full spirit of 42 U.S.C. § 1396a(a)(25)(c). Permitting providers to charge the balance of their bill to entities which are liable to the patient ultimately results in the patient recovering less from the liable entity. Congress passed the balance billing prohibition in order to protect eligible patients from having to pay additional sums for services already compensated by Medicaid. The accompanying regulation was passed in order to ensure that this purpose was carried out by preventing providers from intercepting funds on the way to a patient.

Lizer, 308 F. Supp. 2d at 1009.

A. *The Underlying Contracts*

There are two contracts operating in this scenario. There is a contract between the patient and the insurer and a separate contract between the insurer and the hospital. The patient's contract with the insurer will usually reference plan documents that describe, among other things, what services are covered and what the patient's responsibilities and liabilities are. The contract between the insurer and the provider will similarly describe what will be paid for, how much will be paid (or how that will be determined), and importantly, that the hospital will accept payment from the insurer on behalf of the patient.⁶⁹

An Arizona case, *Andrews v. Samaritan Health Systems*,⁷⁰ provides a good example of our situation. In that case, nine individuals were involved in auto accidents and treated at one of the defendant hospitals.⁷¹ "Pursuant to the provider contracts between the hospitals and the [patients'] insurers," the hospitals submitted the charges for the services to the patients' insurers and were paid the agreed upon amount.⁷² After being paid, the hospitals then filed liens against the patients' tort recoveries for the full list price of the services.⁷³ The nine patients brought suit to enjoin the hospitals from enforcing these liens.⁷⁴ As for the contracts, each provider-insurer contract had language "indicating that the insurers' discounted payments were 'payment-in-full' for treatment."⁷⁵ Some of the contracts in *Andrews* also reserved the right to recourse against third-party payors,⁷⁶ but at least one did not and so only had the "payment-in-full" language.⁷⁷ In another case, the provider-insurer contract included an agreement to

69. See generally *Palmyra Park Hosp. Inc. v. Phoebe Putney Mem'l Hosp.*, 604 F.3d 1291, 1295 (11th Cir. 2010).

Hospitals . . . derive a large amount of their revenue from private insurers. Hospitals negotiate contracts with private insurers that set the rates the insurers will pay for services the hospital provides the insured patients. A hospital with such a contract is considered an in-network provider, and an insurer provides its policy holders with strong financial incentives—usually in the form of lower co-payments or lower insurance premiums—to procure medical services from in-network instead of out-of-network providers. These incentives are strong enough that policy holders tend to choose only in-network hospitals, and hospitals can expect an increase in the number of an insurer's policy holders who choose it for medical services when the hospital becomes an in-network provider for that insurer. The converse also holds true: hospitals can expect to lose much of the business of an insurer's policy holders if the hospital loses its status as an in-network provider for that insurer.

Id.

70. *Andrews v. Samaritan Health Sys.*, 36 P.3d 57 (Ariz. Ct. App. 2001), disapproved of by *Blankenbaker v. Jonovich*, 71 P.3d 910 (Ariz. Ct. App. 2003).

71. *Id.* at 59.

72. *Id.*

73. *Id.*

74. *Id.* at 59-60.

75. *Andrews v. Samaritan Health Sys.*, 36 P.3d 57, 59 (Ariz. Ct. App. 2001), disapproved of by *Blankenbaker v. Jonovich*, 71 P.3d 910 (Ariz. Ct. App. 2003).

76. *Id.* Whether these provisions are valid or enforceable is discussed below.

77. *Id.*

accept payment from the insurer and “not to bill members for the balance.”⁷⁸ Additional cases and common sense likewise suggest that this kind of language is common in provider-insurer contracts.⁷⁹

What happens, however, as in our unfortunate scenario, when the hospital does not submit the claim to the insurance at all or fails to accept the insurer’s payment as payment-in-full for the patient? Has the hospital breached its contract? Is a contract that allows the hospital to carry out this plan legally valid or enforceable? Does the patient have any recourse against the hospital as a third party? This Part will describe possible contract-law-based arguments against the hospital windfall in our scenario and what patients can do, if anything.

B. Breach of the Hospital-Insurer Contract

We consider the following questions: If the provider-insurer contract includes “payment-in-full” language, does the hospital breach its contract when it asserts a statutory lien for the chargemaster rate in excess of the contractual rate? Does a provision that purports to reserve the hospital’s right to a lien work? And finally, what if no claim is ever submitted to the insurer?

1. Breach of Payment-in-Full Provisions

A breach of contract is any non-performance of a duty that is due under the contract.⁸⁰ A claim of breach of contract gives the victim potential access to damages from the hospital and would be the most direct argument to make. Even though the victim is not a direct party to the hospital-insurer contract, he or she is likely entitled to bring a breach of contract claim as a third-party beneficiary.⁸¹

As seen, hospital-insurer contracts often have provisions that purport to require the hospitals to accept payment from the insurer as payment-in-full for the patient. Whether or not it is a breach of that contract to file a lien against such an insured patient when payment has been made is unclear. Cases in several jurisdictions seem to suggest that it is a breach of contract.⁸²

However, at least the court in *Andrews* held that the state’s hospital lien statute granted the hospital a lien in spite of the terms of the contract.⁸³ The court’s reasoning is suspect, however, because it does not

78. *Ansley v. Banner Health Network*, 419 P.3d 552, 556 (Ariz. Ct. App. 2018).

79. *See generally Nahom v. Blue Cross & Blue Shield of Ariz., Inc.*, 885 P.2d 1113, 1116 (Ariz. Ct. App. 1994); *West v. Shelby Cty. Healthcare Corp.*, 459 S.W. 3d 33 (Tenn. 2014).

80. RESTATEMENT (SECOND) OF CONTRACTS § 235 (AM. LAW INST. 1981).

81. *See infra* Part V.

82. *Satsky v. United States*, 993 F. Supp. 1027, 1029-30 (S.D. Tex. 1998); *Dorr v. Sacred Heart Hosp.*, 597 N.W.2d 462, 468, 471-72 (Ariz. Ct. App. 1999); *N.C. ex rel. L.C. v. A.W. ex rel. R.W.*, 713 N.E.2d 775, 776 (Ill. App. Ct. 1999); *Wright v. First Nat’l Bank in Albuquerque*, 941 P.2d 498, 500-02 (N.M. 1997).

83. *See Andrews v. Samaritan Health Sys.*, 36 P.3d 57, 61 (Ariz. Ct. App. 2001), disapproved of by *Blankenbaker v. Jonovich*, 71 P.3d 910 (Ariz. Ct. App. 2003) (holding that

simply follow that because a statute grants a certain right (a hospital lien), a contract provision cannot abrogate that right. That is essentially the definition of consideration by performance or non-performance. If you agreed to not do something you are not allowed to do anyway, that promise would be questionable consideration. Hospitals have also argued that “payment-in-full” language only applies to payments from the insurer and not from third parties, but this assertion has sometimes been rejected.⁸⁴

If provider-insurer contracts contain unqualified “payment-in-full” language, patients may have a strong argument to enforce these provisions against hospitals and demand liens be released or damages paid. If, however, the contracts attempt to reserve the right to go after third parties, further arguments must be made asserting that these provisions are invalid. While such “reserving provisions” may be severable and breach for the payment-in-full provision enforced, these provisions may be so interwoven with the payment-in-full provisions that the two could not be severable and the payment-in-full provision enforced without the invalid reserving provision.⁸⁵ The hospital may also be in breach of the contract by not submitting the claim to insurance.⁸⁶

2. *Reserving Provisions Only Work if the Victim Could Assign His or Her Personal Injury Claim.*

As the contracts in *Andrews*, *West v. Shelby County Healthcare Corp.*, and *Dameron Hosp. Assn. v. AAA* show,⁸⁷ hospitals

although one contract promised to accept payment-in-full from insurer and did not reserve the right to go after third-parties, the lien statute granted the hospital a lien for the full chargemaster amount). *Blankenbaker* thoroughly destroys the *Andrews* analysis of the lien statute, so one must wonder if the analysis of the lien vis-à-vis the contract provision is likewise suspect. *Blankenbaker v. Jonovich*, 71 P.3d 910, 913-14 (Ariz. Ct. App. 2003).

84. *Ansley v. Banner Health Network*, 419 P.3d 552, 560 (Ariz. Ct. App. 2018) (“The Hospitals argue that the reference in § 447.15 to ‘payment in full’ limits a provider’s right to payment from the state Medicaid agency or from the patient but does not apply to payments the provider might be able to intercept from a third-party tortfeasor. That interpretation, however, is contrary to the purpose of the regulation and the purpose of the Medicaid Act itself . . .”).

85. *Louisville & Jefferson Cty. Metro. Sewer Dist. v. T+C Contracting, Inc.*, 570 S.W.3d 551, 559 (Ky. 2018), *reh’g denied* (Apr. 18, 2019) (“Where a contract . . . consists of several covenants and agreements with regard to different subjects, and one of the covenants is illegal and vicious, the general rule which prevails is that, if the illegal covenant of the contract can be eliminated from it without impairing its symmetry as a whole, the courts will adopt that view and eliminate the obnoxious feature and enforce the remainder of the contract.”); *Int’l Paper Co. v. Corporex Constructors, Inc.*, 385 S.E.2d 553, 555 (N.C. Ct. App. 1989) (“When a contract contains a provision which is severable from an illegal provision and is in no way dependent upon the enforcement of the illegal provision for its validity, such a provision may be enforced.”).

86. *See infra* Part IV(B)(3).

87. 36 P.3d 57, 61 (Ariz. Ct. App. 2001), disapproved of by *Blankenbaker v. Jonovich*, 71 P.3d 910 (Ariz. Ct. App. 2003); *West v. Shelby Cty. Healthcare Corp.*, 459 S.W. 3d 33, 46 (Tenn. 2014); *Dameron Hosp. Assn. v. AAA N. Cali., Nev. & Utah Ins. Exch.*, 176 Cal. Rptr.

will attempt to have “reserving provisions” in the hospital-insurer contract that purport to reserve the right of the hospital to get a statutory lien despite being paid by the insurer and accepting that money as payment-in-full. However, a contract cannot create an obligation in an unrelated third-party toward the hospital. When it comes to the lien statute, the contract can simply allow the hospital to avail itself of the lien statute and may not define the obligations granted by the statute. A reserving provision may not be able to save a full price lien when the insurer has paid out unless the provision is simply considered an assignment of the victim’s personal injury claim.

The contract can only govern the parties to the contract and sometimes third-party beneficiaries. The contract could not say, for example, that if a patient is injured by a third-party, the hospital gets the third-party’s house, TV, and vinyl record collection. As the court in *West* stated, “While a contract can establish rights and govern the conduct of the parties to the contract, it cannot establish rights against persons who are neither parties to the contract nor third-party beneficiaries of the contract.”⁸⁸ So the hospital-insurer contract cannot create any obligations or debts in the third-party tortfeasor. It can, however, as many are so worded, allow the hospital to avail itself of the lien statute. In this way, it is simply an affirmative statement that the contract does not restrict the hospital’s preexisting right. The question then becomes what does the lien statute grant?

The statute grants a lien against the victim’s tort recovery in the amount of reasonable charges for services performed. Importantly, it does not say it creates a debt. A lien is not a debt; even a nonrecourse debt is not synonymous with a lien; they are two distinct legal forms.⁸⁹ Confirming this, courts addressing hospital liens have made clear, as seen above, that fundamentally liens are for securing a debt and therefore, there must be a debt underlying hospital liens or the lien does not exist.⁹⁰ The Kansas Supreme Court found it very clear: “We hold that, giving ordinary words their ordinary meaning and following our age-old precedent, a hospital lien requires an underlying debt for the lien to secure. Without such a debt, the lien is invalid.”⁹¹ It follows

3d 851, 860 (Cal. Ct. App. 2014); *see also*, *Rogalla v. Christie Clinic, P.C.*, 794 N.E.2d 384, 389-90 (Ill. App. Ct. 2003).

88. *West v. Shelby Cty. Healthcare Corp.*, 459 S.W.3d 33, 46 (Tenn. 2014).

89. *See, e.g., In re B.R. Brookfield Commons No. 1 LLC*, 735 F.3d 596, 597 (7th Cir. 2013) (“[The claim] is a nonrecourse loan agreement that is secured by a lien”); *In re 500 Fifth Ave. Assocs.*, 148 B.R. 1010, 1016 (Bankr. S.D.N.Y. 1993), *aff’d*, No. 93 CIV. 844 (LJF), 1993 WL 316183 (S.D.N.Y. May 21, 1993) (“ . . . non-recourse claims secured by liens”); *In re W. Real Estate Fund, Inc.*, 109 B.R. 455, 464 (Bankr. W.D. Okla. 1990) “. . . [recourse or non-recourse] claims secured by liens on property”). The reasoning in *Andrews* however conflates the two: “. . . [A] medical *lien* is . . . granted by [the statute] Of course, this is non-recourse *debt*” *Andrews v. Samaritan Health Sys.*, 36 P.3d 57, 61 (Ariz. Ct. App. 2001) (emphasis added), disapproved of by *Blankenbaker v. Jonovich*, 205 Ariz. 383, 71 P.3d 910 (Ariz. Ct. App. 2003).

90. *See supra* notes 87-89 and accompanying text.

91. *Via Christi Reg’l Med. Ctr., Inc. v. Reed*, 314 P.3d 852, 862 (Kan. 2013).

then that without an underlying debt, there can be no lien for the statute to grant. Reserving provisions, therefore, allow hospitals to get exactly what the statute grants: a lien *if* a debt exists.

Now the question is, what debts exist? There is a debt if the victim (or the insurance) has not fulfilled one of its obligations under the contract. In our context, we assume that the victim's debt to pay for the services performed has been "paid in full" under the contract. What other debt could there be? The lien statute does not create any debts, and the contract can only create debts between the hospital, insurer, and victim. The contract cannot create a debt against the third-party tortfeasor on which the lien can be based. In *West*, the hospital claimed its reserving provision allowed it to get a lien after the victim's debt had been paid. The court there disagreed, saying that once any patient obligation had been extinguished by the insurer's payment, there was no more claim for a lien to be based upon. The hospital-insurer contract could not create a claim in relation to the third-party tortfeasor.⁹² Lest someone suggest that the legislature meant to grant the hospital a claim (or debt) against the tortfeasor, the *West* court pointed out that a different statute does, in fact, allow the hospital a direct claim if someone pays or releases funds without satisfying a valid lien first, but the legislature did not include this grant in the lien statute.⁹³

To restate, the only thing the lien statutes grant is a lien, not a debt. There must be some other debt in order for the statutory lien to have effect. No matter what the hospital-insurer contract says in a reserving provision, it cannot create a debt or claim against a third-party tortfeasor. Once the patient's debt is extinguished there is usually no other debt or claim on which a statutory lien can be based.

However, *Andrews* and *Rogalla* claim that a reserving provision can indeed save a full price lien because the provision means there is still a debt.⁹⁴ Both decisions, however, highlight that these provisions are, in reality, assignments or subrogation to the hospital of the victim's personal injury claim. If the hospital-insurer contract cannot create any debt against the tortfeasor, and the hospital is not entitled to recover the full price from the victim directly—because of the paid in full provisions and often because of state statute—the only debt left for

92. *West v. Shelby Cty. Healthcare Corp.*, 459 S.W.3d 33, 46 (Tenn. 2014).

93. *Id.* at 47 n.18.

94. *Andrews v. Samaritan Health Sys.*, 36 P.3d 57, 59-61 (Ariz. Ct. App. 2001), disapproved of by *Blankenbaker v. Jonovich*, 71 P.3d 910 (Ariz. 2003); *Rogalla v. Christie Clinic, P.C.*, 794 N.E.2d 384, 392 (Ill. App. Ct. 2003).

In one case, the California Supreme Court has stated, "If hospitals wish to preserve their right to recover the difference between usual and customary charges and the negotiated rate through a lien under the HLA, they are free to contract for this right." *Parnell v. Adventist Health Sys./W.*, 109 P.3d 69, 80 (Cal. 2005). But this statement was not necessary to the holding in that case and nothing more was said of the idea before or after the holding. Although one California appellate court felt bound by the statement, see *Dameron Hosp. Assn. v. AAA N. Cali., Nev. & Utah Ins. Exch.*, 176 Cal. Rptr. 3d 851, 860 (Cal. Ct. App. 2014), it seems to fit the mold of the dicta.

the provision to relate to is the victim's interest in the personal injury claim.⁹⁵ Indeed, the court in *Rogalla* simply refers to the hospital's right as "subrogation."⁹⁶ Therefore, in order for there to still be a debt on which to base the statutory lien after insurer payment, we must consider the victim obligated by the provision to assign his or her claim or subrogate to the hospital.

Although hospital lien statutes may therefore simply be seen as legislative approval of assignments of personal injury claims, as seen in these cases, the issues are often conflated,⁹⁷ terms are misused,⁹⁸ and the reasoning is circular.⁹⁹ It is important for courts to realize what is actually at stake when considering challenges, policy, and legislative intent surrounding hospitals' uses of these statutes. Reserving provisions are, in reality, the assignment or subrogation of the victim's personal injury claim.

3. *When the Hospital Never Submits the Charges to the Insurer*

Because the victim is being provided a service by the hospital, the victim incurs a debt, which the hospital can legally seek to recover. Often, patients will be given various things to sign when admitted to the hospital, including an acknowledgement of responsibility for payment. This agreement usually only references the hospital's chargemaster charges and so a victim, to start out, is liable for these high charges. Naturally, even without a statutory hospital lien, "[t]he provider can always proceed . . . against the patient for the value of the services rendered."¹⁰⁰

When a victim is insured, usually nothing changes in the hospital's legal right to proceed against the victim. Sometimes, providers are statutorily obligated to submit charges for insured patients to their insurers.¹⁰¹ Hospitals may also be contractually bound to submit the bill to the insurer. This is a very important aspect of the hospital-insurer contract that should be discovered. In Kansas, for example, one hospital network settled a lawsuit for \$3.5 million after it was sued

95. *Andrews*, 36 P.3d at 62 (as opposed to a claim against the victim themselves, "[the hospitals] are asserting a statutory lien against the enrollee's tort claim"); *Rogalla*, 794 N.E.2d at 392 ("provider may recoup payments incurred as a result of the third party. This is the tortfeasor's debt to plaintiff . . .").

96. *Rogalla*, 794 N.E.2d at 392.

97. *Rogalla* says there is a "statutory right to seek relief from third-party tortfeasors." *Id.* But of course, the hospital cannot claim a recourse debt personally against the tortfeasor, only a lien against the tortfeasor's damages payment, which in reality is the victim's interest.

98. See *Andrews*, 36 P.3d at 61 (the conflation of lien versus debt.); see *infra* section III.C.1 (conflating lien and debt); see also *infra* notes 164-75 and accompanying text (conflating lien and assignment).

99. *Andrews v. Samaritan Health Sys.*, 36 P.3d 57, 61 (Ct. App. 2001), disapproved of by *Blankenbaker v. Jonovich*, 71 P.3d 910 (2003) (stating both that the statute creates a non-recourse debt and that the contract creates the debt on which the lien is based).

100. *Blankenbaker v. Jonovich*, 71 P.3d 910, 915 (Ariz. 2003).

101. See, e.g., Iowa and Indiana *supra* notes 55-56, 61 and accompanying text.

for not submitting charges for insured, accident-victim patients to their insurer and for filing liens instead.¹⁰² In addition to releasing and refunding liens, the hospital system agreed to never file full price liens against insured patients again.¹⁰³

If the hospital is under no obligation to submit the bill to the insurer, the hospital may seek to recover from the victim for its full chargemaster rate because the victim agreed to as much at admittance. In a sense, the hospital may take the risk of asserting a higher claim against the individual or receiving a guaranteed insurance payment for a lower amount.¹⁰⁴ Whether the hospital should be able to use its chargemaster rate in this way is discussed below.

C. The Hospital Lien Statute May Not Apply

1. If the Hospital Accepted the Negotiated Payment, There Is No Underlying Debt

There is a good argument for the patient to make that the lien statute does not apply: there is no underlying debt for the lien if the hospital accepted payment from the insurer. As alluded to above, “[a] lien is a means of securing a debt; without a debt, there can be no lien.”¹⁰⁵ For example, in *Parnell v. Adventist Health System/West*, the California Supreme Court held that a hospital lien under the statute requires an underlying debt be owed by the patient.¹⁰⁶ In *Parnell*, a hospital had been paid its negotiated rate by the insurer but sought a lien against the patient for the rest of the hospital’s chargemaster rate.¹⁰⁷ The court noted that under the provider agreements, the hospital had “agreed to accept [the negotiated rate] as ‘payment-in-full’ ” and therefore the patient’s “entire debt to the hospital [was] extinguished.”¹⁰⁸ The court therefore held that the hospital could not assert a lien against the patient.¹⁰⁹ In fact, this is the view of most state courts that have addressed the question.¹¹⁰

102. Steve Everly, *St. Luke’s Hospital Settles Health Insurance Cases with Accident Victims*, KAN. CITY STAR (April 25, 2014), <https://www.kansascity.com/news/business/article346893/St.-Luke%E2%80%99s-Hospital-settles-health-insurance-cases-with-accident-victims.html> [https://perma.cc/VF35-UP7U].

103. *Id.*

104. *Blankenbaker*, 71 P.3d at 915 (“[T]he lien statutes extend to health care providers . . . a lien against those liable to the patient for damages But nothing in the statutes suggests that the legislature thereby intended to restrict any remedy that the provider might have directly against the patient.”).

105. *Ansley v. Banner Health Network*, 419 P.3d 552, 559 (Ariz. Ct. App. 2018) (citing *Matlow v. Matlow*, 361 P.2d 648 (Ariz. 1961)).

106. *Parnell v. Adventist Health Sys./W.*, 35 Cal. 4th 595, 609, 109 P.3d 69, 79 (Cal. 2005).

107. *Id.* at 72.

108. *Id.* at 79.

109. *Id.*

110. *Id.* (“[W]e follow the lead of most of our sister courts that have addressed the same question.”); *Id.* at 79 n.14 (quoting *Satsky v. United States*, 993 F.Supp. 1027, 1027 (S.D.

However, one argument against the type of reasoning illustrated in *Parnell* is offered in *Andrews*.¹¹¹ The *Andrews* court opined that there is indeed a “debt” to support the lien even after the insurer pays the hospital.¹¹² Although the court recognized that the “personal debt” against the patient had been paid, the court distinguished the debt underlying the lien as a non-recourse debt and held it was not a personal debt against the patient.¹¹³ However, this argument is supported by three mistaken premises. First, the court said the lien, and therefore the debt, materializes immediately on caring for a tort-victim.¹¹⁴ This premise was summarily overturned.¹¹⁵ Second, the court points to federal programs which allow these kind of liens.¹¹⁶ This type of billing is now prohibited for all federal medical programs.¹¹⁷ And third, the court said the “provider[-insurer] contracts create an obligation for payment of the customary charges”¹¹⁸ because of the language allowing the provider to go after a third party. This type of provision is problematic as has been shown because a contract cannot create an obligation in an unrelated party.¹¹⁹

State statutes may also prohibit providers from attempting to collect from victims after they have been paid by insurance. But the court in *Andrews*, where Arizona has such a statute, skirted this problem by saying the lien was against the patient’s recovery and not the patient themselves. But it was this same attempted distinction that the Louisiana court called disingenuous and deplorable.

Tex. 1998) “As there is no debt, there can be no lien”; *Id.* at 79 n. 14 (citing to “Maxwell [v. S. Miami Hosp. Found., Inc.], 385 So. 2d [127, 127 (Fla. 3d DCA 1980)] (holding that settlement of the debt underlying the hospital’s lien extinguished the lien); Lopez v. Morley, 817 N.E.2d 592, 599 (Ill. App. Ct. 2004) (holding that a hospital’s lien “covers only the amounts of the debt owed”)); Midwest Neurosurgery, P.C. v. State Farm Ins. Cos., [686 N.W.2d 572, 581 (Neb. 2004)] (limiting the hospital’s lien to the amount the hospital agreed to accept as payment-in-full from the patient and his insurer); Wright [v. First Nat’l Bank in Albuquerque,] 941 P.2d [498,] 500-01 [(N.M. 1997)] (holding that the hospital could not assert a lien for its full charges because it had agreed to accept the insurance payment as payment in full); Dorr [v. Sacred Heart Hosp.,] 597 N.W.2d [462,] 472-73 [(Wis. Ct. App. 1999)] (holding that ‘the hospital is precluded from making any claim for payment’ using the lien statute because its provider agreement ‘negates the existence of a debt owed by the [patient] to the hospital’); Via Christi Reg’l Med. Ctr., Inc. v. Reed, 314 P.3d 852, 862 (Kan. 2013) (“We hold that, giving ordinary words their ordinary meaning and following our age-old precedent, a hospital lien requires an underlying debt for the lien to secure. Without such a debt, the lien is invalid.”).

111. See *Andrews v. Samaritan Health Sys.*, 36 P.3d 57, 61 (Ariz. Ct. App. 2001), disapproved of by *Blankenbaker v. Jonovich*, 71 P.3d 910 (Ariz. Ct. App. 2003).

112. *Id.*

113. *Id.*

114. *Id.*

115. *Blankenbaker v. Jonovich*, 71 P.3d 910, 911 (Ariz. 2003). See also *Weston Reid, LLC v. Am. Ins. Grp., Inc.*, 174 Cal. App. 4th 940, 948 (Cal. Ct. App. 2009) (“The lien does not come into existence until the hospital . . . files the required notice of lien.”).

116. *Andrews*, 36 P.3d at 61-62.

117. *Supra* Part III(B).

118. *Andrews v. Samaritan Health Sys.*, 36 P.3d 57, 61 (Ariz. Ct. App. 2001), disapproved of by *Blankenbaker*, 71 P.3d at 910.

119. See *infra*, Part IV(B)(2).

If insurance has already paid the hospital on the victim's behalf, there may be no reason for the hospital to be able to get a statutory lien. Indeed, there may not be the necessary underlying debt for the lien and state statutes may prohibit collection from an insured victim after being paid.

2. *The Full Chargemaster Amount May Not Be “Reasonable” or “Customary”*

Many state statutes are written to require that the lien be for “reasonable” or “customary” charges only.¹²⁰ How exactly to define reasonable or customary in these situations has been debated.¹²¹ When many of these statutes were written, determining reasonableness was much less complicated and often a hospital employee “would simply testify that the charges were customary and reasonable.”¹²² That witness would usually be enough.¹²³ Since then, payment systems for hospitals have gotten more complicated and greater involvement of government payors and negotiations with insurers have made the definition unclear.¹²⁴

As seen above, chargemaster rates are not “reasonable” in an opportunity-cost economic sense because almost no one sees or pays these amounts. Further, there is no chance for the individual consumer to ask if this is really the amount he or she would exchange for this service.¹²⁵ In fact, insurance itself may, in small part, suggest that the amounts are unreasonable—that people have heard how much these unreduced amounts can be and have decided to pay quite a lot of money to avoid the chargemaster rates. Additionally, chargemaster rates cannot be “customary” when the vast majority of

120. *Supra* Part III(A).

121. For a more complete discussion of chargemaster rates in relation to hospital liens, see Michael K. Beard & Dylan H. Marsh, *supra* note 1, at 255, and George A. Nation III, *Hospitals Use the Pernicious Chagemaster Pricing System to Take Advantage of Accident Victims: Stopping Abusive Hospital Billing*, 66 DRAKE L. REV. 645, 645-47 (2018).

122. Beard & Marsh, *supra* note 1, at 273.

123. *Id.*

124. *Id.*

125. Interestingly, part of the current federal government's push for healthcare-consumer protection has been to require hospitals to publish their prices. A. Pawlowski & Lauren Dunn, *Hospitals to List Procedure Prices Under New Law: What You Need to Know*, NBC NEWS (Dec. 28, 2018), <https://www.nbcnews.com/health/health-news/hospitals-list-procedure-prices-under-new-law-what-you-need-n952686> [https://perma.cc/47XT-W9AM]. And this requirement has been recently upheld by a federal district court. Ricardo Alonso-Zaldivar, *Trump White House Wins Court Ruling Upholding Plan to Require Insurers and Hospitals to Disclose Prices*, USA TODAY (June 24, 2020), <https://www.usatoday.com/story/news/politics/2020/06/24/trump-white-house-wins-court-ruling-health-care-price-disclosure/3248533001/> [https://perma.cc/9CLE-ZST7]. But whether this requirement will help balance billing is questionable because of the high rate of involuntary out-of-network visits, as outlined in Kelly et al., *Out-of-Network Physicians: How Prevalent Are Involuntary Use and Cost Transparency*, 48 HEALTH SERV. RES. 1154, 1154 (June 2013), and the fact that most patients are not in the best place to compare prices. Bai & Anderson, *supra* note 2, at 922, 925.

charges for services in hospitals are the lower, insurance-negotiated charges. If the statute requires that the lien be only for the reasonable or customary amount, it would seem that liens for amounts multiple times greater than the common insurance rate would not be accepted. On the other hand, these are the amounts that patients usually agree to, at least by inoperative reference, when they are admitted to the hospital, and hospitals are theoretically free to set their fees.¹²⁶

In addition to thinking about what is reasonable or customary for the *hospital*, we may also consider what is reasonable in relation to that specific patient. In *West v. Shelby County Healthcare Corporation*, the Tennessee Supreme Court held that because the patient was a third-party beneficiary to the hospital-insurer contract, the reasonable charge for that (insured) patient was the reduced amount; the lien, therefore, could not exceed that amount.¹²⁷ The court in *Garner v. City of Houston* held that because the statute required the charges to be reasonable *and usual*, the lien amount must be usual for someone in the victim's financial condition.¹²⁸

Many cases are not clear on the point of what is reasonable. For example, while two Arizona cases do not directly hold that customary charges refer to the chargemaster amount, they reference the difference between the "customary" amount and the reduced-agreement amount, suggesting that they are not the same.¹²⁹ However, cases from other states suggest varying answers. For example, courts have found: 1) evidence of private health insurance and government reimbursement amounts is admissible and relevant to determining the reasonableness of the hospital's charges;¹³⁰ 2) evidence of government reimbursement is not relevant for determining reasonableness;¹³¹ 3) evidence of contractual discounts is insufficient to prove unreasonableness;¹³² 4) the plain meaning of usual and

126. See Beard & Marsh, *supra* note 1, at 256 (2014).

127. *West v. Shelby Cty. Healthcare Corp.*, 459 S.W.3d 33, 44 (Tenn. 2014) ("The Med's non-discounted charges reflected in the amount of the liens it filed against Mses. West and Heags-Johnson should not be considered reasonable charges for the purpose of [the Hospital lien statute.]").

128. *Garner v. City of Houston*, 323 S.W.2d 659, 662 (Tex. Civ. App. 1959).

129. See *Samsel v. Allstate Ins. Co.*, 59 P.3d 281, 289-90 (Ariz. 2002); *Ansley v. Banner Health Network*, 419 P.3d 552, 559 (Ariz. Ct. App. 2018).

130. *Bowden v. The Med. Ctr., Inc.*, 773 S.E.2d 692, 697 (Ga. 2015) (finding this information relative, at least in the discovery context); *Parkview Hosp., Inc. v. Frost ex rel. Riggs*, 52 N.E.3d 804, 810 (Ind. Ct. App. 2016).

131. *Roberts v. Univ. of Alabama Hosp.*, 27 So. 3d 512, 518 (Ala. Civ. App. 2008) ("[T]he trial court could properly disregard evidence of the hospital's practice of accepting less than full reimbursement from third-party payors . . .").

132. *Hillsborough Cty. Hosp. Auth. v. Fernandez*, 664 So. 2d 1071, 1072 (Fla. 2d DCA 1995).

customary charges is the full chargemaster amount;¹³³ and 5) the full chargemaster amount is reasonable because that is the amount the victim could get from the tortfeasor.¹³⁴

Some commentators have suggested a limit or a formula for determining reasonableness.¹³⁵ Others have suggested looking at factors such as what the providers charge other patients for the same service, the rates of similarly situated hospitals, the amounts routinely accepted by the hospitals for similar services, and “the provider’s ‘internal cost structure’ and historical profit margins.”¹³⁶ At least one court suggested that it makes sense for the term to be undefined “because that is the disputed issue.”¹³⁷ In any event, the limitation is indeed in the statute and should be given meaning. When chargemaster rates are so unrestrained in the hands of hospitals, calling these rates reasonable or customary is a far stretch and practically voids the limitation of any substance.

D. *Validity and Enforceability of the Contract*

Outside of a direct argument that the hospital breached the contract, the patient may also argue that the contracts are void or unenforceable. If the hospital or insurer makes a fraudulent or material misrepresentation, the patient may be able to void his or her patient-insurer contract. Additionally, a patient may be able to argue as a third-party beneficiary that the hospital-insurer contract is invalid or unenforceable because it is based on an illusory promise or is against public policy.

1. *Misrepresentations*

A misrepresentation makes a contract voidable if “a party’s manifestation of assent is induced by either a fraudulent or a material misrepresentation by the other party upon which the recipient is justified in relying.”¹³⁸ The contract is voidable even if the party making the misrepresentation is not a party to the contract at issue.¹³⁹ Does an

133. *Parnell v. Madonna Rehab. Hosp., Inc.*, 602 N.W.2d 461, 464 (Neb. 1999) (“[The statute] plainly states that a lien attaches to ‘the usual and customary charges’ of the service provider. However, [the plaintiff’s] interpretation would require that the amounts actually collected by a service provider be considered instead of the amount charged. Such an interpretation is contrary to the plain language of the statute.”).

134. *MCG Health, Inc. v. Kight*, 750 S.E.2d 813, 818 (Ga. App. 2013), *aff’d on other grounds*, 769 S.E.2d 923 (Ga. 2015).

135. *See, e.g.*, *Nation*, *supra* note 121, at 683-88 (suggesting that liens should be limited to the average negotiated private insurance rate plus 10-15 percent, or to the Medicare rate plus 25 percent.).

136. *Beard & Marsh*, *supra* note 1, at 284.

137. *Parkview Hosp., Inc. v. Frost ex rel. Riggs*, 52 N.E.3d 804, 807 (Ind. Ct. App. 2016).

138. RESTATEMENT (SECOND) OF CONTRACTS § 164 (1981).

139. The contract is voidable unless the other party to the contract gives value or relies on the misrepresentation “in good faith and without reason to know of the misrepresentation.” *Id.*

assertion by the provider in its contract with the insurer that it will accept payment-in-full constitute a fraudulent misrepresentation? “A misrepresentation is fraudulent if the maker intends his assertion to induce a party to manifest his assent and the maker (a) knows or believes that the assertion is not in accord with the facts, or (b) does not have the confidence that he states or implies in the truth of the assertion”¹⁴⁰ A misrepresentation also does not have to be *knowingly* made if it is material.¹⁴¹

In our situation, some hospitals continue to assert in the hospital-insurer contract that insurer payments will be accepted as payment-in-full but then the hospitals systematically file liens for the full chargemaster amount. This could possibly amount to a fraudulent misrepresentation on which the patient relies in entering into his or her patient-insurer contract.

However, a misrepresentation will only make a contract voidable. Thus, even if a patient relied on the hospital’s assertion, his or her possible recourse would be to void the patient-insurer contract and to not be liable for any more premiums. Given how our insurance system is set up (i.e., large portion of people getting insurance through employer and the lack of information for market competition), it is unlikely that voiding his or her insurance contract is practically feasible or even useful. Thus, this fraudulent misrepresentation goes unpunished and uncured because individual patients cannot put pressure on hospitals and the insurance companies are not harmed.

2. *Illusory Promises*

Many hospital-insurer contracts have language that “expressly reserve[s] the right to recapture the difference between any payments made by the insurer and the providers’ customary charges.”¹⁴² This language ironically tracks the Restatement’s definition of an illusory promise: “A promise or apparent promise is not consideration if by its terms the promisor or purported promisor *reserves* a choice of alternative performances,” none of which is consideration.¹⁴³ Put differently,

140. *Id.*

141. RESTATEMENT (SECOND) OF CONTRACTS § 159 (1981). A misrepresentation is simply “an assertion that is not in accord with the facts.” *Id.* at § 159. “A misrepresentation is material if it would be likely to induce a reasonable person to manifest his assent, or if the maker knows that it would be likely to induce the recipient to do so.” *Id.* at § 162(b).

142. *Andrews v. Samaritan Health Sys.*, 36 P.3d 57, 61 (Ariz. Ct. App. 2001), disapproved of by *Blankenbaker v. Jonovich*, 71 P.3d 910 (Ariz. Ct. App. 2003).

143. RESTATEMENT (SECOND) OF CONTRACTS § 77 (1981) (“A promise or apparent promise is not consideration if by its terms the promisor or purported promisor *reserves* a choice of alternative performances unless

(a) each of the alternative performances would have been consideration if it alone had been bargained for; or

(b) one of the alternative performances would have been consideration and there is or appears to the parties to be a substantial possibility that before the promisor exercises his

“A promise is illusory when the price to pay or the performance to be given is left entirely in the control of the promisor.”¹⁴⁴ An agreement that is based upon an illusory promise is not a valid contract because consideration is lacking.¹⁴⁵ If the hospital’s promise is defined as accepting the insurer’s payment as payment-in-full, then “reserving” the right to *not* accept that payment as payment-in-full would leave the performance entirely in the control of the promisor. Factors that normally save contracts from an illusory promise defense, such as advanced notice of a decision,¹⁴⁶ are not present here. However, specific to insurance contracts, the illusory promise may have to negate “all possible coverage” for the contract to be void.¹⁴⁷

3. *Unenforceable as Against Public Policy*

Terms of contracts may also be unenforceable on grounds of public policy.¹⁴⁸ Such public policy is often derived from manifestation of legislation or judicial decisions.¹⁴⁹ Relatedly, a comment to the Restatement (Second) of Contracts § 178 on this point directs that “a decision as to enforceability is reached only after a careful balancing, in the light of all the circumstances, of the interest in the enforcement of the particular promise against the policy against the enforcement of such terms.”¹⁵⁰ The fact that the state legislatures have enacted

choice events may eliminate the alternatives which would not have been consideration.”) (emphasis added).

144. Ann Taylor Schwing, *Lack of consideration—Illusory promises*, 3 CAL. AFFIRMATIVE DEF. § 56:6 (2d ed.) (2019).

145. *Id.* (“An illusory promise is no promise and is no consideration for a return promise.”); RLM Commc’ns., Inc. v. Tuschen, 66 F. Supp. 3d 681, 692 (E.D.N.C. 2014) (finding a confidentiality agreement unenforceable because the employer’s promise to provide the employee with confidential information was optional).

146. *See, e.g.*, Hancock v. American Tel. and Tel. Co., Inc., 804 F. Supp. 2d 1196, 1210 (W.D. Okla. 2011).

147. Amerisure Mut. Ins. Co. v. Carey Transp., Inc., 578 F. Supp. 2d 888, 921 (W.D. Mich. 2008) (An insurance contract must negate all possible coverage under the policy for it to be illusory).

148. Town of Newton v. Rumery, 480 U.S. 386, 392 (1987) (noting that “a promise is unenforceable if the interest in its enforcement is outweighed in the circumstances by a public policy harmed by enforcement of the agreement”); Evans v. Jeff D., 475 U.S. 717, 759 (1986) (noting the “well-established principle that an agreement which is contrary to public policy is void and unenforceable”); RESTATEMENT (SECOND) OF CONTRACTS § 178 (1981). *See, e.g.*, Shadis v. Beal, 685 F.2d 824, 833-34 (3d Cir. 1982) (holding a contract provision that prohibited an award of attorney’s fees against public policy and therefore unenforceable); CSA 13-101 Loop, LLC v. Loop 101, LLC, 341 P.3d 452, 454 (Ariz. 2014); Cariveau v. Halferty, 99 Cal. Rptr. 2d 417, 425 (2000) (finding a confidentiality provision unenforceable based on public policy in federal regulation).

A public policy argument is a defense to enforcement of the contract and “does not concern whether the contract was properly made . . .” Epic Sys. Corp. v. Lewis, 138 S. Ct. 1612 (2018) (Thomas, J., concurring) (quoting AT&T Mobility LLC v. Concepcion, 568 U.S. 333, 357 (2011)).

149. RESTATEMENT (SECOND) OF CONTRACTS § 178 (1981). *See, e.g.*, CSA 13-101 Loop, LLC, 341 P.3d at 454 (noting in the context of the public policy argument for unenforceability, “[w]e discern public policy from our constitution, statutes, and judicial decisions.”).

150. RESTATEMENT (SECOND) OF CONTRACTS § 178 cmt. b (1981).

these hospital lien statutes may seem like strong evidence against any policy-based judicial review of hospitals' actions in these cases.¹⁵¹ However, it is not so clear that the way hospitals *now* use these liens is in accordance with the original public policy expressed by the legislature in these statutes. There may, in fact, be other statutes that more clearly reflect the legislature's intent to protect the public welfare from the hospitals' actions.¹⁵² Indeed, when courts find a provision unenforceable on public policy grounds, that public policy is derived from legislation or "[the court's] own perception of the need to protect some aspect of the public welfare."¹⁵³

(a) *Public Policy Expressed in Hospital Lien Statutes*

One must ask whether these legislatures truly intended for hospitals to be able to force someone to pay many times the hospital's normal rates because he or she was in an accident. As the Restatement notes,

[L]egislation is significant, not as controlling the disposition of the case, but as enlightening the court concerning some specific policy to which it is relevant. A court will examine the particular statute in the light of the whole legislative scheme.... It will look to the purpose and history of the statute.¹⁵⁴

These statutes were generally created to "lessen the burden imposed on hospitals and other medical providers imposed by non-paying accident cases."¹⁵⁵ The public policy expressed in these statutes is that hospitals have an interest in being compensated for care they perform. This interest is clear. But in every case we are concerned with here, the hospital is treating someone insured by an insurance company with which the hospital has an agreement. In every case, the hospital does receive payment from that insurer or could receive payment from that insurer if it submitted the bill,¹⁵⁶ and the hospital receives the benefit of its agreement by getting a customer. In each individual case, there is not a "non-paying accident." Instead, insured victims of torts are being forced to foot the bill and then some for those

151. *Id.* (noting that when courts find a provision unenforceable on public policy grounds "it usually does so on the basis of a public policy derived . . . from legislation that is relevant to that policy . . .").

152. *See supra* Part III(A).

153. RESTATEMENT (SECOND) OF CONTRACTS § 178 cmt b.

154. RESTATEMENT (SECOND) OF CONTRACTS § 179 cmt b.

155. *Andrews v. Samaritan Health Sys.*, 36 P.3d 57, 63 (Ariz. Ct. App. 2001), disapproved of by *Blankenbaker v. Jonovich*, 71 P.3d 910 (Ariz. Ct. App. 2003) (citations omitted).

156. Even if the insurer were to deny the coverage for some reason, a possible middle ground is that the hospital could have a lien for an amount up to what would have been covered by the insurance. *See supra* Part III(A). In this way, the hospital is "fully" compensated for treatment of its insured customer.

few¹⁵⁷ non-paying patients by being gouged by hospital-decided charge-master rates.¹⁵⁸ This is especially true considering the significantly falling rates of uncompensated care and increasing hospital profits.¹⁵⁹ Indeed, the high-rates of the chargemasters are specifically used to generate revenue.¹⁶⁰ A study by Bei and Anderson found that “[h]ospitals have established their chargemaster rates to maximize revenue, initially to maximize revenues in the Medicare programs and now in the private sector.”¹⁶¹ As Bai and Anderson point out: “Clearly, hospitals need to receive sufficient revenue to remain in business This argument, however, cannot completely explain the wide variation in the charge-to-cost ratio shown in [a chart showing hospital charge-master rates averaging 3.4 times Medicare rates] or why some hospitals are charging ten times their own costs.”¹⁶² Thus, a court may decide that the hospitals’ broad use of the lien statute is against the original public policy of the lien statute itself.¹⁶³

(b) *Public Policy Expressed in Other Personal-Injury-Debt Statutes*

Other statutes in the “whole legislative scheme” may more fully enlighten courts as to public policy intended by the legislature. Indeed, a finding that a contract term is against public policy “does not require that the legislation in question expressly prohibit or require an act

157. See EDWARD R. BERCHICK, EMILY HOOD, & JESSICA C. BARNETT, U.S. CENSUS BUREAU, HEALTH INSURANCE COVERAGE IN THE UNITED STATE: 2017 at 1 (2018) (stating that 91.2% of Americans are covered by insurance, while thirty-seven percent of Americans are covered by a government insurance plan). See generally Terence P. Jeffrey, *Census Bureau: 118,395,000 on 'Government Health Insurance' in 2015; 28,966,000 Uninsured for Entire Year*, CNS NEWS (September 13, 2016), <https://www.cnsnews.com/news/article/terence-p-jeffrey/census-bureau-118395000-government-health-insurance-2015-28966000> [<https://perma.cc/Z5TZ-VWUS>]. These types of coverages help hospitals cover bad debts for the small portion of co-payments.

158. As discussed above, patients are not paying nothing when no money leaves their pocket to pay for the hospital bill. They pay premiums every month for health insurance as consideration for the agreement that the hospital will charge the lower, reasonable rate. Further, in many instances, the patient may have to pay out of pocket even after tort recovery because of the attorney’s fees and the fact the hospital lien can attach to the whole recovery and not only the part intended to cover hospital expenses.

159. See *supra* Part II.

160. Jeff Lagasse, *Study: Hospitals Still using Chargemaster Markups to Maximize Revenue*, HEALTHCARE FINANCE NEWS (Sep. 09, 2016), <https://www.healthcarefinancenews.com/news/study-hospitals-still-using-chargemaster-markups-maximize-revenue> [<https://perma.cc/PY7V-PTCS>] (stating that chargemasters serve an important revenue-seeking function).

161. Bai & Anderson, *supra* note 2, at 926.

162. *Id.* at 925.

163. However, the broad use of the lien statute may be what some legislatures had in mind. ARIZ. S., FACT SHEET FOR H.B. 2681, S. 462R-HB2681 (2004). (“To recover the difference between the full price and the discounted amount paid by the health insurers, health care providers can place a lien on payments to the injured person made by parties liable for the injuries, other than health insurers.”).

inconsistent with the contract; it is sufficient if the legislature makes an adequate declaration of public policy which is inconsistent with the contract's terms."¹⁶⁴

It is important to remember that hospital lien statutes may have a valid and important place as originally intended. In the case of non-payment, hospitals may need the right to assert a lien against the tort recoveries to cover their costs.¹⁶⁵ But non-payment is not happening in our situation. It could be argued that the way these statutes have been stretched by hospitals against insured individuals is heavily contradicted by public policy expressed in other statutes, and therefore, the contracts could be voidable as against public policy.

For example, this broad use of the lien statutes may contradict many states' policies against assignment of personal injury claims.¹⁶⁶ As discussed above, a reading of the lien statute that allows the hospital to receive a lien for an amount greater than the insured's debt should be viewed as an assignment of the insured's personal injury claim.¹⁶⁷ This is because a lien is "a charge or encumbrance upon property to secure the payment or performance of a *debt, duty or other obligation*," and it "is distinct from the obligation which it secures."¹⁶⁸ Thus, if the patient's insurance pays the hospital what is due under

164. *Shadis v. Beal*, 685 F.2d 824, 833-34 (3d Cir. 1982).

165. The use of chargemasters at all to determine the lien amount in complete nonpayment situations has been debated.

166. *See, e.g., Hays v. Missouri Highways & Transp. Comm'n*, 62 S.W.3d 538, 540 (Mo. Ct. App. 2001) ("It is well settled that in Missouri, a claim for personal injury cannot be assigned, in whole or in part."); *A. Unruh Chiropractic Clinic v. De Smet Ins. Co. of S. Dakota*, 782 N.W.2d 367, 370 (S.D. 2010) (recognizing "the common-law prohibition on the assignment of personal injury claims"); *see also Midtown Chiropractic v. Illinois Farmers Ins. Co.*, 847 N.E.2d 942, 947 (Ind. 2006) (noting the state's "long-standing prohibition of the assignment of personal injury actions"); *cf. Quality Chiropractic, PC v. Farmers Ins. Co. of Ariz.*, 51 P.3d 1172, 1176 (N.M. App. 2002).

The Arizona Supreme Court explained the public policy behind this prohibition:

The rule against assignability of personal injury claims is based in sound public policy. A victim's medical expense insurance coverage does not provide full indemnity. While it may indemnify him completely for his medical expenses (if the amount of his actual medical expenses falls within his policy limits), such expenses may constitute only a portion of his total loss. In addition to other "out-of-pocket" losses, such as loss of income or earning power and the costs of asserting said claim such as court costs and attorney's fees, an accident victim often suffers non-economic losses such as physical pain and mental anguish which are often not monetarily indemnifiable and never insurable. Under the repayment provision in the instant case, the insurance company obtains full reimbursement for its medical expense payments regardless of whether the victim's tort recovery fully covers his actual damages.

Also, to require an injured policy holder to return to his insurer the benefits for which he has paid premiums is to deny him the benefits of his thrift and foresight.

Allstate Ins. Co. v. Druke, 576 P.2d 489, 491 (Ariz. 1978).

See also Patrick T. Morgan, Unbundling Our Tort Rights: Assignability for Personal Injury and Wrongful Death Claims, 66 MO. L. REV. 683, 683 ("Tort rights are personal and cannot be separated from the person. This is unlike the proprietary right between an owner and his res: tort rights are interpersonal, existing between the tort victim and the tortfeasor.").

167. *See infra* Part IV(B)(2).

168. *Matlow v. Matlow*, 361 P.2d 648, 651 (Ariz. 1961) (citing 53 C.J.S. Liens § 1, at 826) (emphasis added) (citations omitted).

the contract as “payment-in-full,” there is no underlying debt against the patient.¹⁶⁹ Absent the third-party tortfeasor, the hospital would have no claim to come against the patient. But if we read the statutes the way the hospitals want—granting hospitals the right to assert additional liens *above the amount of the debt*—it is analogous to an impermissible assignment.¹⁷⁰

In *Allstate Ins Co. v. Druke*,¹⁷¹ the insurer-insured contract required the insured to reimburse Allstate out of any tort recovery based on the accident. Allstate argued that this was not an impermissible assignment because its interest only arose after a judgment or settlement, if there was any recovery at all. The Arizona Supreme Court rejected this argument as superficial:

We do not believe that this is a meaningful distinction. Allstate's rights come into existence at the creation of the insurance contract It is clear that Allstate intended by the provision in the policy to create a legally enforceable interest in any claim that their insured might have against a third-party tortfeasor. By whatever name, this is an assignment of the insured's cause of action for personal injury against said third party tortfeasor.¹⁷²

While this is not *assignment* in its technical sense—Allstate was not given control or ownership of the suit—the court recognized that this contract provision was analogous under the public policy considerations of the unassignability principle.

The Indiana Supreme Court also held that the assignment of proceeds from a personal injury claim is not distinguishable “from the prohibited assignment of the personal injury claim itself.”¹⁷³ Other courts have likewise disallowed rights in proceeds as being practical

169. See *infra* Part IV(C)(1).

170. *Assignments vs. Liens in the Personal Injury Context*, THE LEGAL EXAMINER (Dec. 9, 2007), <https://www.legalexaminer.com/health/assignments-vs-liens-in-the-personal-injury-context/> [<https://perma.cc/3685-E4B6>] (noting that “what has contributed to the confusion is that the law has undergone centuries of perversion and that it is sometimes hard to tell the difference between an assignment versus a lien on a personal injury claim”).

171. *Allstate Ins. Co. v. Druke*, 576 P.2d 489 (Ariz. 1978).

172. *Id.* at 492.

173. *Midtown Chiropractic v. Ill. Farmers Ins. Co.*, 847 N.E.2d 942, 947 (Ind. 2006).

assignments of the personal injury claim itself¹⁷⁴ and recognized that excessive hospital liens are in fact “transferring the interest of the injured party.”¹⁷⁵ But courts are not unanimous.¹⁷⁶

In our situation, a reserving provision that purports to give the hospital a right to a lien beyond the underlying debt falls in this same category. Said differently, while a lien for the contracted rate is supported by the debt for services rendered, claiming a lien for the higher amount beyond the contracted amount is simply trying to “create a legally enforceable interest [in the recovery].”¹⁷⁷ The hospitals’ broad reading of the lien statutes is not based on a “meaningful distinction”¹⁷⁸ between non-debt-supported liens and acceptance of an assignment in a personal injury verdict. Therefore, the broad reading contradicts the policy against assignment of personal injury claims.

Another set of statutes courts may look at to discern policy is the set of statutes that specifically prohibit a healthcare provider from collecting or attempting to collect from an insured “any amount in excess of the contracted reimbursement rate for covered health care services,”¹⁷⁹ also known as balance billing acts (BBA). This would seem to be clearly expressed public policy that stands against the hospitals’ understanding of the lien statutes. But at least one court has made the impractical distinction that liens pursuant to hospital lien statutes are against tort recoveries and not the individuals themselves.¹⁸⁰

Louisiana has both a hospital lien statute and a BBA that limits providers from collecting from insureds any amount above the contracted rate. In a case where a hospital claimed it could file a lien for its full chargemaster amount because the lien was against the tort recovery and not the patient themselves, the court rejected the argument with a good explanation:

174. *Hays v. Mo. Highways & Transp. Comm’n*, 62 S.W.3d 538, 540 (Mo. Ct. App. 2001); *Goldfarb v. Reicher*, 171 A. 149, 150 (N.J. Sup. Ct.1924), *aff’d per curiam*, 174 A. 507 (N.J. 1934); *Harvey v. Cleman*, 400 P.2d 87, 90 (Wash. 1965), *disapproved on other grounds by* *Wooldridge v. Woolett*, 638 P.2d 566 (Wash. 1981); *S. Farm Bureau Cas. Ins. Co. v. Wright Oil Co.*, 454 S.W.2d 69, 72 (Ark. 1970); *A. Unruh Chiropractic Clinic v. De Smet Ins. Co. of S. D.*, 782 N.W.2d 367, 374 (S.D. 2010).

175. *West Nebraska Gen. Hosp. v. Farmers Ins. Exch.*, 475 N.W.2d 901, 906 (1991) (citing *In re Howard*, 43 B.R. 135 (Bakr. D.Md.1983)); *In re Nelson*, 92 B.R. 837, 842 (Bankr. D.Minn. 1988).

176. For a deeper discussion of the split of authority on the issue see *A. Unruh Chiropractic Clinic*, 782 N.W.2d at 370-72. *See also* *Charlotte-Mecklenburg Hosp. Auth. v. First of Ga. Ins. Co.*, 455 S.E.2d 655, 657 (N.C. 1995) (“There is a distinction between the assignment of a claim for personal injury and the assignment of the proceeds of such a claim.”); *Miller v. Liberty Mut. Fire Ins. Co.*, 289 N.Y.S.2d 726, 727 (N.Y. App. Div. 1968) (“The ‘assignment’ of the proceeds of the personal injury claim does not violate the statutory prohibition against . . . transferring personal injury claims.”) (citations omitted); *In re Musser v. Musser* 24 B.R. 913, 922 (Bankr. W.D. Va. 1982).

177. *Allstate Ins. Co. v. Druke*, 576 P.2d 489, 492 (Ariz. 1978).

178. *See id.*

179. LA. STAT. ANN. § 22:1874 (2018); *see, e.g.*, ARIZ. REV. STAT. ANN. § 20-1072 (2019).

180. *Andrews v. Samaritan Health Sys.*, 36 P.3d 57, 61 (Ariz. Ct. App. 2001), *disapproved by* *Blankenbaker v. Jonovich*, 71 P.3d 910 (Ariz. 2003).

The medical lien statute permits the health care provider to collect “reasonable charges or fees” . . . from “the net amount payable to the injured person”. From a practical stance, although the primary source of these charges or fees is the third party tortfeasor, the injured party . . . can and should be treated as a secondary source since the amount payable to [the hospital] will be deducted from any award [the patient] is entitled to from the third party. By alleging that the medical lien statute authorizes it to collect more than the contracted rate from the third party, [the hospital] is circuitously stating that it can avoid the strict bans imposed by the BBA by simply crafting its bill as a medical lien instead of as a claim filed with the medical insurance company. Not only does this court reject this notion but we also find this practice to be *disingenuous and somewhat deplorable*. If such methods were permissible, there would be no need for the BBA.¹⁸¹

In states with BBAs, the legislative scheme shows that the public policy pronounced by the legislature is that hospitals should be granted a lien when there is non-payment or for their contracted amount, but not that hospitals should be granted a windfall every time a tort victim has the foresight to purchase insurance.

This is all not to say that legislatures could not make their lien statutes explicitly clear—for example, the statute could say hospitals are entitled to whatever their chargemaster rate says regardless of whether they were paid by insurance. That would be a clear expression of public policy. But the statutes are not so clear and are even somewhat conflicting with other statutes. So as a court “careful[ly] balance[s]” . . . the interest[s],¹⁸² uses statutes to “enlighten[] the court concerning some specific policy,”¹⁸³ and “examine[s] the particular statute in the light of the whole legislative scheme,”¹⁸⁴ weight must be given to the substantial amount of countervailing public policy expressed in other statutes. That is, that a hospital should not be granted a lien for its whole chargemaster rate when the hospital has agreed to be paid by the patient’s insurer. While a much broader reading of the public policy behind a specific lien statute is possible, the whole legislative scheme revolving around personal injury debts does not support this reading. Indeed, while one understanding grants windfalls to hospitals on the backs of insured individuals, the other, more narrow understanding based on protecting hospitals against non-payment is supported by the whole rest of the legislative scheme.

E. Other Arguments Warranting Further Inquiry

Another concern that arises but that is not addressed here is whether the insurer is liable for negotiating a contract that allows the

181. *Rabun v. St. Francis Med. Ctr., Inc.*, 50, 849 (La. App. 2 Cir. 8/10/16); 206 So. 3d 323, 328 (emphasis added).

182. RESTATEMENT (SECOND) OF CONTRACTS § 178 cmt b.

183. RESTATEMENT (SECOND) OF CONTRACTS § 179 cmt b.

184. *Id.*

victim to lose the benefit of their insurance. States often have strict liability rules for insurance and treat the insured-insurer relationship as special in tort. Under breach of good faith in contract, normally any sort of breach of good faith or duty under a contract is limited to contractual remedies. That is, a tort claim and the possibilities of its favorable damages are generally not allowed. But a tort claim based on a contract is sometimes allowed, and one of the most common areas is insurance. This usually arises because insurers are considered to be in a “special relationship” or fiduciary role vis-à-vis their insured.¹⁸⁵ Whether insured patients could sue their insurers for some sort of breach of duty under tort law for negotiating invalid or avoidable contracts is a point of further inquiry.

Additionally, equitable contract doctrines, such as equitable estoppel or unconscionability, have had a recent “rise to prominence” because of form contracts and unequal bargaining power.¹⁸⁶ The unequal bargaining power in insurance and healthcare contract as well as the contract-of-adhesion nature of these contracts should be considered further. Although cases have generally disfavored equity claims when there is a contract, these cases usually involve valid and enforceable contracts.¹⁸⁷

Additional research should also consider whether there are any statutory violations in the hospital’s dealings with the insurer, such as unfair trade practices.

V. AVENUES FOR PATIENT RECOVERY OF DAMAGES

If the hospital-insurer contract is valid, what recourse does a patient have? Generally, third-party beneficiaries can enforce contractual duties that relate to them: “A promise in a contract creates

185. See, e.g., *United Servs. Auto. Ass’n v. Law Offices of Herssein & Herssein, P.A.*, 233 So. 3d 1224, 1231 (Fla. 3d DCA 2017) (noting “insurer’s fiduciary obligation to its insured...”) (footnotes omitted); *Berg v. Nationwide Mut. Ins. Co., Inc.*, 189 A.3d 1030, 1037 (PA. 2018) (“Thus, an insurer must act with utmost good faith towards its insured.”); *Id.* at 1170 (citing *Dercoli v. Pennsylvania Nat. Mut. Ins. Co.*, 554 A.2d 906, 909 (Pa. 1989) (“The duty of good faith originates from the insurer’s status as a fiduciary for its insured under the insurance contract”)); *Old Am. Ins. Co. v. Lincoln Factoring, LLC*, 571 S.W.3d 271, 277 (Tex. App. 2018) (“Texas law also recognizes a cause of action for damages for a breach of the common law duty of good faith and fair dealing owed by insurers to insureds and beneficiaries.”).

186. Michael B. Metzger & Phillips J. Phillips, *Promissory Estoppel and Reliance on Illusory Promises*, 44 SW. L. REV. 841, 880 (1990) (“As one of the family of doctrines that ‘restrict unbridled freedom of contract and protect against numerous forms of advantage taking,’ [unconscionability’s] primary function ‘has been to rescue from hard bargains those who are grossly disadvantaged in their dealings with sharp, or at least more sophisticated, traders.’”).

187. *Plavin v. Grp. Health Inc.*, 323 F. Supp. 3d 684, 705 (M.D. Pa. 2018) (“In addition, both New York and Pennsylvania law hold that an unjust enrichment claim, which is a law in equity, will be ‘precluded by the existence of a valid and enforceable written contract governing the particular subject matter’ ”); *Bristol Vill., Inc. v. Louisiana–Pac. Corp.*, 916 F. Supp. 2d 357, 366-67 (W.D.N.Y. 2013). See also *Lomma v. Ohio Nat’l Life Assurance Corp.*, 283 F. Supp. 3d 240, 265 (M.D. Pa. 2017) (“Because it is undisputed that the relationship between the parties is governed by an express written contract, Plaintiffs’ claims for unjust enrichment and promissory estoppel must necessarily fail.”).

a duty in the promisor to any intended beneficiary to perform the promise, and the intended beneficiary may enforce the duty.”¹⁸⁸ A third-party beneficiary can even seek specific performance where that is an appropriate remedy.¹⁸⁹ Individuals with insurance are a classic example of third-party beneficiaries. An insured individual is often a third-party beneficiary to the contracts between his or her insurer and the parties with whom the insurer contracts to provide the individual with the services. In the context of hospital contracts and hospital liens, courts have held that a patient is a third-party beneficiary entitled to enforce a hospital's agreement with the patient's insurer to accept the insurer's payment as payment-in-full.¹⁹⁰

Thus, if the hospital has breached its contract by not submitting a claim to the insurer or by not accepting the insurance payment as payment-in-full, the patient may be entitled to bring a third-party beneficiary claim for breach of contract and may recover traditional damages. If a reserving provision is invalid, it may be severable from the rest of the contract and the payment-in-full provision may still be enforced, especially if the provision is invalid as against public policy.¹⁹¹ In this instance, damages would be the amount of the lien the hospital actually took in excess of the insurance rate if it did not submit the claim or the whole lien amount if the hospital had already been paid by the insurer.

The question is more difficult if the entire contract is ruled void. Then relief might only come in the form of restitution. The patient may be “entitled to restitution for any benefit” that he or she conferred on

188. RESTATEMENT (SECOND) OF CONTRACTS § 304; *S. Tr. Ins. Co. v. Cravey*, 814 S.E.2d 802, 804 (Ga. 2018) (“The beneficiary of a contract made between other parties for his benefit may maintain an action against the promisor on the contract. . . . A third party has standing to enforce a contract under OCGA § 9–2–20 if it clearly appears from the contract that it was intended for his benefit; the mere fact that he would benefit from performance of the contract is insufficient.”); *McShane Constr. Co., LLC v. Gotham Ins. Co.*, 867 F.3d 923, 930 (8th Cir. 2017) (“In order for those not named as parties to a contract to recover thereunder as third-party beneficiaries, it must appear by express stipulation or by reasonable intentment that the rights and interests of such unnamed parties were contemplated and provision was made for them.”); *R & R Sails, Inc. v. Ins. Co. of State of Pennsylvania*, 610 F. Supp. 2d 1222, 1227 (S.D. Cal. 2009) (“Under California law, both the parties to an insurance contract and third-party beneficiaries of the contract are entitled to enforce the contract.”).

189. RESTATEMENT (SECOND) OF CONTRACTS § 307 (“Where specific performance is otherwise an appropriate remedy, either the promisee or the beneficiary may maintain a suit for specific enforcement of a duty owed to an intended beneficiary.”).

190. *Nahom v. Blue Cross & Blue Shield of Ariz., Inc.*, 885 P.2d 1113, 1117-20 (Ariz. Ct. App. 1994). *See also* *Linton v. Comm'r of Health & Environ.*, 65 F.3d 508, 520 (6th Cir. 1995) (holding that patients are third-party beneficiaries of healthcare provider's contracts with the state Medicaid agency).

It is worth noting here that victims are likely unable to bring suit against the hospital in tort for things like negligent misrepresentation because the victim did not become a third-party beneficiary until the contract was entered into. *See Erwin v. Texas Health Choice, L.C.*, 187 F. Supp. 2d 661, 668 (N.D. Tex. 2002). *See also* *Ansley v. Banner Health Network*, 419 P.3d 552, 563 (Ariz. Ct. App. 2018).

191. RESTATEMENT OF CONTRACTS § 184 (AM. LAW INST. 1981); *see infra* Part IV(D)(3).

the other party.¹⁹² “Indeed, wherever justice requires compensation to be given for property or services rendered under a contract, and no remedy is available by an action on the contract, restitution of the value of what has been given must be allowed.”¹⁹³ However, “a party seeking restitution must generally return any benefit that he has himself received.”¹⁹⁴ If the victim only ever had the treatment for this injury, then restitution would make sense. The patient would receive his or her premiums back and then have to give back the benefit he or she received, which would be the amount for the care. This would work out because the tort recovery would theoretically pay for the full, unreduced amount and the patient will receive his or her premiums back. The patient would not be worse off than if the accident had not occurred, and the hospital will not be unjustly enriched. However, the situation is complicated because it would be nearly impossible to know what portion of the premiums paid by the victim corresponded to the benefit she received for this particular injury.

Specific performance judgments, like to stop this practice for insured patients, are generally hard to receive. Such judgment is often only available after breach of contract.

VI. IMPLEMENTING THE BEST PUBLIC POLICY

Finally, in a broad sense, we consider whether what hospitals are doing accords with good public policy. If legislatures had to act, should they explicitly condone this behavior or rather make clear that liens should only compensate hospitals for *reasonable* payment the hospitals *do not* receive? As seen above, several states have already stopped hospitals from doing this. There are three important considerations: is the patient actually damaged? Is this wrongly bringing insurance and the accompanying contracts into the realm of torts? And who is actually receiving an inequitable windfall?

Even if a legal argument is convincing, we may want to know if the patient has actually been harmed. Indeed, hospitals argue that not only did the patient not suffer damages, but then to allow the patient to recover his or her money in a tort action would constitute a windfall to the patient. The patient, after all, has not paid out of pocket for the care provided by the hospital. On closer inspection, however, the patient has suffered damages if she did not receive the benefit of her insurance.

192. RESTATEMENT (SECOND) OF CONTRACTS § 376, cmt. a (AM. LAW INST. 1981). “A party who has avoided a contract on the ground of lack of capacity, mistake, misrepresentation, duress, undue influence or abuse of a fiduciary relation is entitled to restitution for any benefit that he has conferred on the other party by way of part performance or reliance.” *Id.* at § 376.

193. 26 Williston on Contracts § 68:4 (4th ed. 2019), *Restitution Independent of Liability on Contract*.

194. RESTATEMENT (SECOND) OF CONTRACTS § 376 cmt a. (AM. LAW INST. 1981); *id.* at § 384.

The baseline matter is that insured patients pay for the benefit of the lower, contracted rate. This may be through monthly premiums, foregone wages, or a combination. For example, according to the Bureau of Labor Statistics, health insurance accounts for 7.5% of private industry employee compensation.¹⁹⁵ For an employee making \$60,000 a year, this means the employer is paying over \$4,500 per year for that employee's health insurance. That \$4,500 is part of the employee's compensation for which that employee labored. If a hospital (through a lien) is able to force the patient to pay the full amount despite their insurance, the patient loses the benefit of what he or she has paid for, and that money is lost to the patient—it is damages. Suppose I paid for a Costco membership, but I was somehow forced to do my shopping at a different store where the items I would have purchased at Costco were 3.4 times as expensive.¹⁹⁶ This would represent a traditional damage under contract law. If I had contracted with a party to buy a widget for \$100 but the party failed to deliver, and I was forced to buy the widget someplace else for \$150, I would have suffered \$50 in damages. Here I paid for a certain widget—being able to pay the lower insurance rate—but a state law allowed the hospital to deliver to me a far less valuable widget—having to pay the full amount. The difference is damage caused to me by the law. So, while a hospital may claim that a victim is no worse off because no money came out of their pocket for the services, it is simply because the hospital took the victim's money before it even reached his or her pocket.

This idea parallels and is confirmed by the important principle that insurance should not be considered in calculation of damages in a tort action—known as the collateral source rule. The Restatement (Second) of Torts §920A states that “[p]ayments made to or benefits conferred on the injured party from [sources other than the tortfeasor] are not

195. U.S. DEPARTMENT OF LABOR, BUREAU OF LABOR STATISTICS, NEWS RELEASE: USDL-19-2195, EMPLOYER COSTS FOR EMPLOYEE COMPENSATION –SEPTEMBER 2019 at 3 (2019), <https://www.bls.gov/news.release/pdf/ecec.pdf> [<https://perma.cc/5ELL-WLW3>].

196. Another more analogous example would be Amazon Prime. Amazon Prime members pay a certain annual amount. One benefit of being a Prime member is that the member does not have to pay for shipping on many eligible items. Notably, not all of these items are sold or shipped by Amazon. Until recently, almost all final leg deliveries (to your mailbox or doorstep) were done by a third party like UPS. So, it is not that Prime members are paying Amazon to ship the package. Instead, they are paying for the benefit of Amazon coordinating carriers for their services. Much like insurers negotiating rates with hospitals, Amazon negotiates special rates with the carriers. A different item a Prime member may want to buy is “out-of-network”—or not a prime-eligible item—and the member must pay out of pocket for the shipping rate. This is in addition to the annual membership fee.

Now, suppose my friend breaks my prize widget in my house. Being conscientious, my friend, not a Prime member, gets on Amazon, finds the widget (which is Prime eligible), and sends me the money to cover it, including the full shipping price. Would Amazon now be in the right to demand I pay the full shipping price despite having paid for my membership and the free-shipping arrangement? Should Amazon be given a lien on my friend's assets when I order the item? Should Amazon get my annual membership money and the extra shipping costs as profit? Or should I get the extra shipping money from my friend to slightly offset the amount I pay for the membership and the shipping arrangement?

credited against the tortfeasor's liability, although they cover all or a part of the harm for which the tortfeasor is liable."¹⁹⁷ Thus, an insured victim can both recover the full damages from a tortfeasor and be paid by his or her own insurance claim – sometimes giving the victim more than he or she had before the incident. This is a mainstay of tort law. It began in British courts and has been generally in use in the United States since 1854.¹⁹⁸ What does this mean for the hospital and the lien statute? This shows that any “extra” money that the victim may receive—because he or she would recover from the tortfeasor but not pay anything to the hospital out of pocket—is not “extra” money at all.¹⁹⁹ It should be the victim's. As a comment to this Restatement section succinctly states,

[I]t is the position of the law that a benefit that is directed to the injured party should not be shifted so as to become a windfall for the tortfeasor. If the plaintiff was himself responsible for the benefit, as by maintaining his own insurance . . . , the law allows him to keep it for himself. . . . [H]e should not be deprived of the advantage that [the benefit] confers.²⁰⁰

Indeed, “to require an injured policy holder to return to his insurer the benefits for which he has paid premiums is to deny him the benefits of his thrift and foresight.”²⁰¹

One argument against this logic, called by one scholar a “serious deficiency,” is that insurance benefit arrangements are contractual.²⁰² The price of the insurance, the argument goes, is based on the benefits agreed to, and the hospital recovering its full charge through a lien is built into the agreement price. This is logical on its face. However, this would be nothing more than reimbursement or subrogation of personal injury claims. As described above, when a contract seeks “to create a legally enforceable interest,” like a lien in a recovery against a tortfeasor, “[b]y whatever name, this is an assignment of the insured's cause of action for personal injury against said third party tortfeasor.”²⁰³

Lastly, as noted in the Restatement, treating the excess recovery as belonging to the victim should not be counted as a windfall to the victim.²⁰⁴ Instead, the hospitals reap a windfall when they are allowed

197. RESTATEMENT (SECOND) OF TORTS §920A (AM. LAW INST. 1965).

198. Note, *Unreason in the Law of Damages: The Collateral Source Rule*, 77 HARV. L. REV. 741, 741-42 (1964).

199. See generally *Dedmon v. Steelman*, 535 S.W.3d 431, 433 (Tenn. 2017) (explaining that, although the court had held that hospitals could only file a hospital lien for the lower contracted rate against an insured patient, this holding does not change the collateral source rule in personal injury tort cases; the tortfeasor was still responsible for unreduced medical damages).

200. RESTATEMENT (SECOND) OF TORTS §920A cmt b.

201. *Allstate Ins. Co. v. Druke*, 576 P.2d 489, 491 (Ariz. 1978).

202. *Unreason in the Law of Damages*, *supra* note 198, at 751.

203. *Druke*, 576 P.2d at 492.

204. See RESTATEMENT (SECOND) OF TORTS §920A cmt b.

to collect both the benefit of their contract and the full chargemaster amount they agreed not to collect.

Windfall may be a loaded idea. In some instances across public discourse, it simply refers to an outcome that might seem unfair.²⁰⁵ But designating something as a windfall can also have important legal consequences. Indeed, in an article dedicated to the meaning of windfalls, Christine Hurt explained that it is a “legal truth” that a party

is not legally entitled to a windfall, notwithstanding the fact that a windfall would be the natural result of an automatic enforcement of a contract or a common law rule. An extension of this legal truth . . . is that windfalls are not legally desirable or even legal at all . . . Furthermore, in court, once a judge classifies an economic gain as a windfall, that gain is then unlawful and will be prohibited.²⁰⁶

The question then is whether there is actually a windfall here and if so, who is receiving it?

Hurt summarizes the narrow legal definition of wrongful windfalls, in part, as “attempt[ing] to compensate once more a party that has already been made whole. . . . [Or] relieving an owing party of a legal debt without further obligation.”²⁰⁷ As explained above, for good policy reasons and because he or she paid for it, a victim’s insurance payout will not be considered a windfall and will not reduce tort recovery.²⁰⁸ The hospital, however, is seeking a lien to compensate the hospital “once more” even though it “has already been made whole.”²⁰⁹

In exchange for agreeing to charge a lower rate, the hospital receives the benefit of a more reliable payment from the insurance company.²¹⁰ The hospital is also compensated through customer capital when more patients are funneled its way.²¹¹ The hospital already has

205. Christine Hurt, *The Windfall Myth*, 8 GEO. J. L. & PUB. POLICY 339, 343 (2010) (“Moreover, while the popular use of the word ‘windfall’ may bring to mind examples of the wind literally blowing objects of treasure to unsuspecting persons, such as inheritances, lottery winnings or literal found treasures, the term is increasingly used in the media and elsewhere to label profits from legitimate and useful businesses and investments.”).

206. *Id.* at 341.

207. *Id.* at 351.

208. See *supra* notes 195-201 and accompanying text. Cf. *Samsel v. Allstate Ins. Co.*, 59 P.3d 281, 290 (Ariz. 2002). (“We are unable to see any greater windfall to the insured when he or she recovers expenses paid by the insured’s HMO as compared to recovery permitted from any other collateral source. Allstate has offered no evidence that its premiums for medical payments coverage were reduced by reason of the expectation that it would be relieved of coverage for expenses paid by HMOs for their enrollees. Thus, we see no windfall when insureds who paid for a separate coverage collect just what they have paid for.”).

209. See Hurt, *supra* note 205.

210. *Galvan v. Nw. Mem’l Hosp.*, 888 N.E.2d 529, 539 (Ill. App. 2008) (noting that hospitals negotiate contracts with private insurers because of the guaranteed payment).

211. See *Palmyra Park Hosp. Inc. v. Phoebe Putney Mem’l Hosp.*, 604 F.3d 1291, 1295 (11th Cir. 2010) (noting that hospitals negotiate contracts with private insurers expecting to increase the number of patients); *Rogalla v. Christie Clinic, P.C.*, 794 N.E.2d 384, 389 (Ill. App. 2003) (“According to [the hospital-insurer contract], the insurer would encourage its

or could receive payment from the insurer; it has received more patients through its contract with that insurer. Compensation in the form of an excessive lien on top of these gains is “compensat[ing] once more a party that has already been made whole” on the contract.²¹² Likewise, the hospital’s reading of lien statutes allows the hospital to be relieved of its legal debt—the agreement to accept payment from the insurer—without further obligation. After conceptualizing the legal gestalt of windfall and who is being compensated, we see that it is often the hospitals that are using these statutes to reap windfalls—compensation up to even 3.4 times more than they were already compensated.²¹³ They are receiving the benefit of their contract while being relieved of the obligation of that contract. There are two options here: the hospital gets paid what it asked for, the customers *and* the extra money,²¹⁴ or the patients get the benefits of the insurance for which they have been paying and for which they will continue to pay.

VII. CONCLUSION

Although these stories rarely reach a loud enough platform, for the patients who are unlucky enough to experience this situation the results are damaging. They lose the benefit of the insurance for which they paid so that hospitals can be paid more than the amount to which the hospitals agreed. These tort-victims are being made victims again at the hands of hospitals.

The hospitals may be breaching their contracts with the insurers and patients. The contracts between the hospitals and insurers may be void and against public policy. In the end, legislatures should revisit the prudence of hospital lien laws and take note of how hospitals are now wielding the laws against insured victims to gain an unfair *and* legally wrong windfall. Insured victims are being harmed when the benefit of their paid-for insurance is taken away and given to hospitals. The interests and property of insured tort victims should be protected from these “disingenuous and somewhat deplorable” practices.

members to obtain services from the hospital, and the hospital would bill the insurer at reduced rates.”).

212. See Hurt, *supra* note 205, at 351.

213. Bai and Anderson, *supra* note 2.

214. Cf. EDWIN PATTERSON, ESSENTIALS OF INSURANCE LAW 151–52 (Ralph H. Blanchard ed., 2d ed. 1957) (“Subrogation is a windfall to the insurer.”).

