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Economic Insights: The Role of Economic Analyses in Consumer Class Actions Challenging Provider Pricing and Billing Practices

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Consumer class actions that challenge provider pricing and billing practices are common in the healthcare industry. These cases are typically initiated by a group of patients who claim to have been harmed similarly by the pricing or billing practices of their healthcare providers. These class action cases raise several questions with regard to ascertainability, common proof, common impact, and harm mitigation. This article discusses the role of economic analyses in addressing these questions, including the need for determining the appropriate but-for world and how the complexities and unique characteristics of healthcare markets (such as heterogeneity in patient preferences and decision-making processes) can inform economic analyses.

Background

These cases often arise from allegations of inadequate or lack of disclosure of various fees or out-of-pocket expenses before or when services are provided. These disputes often focus on facility fees (or surcharges), operating room access fees, and co-provider charges. In such matters, damages pursued are often based on the premise that proposed class members would have sought an alternative treatment or no treatment if they had known the existence and amounts of allegedly undisclosed fees or expenses.

For example, in a lawsuit filed in February 2019, the plaintiffs contested Sutter Health's alleged practice of charging its emergency care patients an "undisclosed" and "hidden" emergency room (ER) surcharge, which was billed on top of the charges for the individual treatments and services provided.[1] The plaintiffs alleged that this surcharge was not disclosed and was concealed from Sutter Health's ER patients because a Conditions of Admission form, which all ER patients were requested to sign and which did not disclose the presence of a surcharge, and that the surcharge was not disclosed on posted signage or verbally mentioned to patients during the registration process.[2] The plaintiffs claimed that such surcharges would be a material factor for an ER patient's decision regarding whether to remain at the hospital to proceed with treatment or seek alternative treatment options.[3]

Consumer class actions contesting allegedly undisclosed out-of-pocket cost expenses are not limited to ER services. In a complaint filed in June 2020, the plaintiff brought a class action including all persons who received non-emergency procedures from a Centura Health facility but did not receive an estimated patient responsibility statement at the time of or before the non-emergency medical care was provided. The complaint claimed that this practice of inadequate disclosure of out-of-pocket expenses prevents patients from "shopping around for more cost-effective treatment or holding off elective procedures" and allowed Centura Health to "reduce transparency for its billing practices and charge outrageous amounts for items such as routine medication."[4]

In other consumer class actions, plaintiffs often allege that hospitals breach their contracts with patients and their communities by implementing arbitrary pricing schemes across different patient groups—for instance, by charging chargemaster rates[5] to uninsured patients while negotiating substantial discounts with insurers for the care of plan beneficiaries.

For example, a proposed class of self-pay patients claimed that when receiving ER services at Fresno Community Hospital and Medical Center, they expected to be billed the same rates as other emergency care patients who are insured by commercial or governmental plans,[6] signing the same Conditions of Admission or Service form and receiving the same level of emergency care. The plaintiffs claimed that the language in the form was not sufficiently specific, leaving an open price term to be filled by a "reasonable and customary" amount for services received by proposed class members. However, according to the plaintiffs, chargemaster rates for uninsured patients were substantially higher than the reimbursed rates the hospital received for patients insured by private or governmental plans.[7] The plaintiffs also claimed that the chargemaster rates were also substantially higher than the hospital's actual cost of providing care, making the charges higher than the "reasonable value" of the care provided.[8]

Legal commentators have noted that recent regulations and compliance procedures such as the federal Price Transparency Rule and the No Surprises Act have intensified public focus on provider pricing and billing practices.[9] The remainder of this article discusses potential economic analyses in consumer class actions against provider pricing and billing practices, including challenges in addressing questions of ascertainability, common proof, common impact, and harm mitigation.

Ascertainability

While the federal circuit courts continue to address ascertainability requirements in the context of consumer class actions in varying ways, ascertainability generally refers to a court's ability to identify individuals in the class.[10] In cases involving allegations of inadequate

disclosure, the issue of ascertainability of proposed class members can be particularly salient. In such cases, the condition for being in the class is that there was an undisclosed price term as part of a healthcare encounter and an unexpected surcharge was later added to the patient's bill. It can be challenging to establish this condition if certain patients might have been aware of such purportedly undisclosed fees, which could be true for a number of reasons. First, hospitals that routinely charge ER services-related fees may publicly disclose such fees outside the context of an individual patient encounter; for example, federal price transparency regulations require hospitals to establish and make public a list of their standard charges for items and services.[11] Second, it is possible that putative class members had prior ER encounters, perhaps even at the same hospital, which would have alerted them to the presence of such fees. Thus, further investigation might be required to ascertain whether a putative class member was aware of such fees, either through a publicly available disclosure or personal experience.

Even among patients who were unaware of the allegedly undisclosed fees, economic analysis can be necessary to evaluate the allegation that proposed class members were charged more than a "reasonable" amount for the service that they received. Such an evaluation could entail comparing actual fees charged to a reasonable benchmark, such as the typical cost of providing the services for a hospital or average reimbursement rates paid by insurers that cover the services. To the extent there is variation across individual class members in terms of what a reasonable benchmark is, an individualized inquiry would be required. It is possible that there is no single price that will be "reasonable" given differences in circumstances, preferences, and actions among putative class members.

Ascertaining individual class members can similarly be a difficult exercise in breach of contract cases, where putative class members are typically those uninsured patients who went to

the ER and were later charged an allegedly "surprise" amount greater than a "reasonable and customary" charge. In such cases, plaintiffs typically contend that the agreement they enter into with hospitals entitles them to receive "reasonable" prices for their care consistent with amounts received by the hospital for the care of insured patients. An individualized inquiry may be needed to assess what kind of insurance a class member would have had in the but-for world to determine a "reasonable" price for that class member. Given the substantial variation in insurance arrangements among those who are insured, this could be a challenging exercise.

For both types of cases, to assess ascertainability, a reasonable value needs to be established to pinpoint whether actual charges were greater than this reasonable value. Potential benchmarks for determining a reasonable value may include the cost of a class member's care or reimbursement to the providers by insurers for such care. Regarding the first benchmark, determining the cost of a particular class member's care involves analyzing many factors including, but not limited to, treatments received, the severity of the member's condition, the patient's comorbidities, and the date and time of the visit or treatment. Similarly, with regard to the second benchmark, establishing reasonable value based on what insurers would have reimbursed for a given service can require knowledge of a host of patient-specific factors. Even the same insurer, under the same plan, may cover the same service differently under different circumstances. Such complexities of establishing either of these benchmarks may render ascertainability difficult or implausible.

Common Proof and Common Impact

A critical question in consumer class actions is whether the fact and quantum of the alleged injury to individual putative class members can be determined by a common method without resorting to individualized inquiry. In consumer class actions challenging provider pricing and billing practices, plaintiffs often argue common injury to proposed class members by referencing the provider's "uniform practice" of billing patients for undisclosed fees or charging self-pay patients more than a "reasonable" amount for their care.[12]

A key component of reliably assessing alleged injury to individual putative class members requires comparing the economic position of proposed class members in the actual world to the economic position in an alternative ("but-for") world (e.g., where the presence and the amounts of surcharge were included in the Conditions of Admission form). Determining an appropriate but-for world, in turn, requires economic analyses across several dimensions.

Patient Behavior in the But-For World

In undisclosed fee cases, a key question is whether additional disclosures about the existence and amounts of fees would have uniformly impacted all proposed class members' decisions on whether to receive the service at the hospital or seek alternative options. Plaintiffs generally argue all proposed class members would have sought alternative treatment options or held off on treatment. However, this can be challenging to establish on a class-wide basis. A thorough economic analysis could be required to determine which, if any, class members would have been impacted by the proposed additional disclosures. Such disclosures can have different effects on different patients because of variations in patients' awareness of ER-level fees, reasons

for their ER use, patients' insurance plans, and ability to pay for healthcare, their ability to seek alternative treatments or providers depending on the severity of their medical problem, and heterogeneity in patients' use of other healthcare services.

Patients might have still chosen to be treated at the same ER, among other reasons, either if (1) they were, in fact, already aware of the fees, as discussed above; (2) they did not care about the fees; (3) the seriousness of their medical problem prevented them from seeking alternative providers; or (4) they did not have access to other providers. For example, insured patients may not care about such fees if they only care about out-of-pocket costs, which vary based on their insurance arrangements. To determine whether further disclosures of fees would affect an individual's decision to go elsewhere for treatment, it is thus important to consider proposed class members' out-of-pocket costs for ER visits.

Out-of-Pocket Costs for Putative Class Members

If an insurer pays for all or the majority of the costs of a class member's ER visit, this class member's out-of-pocket cost for the ER visit would be minimal or zero. If a class member knew of such an insurance arrangement, additional disclosures of charges would not have influenced the class member's decision to go or remain at the ER, because the class member would not have been responsible for those charges.

Out-of-pocket costs are affected by type of insurance plan. Different types of private health insurance plans offer different levels of insurance cost sharing. While traditional Medicare requires some cost sharing, some individuals with traditional Medicare obtain supplementary coverage that can pay some or all of the cost sharing required by traditional Medicare. Economic analysis is needed to assess who was affected, because it is unlikely that every patient would

have incurred out-of-pocket costs as a result of undisclosed fees. Proposed class members' out-of-pocket costs vary based on their health insurance, the features of their specific plan, their own use of healthcare services, and other factors. These all influence the amounts that individuals pay out-of-pocket for copayments, coinsurance, deductibles, and other out-of-pocket payments.

Determining "Reasonable" Fees in the But-For World

A key component of establishing common impact in class actions against providers is determining reasonable fees in the but-for world. As discussed above, potential benchmarks for determining reasonable value include the cost of a class member's care or reimbursement to the providers by insurers for such care. Detailed economic analysis is necessary to establish these benchmarks on a class-wide basis.

First, the cost of care depends on the patient's condition. Patients visit ERs for a wide variety of reasons, which can vary immensely across class members.[13] The cost of delivering care to individual patients depends on a multitude of factors, including the treatments received, the severity of the patient's condition, the facility visited, and the date and time of the visit.

Second, the comparable reimbursement by a third-party payor depends on the type of insurance the patient has. Commercial health insurance plans differ in the size of the network, the relative costs, the ability for enrollees to use in-network versus out-of-network providers, and cost-sharing requirements, such as deductibles and copayments. Critically, they differ in negotiated rates with healthcare providers. Private payors often have opaque contracts with healthcare providers, and accordingly, different payors can reimburse the same treatments at substantially different rates. For a given payor, the allowable payment for a treatment can be a function of the characteristics of the patient, the nature of their visit, and the facility visited. In

fact, under the same plan, the same payor may cover the same treatment differently under different circumstances. Thus, establishing "reasonable value" based on what a commercial payor would have paid for a given episode of care could require consideration of individual-specific patient factors.

One issue to keep in mind is that imposing any particular economic approach to determine reasonable fees in the but-for world could create class conflict when proposed class members may be situated differently in relation to costs, comparable reimbursements, and overall ratios of various approaches, and will thus prefer one possible approach to the measurement of "reasonable value" to another.

Harm Mitigation

Economic analysis might be required to determine whether a given putative class member could have mitigated the harm that plaintiffs might allege in such cases. Several factors could mitigate harm to certain class members, which may then make those class members not impacted, or impacted variably by the alleged act. For instance, the member might have applied for financial assistance from the provider or had secondary health insurance that gave them financial protection. In these instances, the analysis may show the ability of the member to mitigate the alleged harm.

Conclusion

As recent regulations and compliance procedures have intensified public focus on provider pricing practices, consumer class action litigation challenging provider pricing and billing practices will continue to be active. In such cases, economists might be asked to opine on questions of ascertainability, common proof, common impact, and harm mitigation. Appropriate and rigorous economic analyses to address such questions should involve defining an appropriate but-for world and account for proposed class members' behavior in the but-for world, which can exhibit significant variations given differences in circumstances, preferences, and actions among putative class members.

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The views expressed herein are solely those of the authors, who are responsible for the content, and do not necessarily represent the views of Cornerstone Research.

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[1] Saini v. Sutter Health, 80 Cal.App.5th 1054 (Cal. Ct. App. Feb. 26, 2019), at 1–3.
[2] *Id.* at 3–4.
[3] *Id.* at 4.
[4] Walter v. Centura Health Corp., No. 1:2020cv01752 (D. Colo. June 15, 2020).
[5] A hospital chargemaster is the collection of standard list prices for hospital services.
[6] Solorio v. Fresno Cmty. Hosp. & Med. Ctr., No. F073953 (Cal. Ct. App. July 11, 2018).
[7] *Id.*
[8] *Id.*
[9] *Medical Price Transparency Marches On, Part II: Risks and Opportunities with Comprehensive Good Faith Estimate Compliance*, ROBINSON BRADSHAW, July 14, 2022, https://www.robinsonbradshaw.com/newsroom-publications-Medical-Price-Transparency-Marches-On-Part-II-Risks-And-Opportunities-With-Comprehensive-Good-Faith-Estimate-Compliance.html.
[10] *Class Action Lawsuits: A Legal Overview for the 115th Congress*, CONG. RES. SERVICE, Apr. 11, 2018, at 26, https://crsreports.congress.gov/product/pdf/R/R45159.
[11] *Charges and Fees*, JOHNS HOPKINS MED., https://www.hopkinsmedicine.org/patient-care/patients-visitors/billing-insurance/pay-bill/charges-fees (last visited Oct. 3, 2023).
[12] *See, e.g.*, Solorio v. Fresno Cmty. Hosp. & Med. Ctr., *supra* n. 6.
[13] *See, e.g.*, *Most Frequent Reasons for Emergency Department Visits, 2018*, AGENCY FOR HEALTHCARE RES. & QUALITY, Dec. 2021, https://www.hcup-us.ahrq.gov/reports/statbriefs/sb286-ED-Frequent-Conditions-2018.pdf.

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