The Controversy over Hospital Charges to the Uninsured - No Villains, No Heroes

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I. Introduction

BEGINNING in March 2003, the Wall Street Journal ran a series of articles focusing on hospitals that charge uninsured patients inflated hos-


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(95)
pital rates and aggressively hound them to make collections. The articles emphasized the draconian collections methods used by some hospitals, including residential foreclosures and even “body attachments,” where the patient debtors were jailed until they could pay bail.

At the same time, a number of investigational reports were being published showing the devastating effects of overwhelming medical debt on families, coupled with census figures showing an ever-rising number of uninsured in this country. One such report by The Commonwealth Fund announced findings in June 2003 that hospitals’ reluctance to lower charges to the uninsured resulted in long term debt for the affected families. The report also announced that the problem was apparently caused by unclear federal laws and regulations that had the unintended effect of discouraging hospitals from offering services at free or reduced rates to the uninsured.

During the summer of 2004, the increased attention to the issue of excessive hospital charges to the uninsured resulted in a wave of class action lawsuits across the nation. Uninsured patients alleged that hospitals charged them substantially higher rates than the hospitals accepted from private insurance plans, Medicare and Medicaid for comparable services. The lawsuits also alleged that the hospitals failed to advise the uninsured patients of available options for charity care, and then aggressively pursued the patients to make collection on the exorbitant bills.

Also in the summer of 2004, the Committee on Energy and Commerce of the House of Representatives held a hearing to review hospital billing and collections practices for the uninsured. The hearing followed a year-long investigation of the issue, wherein the Committee col-

2. For a further discussion of the Wall Street Journal ("Journal") articles on hospital billing and collections for the uninsured, see infra notes 23-66 and accompanying text.
3. For a further discussion of the aggressive collections methods used by some hospitals, see infra notes 23-66 and accompanying text.
4. For a further discussion of the devastating effects that medical debt and the rising number of uninsured have in America, see infra notes 67-98 and accompanying text.
5. For a further discussion of the Commonwealth Fund’s report, see infra notes 90-92 and accompanying text.
6. For a further discussion of the report’s suggestion that hospital billing and collections practices were encouraged by ambiguous federal health care laws, see infra note 91 and accompanying text.
7. For a further discussion of class action lawsuits alleging excessive medical charges, see infra notes 116-37 and accompanying text.
8. For a further discussion of the uninsured patients’ allegations in the excessive medical charges class action suits, see infra notes 121-36 and accompanying text.
9. For a further discussion of the types of patient mistreatment alleged in the class action lawsuits, see infra notes 121-36 and accompanying text.
10. For a further discussion of the hearing held by the Committee on Energy and Commerce of the House of Representatives to review hospital procedures relating to the uninsured, see infra notes 138-59 and accompanying text.
lected detailed information from twenty hospital systems on their billing and collections practices. Thus began an intensive examination of a healthcare anomaly that was not appreciated by the general population of healthcare consumers, but which was generally known and accepted by the healthcare industry for decades: the only segment of society that pays full and undiscounted charges for hospital care is the uninsured—the very segment of the population that is least able and likely to pay full charges for medical care. Governmental agencies in charge of regulating healthcare have known this, the hospital industry has known this and private insurers and HMOs have known this; nonetheless, these entities have done little or nothing to complain about the inequity or press for reform.

This Article will examine how this situation came about and what the healthcare regulators and industry have done about it. Part II will describe the Wall Street Journal articles that woke the nation to the exorbitant hospital charges for uninsured patients. Part III will discuss the findings of investigational reports that hospitals have largely failed to provide charity care to uninsured patients. Part IV will explain how hospitals develop their charges and why the charges have become so much higher than the rates payable by government plans and private insurers. Part V will look at the recent wave of class action lawsuits across the country, wherein uninsured patients are suing hospitals for what they contend are unreasonable charges and overly aggressive collections practices. Part VI will look at

11. For a further discussion of the Committee’s investigation into the billing and collections procedures used by hospitals on the uninsured, see infra notes 138-62 and accompanying text.

12. But see Hearing, supra note 1, at 7 (statement of Rep. Greg Walden, Member, H. Comm. on Energy and Commerce, Subcomm. on Oversight and Investigations) (pointing out that of those who went without health insurance for given year, 8.2% had household income in excess of $75,000 and 20% had household income over $50,000). Certain uninsured patients are not indigent; uninsured patients are also those who have the apparent means but choose not to purchase insurance. See id. (stating that not all uninsured are indigent). Non-indigents who pay full charges include patients with medical savings accounts and international visitors who come to the United States for healthcare. See id. at 16 (describing groups of uninsured patients).


14. For a further discussion of the Wall Street Journal articles that brought the issue of hospital charges for uninsured patients to the public’s attention, see infra notes 23-66 and accompanying text.

15. For a further discussion of the investigational reports regarding hospitals’ failures to provide charity care to uninsured patients, see infra notes 67-98 and accompanying text.

16. For a further discussion of the development of hospital charges and an explanation of why charges for uninsured patients are so high, see infra notes 99-115 and accompanying text.

17. For a further discussion of the recent wave of class action lawsuits, see infra notes 116-37 and accompanying text.
the testimony produced at a June 2004 congressional hearing on hospital billing and collections practices ("congressional hearing").18 Part VII will analyze the respective positions of the hospitals and the federal regulators on the issue of uninsured charges.19 Part VIII will examine the initial outcomes in the federal class actions and Part IX will look at the early outcomes in the class actions that have been filed in state forums.20 Part X will examine the recent changes in hospital billing and collections practices.21 Finally, Part XI will state the author’s conclusions: the recent changes in hospital billing and collections practices have alleviated some of the uninsureds’ problems, but numerous others still remain.22

II. WALL STREET JOURNAL ARTICLES AWAKEN THE NATION TO THE REALITIES OF HOSPITAL CHARGES TO THE UNINSURED

America first became aware of the issue of exorbitant hospital charges for the uninsured through a series of Wall Street Journal ("Journal") articles beginning in March 2003. The articles began by telling the story of Quinton White, a seventy-seven year-old retired dry-cleaning worker suffering from kidney and heart ailments who was paying off a hospital debt that his now-deceased wife had incurred twenty years previously when she was treated for cancer at Yale-New Haven Hospital.23 The article, Twenty Years and Still Paying, described how the original $18,740 hospital bill had blossomed to nearly $55,000 after the addition of interest and fees.24 The hospital, through its attorney, put a lien on Mr. White’s modest home25 and seized most of his bank account.26 Over time, Mr. White paid the hospital close to the amount of the original bill, but $39,000 still remained, with interest alone reaching $33,000.27

18. For a further discussion of the testimony regarding hospital billing and collections practices produced at the congressional hearing, see infra notes 138-62 and accompanying text.
19. For a further discussion of the positions of hospitals and federal regulators, see infra notes 163-204 and accompanying text.
20. For a further discussion of the initial outcomes in the federal class actions, see infra notes 205-43 and accompanying text. For a further discussion of the early outcomes in state class actions, see infra notes 244-64 and accompanying text.
21. For a further discussion of recent changes that have occurred in hospital billing and collections practices, see infra notes 265-312 and accompanying text.
22. For a further discussion of the author’s conclusions, see infra notes 313-27 and accompanying text.
23. See Lucette Lagnado, Twenty Years and Still Paying, WALL ST. J., Mar. 13, 2003, at B1 [hereinafter Lagnado, Twenty Years and Still Paying] (explaining that patient’s husband still owes debt to hospital and that amount is growing due to ten percent interest charges on original bill).
24. See id. (elaborating growth of debt from medical bills).
25. See id. (stating that lien was placed on White’s house in 1983).
26. See id. (stating that hospital’s lawyer drained Mr. White’s bank account to pay for his wife’s medical bill debt in 1996).
27. See id. (explaining that despite paying almost entire original bill for medical care, due to interest and other fees, total bill for treatment grew to $55,000).
Almost immediately after publication of the White article, the *Journal* received over 100 e-mails from readers seeking to help Mr. White. Air France offered Mr. White free round-trip tickets to allow him to realize his lifelong dream of visiting France. Dozens of readers offered cash contributions or frequent flyer miles. The public reaction led the hospital’s senior vice president to personally phone Mr. White’s son to announce that the hospital was forgiving the debt. The attorney who had relentlessly pursued Mr. White for twenty years followed with a letter stating that the lien had been lifted from Mr. White’s home.

The *Journal* followed up with the story of Rebekah Nix. Ms. Nix was a completely different type of patient from Mr. White: she was young (only twenty-five years old), relatively healthy and a college graduate. But after declining to maintain her health insurance through her past employer, she too found herself uninsured and in need of hospital treatment in April 2002 when she arrived at the New York Methodist Hospital emergency room with severe abdominal pains. She was temporarily unemployed, living on unemployment benefits of $1122 a month and unable to afford health insurance. After tests confirmed that she had appendicitis,

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29. See id. (describing public contributions to White).

30. See id. (documenting outpouring of support).

31. See id. (noting decision of Yale-New Haven Hospital to cancel White’s debt).

32. See id. (summarizing letter from Yale-New Haven Hospital’s attorney that notified White of removal of lien).


34. See id. (describing patient’s background).

35. See id. (accounting events leading to Nix’s hospitalization).

36. See id. (describing Nix’s status as unemployed with reduced income and, thus, no health insurance). Ms. Nix qualified for coverage under the 1986 Consolidated Omnibus Budget Reconciliation Act (COBRA), but did not take advantage of it. See id. (stating that Nix chose not to continue health coverage under health plan provided by employer). COBRA allows qualified workers to retain their employer-sponsored health insurance for a limited period of time after they leave their employment by paying the employer's costs of the coverage plus a two percent administrative fee. See 29 U.S.C. §§ 1161-1169 (2000) (detailing plan for continuing coverage). Most unemployed individuals, however, find it difficult to afford the COBRA premiums required to retain the coverage. See Robert Wood Johnson Found., *Going Without Health Insurance: Nearly One in Three Non-Elderly Americans 11 (2003) [hereinafter Going Without Health Insurance], available at http://covertheuninsuredweek.org/media/GoingWithoutReport.pdf (finding that only one out of five unemployed workers who were eligible for COBRA coverage purchased it).
she underwent a one-hour laparoscopic surgery to have her appendix removed.37 She left the hospital forty-two hours after her arrival.38

Ms. Nix learned two weeks later that her hospital bill would be over $12,000.39 She applied for Medicaid, but was turned down because her unemployment benefits exceeded Medicaid’s monthly revenue limit.40 When the hospital bill arrived about two months later, the total had climbed to $13,110.41 In addition, Ms. Nix received separate bills totaling $5000 from the anesthesiologist and other doctors who had seen her at the hospital.42 A month later, an updated bill arrived from the hospital, raising the total to $14,182 by adding a mandatory surcharge for New York’s bad debt and charity care pool.43 This brought the total for the less than two-day stay to more than $19,000.44

While the White articles focused on the relentlessness and aggressiveness of Yale-New Haven’s collections techniques,45 the Nix article focused on what the Journal termed “a troubling fact of health-care economics.”46 While governmental programs like Medicare and Medicaid and private insurers pay steeply discounted rates that they negotiate with hospitals, patients who are not covered by healthcare programs or private insurers pay full charges—i.e., the full retail price that hospitals set for their services.47

37. See Lagnado, Full Price, supra note 33 (detailing events of surgery).
38. See id. (stating length of hospital stay).
39. See id. (describing note from hospital estimating total bill).
40. See id. (explaining that under New York’s Medicaid rules single person’s income cannot exceed $552 per month unless person is certified as disabled).
41. See id. (providing itemized list of charges incurred during hospital visit).
42. See id. (describing other doctors’ bills incurred during hospital visit).
43. See id. (quoting patient as stating: “Tack on another grand I can’t pay, but use it to help someone else”). New York’s bad debt and charity care pool reimburses hospitals for a portion of their bad debt (bills that a hospital seeks to collect but is unsuccessful in doing so) and charity care (bills that a hospital voluntarily waives and does not seek to collect). See LONG ISLAND HEALTH ACCESS MONITORING PROJECT, THE LONG ISLAND COALITION FOR A NATIONAL HEALTH PLAN, HOSPITAL COMMUNITY BENEFITS AND FREE CARE PROGRAMS: AN INITIAL STUDY OF SEVEN LONG ISLAND HOSPITALS 13-14 (2001) [hereinafter STUDY OF SEVEN LONG ISLAND HOSPITALS], available at http://www.communitycatalyst.org/resource.php?doc_id=380 (explaining hospital indigent care pool in New York State); id. at 14 (explaining sources of funds for pool and method of disbursement to hospitals); see also N.Y. PUB. HEALTH LAW § 2807-k (McKinney 2002) (describing methodology of pool disbursements). The pool is funded by surcharges on patients’ hospital bills. See N.Y. PUB. HEALTH LAW § 2807-j (McKinney 2002) (stating guidelines for surcharges).
44. See Lagnado, Full Price, supra note 33 (explaining charges).
45. For a further discussion of the White articles, see supra notes 23-32 and accompanying text.
46. See Lagnado, Full Price, supra note 33.
47. See id. (comparing charges billed by hospitals to uninsured with prices accepted for patients covered by private insurance, Medicare and Medicaid).
Through "the insanity of the system," uninsured patients, those who are least able to pay, are charged at the highest point of the rate scale.\(^{48}\) In fact, these uninsured patients often pay twice, or even several times, the rates being paid by state and federal programs and private health insurers.\(^{49}\)

A later *Journal* article gave concrete comparisons between hospital charges and the rates paid by governmental programs and private insurers.\(^{50}\) This article told the story of Paul Shipman, an uninsured individual who ended up spending twenty-one hours at the Inova Fairfax Hospital in Fairfax, Virginia, when he experienced chest pains.\(^{51}\) Mr. Shipman ended up having a stent installed to prop open one of the arteries to his heart.\(^{52}\) The *Journal* reported that as a result of this procedure, Mr. Shipman received a $29,500 hospital bill, plus a $1,000 bill for the ambulance trip, a $7,000 bill from the cardiologist who performed the stent procedure and several thousand dollars in additional bills for the emergency room visit.\(^{53}\) The twenty-one hours of medical care cost Mr. Shipman nearly $40,000, an exorbitant bill by any standard.

The *Journal* then compared the Shipman bills to what the hospital would receive for the same services from private insurers, Medicare and Medicaid.\(^{54}\) While insurance plans might pay a "case based" rate (a flat dollar amount corresponding to a given diagnosis that covers all of the care the patient receives at the hospital), the uninsured receive a bill with line by line charges for every item, down to band-aids and aspirins.\(^{55}\) The two systems of pricing result in huge differentials to the bills.\(^{56}\)

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48. See id. (quoting Bruce Vladeck, who ran Medicare in 1990s).
49. See Lucette Lagnado, *Anatomy of a Hospital Bill; Uninsured Patients Often Face Big Markups on Small Items; "Rules Are Completely Crazy*, WALL ST. J., Sept. 21, 2004, at B1 [hereinafter Lagnado, *Anatomy of a Hospital Bill*] (describing different rates charged to uninsured, governmental plan beneficiaries and privately insured); see also *Hearing*, supra note 1, at 20 (statement of Gerard F. Anderson, Director, Johns Hopkins Center for Hospital, Finance and Management) (stating that "[i]t is now common for charges to be two to four times higher than costs"); *The Legal Aid Soc'y Health Law Unit, State Secret: How Government Fails to Ensure That Uninsured and Underinsured Patients Have Access to State Charity Funds* 30 (2003) [hereinafter *Health Law Unit*], available at http://www.legal-aid.org/Uploads/BDDCRReport.pdf (reporting that bill from St. Francis Hospital on Long Island for 2003 emergency room services, where coverage was denied by patient's insurer, was more than five times hospital would have accepted from insurer).
51. See id. (recounting patient's medical condition that prompted hospital stay).
52. See id. (retelling details of patient's stay in hospital).
53. See id. (elaborating on charges incurred from medical treatment).
54. See id. (comparing hospital rates charged to uninsured persons with rates charged to persons with government plan or private insurance coverage).
55. See id. (describing hospitals' line-by-line billing of full charges as similar to à la carte billing by restaurants).
56. See id. (making billing comparison). Even on a line item basis, the rates paid by governmental programs, for example, are much less than full charges. For example, the *Journal* reported that Shipman's cardiologist's bill for installing the
Further, the *Journal* illustrated the enormous gap between Mr. Shipman’s charges and the hospital’s actual costs. For example, the charge to Mr. Shipman for the stent was $7560, compared to the manufacturer’s listed retail price of $3,195, a markup of 237%.\(^5\)\(^7\) The hospital charged Mr. Shipman $532.50 for three bottles of dye to image his arteries, while the manufacturer sells the product to hospitals for twenty-eight dollars to fifty dollars a bottle, a markup of at least 355%.\(^5\)\(^8\)

In the fall of 2003, the *Journal* reported on two hospitals in Illinois—the Carle Foundation Hospital\(^5\)\(^9\) and Provena Covenant\(^6\)\(^0\)—focusing on their particularly heartless collections practices. Provena Covenant reportedly seized a large part of the retirement savings of Harold Quinn, a sixty-five year old man whose insurance had expired only days before he was forced to check into the hospital for abdominal pain from kidney stones.\(^6\)\(^1\) A seven-day stay and one-day outpatient kidney stone removal procedure left Mr. Quinn with a bill of $34,500, which was the hospital’s full charge for the care.\(^6\)\(^2\)

The same article also described a little known practice utilized by the Carle Foundation ("Carle") known as “body attachment.”\(^6\)\(^3\) When uninsured patients whom Carle had sued for medical debts missed their court appearances, Carle had them arrested and jailed, thereby requiring them to pay bail before they could return home.\(^6\)\(^4\) In one case, Carle had executed a body attachment on an uninsured part-time musician whose origi-

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57. See id. (comparing charges to costs).
58. See id. (discussing pricing differential). Due to the huge disparity between costs and charges, some healthcare researchers have speculated whether hospitals are actually making a profit off billing full charges to the uninsured. See, e.g., SEIU Hosp. ACCOUNTABILITY Project, UNINSURED AND OVERCHARGED: How ADVOCATE HEALTH CARE OVERCHARGES CHICAGO HOSPITAL PATIENTS 9-11 (2003) [hereinafter UNINSURED AND OVERCHARGED], available at http://www.seiu.org/docUploads/Discriminatory_Pricing_DP_Advocate.pdf (reporting that data on California hospitals show that some of them are profiting from uninsured collections).
61. See id.
62. See id.
63. See Lagnado, Medical Seizures, supra note 59.
64. See id. The *Journal* reported that Yale-New Haven Hospital had likewise obtained at least sixty-five civil arrest warrants in the prior three years for debtors who had missed court appearances. See id. Reportedly, body attachments are also used in Indiana, Kansas, Michigan and Oklahoma to collect medical debt. See id.
nal treatment at Carle was for a self-inflicted gunshot wound in a botched suicide attempt.65

The *Journal* articles on hospitals’ treatment of the uninsured put a personal face to the thousands of uninsured patients facing insurmountable hospital debt. Hospitals had not only failed to offer free or reduced charges to these patients, but had actually charged them rates that far exceeded what the hospitals were readily accepting from governmental programs and private insurance. Moreover, the hospitals apparently availed themselves of every legal means to make collections, including lawsuits, liens on residences, arrests, jailing and monthly interest charges that exceeded the installment payments themselves so that some of these debts, like Mr. White’s, would continue to grow even when the debtor faithfully made every payment.66 The light that the *Journal* shone on these cruel practices created a national sense of outrage over the treatment that supposedly charitable hospitals were giving to the uninsured.

### III. Numerous Reports Find That Hospitals Generally Were Not Providing Charity Care to the Uninsured

At about the same time that the *Journal* was giving the public a dramatic picture of the devastating consequences of medical debt for the uninsured, a number of investigational reports were being published that conclusively established the failure of hospitals to provide charity care to this population. Although the researchers were examining hospitals located in different geographical areas, their findings were shockingly similar: hospitals did not tell the uninsured about charity care, did not offer charity care, did not discount bills to the uninsured and aggressively pursued payment.

The reports consistently found that most hospitals did not tell uninsured patients about the availability of charity care.67 It was extremely rare (listing states that use arrest and jailing of patients who miss their court hearings regarding their hospital debts).

65. See id. (providing example of particularly aggressive use of body attachment).

66. For a further discussion of Mr. White’s medical bills, see *supra* notes 23-32 and accompanying text.

to locate hospitals having a well-defined policy of charity care that was explained to uninsured patients. In fact, staffers at many hospitals were unable or flatly refused to provide any information on free care and many hospitals mistakenly stated that free care was unavailable. Not surprisingly, most uninsured patients did not receive free care or any substantial reduction to their hospital bills.

Compounding the problem, as confirmed by the researchers, was that the surveyed hospitals all charged the uninsured full undiscounted charges. For example, a study of Chicago area hospitals found that each hospital charged uninsured patients up to twice the payments the hospitals accepted from insurance plans. The researchers found that the victims of such "discriminatory pricing" were largely the working poor. Due to the exorbitant rates, the average inpatient hospital bill for uninsured services often amounted to twenty-seven percent to fifty-nine percent of the median annual income within the locality, virtually guaranteeing that the uninsured patient would be unable to pay the bill. Even if the patient were not sued and thus managed to avoid the tacked on court costs and legal fees, most hospitals charged interest that continued to accrue on unpaid portions of the bill.


68. See, e.g., STUDY OF SIXTEEN LONG ISLAND HOSPITALS, supra note 67, at 2 (reporting that most hospitals surveyed did not inform surveyors that free care was available to low income patients, and did not provide written free care policy).

69. See id. at 3 (reporting that at majority of hospitals surveyed, billing staff did not know if free care was available).

70. See, e.g., STUDY OF SEVEN LONG ISLAND HOSPITALS, supra note 43, at 8.

71. See, e.g., UNINSURED AND OVERCHARGED, supra note 58, at 3.

72. See id. at 2 (stating that financial assistance offered to uninsured most often consisted of offer to allow payment of full bill in installments, rather than discounting or waiving charges); see also Hearing, supra note 1, at 75 (statement of Gerard F. Anderson, Director, Johns Hopkins Center for Hospital, Finance and Management) (explaining that it is difficult for uninsured to negotiate discounted rates pre-treatment, because charges are per item, and parties do not know ahead of time what items and services will be required).


74. See WORKING POOR, supra note 73, at 2 (identifying victims of inflated pricing as those who earn too much to qualify for Medicaid, but too little to afford private insurance).

75. See id. (describing disparities in bills to insured versus uninsured for emergency treatment and financial effect of such disparities on uninsured families).

76. See THE ACCESS PROJECT, THE CHAMPAIGN COUNTY HEALTH CARE CONSUMERS, HUMAN SERVICES COAL. OF DADE COUNTY, TENANTS’ AND WORKERS’ SUPPORT
Further, when hospitals reported their amounts of bad debt and charity care, they often reported in terms of charges, not costs. This potentially created a misconception that hospitals were shouldering a much larger burden of charity care than they actually were.

Several of the studies also confirmed the Journal reports that exposed the hospitals’ relentless pursuit of collections from uninsured patients. The most damning, titled "Uncharitable Care," focused on Yale-New Haven Hospital’s practices of suing uninsured patients, seizing their wages, garnishing their bank accounts and foreclosing on their homes, even when relatively small amounts were at stake. In one case, the hospital sued to foreclose on a patient’s home to collect a debt of only $4000.

Other reports focused on the massive scope of the problem. The Robert Wood Johnson Foundation reported that, according to Census Bureau figures, there were 41 million uninsured persons in the United States in 2001. When persons who were uninsured for only a part of the year

Comm., The Consequences of Medical Debt: Evidence from Three Communities 18 (2003) [hereinafter Consequences of Medical Debt], available at http://www.accessproject.org/downloads/med_eseng.pdf (reporting that often interest continued to accrue even when patient was making installment payments); see also Champaign County Ill. Bd. of Review, Notes on Exempt Applications 7 (2003), available at http://www.co.champaign.il.us/SOAOFF/PROVENA.pdf (finding interest charges of 12.9% when patients financed their debt to Provena via financing plan suggested by Provena through Capstone Bank, N.A.).

77. See, e.g., Uncharitable Care, supra note 67, at 12 (stating that value of Yale-New Haven’s bad debt and free care is reported in terms of charges, not at hospital’s cost of providing services).

78. See, e.g., Uninsured and Overcharged, supra note 58, at 10-11 (reporting that Advocate Health Care "distorts the value of the charity care its hospitals provide by reporting charity care amounts as gross charges, rather than as the cost of providing the care").


80. See Uncharitable Care, supra note 67, at 7 (describing case of Sondra Henderson, among others, who was sued by Yale-New Haven Hospital in late 1990s for approximately $4000, which she had incurred as uninsured admitted for heart condition, where hospital ultimately won default foreclosure on her home, forcing Henderson to pay $10,313, including interest, costs and legal fees to settle case and retain residence).

81. See Going Without Health Insurance, supra note 36, at 1 (stating number of people in 2001 “who did not have any type of health insurance at any point in time during the entire year”). The figure in New York City alone was over 1.8 million uninsured in 2001. See Health Law Unit, supra note 49, at 7; see also Citizens Research Council of Mich., Health Insurance Coverage and Uninsured/Uncompensated Care in Michigan Hospitals 12 (2002), available at http://www.crcmich.org/PUBLICAT/2000s/2002/memo1061.pdf (reporting that “[t]here are indications that numbers [of Michigan uninsured] may be on the rise again [after
were considered, the figure rose to approximately 74.7 million under the age of sixty-five, or nearly one out of every three persons.\textsuperscript{82} Surprisingly, nearly four out of five individuals who went without health insurance during 2001-2002 were employed,\textsuperscript{83} confirming the findings of other studies that it is predominantly the working poor, not the unemployed, who go without health insurance.\textsuperscript{84}

The reports also confirmed that the consequences of medical debt on the uninsured caused substantial changes in their lives. Medical debtors found it difficult to obtain bank loans and credit cards; worked longer hours to meet their basic needs; and battled stress, anxiety and "feelings of hopelessness."\textsuperscript{85} A study of healthcare on Long Island found that the uninsured often did not get needed medical care because they could not afford it.\textsuperscript{86} A study of the Chicago area found that the uninsured were often denied access due to providers' requirements that the uninsured pay cash up-front or due to providers' refusals to treat because of outstanding bills.\textsuperscript{87} Ironically, the denial of access to medical care for the uninsured often resulted in their use of more costly hospital emergency depart-

\textsuperscript{82}. See \textit{Going Without Health Insurance}, supra note 36, at 1 (noting that almost two-thirds of individuals in study were uninsured for six months or more); see also Hearing, supra note 1, at 5 (statement of Rep. Diana DeGette, Member, H. Comm. on Energy and Commerce, Subcomm. on Oversight and Investigations) (noting that forty-three to eighty-one million Americans go without health insurance for at least part of year).

\textsuperscript{83}. See \textit{Going Without Health Insurance}, supra note 36, at 5 (observing that most uninsured were employed).

\textsuperscript{84}. See, e.g., \textit{Working Poor}, supra note 73, at 2 (reporting that sixty-four percent of uninsured adults in Illinois in 2001 were employed).

\textsuperscript{85}. See \textit{Consequences of Medical Debt}, supra note 76, at 18-21 (providing testimonial from individuals affected by large medical debt).

\textsuperscript{86}. See generally \textit{Long Island Health Access Monitoring Project, The Long Island Coal. for a Nat'l Health Plan, Neglected and Invisible: Understanding the Unmet Healthcare Needs of People on Long Island} 32 (2002) [hereinafter \textit{Neglected and Invisible}], available at http://www.accessproject.org/downloads/_DI%20Final%20Report45.pdf (describing uninsured's need for medical services, prescription drugs and dental coverage). Some researchers have noted that hospitals' debt and collections activities can adversely affect patients' health. See Hearing, supra note 1, at 28 (statement of Melissa B. Jocoby, Associate Professor, University of North Carolina at Chapel Hill) (noting that "[s]ome researchers are concerned specifically about the negative impact of indebtedness and related financial trouble on certain diseases and conditions").

\textsuperscript{87}. See \textit{Consequences of Medical Debt}, supra note 76, at 13 (detailing various bars to access to medical treatment); see also Health Law Unit, supra note 49, at 35 (reporting that eight of twenty-two New York hospitals interviewed regularly asked uninsured patients to pay 100% of their anticipated bill prior to admission). A financial representative from New York University Hospital has been quoted as saying that "people have to pay for the services they receive here . . . [and] if they can't pay, they have to just get the hell out!" See id. at 20; see also Pryor, Unintended Consequences, supra note 79, at 3 (reporting on study where more than half of low-income healthcare consumers with medical debts told researchers that their medical debts made it harder for them to get medical care, as providers re-
mments, where the hospitals are required to screen and treat by the Emergency Medical Treatment and Active Labor Act (EMTALA).

One of the more influential reports, by The Commonwealth Fund, was unique in suggesting regulatory causes for the hospitals' billing full charges to the uninsured. The report stated that federal fraud and abuse laws aimed at preventing overbilling to the Medicare system may have inadvertently inhibited hospitals from offering reduced charges and from forgiving debt. The report, however, also faulted hospitals for failing to have formal policies for identifying and connecting uninsured patients to programs that were available to provide free or reduced-cost care.

Several reports were especially critical of New York's bad debt and charity care system. While New York hospitals can recover a portion of their bad debts and charity care from a statewide pool, there are no requirements for hospitals to alert patients to the existence of the pool or to provide minimal levels of charity care. Not only do New York hospi-

88. See Going Without Health Insurance, supra note 36, at 14 (stating that uninsured adults are four times more likely to use emergency room for care); Neglected and Invisible, supra note 86, at 27, 32 (finding that more than half of respondents who reported family use of emergency room said it was due to lack of insurance or inability to pay).

89. See 42 U.S.C. § 1395dd (2000) (requiring hospitals to provide medical screening exam to determine whether emergency condition exists when patients come to hospital emergency department and make request for treatment, and if emergency condition is identified, requiring hospital to provide stabilizing treatment within its capability, or to transfer patient to another facility that can provide such treatment).

90. See Pryor, Unintended Consequences, supra note 79, at 4 (suggesting regulatory reasons for hospitals' uninsured billing practices).

91. See id. (referring to Medicare rules that prohibit providers from waiving collection and require providers to set uniform fees).

92. See generally id. at 12-18 (describing shortfalls in hospitals' billing practices).


94. See Health Law Unit, supra note 49, at 20 (reporting that pool distributions for 2001 covered approximately fifty percent of hospitals' cost of providing uncompensated care); New York Hospital Free Care, supra note 93, at 25 (stating that seventy hospitals surveyed received more than $400 million from New York's bad debt and charity care pool).

95. See New York Hospital Free Care, supra note 93, at 27-28. The source reports:

New York State spent $847 million dollars a year [for 2002-2003] through the HCRA Indigent Care and High Need Indigent Care Adjustment
tals bill the uninsured an added tax for the state's bad debt and charity care pool, but when the hospital collects from the pool to compensate it for a portion of its uncollected bills, those collections never get credited to specific patients. This enables New York hospitals to continue to pursue uninsured patients for collection even after the hospitals have collected from the pool to compensate them, at least in part, for those uncollected debts.

IV. Hospital Charges—How They Are Determined, Why They Are So High and the Inequity This Produces for the Uninsured

Historically, hospitals set their charges in much the same manner as any other industry. They had discretion to set whatever charges they determined would be sufficient to cover their costs and give them a predetermined level of profit, keeping in mind the charges sought by competing hospitals in their local markets. Beginning in the early 1980s, however, managed care plans began demanding negotiated discounts.

Pools, but there is no accountability by hospitals on how many uninsured and underinsured individuals they treat as a result of receiving funds from the pools. . . . [T]here is no real basis for determining whether they provide care to the neediest patients.

*Id.; see also Health Law Unit, supra note 49, at 9 (“Hospitals do not have to actually provide access to free or reduced fee care funds to individual uninsured or underinsured patients in exchange for these [bad debt and charity care pool] funds.”).*

96. *See N.Y. Pub. Health Law § 2807j (McKinney 2002) (requiring surcharges to be paid for services provided to all non-Medicare patients); see also Lagnado, Full Price, supra note 33 (reporting that New York Methodist Hospital's bill for uninsured patient Rebekah Nix included tax of $1072 for bad debt and charity care pool contribution).*

97. *See Health Law Unit, supra note 49, at 2 (describing how hospitals' receipt of bad debt and charity care funds from state pool does not benefit individual uninsured).*

98. *See id. at 11 (providing illustration wherein uninsured patient is pursued by hospital for full charges, even though hospital collects fifty percent of its costs from state's pool). New York has also come under fire for a state law that allows debt collectors, acting on the hospitals' behalf, to go after old court judgments against patients and attach their bank accounts electronically. See Lucette Lagnado, Cold-Case Files: Dunned for Old Bills, Poor Find Some Hospitals Never Forget, WALL ST. J., June 8, 2004, at A1 (describing New York law that allows electronic attachment of bank accounts). See generally N.Y. C.P.L.R. 5222(a), (g) (McKinney Supp. 2001) (describing statutory process for debt collection by use of restraining notice).*

99. *See, e.g., Lucette Lagnado, Medical Shift: Hospitals Will Give Price Breaks to Uninsured, if Medicare Agrees, WALL ST. J., Dec. 17, 2003, at A1 [hereinafter Lagnado, Medical Shift] (stating that in 1960s, "hospital charges generally reflected the cost of providing care plus a modest profit"); see also Hearing, supra note 1, at 19 (statement of Gerard F. Anderson, Director, Johns Hopkins Center for Hospital, Finance and Management) (noting that in 1960s and 1970s hospitals had "complete discretion" to establish their charges).*

100. *See Hearing, supra note 1, at 19 (statement of Gerard F. Anderson, Director, Johns Hopkins Center for Hospital, Finance and Management) (explaining that in early 1980s managed care plans began negotiating discounts off hospitals' charges).*
cases, these negotiated rates for managed care plans were expressed as percentage discounts off charges.\textsuperscript{101}

In the mid-1980s Medicare and Medicaid largely converted to “case based” rates of payment, whereby they paid hospitals one set price for all services rendered to an inpatient with a particular diagnosis.\textsuperscript{102} Although the case based methodology was not related to the hospitals’ charges, the governmental programs still used charges to calculate payments for “outlier” cases, i.e., cases where complications required, for example, a longer inpatient stay or a more intensive use of hospital resources, thereby rendering the case based rate inadequate.\textsuperscript{103}

For the past twenty years, health insurers, managed care plans and governmental programs have all sought to drive down their rates for hospital care,\textsuperscript{104} which often comprises the largest segment of expense for healthcare insurers.\textsuperscript{105} Because the hospital rates payable by health insurers, managed care plans and governmental programs (covering the majority of hospitals’ patients)\textsuperscript{106} were not full charges and often times were quite a bit less than the hospitals’ charge levels, there was little incentive for state or federal governments to regulate charges.\textsuperscript{107} Additionally, charges in return for placing hospitals in plans’ networks); see also Lucette Lagnado, \textit{Medical Markup: California Hospitals Open Books, Showing Huge Price Differences}, \textit{Wall St. J.}, Dec. 27, 2004, at A1 [hereinafter Lagnado, \textit{Medical Markup}] (stating that during 1990s HMOs demanded “steep discounts off retail prices” from hospitals).

\textsuperscript{101.} See, e.g., \textit{Hearing}, supra note 1, at 114 (statement of Jack O. Bovender, Jr., Chairman and CEO, the Hospital Corporation of America) (providing that many negotiated rates with managed care providers are based on discounts off charges).

\textsuperscript{102.} See, e.g., Lagnado, \textit{Full Price}, supra note 33 (reporting that beginning in mid-1980s Medicare started basing payments on standardized diagnostic codes related to patients’ diagnoses rather than to hospitals’ charges).


\textsuperscript{104.} See, e.g., \textit{Hearing}, supra note 1, at 19 (statement of Gerard F. Anderson, Director, Johns Hopkins Center for Hospital, Finance and Management) (acknowledging that by 1990, federal and state governments, private insurers and managed care plans were no longer paying charges to hospitals, but were instead using case based rate methodologies or negotiating discounts with hospitals).

\textsuperscript{105.} See RAND E. ROSENBŁATT ET AL., \textit{LAW AND THE AMERICAN HEALTH CARE SYSTEM} 467-68 (David L. Shapiro et al. eds., 1997) (stating that hospitals receive largest portion of money spent on healthcare).

\textsuperscript{106.} See \textit{id.} at 468 (explaining that in 1993 hospitals received 36% of their revenues from private insurers, 28% from Medicare, 13% from Medicaid, 15% from other federal programs, 5% from philanthropic or non-patient income and only 3% from patients directly).

\textsuperscript{107.} See \textit{Hearing}, supra note 1, at 19 (statement of Gerard F. Anderson, Director, Johns Hopkins Center for Hospital, Finance and Management) (indicating that when federal and state governments, private insurers and managed care plans ceased paying full charges by 1990, “the regulatory and market constraints on hospital charges were virtually eliminated”). For example, before New York deregulated hospital rates in 1997, charges could not be more than twenty percent above the case based rates payable by commercial insurers. See \textit{N.Y. Pub. Health Law}...
there was little incentive for the hospitals to decrease their charges because many of the negotiated rates continued to be structured as discounts off charges.\textsuperscript{108} High charges could also trigger extra outlier payments from Medicare, encouraging hospitals to keep their charges high.\textsuperscript{109} As a result, charges continued to climb.

As such, the only patient group that did not benefit from the drive down of hospital rates was the uninsured.\textsuperscript{110} The employed population largely came to receive health insurance benefits through their employers' health benefit plans.\textsuperscript{111} The age sixty-five and older population became covered by Medicare.\textsuperscript{112} The extremely indigent often met the state's cri-

\textsuperscript{108} See Pryor, UNINTENDED CONSEQUENCES, supra note 79, at 17 (reporting that hospitals' use of charges as basis for negotiating discounts with public and private insurers may lead hospitals to keep charges high); Lagnado, Medical Shift, supra note 99 (stating that hospitals began boosting their charges in 1980s "as an effort to set a higher starting point for negotiations [with HMOs]").

\textsuperscript{109} See Hearing, supra note 1, at 127-28 (statement of Rep. James C. Greenwood, Member, H. Comm. on Energy and Commerce, Chairman, Subcomm. on Oversight and Investigations) (indicating that outliers were reimbursed by Medicare on ratio formula with cost as numerator and charge as denominator, creating incentive for hospitals to set their charges as high as possible); Serafini, supra note 103 (stating that to determine whether particular patient qualifies as outlier, Medicare determines difference between hospital's charges and costs, but as cost lists used by Medicare were two years old, hospital could increase charges to create greater difference between costs and charges, triggering outlier payment). In August of 2003, the Centers for Medicare and Medicaid Services changed its outlier reimbursement rules to remove the troubling incentive, creating a system where rapid increases in gross charges do not increase outlier payments. See Hearing, supra note 1, at 142-43 (statement of Herb Kuhn, Director, Center for Medicare Management, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services) (providing that new regulations "tighten the time period between costs and charges" so that hospitals no longer have the opportunity "to accelerate charges because of . . . incentives in the Medicare program").

\textsuperscript{110} See Lagnado, Medical Shift, supra note 99 (reporting that uninsured were "[l]ost in the mix," billed at full charges, unaware of discounted rates and with no one to negotiate discounts for them).

\textsuperscript{111} See ROSENBLATT ET AL., supra note 105, at 38 (stating that most important determinant of health insurance coverage was employment, with nearly two-thirds of non-elderly having employment-based coverage).

\textsuperscript{112} See id. at 369-70 (asserting that generally, Medicare Part A (covering hospital services) covers individuals who are age sixty-five or older and who have paid social security taxes for at least ten years).
teria to qualify for Medicaid. All these groups paid discounted hospital rates or case based rates. A portion of the middle class, however, either newly unemployed or not covered by an employer sponsored health benefit plan, did not qualify for Medicaid and was not old enough to be covered by Medicare. It was only this group of uninsured patients that was left to pay full charges when they received hospital services.

V. Nation-Wide Wave of Class Actions Challenges Hospitals' Uninsured Billing and Collections Practices

Beginning in the summer of 2004, uninsured patients across the United States commenced a number of class action lawsuits against hospitals alleging excessive charges and overly aggressive collections practices. The litigations were coordinated by Richard F. Scruggs, the Oxford, Mississippi, attorney who had successfully represented plaintiffs in the tobacco class actions. By January 2005, more than seventy such lawsuits had been commenced in federal courts in more than forty states, with

113. According to the New York State Department of Health's Website, a single individual may qualify for Medicaid if he or she receives no more than $667 in income per month. See N.Y. State Dep't of Health, Medicaid, http://www.health.state.ny.us/health_care/medicaid/index.htm#qualify (last visited Nov. 12, 2005) (presenting Medicaid eligibility chart).

114. For example, the standard 2003 charge for a hysterectomy at North Shore University Hospital in Manhasset, New York, was $21,508; however, Medicaid paid $8456, Medicare paid $7600 and private insurers and HMOs paid approximately the same rate as Medicare. See Lagnado, Medical Shift, supra note 99 (describing differences in billing insured versus uninsured patients).

115. See Hearing, supra note 1, at 5 (statement of Rep. Diana DeGette, Member, H. Comm. on Energy and Commerce, Subcomm. on Oversight and Investigations) (noting that "the uninsured are the only ones who have no advocate [to negotiate a discounted hospital rate]"). Professor Elizabeth Warren of Harvard Law School has accurately summarized the current situation, stating: "there is no one to negotiate on behalf of people without insurance." See UNINSURED AND OVERCHARGED, supra note 58, at 7 (quoting Professor Elizabeth Warren).


more than 600 hospitals named as defendants.119 Dozens of similar class actions were also commenced in state forums.120

For the most part, the various state and federal complaints made the same allegations. The chief claim was that by receiving federal charitable tax exemption under § 501(c)(3) of the Internal Revenue Code,121 the hospitals had entered into an express or implied contract with the federal


120. See Multidistrict Judicial Panel Rejects Motion to Consolidate, Transfer Charity Care Cases, supra note 119, at 1533 (stating that as of fall 2004, approximately forty additional state court actions had been filed).

121. See 26 U.S.C. § 501(c)(3) (2000). The statute provides that an organization may be exempt from taxation if it is:

[O]rganized and operated exclusively for . . . charitable . . . purposes, . . . no part of the net earnings of which inures to the benefit of any private shareholder or individual, no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation . . . and which does not participate in, or intervene in . . . any political campaign on behalf of (or in opposition to) any candidate for public office.

Id.
government obliging them to provide charity care. Plaintiffs alleged that when they were billed excessive charges for hospital services and were aggressively pursued by the hospitals for collection, the hospitals were in breach of their charitable obligations. Plaintiffs also asserted various state and federal claims against the hospitals for breach of express or implied charitable duties, breach of the duty of good faith and fair dealing, breach of charitable trust and unjust enrichment, but these claims were premised, at least in part, upon the same legal theory that the hospitals' charitable tax exemption under § 501(c)(3) created an express or implied contract with the government to furnish charity care.

Various plaintiffs asserted additional federal claims. Some alleged violations of the Fair Debt Collection Practices Act (FDCPA), asserting that the hospital's "aggressive, abusive and humiliating collection practices" were prohibited by the FDCPA. Others asserted violations of EMTALA, based on the hospitals' alleged insistence that the plaintiffs sign payment guarantees before receiving emergency treatment. Some plaintiffs asserted civil rights claims under 42 U.S.C. § 1983 for alleged violations of the equal protection provisions of the Fifth and Fourteenth Amendments, claiming that the hospitals had engaged in invidious discrimination against uninsured patients by charging them more than in-


123. See id. ¶¶ 30-36, 70-79 (elaborating on alleged breaches of charitable duties).

124. See id. ¶¶ 70-79.

125. See id. ¶ 80-83.

126. See id. ¶ 88-92.


128. See id. (explaining that basis for all claims stemmed from reading § 501(c)(3) as creating express or implied contract between hospitals and government to furnish charity care in exchange for tax exemption).


130. See, e.g., Complaint ¶ 86, Carlson, No. CV 04-3086 (arguing that Fair Debt Collection Practices Act (FDCPA) prohibited hospitals' collections practices).

131. See 42 U.S.C. § 1395dd (2000) (prohibiting hospitals from, inter alia, denying or delaying emergency screening and treatment). For a further discussion of Emergency Medical Treatment and Active Labor Act (EMTALA), see supra note 89.


133. See U.S. CONST. amends. V, XIV, § 1 (providing due process protection). The Due Process Clause of the Fifth Amendment states: "nor shall any person . . . be deprived of life, liberty, or property, without due process of law . . . ." U.S. CONST. amend. V. The Fourteenth Amendment provides, in relevant part, that "no state shall . . . deny to any person within its jurisdiction the equal protection of the laws." U.S. CONST. amend. XIV, § 1.
sureds for the same services. Finally, plaintiffs asserted various state law claims, such as breach of express contracts and violations of state consumer fraud statutes. Plaintiffs named the American Hospital Association (AHA) as an additional defendant, alleging that the AHA had conspired with the hospitals and aided and abetted the alleged breaches.

VI. HOSPITALS AND HHS FACE OFF AT THE CONGRESSIONAL HEARING ON HOSPITALS’ BILLING AND COLLECTIONS PRACTICES

In the summer of 2003, the House Energy and Commerce Committee commenced an investigation of hospital billing and collections practices, sending letters to twenty hospitals and hospital systems nationwide asking detailed questions about their charity care policies. A year later, the Subcommittee on Oversight and Investigations convened a hearing on the problem, taking testimony from a number of health policy researchers, hospital industry representatives and representatives from the Centers for Medicare and Medicaid Services (CMS) and the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS).

The researchers reiterated their findings regarding the magnitude of the problem of medical debt for the uninsured. Further, they confirmed that hospital reimbursement methodologies incentivized hospitals

135. See id. at 499 (detailing plaintiffs’ breach of contract claim).
136. See, e.g., Complaint ¶¶ 93-97, Carlson v. Long Island Jewish Med. Ctr., No. CV 04-3086 (E.D.N.Y. July 2, 2004) (asserting violations of New York’s consumer fraud law); see also N.Y. GEN. BUS. LAW § 349 (McKinney 2004) (prohibiting deceptive business practices). Moreover, others of plaintiffs’ various common law claims, such as breach of the duty of good faith and fair dealing, could also be premised upon principles of New York common law. See, e.g., Complaint ¶¶ 80-83, Carlson, No. CV 04-3086 (asserting claim for breach of good faith and fair dealing).
137. See Complaint ¶¶ 43-46, 102-116, Carlson, No. CV 04-3086 (alleging that American Hospital Association (AHA) conceals and misrepresents amount of charity care provided by its member hospitals and that it falsely asserts that its billing is required by Medicare regulations).
139. See Hearing, supra note 1, at III (listing names of witnesses appearing at hearing, including: researchers from the Johns Hopkins Center for Hospital Finance and Management; The Commonwealth Fund; the University of North Carolina at Chapel Hill School of Law; the Access Project; hospital representatives from Hospital Corporation of America, Tenet Healthcare Corporation, Catholic Health Initiatives, New York Presbyterian Hospital, and Ascension Health; representatives of Centers for Medicare and Medicaid Services (CMS); and representatives of Office of Inspector General (OIG)).
140. See id. at 15 (statement of Rep. Allen, Member, House Subcomm. on Oversight and Investigations) (asserting that medical debt is leading cause of personal bankruptcy in United States).
to retain high charges and that states’ deregulation of hospital rates largely had removed charges from governmental limitations.\textsuperscript{141} Representatives of the hospital industry defended their charity care practices, emphasizing that they ended up “writing off” most uninsured bills.\textsuperscript{142} The hospitals also explained that most of their managed care contracts were structured as percentage discounts off charges; thus, lowering charges would have huge impacts on all of the managed care rates collected by the hospitals, not just their rates to the uninsured.\textsuperscript{143}

The hospitals’ primary defense at the hearing, set forth in a white paper produced by the AHA,\textsuperscript{144} was that federal regulations governing Medicare had restricted the hospitals’ ability to lower charges for the uninsured and underinsured, and to forgive their debts.\textsuperscript{145} The AHA argued that Medicare billing rules require a uniform charge structure for all patients.\textsuperscript{146} Although there are exceptions to the uniform charge rule to allow hospitals to discount charges to needy Medicare beneficiaries, the AHA argued that fulfilling the requirements to qualify for the exceptions is onerous and uncertain.\textsuperscript{147} The hospitals must either assume “considerable administrative burdens” and obtain prior approval from CMS agents or make detailed and verified financial findings to support their identification of Medicare beneficiaries as indigent.\textsuperscript{148} Further, in order to receive payments from Medicare for cost sharing amounts that hospitals have been unable to collect from Medicare beneficiaries, the hospitals must engage in “reasonable collection efforts” which are uniform for all patients.\textsuperscript{149} The “reasonable collection efforts” required by Medicare have come to be defined through Medicare audits as rather aggressive collections practices.\textsuperscript{150} The AHA also noted that CMS and the OIG had vigorously enforced the Medicare bad debt rules, subjecting hospitals to

\begin{itemize}
  \item \textsuperscript{141} See id. at 16, 19 (statement of Gerard F. Anderson, Director, Johns Hopkins Center for Hospital, Finance and Management) (opining reasons for excessive charges).
  \item \textsuperscript{142} See id. at 98 (statement of Herbert Pardes, President and CEO of New York Presbyterian Hospital) (explaining that New York Presbyterian Hospital writes off $70 million in bad debt each year).
  \item \textsuperscript{143} See id. at 92 (statement of Jack O. Bovender, Jr., Chairman and CEO, the Hospital Corporation of America).
  \item \textsuperscript{144} See id. at 240-53 (presenting document submitted by AHA, setting forth various hospital defenses to alleged inappropriate billing and collections practices).
  \item \textsuperscript{145} See id. (providing AHA’s primary defense offered to support hospitals’ alleged inappropriate billing and collections practices against uninsured patients).
  \item \textsuperscript{146} See id. at 241 (presenting AHA’s defense that Medicare does not permit hospitals to lower charges for uninsured).
  \item \textsuperscript{147} See id. at 245-46 (detailing difficulties in complying with exceptions to uniform charge requirement).
  \item \textsuperscript{148} See id. (noting tasks required to be performed by hospitals to utilize uniform patient charge exception).
  \item \textsuperscript{149} See id. at 246 (discussing Medicare debt collection rules).
  \item \textsuperscript{150} See id. at 241-42 (stating that Medicare reviews and audits have shaped definition of reasonable collection efforts).
\end{itemize}
expensive and time consuming audit appeals whenever Medicare challenged the hospitals' lack of sufficient substantiation of indigence or insufficient collection efforts. In addition, the AHA stated that the federal anti-kickback law and a Fraud Alert issued by the OIG warning hospitals about routinely waiving Medicare deductibles and copayments chilled hospitals' willingness to discount charges or forgive debt for Medicare beneficiaries. Therefore, the AHA concluded that the Medicare rules, albeit "inaudientently," had discouraged hospitals from creating across-the-board exemptions for uninsured or underinsured patients and from being more lenient in collections.

In response, the OIG flatly denied any basis to contend that the Medicare rules or fraud and abuse laws prohibited hospitals from offering discounts to the uninsured and underinsured. With regard to the uninsured, the OIG stated:

Frankly, we do not know why lawyers advising hospitals would tell them that the fraud and abuse laws are an impediment to discounts to the uninsured. Such discounts do not violate the fraud and abuse laws. We have never taken any enforcement action in this area.

CMS also asserted that while Medicare reimbursement could be affected by hospitals' charge levels, charges are currently utilized as a basis for Medicare payment only in very limited circumstances. Moreover, debts could be forgiven for Medicare beneficiaries as long as the hospitals com-

151. See id. at 246-50.
152. See 42 U.S.C. § 1320a-7b (2000) (prohibiting remuneration to hospitals for referrals for services under federal health care program). The federal anti-kickback law states:

Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind—

   (A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program.

Id.

154. See Hearing, supra note 1, at 251-52 (stating that anti-kickback laws incentivized hospitals to aggressively seek payment from uninsured).
155. See id. at 240-41 (asserting that Medicare regulations prohibited hospitals from offering more lenient billing and collections procedures for uninsured).
156. See id. at 136 (statement of Lewis Morris, Chief Counsel, Office of Inspector General, U.S. Department of Health and Human Services).
157. Id.
158. See id. at 133-34 (statement of Herb Kuhn, Director, Center for Medicare Management, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services) (stating that most providers are currently reimbursed under "prospective payment" methodology where charges are not considered).
Applied with the anti-kickback waiver requirements, which require only that the waivers not be advertised or routinely given and that the hospital make a case-by-case finding of need.159

As of the date of this writing, the congressional probe into hospitals' charity care practices is continuing.160 In April 2005, the House Energy and Commerce Committee sent additional requests for information to ten

159. See id. at 135-36 (referring, apparently, to civil monetary penalty statute, 42 U.S.C. § 1320a-7a (2000), which authorizes CMS to impose civil monetary penalties for Medicare fraud, but which excepts any waivers of coinsurance and deductible amounts that are unadvertised, non-routine and pursuant to individualized determination of financial need or after failure of reasonable collection efforts).

160. See Witnesses Tell Senate Finance Committee Nonprofit Health Care Needs More Oversight, 14 Health L. Rep. (BNA) 493, 493 (2005) (reporting on Finance Committee's April 2005 hearing on charitable tax exemptions for hospitals). The recent congressional hearing before the Senate Finance Committee addressed the need for greater oversight of charitable healthcare organizations as part of a proposed nonprofit taxation reform. See id. (reporting that witnesses testified that any nonprofit taxation reform legislation should provide for greater oversight of charitable healthcare organizations). The Commissioner of Internal Revenue testified that the Internal Revenue Service (IRS) needs more flexibility to penalize charitable abuses and specifically noted that charitable healthcare entities may not sacrifice their charitable purposes for the sake of profit. See id. (stating that Mark Everson, IRS Commissioner, argued that IRS needs more resources to address nonprofit tax exemption issues). The IRS has reportedly sent letters to approximately 2000 nonprofit organizations (including healthcare organizations) asking the nonprofits to demonstrate that they are in compliance with IRS guidelines for establishing reasonable compensation for their executives and board members. See Nonprofit Health Care Entities Gear up to Respond to IRS Compensation Audits, 14 Health L. Rep. (BNA) 629, 629 (2005) (discussing problems nonprofit healthcare organizations may encounter in responding to audit letters). On May 25, 2005, the Senate Finance Committee sent letters to ten hospital systems asking for information about charitable activities, patient billing and ventures with for-profit entities, seeking to discover whether "the benefits [the hospitals] provide to the needy justify the tax breaks they receive." See Press Release, Senate Fin. Comm., Grassley Asks Non-Profit Hospitals to Account for Activities Related to Their Tax-exempt Status (May 25, 2005), available at http://finance.senate.gov/press/Gpress/2005/prg052505.pdf (including text of letter).

In May 2005, the House Ways and Means Committee held hearings to examine whether tax-exempt hospitals should be subjected to improved congressional oversight and increased IRS enforcement. See generally A Review of the Tax-Exempt Hospital Sector: Hearing Before the House Comm. on Ways and Means, 109th Cong. 1-8 (May 26, 2005), available at http://waysandmeans.house.gov/hearings.asp?formmode=view&id=3193 (presenting testimony regarding oversight of tax exemption requirements for hospitals). The stated goal of the hearing was to examine "what is the taxpayer getting in return for the tens of billions of dollars per year in tax subsidy." See id. at 3. The Committee considered a recently released General Accounting Office (GAO) study which had found that "current tax policy lacks specific criteria with respect to tax exemptions for charitable entities and detail on how that tax exemption is conferred." See id. at 7-8 (citing recent GAO study).

According to a work plan released by the IRS on October 26, 2005, the IRS will continue to focus on whether tax-exempt hospitals are furnishing sufficient community benefits to warrant their exemption. The IRS intends to send compliance check letters to hospitals on this and related matters in 2006. See IRS Predicts
leading hospitals, this time seeking explanations of how hospital charges are "presented, explained, and understood by the medical consumer" and "how patients . . . are affected by . . . high prices for services."

VII. AN EVALUATION OF THE HOSPITALS' AND HHS' POSITIONS

While there is no question that many hospitals have not acted charitably with regard to uninsured patients, it also appears that, contrary to the denials by HHS, hospitals had legitimate reasons for believing that lowering charges for the uninsured and underinsured or failing to take aggressive collections activities would expose themselves to regulatory risk. CMS's and the OIG's Advisory Opinions, Bulletins, Fraud Alerts, audit findings and even their express statements at the congressional hearing support the hospitals' position that waiving cost sharing or forgiving debt created regulatory risk. Although the hospitals' defenses with regard to the uninsured are substantially weaker than their defenses regarding Medicare beneficiaries, there are some legitimate bases supporting the hospitals' reluctance to discount charges or forgive debt.

There is substantial evidence that with regard to indigent Medicare beneficiaries, cost sharing waivers can create exposure under the federal fraud and abuse laws. On December 19, 1994, the OIG published a Fraud Alert warning that the routine waiver of copayments or deductibles under


162. See House Committee Seeks More Data on Hospital Charges, Billing Clarity, supra note 161, at 580. The letter to the hospitals stated that the Committee was looking at balance billing for out-of-network patients (patients who receive treatments at hospitals that have not negotiated discounts with the patients' insurance plans) and rates for property/casualty insurers, which “may be paying medical benefits under their policies at or close to the full charge master rates.” See Press Release, Committee Expands Inquiry, supra note 161 (providing text of letter sent to hospitals).

163. For a discussion of news articles and research findings reporting that hospitals did not advise uninsured patients of charity care that was available to them, did not negotiate reduced charges or reasonable payment plans, charged unreasonably high interest and took extremely aggressive collections actions, such as foreclosure of the patients' residences or body attachments, see supra notes 29-98 and accompanying text.

164. For a discussion of the denials by Department of Health and Human Services (HHS), see supra notes 138-59 and accompanying text.
Medicare Part B exposed a provider to anti-kickback risk. The OIG stressed that while cost sharing amounts could be forgiven where the provider makes a determination of the beneficiary's financial hardship, such forgiveness was to be an exception used only occasionally. As recently as August 2002, the OIG was still sending much the same message. In a Special Advisory Bulletin, the OIG warned against "Offering Gifts and Other Inducements to Beneficiaries." Therein, the OIG declared the same general rule that giving free services typically violates Medicare rules. Further, the OIG announced that anti-kickback exposure existed when a provider gave free services to Medicare beneficiaries based on a broad category of financial need as opposed to a case-by-case finding of indigence.

165. See OIG Special Fraud Alerts, 59 Fed. Reg. 65,372, 65,375 (Dec. 19, 1994). While Medicare Part B generally refers to physician services, the OIG noted that the Fraud Alert was not intended to legitimize Part A (hospital) waivers: This fraud alert is not intended to address the routine waiver of copayments and deductibles by providers, practitioners or suppliers who are paid on the basis of costs or diagnostic related groups. Inpatient hospital services are generally reimbursed by Medicare under a diagnostic related group (DRG) methodology.] The fact that these types of services are not discussed in this fraud alert should not be interpreted to legitimize routine waive of deductibles and copayments with respect to these payment methods.

166. See OIG Special Fraud Alerts, 59 Fed. Reg. at 65,375 ("This hardship exception, however, must not be used routinely; it should be used occasionally to address the special financial needs of a particular patient. . . . Except in such special cases, a good faith effort to collect deductibles and copayments must be made.").


168. Id. at 1.

169. See id. at 2 (stating that "unless a provider’s practices fit within an exception (as implemented by regulations) or are the subject of a favorable advisory opinion covering a provider’s own activity, any gifts or free services to [Medicare or Medicaid] beneficiaries should not exceed the $10 per item and $50 annual limits").

170. See id. at 5. The OIG stated that:
[T]here is no meaningful statutory basis for a broad exemption based on the financial need of a category of patients. The statute specifically applies the prohibition to the Medicaid program—a program that is available only to financially needy persons. The inclusion of Medicaid within the prohibition demonstrates Congress’ conclusion that categorical financial need is not a sufficient basis for permitting valuable gifts. This conclusion is supported by the statute’s specific exception for non-routine waivers of copayments and deductibles based on individual financial need. If Congress intended a broad exception for financially needy per-
A number of Advisory Opinions issued by the OIG confirm that waivers of coinsurance or deductibles for Medicare beneficiaries can be problematic unless based upon a documented individualized determination of need.\textsuperscript{171} Although the OIG has issued a number of Advisory Opinions declining to impose sanctions for free services or waiving cost sharing amounts to Medicare beneficiaries, the OIG has made it clear that these cases are unique. For example, waivers have been approved where they were offered to encourage patients to obtain preventive services that they might not otherwise opt to receive,\textsuperscript{172} to encourage patients to participate in clinical trials that could lead to important scientific findings\textsuperscript{173} and to fulfill a provider’s nationally recognized charitable mission.\textsuperscript{174}

\textit{Id.}

\textsuperscript{171} See, e.g., Op. Off. Inspector Gen. No. 02-7, slip op. at 1 (June 12, 2002), http://oig.hhs.gov/fraud/docs/advisoryopinions/2002/ao0207.pdf (stating that waiver of coinsurance for portable x-ray services provided to nursing home residents could violate anti-kickback statute and be grounds for sanctions under Social Security Act as waivers were not based on financial need, but on administrative burdens sought to be avoided by nursing homes); Op. Off. Inspector Gen. No. 97-4, slip op. at 1 (Sept. 25, 1997), http://oig.hhs.gov/fraud/docs/advisoryopinions/1997/97_4.pdf (advising ambulatory surgical center that declining to pursue collection of copayments from patients with employer-sponsored Medicare supplemental coverage may constitute grounds for sanctions under fraud provisions of Health Insurance Portability and Accountability Act, anti-kickback statute and Social Security Act, as waivers were not based on individualized determination of financial need and were intended to induce beneficiaries to obtain services at ambulatory surgery center).


Statements made by CMS and the OIG at the congressional hearing further confirm that routine waivers for Medicare beneficiaries are prohibited. When asked by the Subcommittee whether setting an indigence threshold at a given percentage of the federal poverty level\(^{175}\) would violate the Medicare rules,\(^{176}\) CMS responded that there could be a problem if the level selected amounted to a waiver of coinsurance in every case.\(^{177}\) When asked to confirm that a hospital’s posting of its charity care policy on its website or including its charity care policy on its bills would not violate Medicare rules, once again, the OIG declined to give a clear “yes” answer. The OIG responded that “one of the elements [of meeting the anti-kickback safe harbor] is not advertising the promotion of those routine waivers.”\(^{178}\)

Even when hospitals presumably seek to fulfill Medicare’s requirements for individualized assessments of need and reasonable collection efforts prior to waiving cost sharing or forgiving debt for Medicare beneficiaries, Medicare audits show that Medicare often challenges hospitals’ claims for bad debt reimbursement on the grounds that the indigence findings were not sufficiently documented\(^ {179}\) or that the collection efforts

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\(^{175}\) See Lagnado, *Full Price*, supra note 33 (stating that federal poverty level in 2004 was $8980 for individual and $18,400 for family of four).

\(^{176}\) See *Hearing*, supra note 1, at 147 (statement of Rep. James C. Greenwood, Member, H. Comm. on Energy and Commerce, Chairman, Subcomm. on Oversight and Investigations) (asking CMS whether setting charity care policy that triggered at 500, 700 or 800% of federal poverty level would trigger regulatory concern).

\(^{177}\) See id. (statement of Herb Kuhn, Director, Center for Medicare Management, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services) (stating that setting income level too high to consistently waive deductible would be problem).

\(^{178}\) See id. at 146 (statement of Lewis Morris, Chief Counsel, Office of Inspector General, U.S. Department of Health and Human Services). The OIG stated that public service announcements and fliers would be permissible, but that “people should not be encouraged to seek medical care where they are told there is no out-of-pocket, and it is being put on the side of buses.” *Id.*

were not sufficiently rigorous. Moreover, the audits illustrate that when hospitals' claims for bad debt reimbursement are challenged by Medicare, substantial reimbursement amounts may be withheld for a significant period of time pending appeal. Therefore, these audits justifiably rein-


Recently, in announcing Compliance Program Guidance for hospitals, the OIG confirmed that the documentation required for claiming reimbursement for Medicare bad debt is substantial:

A hospital should examine a patient's total resources, which could include, but are not limited to, an analysis of assets, liabilities, income, expenses, and any extenuating circumstances that would affect the determination. The hospital should document the method by which it determined the indigency and include all backup information used to substantiate the determination. If, instead of making such a determination, a hospital attempts to collect the outstanding amounts from the Medicare beneficiary, such efforts must be documented in the patient's file with copies of the bill(s), follow-up letters, and reports of telephone and personal contacts. In the case of a dually-eligible patient (i.e., a patient entitled to both Medicare and Medicaid), the hospital should document the bad debt claim by including a denial of payment from the State.


180. See, e.g., Metro Physical Therapy & Rehab., Inc. v. Blue Cross and Blue Shield Ass'n/United Gov't Servs., LLC, No. 2002-D35, 2002 WL 31005907, at *4 (P.R.R.B. Aug. 28, 2002) (finding that provider sent working patients' accounts to collection agency, but that non-working patients' accounts, presumed to be mostly Medicare, were written off as bad debt without being sent to collection agency); Office of Audit Services, U.S. Dep't of Health and Human Services, Review of Medicare Debts for Florida Hospital for the Fiscal Year Ended December 31, 1999, Audit No. A-04-02-02011, at 4-6 (2002), available at http://oig.hhs.gov/oas/reports/region4/40202011.pdf (finding that hospital used more collection efforts for its non-Medicare patients than it did for Medicare patients); see also AHA, Federal Regulations Hamper Hospitals' Efforts to Assist Patients of Limited Means 2-3 (2003) [hereinafter Regulations Hamper Hospitals], available at http://www.caringforcommunities.org/caringforcommunities/content/031217 fedregs.pdf (stating that OIG reviews and audits have "created an expectation that hospitals must be aggressive in their collection efforts or risk losing Medicare reimbursement for bad debt").


forced hospitals' perceptions that the safest route from a Medicare reimbursement perspective was to reduce charges or forgive debt for Medicare beneficiaries only in rare instances or not at all, and to undertake vigorous collection activities for all Medicare patients.\(^\text{183}\)

The hospitals' argument that Medicare rules and fraud and abuse laws prohibited them from discounting charges to the uninsured is considerably weaker than its defenses with regard to Medicare beneficiaries, as there are no direct statutory or regulatory prohibitions on waiver for uninsured patients. The Medicare billing rules and federal anti-kickback law do not apply directly to this class of patients because they are not covered by Medicare or any other federal healthcare program.\(^\text{184}\)

Nevertheless, there were still some bases for hospitals to have been legitimately concerned over discounting charges to the uninsured. The hospitals' best defense is Medicare's "uniform charge rule," which requires hospitals to set uniform charges for all patients\(^\text{185}\) to ensure that costs of treating non-Medicare patients are not being shifted to the Medicare program.\(^\text{186}\) As the OIG noted at the congressional hearing, it is authorized to exclude from Medicare participation any provider that charges Medicare more than it charges other patients for the same service.\(^\text{187}\) The AHA

\(^{183}\) See Regulations Hamper Hospitals, supra note 180, at 10-11 (explaining that Medicare audit procedures further pushed hospitals to bill uninsured patients in full and aggressively collect debts owed). The AHA asserted:

The length and the complexity of the appeals process for disallowed payments further deter hospitals from curtailing collection efforts from low-income patients . . . . [In one instance], [t]he hospital had to fight the issue administratively and in federal court for more than 10 years to receive definitive guidance on the question from a federal appeals court. Thus, when the Medicare policies on bad debts are unclear, it takes years to settle the disputes, at substantial cost and with substantial sums of Medicare reimbursement at stake . . . . The effect of the entire regulatory scheme is to pressure hospitals in these circumstances to be conservative in following the standard collection agency course, rather than negotiate a lower payment amount.

Id.

\(^{184}\) See 42 U.S.C. § 1320a-7b(b)(1) (2000) (restricting applicability of anti-kickback law to payments made under "federal healthcare program"). Obviously, the Medicare billing rules are applicable only to Medicare members.

\(^{185}\) See Regulations Hamper Hospitals, supra note 180, at 4 (examining Section 2203 of the Medicare Provider Reimbursement Manual, which states, in relevant part, that "[s]o that its charges may be allowable for use in apportioning costs under the program, each facility should have an established charge structure which is applied uniformly to each patient as services are furnished to the patient").

\(^{186}\) See Hearing, supra note 1, at 19 (statement of Gerard F. Anderson, Director, Johns Hopkins Center for Hospital, Finance and Management) ("In order to prevent fraud and abuse, the Medicare program required hospitals to establish a uniform set of charges that would apply to everyone . . . . Otherwise the hospitals could allocate charges in such a way that would result in more costs to the Medicare program.").

\(^{187}\) See id. at 137 (statement of Lewis Morris, Chief Counsel, Office of Inspector General, U.S. Department of Health and Human Services) ("The anti-kickback statute and permissive exclusion authority [prohibit] suppliers from charging
stated that this was a justifiable basis for hospitals to resist discounting charges to the uninsured.188

The OIG attempted to dispel the hospitals' concern over the uniform charge rule, however, by pointing out that it has proposed regulations clarifying that reduced charges offered to uninsured patients will not be considered as the hospital's usual charges for purposes of the OIG's exclusionary authority.189 Nevertheless, as the OIG itself conceded, these regulations are still in proposed form, not finalized.190 Moreover, this declared change in Medicare reimbursement policy is relatively recent, having appeared in the Federal Register on September 15, 2003.191

Medicare and Medicaid substantially more than they usually charge other customers.188. The OIG is statutorily authorized to exclude from participation in Medicare and Medicaid any individual who: "has submitted or caused to be submitted bills or requests for payment [under Medicare] or a State health care program . . . containing charges . . . for items or services furnished substantially in excess of such individual's or entity's usual charges . . . ." See 42 U.S.C. § 1320a-7(b)(6)(A) (2000) (stating grounds for exclusion). The implementing regulations restate that the OIG may exclude an individual or entity that has "[s]ubmitted, or caused to be submitted, bills or requests for payments under Medicare or any of the State health care programs containing charges or costs for items or services furnished that are substantially in excess of such individual’s or entity’s usual charges or costs for such items or services . . . ." See 42 C.F.R. § 1001.701(a)(1) (2004) (authorizing exclusion of individuals from Medicare and Medicaid where reimbursement requests exceed usual charges). The OIG explained at the congressional hearing that "[t]his law is intended to protect the Medicare and Medicaid programs—and the taxpayers—from providers and suppliers that routinely charge the Medicare or Medicaid programs substantially more than they usually charge other customers." See Hearing, supra note 1, at 137 (statement of Lewis Morris, Chief Counsel, Office of Inspector General, U.S. Department of Health and Human Services).

188. See Regulations Hamper Hospitals, supra note 180, at 4 ("The practical result of CMS’s insistence on uniform charges is that hospitals have been discouraged from lowering their charges to patients of limited means."); see also Pryor, Unintended Consequences, supra note 79, at 6 (reporting that Medicare carriers manual states that routinely waiving fees constitutes reduction in provider’s usual and customary charges, so that Medicare may reduce reimbursement for Medicare patients by amount of waived fees). When questioned at an Open Door Forum on June 1, 2004, whether the indigency criteria for Medicare patients must be applied to non-Medicare patients, CMS staffers provided very little clarification, responding that "differences in the criteria for Medicare and non-Medicare patients would be permitted so long as the threshold requirements are 'similar.'" See AHA, CMS/OIG Open Door Forum on Hospital Billing and Collections, A Summary 1 (2004), available at http://www.caringforcommunities.org/caringforcommunities/content/040601opendoor.pdf.

189. See Hearing, supra note 1, at 137 (statement of Lewis Morris, Chief Counsel, Office of Inspector General, U.S. Department of Health and Human Services) (stating that OIG proposed regulations "clarify that free or substantially reduced prices offered to uninsured do not need to be factored into a hospital’s usual charges for purposes of the exclusion authority").

190. See id.

Further, despite the OIG’s efforts to ameliorate concerns over the uniform charge rule, the OIG has never stated that a hospital’s “usual charges” can be amounts that, in fact, are never billed to any patients or perhaps only to a few patients. This leaves open the question of how extensively hospitals can waive and discount their charges to the uninsured while still maintaining that they have master charges against which their Medicare rates can be measured for purposes of compliance with the uniform charge rule.

In addition, CMS and the OIG failed to address the hospitals’ legitimate dilemma regarding how discounting charges to the uninsured might impact the hospitals’ use of charges as the benchmark for negotiating third-party rates. As stated at the congressional hearing by the CEO of the Hospital Corporation of America (HCA):

The more complicated problem is that many of our contracts—and at HCA we have over 5,000 contracts with managed care providers across the country. Many of those contracts are not on a per diem basis or case rate basis, but are really based on a discount off of charges. . . . It will take us probably two to two and a half years to renegotiate all of those contracts because many of them are multiple year contracts.

As a result, any lowering of charges to benefit the uninsured could have unintended and drastic consequences to the reimbursements collected by the hospitals under their third-party contracts. While rates with third-party payors could be renegotiated to address this contingency in the future, multi-year term third-party contracts might presently bar hospitals from tampering with their charge schedules.

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2004 that it would not consider free or reduced charges to uninsured or underinsured patients when calculating usual charges for purposes of its exclusionary authority. See Offered Discounts, supra note 179, at 1 (presenting decision not to consider free or reduced charges to uninsured or underinsured persons when calculating Medicare reimbursement).

192. Even if a hospital discounted charges for all uninsured patients, it could still bill full charges to non-indigent international visitors who come to the United States for healthcare. See Hearing, supra note 1, at 16 (statement of Gerard F. Anderson, Director, Johns Hopkins Center for Hospital, Finance and Management) (stating that these international visitors are “typically affluent individuals who need a procedure that can be performed most effectively in the United States”).

193. Id. at 114 (statement of Jack O. Bovender, Jr., Chairman and CEO, the Hospital Corporation of America).

194. See Lagnado, Full Price, supra note 33 (providing that “[t]he elaborate pricing systems hospitals have developed over the years will be difficult to change”). The article further stated: “‘The entire system will have to be blown up [if charges are discounted for the uninsured].’” Id. (quoting Jan Emerson, spokeswoman for California Healthcare Association).

195. See Hearing, supra note 1, at 114 (statement of Jack O. Bovender, Jr., Chairman and CEO, the Hospital Corporation of America) (“It will take us probably two to two and a half years to renegotiate all of those [managed care] contracts because many of them are multiple year contracts.”); see also Pryor, UNINTENDED
Hospitals also legitimately argued that the "uniform collections rule" served as an impediment to across-the-board free or discounted care for the uninsured. The uniform collections rule requires providers to use similar efforts to collect debts from Medicare beneficiaries as from non-Medicare patients. \(^{196}\) CMS and the OIG confirmed at the congressional hearing that "[i]f a hospital wants Medicare bad debt reimbursement, it must at the very least send non-indigent Medicare patients a bill for the debt, and must make some reasonable effort to collect from Medicare patients as it does from non-Medicare patients." \(^{197}\) CMS has made similar statements in opinion letters. \(^{198}\) These statements justifiably signaled to the hospitals that they must undertake the same vigorous collections efforts for all patients, including the uninsured, or risk losing Medicare bad debt reimbursement. \(^{199}\)

Finally, there are still some explicit link-ups between hospitals' uninsured billing practices and Medicare billing rules. CMS conceded at the congressional hearing that for at least a limited group of providers subject

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**Consequences**, *supra* note 79, at 10 ("Many managed care contracts also stipulate that the provider must charge the 'usual' fee for services rendered to members.").

196. *See* REGULATIONS HAMPER HOSPITALS, *supra* note 180, at 4 (discussing Medicare collections requirement). The uniform collections rule has been recognized by the federal courts. *See* Mt. Sinai Hosp. Med. Ctr. v. Shalala, 196 F.3d 703, 706 (7th Cir. 1999) ("Section 310 of the Provider Reimbursement Manual provides that: 'To be considered a reasonable collection effort, a provider's effort to collect Medicare deductible and coinsurance amounts must be similar to the effort provider puts forth to collect comparable amounts from non-Medicare patients.'").

197. *Hearing, supra* note 1, at 145 (statement of Herb Kuhn, Director, Center for Medicare Management, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services) (emphasis added). A CMS representative also stated at the congressional hearing that "if the hospital wants to bill the Medicare program for bad debt related to unpaid deductibles and co-insurance by Medicare beneficiaries, it must use the same level of collection activity to secure collection of those debts by Medicare patients as it does to secure collection of debts by non-Medicare patients." *See id.* at 131-32 (providing that "[e]fforts to collect from non-Medicare patients must be similar to the efforts to collect from Medicare patients").

198. *See, e.g.,* REGULATIONS HAMPER HOSPITALS, *supra* note 180, at 8 (suggesting that "[w]here a provider expends less effort to collect from some patients than from others . . . it has an inconsistent collection effort contrary to Medicare policy" (quoting Letter from Laurence D. Wilson, Director Chronic Care Policy Group, CMS, to Mark Rukavina (Sept. 11, 2003) (on file with author))).

199. The hospitals' argument that the uniform collections rule compelled collections of uninsured debt is not completely logical, however. Presumably, the rule was adopted by Medicare to preserve Medicare funds, by preventing hospitals from collecting bad debt reimbursement from the program without first making the same reasonable collections efforts for Medicare patients that the hospitals used for non-Medicare patients. Here, however, the issue was whether the hospitals could forego collections from uninsured patients, resulting in their using more stringent, not more lax, debt collection practices for Medicare beneficiaries. Forgiving debt for the uninsured would not cause hospitals to abandon reasonable collections for Medicare members, so that doing so, at least in principle, would not appear to offend the uniform collections rule.
to the "lesser of cost-or-charges" reimbursement principle\(^{200}\) (whereby Medicare reimbursement is based upon the lesser of the provider's cost or charge level)\(^{201}\) reducing charges, even if just for the uninsured, could decrease the hospital's reimbursement from Medicare.\(^{202}\) In new guidance issued in February 2004, the OIG noted that charges reported for purposes of setting a hospital's cost-to-charge ratio are still "used to set reimbursement in certain areas of the Medicare program, such as some features of the outpatient prospective payment system."\(^{203}\) And as noted by the AHA, Medicare's entire conversion to a case based system has been relatively recent, with the program's discontinuance of cost-based outpatient payments having occurred only three years prior to the congressional hearing.\(^{204}\) Accordingly, hospitals' rate structures and discounting policies understandably may still reflect older charge-based methods of determining reimbursement.

VIII. INITIAL RULINGS ON THE FEDERAL CLAIMS IN THE CHARITY CARE CLASS ACTIONS

The early decisions rendered by the district courts in the class actions challenging hospitals' billing and collections practices have been almost unanimously in favor of the hospitals. First, a serious early blow to the class action plaintiffs occurred when the Judicial Panel on Multidistrict

\(^{200}\) See Hearing, supra note 1, at 134 (statement of Herb Kuhn, Director, Center for Medicare Management, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services) ("Few providers are subject to the [lesser of cost or charges] principle at all . . . . The only example I am aware of is a pediatric or cancer hospital in its first year of operation . . . .").

\(^{201}\) See id. at 133 (providing that "where the LCC [lesser of cost or charges] principle is applicable, a Medicare provider is paid the lesser of its actual costs or its actual charges").

\(^{202}\) See id. (noting hospitals' potential loss of Medicare reimbursement after reducing charges to uninsured). Kuhn continues:

Implementing a reduced charge program for uninsured patients could potentially trigger the LCC [lesser of cost or charges] principle because if a hospital lowered charges for enough patients, a hospital's fiscal intermediary could take the position that a hospital's charges were not its posted, or stated, charges, but rather, the charges applicable to most of its patients who were receiving discounted services. If the FI [fiscal intermediary] did take that position, it could then invoke the LCC principle and pay the hospital that lower charge-based amount.


\(^{204}\) See REGULATIONS HAMPER HOSPITALS, supra note 180, at 6-7.
Litigation refused to centralize the federal class actions. The theory supporting centralization was that the lawsuits all challenged the same types of billing and collections practices by the hospitals. The panel denied centralization, however, ruling that it would neither serve the convenience of the parties and witnesses nor further the just and efficient conduct of the litigation. The court held that "in not withstanding the numerosity of actions, movants have failed to persuade us that these actions share sufficient common questions of fact to warrant § 1407 transfer." This was a substantial defeat for the plaintiffs because they lost the economies of time and cost, as well as the sheer leverage, of handling the pre-trial motions of all the federal cases in one forum.

The centralization denial was followed by a growing number of dismissals of the federal claims by the various district courts that had occasion to rule. These courts virtually unanimously dismissed with prejudice.

205. See 28 U.S.C. § 1407(a) (2000) (permitting "civil actions involving one or more common questions of fact . . . pending in different districts [to be] transferred to any district for coordinated or consolidated pretrial proceedings").


207. See Multidistrict Judicial Panel Rejects Motion to Consolidate, Transfer Charity Care Cases, supra note 119 (observing that lawsuits "share a common theme").

208. See In re Not-For-Profit Hospitals, 341 F. Supp. 2d at 1356 (J.P.M.L. 2004) (denying centralization).

the federal tax, FDCPA, EMTALA and § 1983 claims, and declined jurisdiction over the state law claims, dismissing them without prejudice to replead in a state forum.210

Fatal to plaintiffs' federal tax claims was the district courts' uniform rulings that the grant of a § 501(c)(3) charitable tax exemption does not create a contract between the recipient and the federal government.211 The courts indicated that such a holding was compelled by a historic line of cases unequivocally rejecting the notion of such a contract: "The notion that the Federal Income Tax is contractual or otherwise consensual in nature is . . . utterly without foundation, . . . [and] has been repeatedly rejected by the courts."212 Based on this finding, the courts ruled that the grant of a federal charitable tax exemption could not give rise to a claim for breach of contract or breach of an implied contractual duty of good faith and fair dealing.213 The district courts further held that even assuming, *arguendo*, a contract existed, § 501(c)(3) does not give rise to a private


210. For a further discussion of the federal tax, FDCPA, EMTALA and § 1983 claims asserted by the class action plaintiffs, see *infra* notes 211-30 and accompanying text.


212. *Amato*, 371 F. Supp. 2d at 755 (quoting from McLaughlin v. Comm'r, 832 F.2d 986, 987 (7th Cir. 1987)).

213. *See e.g.*, *id.* at 755-56 (ruling against plaintiffs' contract claims).
right of action\textsuperscript{214} and that plaintiffs lacked standing to assert such a claim.\textsuperscript{215} In addition, the courts ruled that § 501(c)(3) does not contain language demonstrating intent to create a trust, so that there was no basis to claim breach of a charitable trust.\textsuperscript{216} To the extent that unjust enrichment or constructive trust claims were premised upon the existence of a contract under § 501(c)(3), the district courts dismissed those counts as well.\textsuperscript{217} Finally, the district courts dismissed the conspiracy and aiding and abetting claims against the AHA to the extent that the claims were based on the faulty federal breach of contract and breach of trust claims.\textsuperscript{218}

\textsuperscript{214} See, e.g., id. at 756 (finding no private right of action under § 501(c)(3)).

\textsuperscript{215} See, e.g., Jellison, 2005 U.S. Dist. LEXIS 8036, at *10-11 (ruling that there is no language in § 501(c)(3) demonstrating that plaintiffs were intended beneficiaries of hospital’s tax exempt status).

\textsuperscript{216} See, e.g., Amato, 371 F. Supp. 2d at 757 (finding IRS revenue rulings did not evince creation of charitable trust under § 501(c)(3)).

\textsuperscript{217} See, e.g., Quinn v. BJC Health Sys., 364 F. Supp. 2d 1046, 1054-55 (E.D. Mo. 2005) (dismissing count for unjust enrichment and constructive trust); see also Kizzire v. Baptist Health Sys., 343 F. Supp. 2d 1074, 1082-83 (S.D. Ala. 2004) (dismissing plaintiffs’ unjust enrichment and constructive trust claims, \textit{inter alia}, on basis of \textit{res judicata}, holding that claims were compulsory counterclaims which were required to be raised in state court collections actions, and that failure to raise claims in that forum barred plaintiffs’ ability to raise them in later action).

\textsuperscript{218} See, e.g., Lorens v. Catholic Health Care Partners, 356 F. Supp. 2d 827, 835 (N.D. Ohio 2005) (dismissing claims for aiding and abetting breach of contract because no contract existed under § 501(c)(3)). Even if the courts had found the existence of a contract between the hospitals and the federal government, a private right of action and standing, it still remains questionable whether, under current revenue rulings, the contracts were breached by the hospitals’ manner of implementing charity care. In 1956, the IRS ruled that “[t]he fact that [a hospital’s] charity record is relatively low is not conclusive that a hospital is not operated for charitable purposes . . . .” See Rev. Rul. 56-185, 1956-1 C.B. 202. The IRS declared that the only requirement was that the hospital must not turn away patients due to their inability to pay. See id. (remarking that hospitals cannot refuse to accept patients who cannot pay for services). In 1969, the IRS ruled that a hospital that limits admissions only to those who can pay for their care and generally does not provide emergency services still can be tax exempt, insofar as it furthers the charitable purpose of “providing hospital care on a nonprofit basis for members of its community . . . .” See Rev. Rul. 69-545, 1969-2 C.B. 117 (noting that free services are not sole basis for charitable exemption); see also Rev. Rul. 83-157, 1983-2 C.B. 94 (ruling that hospital that limits admissions to patients able to pay for their care, including Medicare and Medicaid beneficiaries, and does not operate emergency room, nevertheless operates exclusively to benefit community and is thus entitled to tax exempt status).

In 2001, the IRS heightened the test by declaring that the charity care requirement of the community benefit standard requires a hospital to demonstrate that it delivers “significant health care services to the indigent.” See I.R.S. Field Serv. Adv. Mem. 200110030, 2001 WL 234018, at *4 (Feb. 5, 2001) (strengthening charity care requirements). The IRS further declared that “[t]he provision of free or subsidized care to the indigent is a significant indicator to the courts and the Service that a hospital promotes health for the benefit of the community.” See id. at *6. Nevertheless, the Advice Memo falls short of stating an amount or form of charity care that a hospital must provide to retain its tax exemption, and states that satisfaction of the community benefit standard “is based on all the facts and circum-
The district courts dismissed the FDCPA claims because the statute applies only to "debt collectors," and the hospitals did not qualify as debt collectors under the statutory definition. Indeed, in at least one case, plaintiffs conceded at the hearing on the dismissal motion that the hospital defendant was not governed by the FDCPA.

Next, the district courts dismissed virtually all of the EMTALA claims. The gist of plaintiffs' allegations was that the hospitals had required them to sign a guarantee of payment before rendering emergency services. See id. at *7 (explaining that whether hospital operates for charitable purposes is inevitably case-by-case determination). Therefore, the standard currently does not require hospitals to offer a given amount or type of charity care.

219. The statute defines a "debt collector" as "any person who uses any instrumentality of interstate commerce or the mails in any business the principal purpose of which is the collection of any debts, or who regularly collects or attempts to collect, directly or indirectly, debts owed or due or asserted to be owed or due another." 15 U.S.C. § 1692a(6) (2000). The term also "includes any creditor who, in the process of collecting his own debts, uses any name other than his own which would indicate that a third person is collecting or attempting to collect such debts." Id.


221. See Darr, 2004 U.S. Dist. LEXIS 24592, at *14 (acknowledging that defendant is neither creditor nor debt collector and thus not governed by FDCPA).

The district courts ruled that EMTALA does not forbid such inquiries into ability to pay, "so long as [the hospital’s] inquiry does not delay screening or treatment." Because the EMTALA claimants had received prompt emergency treatment despite the hospitals’ inquiries regarding source of payment, there was no basis to assert a violation of EMTALA. In addition, the federal courts ruled that EMTALA claimants must suffer "personal harm" due to the hospital’s delay or refusal to render emergency treatment. Here the EMTALA claimants asserted that they had suffered "economic injury" only, rendering their EMTALA claims deficient.

223. See, e.g., Amato, 371 F. Supp. 2d at 758 (stating plaintiffs' allegation that "before UPMC provided them emergency medical screening or treatment, it first determined their ability to pay for such care and required them to sign form contracts agreeing to pay UPMC in full for their care").

224. See, e.g., id. (quoting 42 C.F.R. § 489.24(d)(4)(iv) (2005)) (permitting hospitals to conduct "reasonable registration processes" for emergency patients). The court stated:

Hospitals may follow reasonable registration processes for individuals for whom examination or treatment is required by this section, including asking whether an individual is insured and, if so, what that insurance is, so long as that inquiry does not delay screening or treatment.

Id.

225. See, e.g., id. (explaining that EMTALA claim fails because no allegation that hospital delayed screening or treating plaintiffs); see also Pryor, UNINTENDED CONSEQUENCES, supra note 79, at 1 ("EMTALA only requires that hospitals provide acute care, and it does not require that they provide the care for free or at a discount.").

226. See, e.g., Amato, 371 F. Supp. 2d at 758 (citing 42 U.S.C. § 1395dd(d)(2)(A) (2005)) (allowing both damages for injury and equitable relief for those injured by delayed screening or treatment). The statute provides:

Any individual who suffers personal harm as a direct result of a participating hospital’s violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

Id. (emphasis added).

227. See id. at 758-59 (ruling EMTALA claim deficient because plaintiffs alleged economic injury only); see also Ferguson v. Centura Health Corp., 358 F. Supp. 2d 1014, 1020 (D. Colo. 2004) (declining to rule on EMTALA claim as hospital defendants had not moved to dismiss that claim, but noting that plaintiffs had failed to allege personal harm). Several district courts stated additional grounds for dismissal of the EMTALA claims. See, e.g., Jellison, 2005 U.S. Dist. LEXIS 8096, at *15 (dismissing EMTALA claim as time barred); Sabeta, 2005 U.S. Dist. LEXIS 6132, at *37-38 (same); Quinn, 364 F. Supp. 2d at 1054 (same); Kizzire, 543 F. Supp. 2d at 1084-85 (same); Burton, 373 F. Supp. 2d at 714 (same). At least one court ruled that the EMTALA claim was defective in that the challenged conduct occurred after plaintiff had been admitted to the hospital as an inpatient, and that EMTALA applies only to emergency room treatment, citing the proposition that "[i]f the hospital admits the individual as an inpatient for further treatment, the hospital’s obligation [under EMTALA] ends." See Quinn, 364 F. Supp. 2d at 1054 (citing 42 C.F.R. § 489.24(a)(1)(iii)) (discharging hospital’s obligation under EMTALA when it admits emergency patient as inpatient).

http://digitalcommons.law.villanova.edu/vlr/vol51/iss1/11
The district courts' dismissals of the § 1983 claims were equally decisive. The courts ruled that a private hospital's receipt of federal and state funding and tax exempt status does not transform it into a state actor, and that none of the state action tests had been met.

Finally, nearly unanimously, the federal district courts declined to exercise supplemental jurisdiction over the state law claims once all the federal claims were dismissed. These state law claims were dismissed without prejudice to be asserted in a state court action.

Not only were the district courts' dismissals of the federal claims remarkable for their uniformity, but at least one federal district court judge declared that based on all the prior dismissals, he would examine the claims very carefully in light of Rule 11's prohibition of frivolous claims.


229. See, e.g., Burton, 347 F. Supp. 2d at 499 (defining state action).

230. See, e.g., Washington, 2005 U.S. Dist. LEXIS 2614, at *26-29 (setting forth state action test). The three tests to determine if action is taken under color of state law are as follows:

A private party may be held liable as a state actor only if one of the following three conditions is met: (1) the State has coerced or at least significantly encouraged the action alleged to violate the Constitution ("State compulsion test"); (2) the private parties performed a public function that was traditionally the exclusive prerogative of the State ("public function test"); or (3) the State had so far insinuated itself into a position of interdependence with the [private parties] that it was a joint participant in the enterprise ("nexus/joint action test").


In the usual case in which all federal-law claims are eliminated before trial, the balance of the factors to be considered under the pendent jurisdiction doctrine—judicial economy, convenience, fairness, and comity—will point toward declining to exercise jurisdiction over the remaining state-law claims.

233. See, e.g., id. at *16.

234. See Charity Care Class Action Litigation Is Denied Federal Status, supra note 118, at 6 n.10 (quoting Collins v. Baptist Hosp., Inc., No. 3:04CV00276 (N.D. Fla. Dec. 10, 2004)) (noting concerns whether plaintiffs' claims were frivolous).
Perhaps the most telling dismissal of the federal claims was that of *Rivera v. Yale-New Haven Hospital, Inc.* The allegations against Yale New Haven Hospital were among the nation’s most egregious, so that dismissal of these federal claims signaled most clearly that the hospitals’ billing and collections practices were simply not actionable under the federal tax laws, EMTALA or FDCPA.

These dismissals led to a rash of voluntary withdrawals by plaintiffs in the federal district courts, presumably to re-file in state forums. In one such case, the court held the plaintiffs and their counsel jointly liable for an attorney’s fee award to the hospital of $40,000. The court noted the extraordinary nature of such an award, but justified it because “the plaintiffs’ claims likely amounted to millions of dollars and would have, at a minimum, forced major changes in the financial operations and structure of [the hospital].” Further, the court noted that plaintiffs had made “lengthy, pointed and serious accusations of misconduct . . . [that would] tend to discredit the defendant in ways that would reasonably be expected to garner substantial public attention.” While the court recognized that the indigent plaintiffs would have little or no ability to re-

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235. No. 3:04-CV-1515 (D. Conn. Feb. 8, 2005); see also *Claims Against Yale-New Haven Hospital Dismissed in Oral Ruling by Federal Court,* supra note 119, at 241 (discussing dismissal of federal claims).

236. For a discussion of the aggressive hospital billing and collections practices used by Yale-New Haven Hospital, see *supra* notes 23-32.


Reportedly, in some cases the Scruggs team moved to voluntarily dismiss their federal cases when confronted with a demand from the court to produce evidence in response to dismissal motions from the hospitals. *See Dodging a Bullet; Scruggs Has Four Hospital Class-Action Suits Dismissed, 34 MODERN HEALTHCARE 14* (2004) (reporting dismissals initiated by Scruggs team when required to produce evidence).

One published report declared that as of February 17, 2005, approximately seventeen cases filed in federal courts had been voluntarily dismissed by the plaintiffs. *See Claims Against Yale-New Haven Hospital Dismissed in Oral Ruling by Federal Court,* supra note 119, at 241 (reporting that federal hostility to plaintiff claims against hospitals has led to widespread voluntary dismissals).


239. *See id. at *2* (stating that “[t]he court is mindful of the risk that an award of attorneys’ fees in this context might unreasonably chill the prospect of these or other potential plaintiffs bringing an otherwise reasonable class action”).

240. *See id.* (explaining that it would be unfair to put defendant’s very existence at issue, force it to expend substantial defense costs and then merely dismiss case).

241. *See id.* (noting that plaintiff’s complaint attacked reputation of defendant, would garner unfavorable publicity, and that dismissing case would unfairly deprive defendant of opportunity to put forth truth about its operations).
spond to the fee award, the court stated that its concern was ameliorated by the fact that the lawsuit appeared to be part of a "coordinated, nation-wide effort" to attack non-profit hospitals, and was "more attorney driven than client driven." 242

The wholesale federal dismissals have likely discouraged some defendant hospitals from prematurely settling these cases in an effort to avoid the enormous time commitments and expenses that they entail. 243

IX. Early Charity Care Class Action Rulings on the State Law Claims

As a result of the numerous class action dismissals in the federal forums, the focus of the class actions has been shifting to state courts. 244 In contrast to the ruling on the federal claims, some early results on the state claims have been favorable for the plaintiffs. The Connecticut Superior Court in Ahmad v. Yale-New Haven Hospital, Inc. 245 sustained plaintiffs' state law claims against Yale-New Haven Hospital based upon Connecticut's bed

242. See id.

243. In April 2005, North Mississippi Health Services announced that it would not finalize a settlement that it had tentatively agreed to in August 2004. See Mississippi Nonprofit Hospital System Shuns Proposed Charity Care Settlement, 14 Health L. Rep. (BNA) 513, 513 (2005) (reporting on lawsuit against North Mississippi Health Services). The hospital reportedly stated that the increased number of claims for charity care that had arisen since it had signed the memorandum of understanding had forced it to rethink its decision to settle. See id. (quoting hospital official as saying it had "reached an impasse in its attempt to reach a final agreement with respect to charity discounted care to the uninsured" largely because claims are rising too high and too many patients are bypassing other local hospitals in order to receive charity care). For a discussion of class action settlements that have occurred, see infra notes 299-312 and accompanying text.

244. See As Federal Trial Court Setbacks Continue, Uninsured Plaintiffs Head for State Courts, 14 Health L. Rep. (BNA) 208, 208 (2005) (stating that Scruggs, coordinating litigator, announced that lawsuits will be shifting from federal to state forums).

fund law\textsuperscript{246} and the state’s unfair trade law.\textsuperscript{247} An Illinois state court

246. See id. at *23 ("[P]lainiffs have pleaded that the defendants failed to provide them adequate notice of the availability of free bed funds and failed to process properly any bed funds applications. . . . These specifications would, if proven, constitute violations of the statute.").

Connecticut’s bed fund law provides:

(b)(1) Each hospital which holds or administers one or more hospital bed funds shall post or cause to be posted in a conspicuous public place in each patient admitting location, including but not limited to, the admissions office, emergency room, social services department and patient accounts or billing office, information regarding the availability of its hospital bed funds . . . . Such information shall include: (A) Notification of the existence of hospital bed funds and the hospital’s program to administer them and (B) the person to contact for application information.

(2) Each hospital which has a hospital bed fund shall train staff, including but not limited to, hospital social workers, discharge planners and billing personnel concerning the existence of such fund, the eligibility requirements and the procedures for application.

(c) Each hospital which holds or administers one or more hospital bed funds shall make available to individual members of the public, a one-page summary describing hospital bed funds and how to apply for them. This summary shall clearly distinguish hospital bed funds from other sources of financial assistance. The summary shall be available in the patient admissions office, emergency room, social services department and patient accounts or billing office. If during the admissions process or during its review of the financial resources of the patient, the hospital reasonably believes the patient will have limited funds to pay for any portion of the patient’s hospitalization not covered by insurance, the hospital shall provide the summary to each such patient.

CONN. GEN. STAT. § 19a-509b (2003).

247. See Ahmad, 2004 Conn. Super. LEXIS 2765, at *27-28 (ruling that defendants’ practices violated public policy). The court opined:

[T]he defendants engaged in aggressive debt collection practices—such as wage garnishments, collection calls, capias arrests, placement and foreclosure of liens, and seizure of assets—despite their actual or constructive knowledge that the plaintiffs were eligible for free beds under the bed funds statute or discounted care under the collecting at cost statute . . . sufficiently state a case that the defendants’ practices offended public policy established by statutes or were ‘immoral, unethical, oppressive, or unscrupulous’ so as to satisfy the ‘cigarette rule’ test of unfair trade practice.

Id. Connecticut’s Unfair Trade Practices Act (CUTPA) provides as follows: “No person shall engage in unfair methods of competition and unfair or deceptive acts or practices in the conduct of any trade or commerce.” CONN. GEN. STAT. § 42-110b (a) (2004).

The Ahmad court, however, dismissed a claim under the “collecting at cost statute.” See CONN. GEN. STAT. § 19a-673(b) (2003) (providing that “no hospital that has provided health care services to an uninsured patient may collect from the uninsured patient more than the cost of providing services”). That court held that the express language of the statute foreclosed the claim where plaintiffs were unable to show that the hospital had collected more than its cost. See Ahmad, 2004 Conn. Super. LEXIS 2765, at *26-27 (ruling that plaintiffs cannot redress overcharging under statute unless hospital collects more than its cost). Ironically, this statute, promulgated to prevent excessive hospital charges to the uninsured, was of no assistance to the plaintiffs because they were too indigent to pay the bills. In addition, the Ahmad court dismissed state law claims for breach of contract (no allegations that hospital agreed to charge the plaintiffs third-party rates), recission (refund of medical services was impossible) and tortious interference with plain-
ruled in *Servedio v. Our Lady of the Resurrection Medical Center*\(^{248}\) that state law claims alleging consumer fraud,\(^{249}\) unfair practices\(^{250}\) and breach of contract were adequately pleaded.\(^{251}\)

In contrast to these favorable state rulings, several federal courts opted to dismiss plaintiffs' state law claims with prejudice, thereby precluding any re-filing in a state forum. The court in *Kolari v. New York-Presbyterian Hospital*\(^{252}\) ruled that the hospital was not required to provide discounted care as a condition of its state tax exemption.\(^{253}\) Further, the court rejected plaintiffs' state law breach of contract claim on the basis that the hospital's charges were not unreasonable simply because the hospital had negotiated lower rates with governmental programs and private payors.\(^{254}\) The court rejected plaintiffs' state unfair trade\(^{255}\) claim on the ground that the hospital had not made deceptive statements.\(^{256}\) Plaintiffs' unjust enrichment claim also failed because plaintiffs had not paid their relationships with financial institutions (no allegations that hospital even knew about these relationships). See id. at *29-30 (explaining dismissal of claims).


249. See id. at 3-6 (rejecting defendant's motion to dismiss plaintiffs' consumer fraud claim). The Illinois Consumer Fraud and Deceptive Business Practices Act (ICFA) prohibits "unfair or deceptive acts or practices." See 815 ILL. COMP. STAT. 505/2 (1999).

250. See *Servedio*, No. 04 L 3381, at 7-8 (ruling that plaintiffs adequately stated claim for unfair practices under ICFA where they alleged that hospital charged uninsured patients higher rates than most other patients and did not screen patients to identify those who qualified for charity care).

251. See id. at 9-10 (ruling that plaintiffs adequately stated claim for breach of implied duty to charge reasonable price where hospital gave discount to all insured patients, potentially rendering its so called "usual and customary charges" billed to uninsured patients unreasonable); see also Cristiani v. Advocate Health Sys. Care Network, Inc., No. 03 L 14635, slip op. at 3-9 (Cir. Ct. Cook County, Ill. Nov. 15, 2004) (declaring viability of plaintiffs' state law breach of contract or alternative unjust enrichment claim pending amended pleadings, but dismissing plaintiffs' tortious interference claim); Hudson v. Cent. Ga. Health Servs., No. 5:04CV301 (DF), 2005 U.S. Dist. LEXIS 2613, at *18-19 (M.D. Ga. Jan. 13, 2005) (declaring, in dicta, that where hospital has two sets of "regular" prices, one for insurers and governmental programs and another for uninsured patients, its contractual promise to uninsured to charge "regular" prices may be ambiguous). But see *Pitts v. Phoebe Putney Health Sys., Inc.*, No. 04CV1991-3, slip op. at 3-11 (Super. Ct. Dougherty County, Ga. June 27, 2005) (dismissing plaintiffs' complaint upon finding no merit to plaintiffs' state law claims for breach of contract, breach of duty of good faith and fair dealing, constructive trust, deceptive trade practices, fraud, constructive fraud, negligent misrepresentation, breach of fiduciary duty and negligence).


253. See id. at 575 (characterizing claim as "baseless").

254. See id. at 576 (rejecting plaintiffs' breach of contract claim).

255. New York General Business Law Section 349(a) prohibits "[d]eceptive acts or practices in the conduct of any business, trade or commerce." See N.Y. GEN. Bus. LAW § 349(a) (McKinney 2004).

256. See *Kolari*, 382 F. Supp. 2d at 577 (ruling that hospital's charging plaintiffs higher rates does not make its statements deceptive).
bills and thus had not enriched the hospital.\textsuperscript{257} The district court dismissed plaintiffs' state law fraud claim due to failure to plead fraud with particularity and failure to plead the elements of fraudulent intent and detrimental reliance.\textsuperscript{258} The court dismissed the constructive fraud claim, ruling that plaintiffs had not established that the hospital had a duty to speak or that it had fiduciary obligations to plaintiffs.\textsuperscript{259} Another district court, following \textit{Kolari}, also dismissed plaintiffs' state law claims with prejudice, ruling that they were "indispensably premised" on the meritless federal claims.\textsuperscript{260}

It is possible that the inconsistent results in the state and federal forums on the state law claims signal merely that the state forums will be more receptive to plaintiffs' state causes of action. It is equally likely, however, that the state actions will yield mixed results.\textsuperscript{261} These state claims necessarily depend upon unique state interpretations of common law or upon particular language of state statutes, so that one state's outcome does not necessarily predict what will happen in others.

There have also been some interesting developments in at least one state's tax agency. In April 2005, Illinois tax officials recommended denying property tax exemptions for parcels owned by the Carle Foundation.\textsuperscript{262} The officials found that Carle does not meet the state's criteria for a charitable tax exemption because, among other reasons, it overcharged the uninsured and spent only one-half of one percent of its revenue on charity care.\textsuperscript{263} A similar tax ruling was rendered earlier in the same forum against Provena Covenant Hospital.\textsuperscript{264}

\begin{itemize}
\item \textsuperscript{257} See id. at 577-78 (rejecting unjust enrichment claim).
\item \textsuperscript{258} See id. at 578 (dismissing fraud claim).
\item \textsuperscript{259} See id. at 578-79 (dismissing constructive fraud claim).
\item \textsuperscript{262} See \textit{Another Illinois Nonprofit Hospital Caught in Move to Revoke Property Tax Exemption}, 14 Health L. Rep. (BNA) 583, 583 (2005) (discussing county board's recommendation to state's Revenue to deny Carle Foundation Hospital charitable tax exemptions).
\item \textsuperscript{263} See id. at 583 (reporting that Carle Foundation provided "relatively small amount of true charity care").
\item \textsuperscript{264} See id. (reporting similar ruling against Provena Covenant Hospital). In February 2004, the State of Illinois upheld Champaign County's decision to revoke Provena Covenant Medical Center's local property tax exemption. See \textit{Carol Pryor \& Robert Seifert, The Access Project, The Heller School for Social Policy and Management, Brandeis University, Unintended Consequences, An Update on Consumer Medical Debt}, \url{http://www.cmwf.org/usr_doc/pryor_medicaldebt_749.html} (last visited Nov. 20, 2005) [hereinafter \textit{Update on Consumer Medical Debt}].
\end{itemize}
X. CHANGES OCCURRING IN HOSPITALS' UNINSURED BILLING AND COLLECTIONS PRACTICES

At this relatively early stage in the state forum-based charity care class actions, it is difficult to predict what the outcomes will be. After examining the voluntary changes that hospitals have made to their billing and collections policies and the terms of the few settlements that have occurred, however, we can begin to see the changes that are likely to result regarding hospitals' billing and collections practices.

Once the House Committee on Energy and Commerce commenced its investigation into hospitals' billing practices, hospital associations moved swiftly in an attempt to contain the problem.265 The AHA issued an “Alert” on June 10, 2003 to its 4,800 member hospitals across the country, urging them to stop harsh collections tactics for patients who did not have the ability to pay and reminding hospitals that “compassion has to go from the bedside to the billing office.”266 The AHA Alert suggested that hospitals should be able to state their charges to patients before treatment, should identify low-income patients who might qualify for free or discounted care and should avoid harsh collections practices.267

In December 2003, the AHA followed up by issuing guidelines for billing and collections.268 The guidelines suggest that hospitals should communicate clearly with patients about charges, help patients apply for free or discounted care, review charge levels to make sure they are reasonable and pursue patient accounts in a fair manner.269 The guidelines have reportedly been adopted by 3000 of the AHA's member hospitals.270

State hospital associations followed suit. The Healthcare Association of New York State (HANYS) was one of the earliest to publish its own bill-
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ing and collections guidelines. HANYS recommended that hospitals should promulgate financial aid policies to provide financial assistance to all patients below 200% of the federal poverty level and sliding scale discounts to indigent patients with incomes at higher levels. Significantly, HANYS suggested that hospitals could apply Medicaid or private insurer rates to the low-income uninsured, rather than full charges. HANYS also asked hospitals to communicate their financial aid policies to patients and train their staffs to administer the policies. Finally, HANYS urged against foreclosures on patients' primary residences and body attachments, as well as asking hospitals to forego garnishments of wages unless there was evidence that the patients had resources to pay their bills. The primary author of the HANYS guidelines, Ray Sweeney, described the message of the guidelines as “[d]on’t try to get blood from a stone.” Other state hospital associations approved similar billing and collections guidelines for their member hospitals, including those in California, Oregon, Illinois and Tennessee.

Individual hospitals also announced changes that they were voluntarily implementing. A major not-for-profit hospital chain, HCA Inc., based in Nashville, Tennessee, announced in fall 2003 that it would provide free care to uninsured patients earning up to twice the federal poverty level


272. See id. at 2-3 (recommending financial aid policies).

273. See id. at 3 (discussing application of Medicaid or private insured rates for low-income patients).

274. See id. at 4 (reminding hospitals to communicate availability of financial aid to patients).

275. See id. at 5 (reminding hospitals to “have collections policies that reflect the mission and values of the hospital”).

276. Lagnado, Cold-Case Files: Dunned for Old Bills, Poor Find Some Hospitals Never Forget, supra note 98.


and sliding scale discounts for patients with earnings up to four times the poverty level. HCA's new policy went into effect on January 1, 2005. Tenet Healthcare Corp., a large for-profit chain, announced that it was ready to implement a compact with uninsured patients, pledging to bill low-income uninsured patients at the same rates the chain received from HMOs, subject to approval of the policy from the OIG. North Shore-Long Island Jewish Health System unveiled plans to provide financial assistance to patients earning up to 300% of the federal poverty level. Other hospital systems have made similar announcements.

On the regulatory front, HHS moved quickly to issue guidance confirming that "hospitals can provide discounts to uninsured and underinsured patients who cannot afford their hospital bills and to Medicare beneficiaries who cannot afford their Medicare cost-sharing obligations." HHS declared that "The Federal anti-kickback statute does not prohibit discounts to uninsured patients who are unable to pay their hospital bills." With regard to Medicare beneficiaries, however, HHS continued to warn that to avoid anti-kickback risk, the hospitals should not routinely waive cost sharing amounts without first verifying financial need or before reasonable collection efforts have failed. In December 2004, HHS further

281. See Lagnado, Medical Shift, supra note 99 (describing Hospital Corporation of America (HCA) policy to discount rates to indigent patients).
284. See Cinda Becker, Bill Collection, Self-Reflection, MODERN HEALTHCARE, Feb. 9, 2004, at 8 (noting that such assistance would exceed recommendations for charity care from Healthcare Association of New York State).
285. For example, at the end of 2003, the nation's largest Catholic hospital chain, Ascension Health, stated that it would offer free care to every uninsured patient whose income falls below the federal poverty level. See Lagnado, Medical Shift, supra note 99 (outlining new charity care policy for indigent patients who do not qualify for Medicaid). Yale-New Haven Hospital reportedly closed accounts where the debts were more than five years old, removed property liens against patients and created a sliding scale to provide discounted and free care to indigent patients. See Ellen Moskowitz, Recent Developments in Health Law: Class Action Suits Allege Improper Charitable Care Practices, 33 J.L. MED. & ETHICS 168, 169 (2005) (describing steps Yale-New Haven Hospital has taken to implement charity care). The University of California-Davis reportedly has a policy of not suing uninsured patients to collect debts. See Lagnado, Medical Markup, supra note 100 (stating policy).
287. See OFFERED DISCOUNTS, supra note 179, at 1.
288. See id. at 1-4; see also Questions on Charges for the Uninsured, supra note 203 (providing guidance on application of Medicare payment rules to hospital discounting practices).
clarified that hospitals could offer across-the-board discounts to uninsured patients without first making individualized determinations of need and that such discounting policies would not affect the hospitals' Medicare reimbursements.289

Several state and local governments also acted, promulgating statutes requiring hospitals to make their charges public,290 to disclose their charity care policies291 and to restrict their collections procedures.292 Several

289. See Ctr. for Medicare and Medicaid Servs., U.S. Dep't of Health and Human Services, FAQ, http://www.cms.gov/providers/FAQ_Uninsured_Additional.pdf (last visited Jan. 12, 2006) (stating that, contrary to earlier statement made by OIG, "when a hospital discounts charges to non-Medicare patients, such as uninsured patients, there is no effect on outlier payments under either Medicare's Hospital Inpatient Prospective Payment System or Medicare's Hospital Outpatient Prospective Payment System"). OIG, at a previous congressional hearing, had declared that an across-the-board waiver of cost sharing obligations for uninsured patients would be "problematic," insisting that "[t]here would need to be an individualized determination" of indigency. See Hearing, supra note 1, at 147 (statement of Lewis Morris, Chief Counsel, Office of the Inspector General, U.S. Department of Health and Human Services) (stating that individualized determinations would be necessary).

Here, however, the OIG may have confused uninsured patients with Medicare patients. Copayments are payable only when there is another primary payor, i.e., an insurance plan, so that uninsured patients are never in a position of paying copayments. In fact, the OIG later stated:

[W]hen we talk about Medicare co-pays and deductibles, we are therefore talking about people who have insurance, they are covered by a program, as distinct from those who are uninsured, for which, from a fraud and abuse standpoint, we have no jurisdiction directly. So, if we are talking about waivers of co-pays and deductibles for those who have Medicare coverage, what we expect is some reasonable assessment of financial need with a great deal of flexibility.

Id.


292. A Connecticut law went into effect in October 2003 placing restrictions on collections procedures for hospital patients and limiting interest on bills to five percent. See 2003 Conn. Acts 266 (Reg. Sess.) (enacted) (establishing collections restrictions and interest limits); see also Lagnado, Medical Shift, supra note 99 (reporting that statute makes it more difficult for hospitals to sue patients, seize their bank accounts and place liens on their homes).
state legislatures considered statutes to limit charges to the uninsured.\textsuperscript{293} Congress is considering a bill to require hospitals to post their charges.\textsuperscript{294}

In recognition of these changes, the authors of The Commonwealth Fund report issued an updated report.\textsuperscript{295} They pointed out hospitals’ abandonment of harsh collections practices, the passage of state laws to ameliorate harsh treatment of the uninsured, several states’ consideration of bills to limit uninsured charges, the adoption of billing and collections guidelines by state hospital associations and regulatory clarifications from HHS.\textsuperscript{296} The report declared that “[t]hese developments have significantly altered the environment related to hospital billing and collection practices” and “represent a major shift in the environment surrounding the development and implementation of hospital financial assistance policies.”\textsuperscript{297} The authors questioned, however, whether hospitals’ voluntary efforts would be sufficient to curb the abuses, or whether legislation was necessary.\textsuperscript{298}

On March 10, 2005, Tenet Healthcare Corporation announced a proposed agreement to settle thirteen charity care cases against it.\textsuperscript{299} This

\textsuperscript{293.} See, e.g., Assem. B. 2521, 2005 Gen. Assem., Reg. Sess. (N.Y. 2005) (announcing bill to limit hospital charges to patients with household income at or below 400% of federal poverty level to amount hospital would have accepted from Medicare or its highest volume payor); H.B. 805, 2004 Leg., Reg. Sess. (Ala. 2004) (presenting bill to prohibit hospitals and other healthcare providers from charging uninsured patients more than Medicare rate); H.R. 1535, 1573, 147th Gen. Assem, Reg. Sess. (Ga. 2004) (considering two bills to prohibit hospitals from charging uninsured patient greater rate than average managed care rate); S.B. 379, 2003 Leg., Reg. Sess. (Cal. 2003) (presenting bill to cap hospital charges to low income patients at Medicare or workers’ compensation amounts); S.B. 2579, 93rd Gen. Assem., Reg. Sess. (Ill. 2003) (considering bill to prohibit hospitals from charging patients with incomes equal to or less than federal poverty level and to limit charges to cost for patients with incomes up to 400% of federal poverty level). \textit{But see} \textit{Colo. Rev. Stat.} § 18-13-119 (2004) (prohibiting providers from waiving deductibles and copayments as “regular business practice,” but allowing such waivers for charity care where providers determine indigency on case-by-case basis and where such waivers are not applied to more than one-quarter of providers’ patients).

\textsuperscript{294.} See Hospital Price Disclosure Act of 2005, H.R. Res. 1362, 109th Cong. (2005) (requiring hospitals and ambulatory surgery centers to disclose charges for their twenty-five most frequently performed inpatient and outpatient procedures, and their fifty most frequently administered drugs dispensed to inpatients).

\textsuperscript{295.} See generally \textit{Update on Consumer Medical Debt}, \textit{supra} note 264 (describing changes in hospital billing and collections).

\textsuperscript{296.} See \textit{id.} (summarizing changes to alleviate consumer medical debt).

\textsuperscript{297.} See \textit{id.}

\textsuperscript{298.} See \textit{id.} (considering voluntary versus regulatory approaches). Another study announced in October 2005 made similar findings, observing that many non-profit hospitals across the nation have expanded their charity care to include sliding scale discounted rates depending on the patients’ income levels. \textit{See Ctr. for Studying Health Sys. Change, Balancing Margin and Mission: Hospitals Alter Billing and Collection Practices of Uninsured Patients 5-4 (2005), available at http://hschange.org/CONTENT/788/788.pdf.}

settlement requires the hospital to give estimates of charges and financial counseling to uninsured patients, to provide discounted pricing at managed care rates, to offer reasonable installment payment schedules, to refrain from suing uninsured patients and to refrain from placing liens on homes of uninsured patients. 300 In addition, Tenet agreed to make refunds to uninsured patients who had received treatments between June 15, 1999 and December 31, 2004 and who had paid more than a given percentage of gross charges, with the percentages varying by year of treatment. 301 Tenet stated that the terms of the proposed settlement are consistent with its compact with uninsured patients announced in 2003. 302 The California Superior Court approved the settlement on August 5, 2005. 303

Other settlements have been reached as a result of the Minnesota Attorney General’s investigation of hospitals’ charity care practices. 304 A settlement with Fairview Health Services allows uninsured patients and families earning up to 450% of the federal poverty level to receive discounted pricing. 305 Fairview is also required to reform its debt collection methods, which had included suing indigent patients, garnishing their wages and sending debt collectors after them. 306 Settlements announced on May 5, 2005, with four other Minnesota hospitals require the hospitals to charge the uninsured and patients with annual incomes less than $125,000 no more than the hospitals charge their private payor providing


300. See Tenet Announces Proposed Settlement of Suits Alleging Overcharging of Uninsured, supra note 299, at 354.

301. See id. at 353 (noting that Tenet estimates it billed $400 million in charges between June 15, 1999 and December 31, 2004).

302. See id. at 354 (describing stratified Tenet refund policy for uninsured patients). For a further description of individual hospitals’ voluntary election to modify uninsured billing practices, see supra notes 299-301 and infra notes 303-12 and accompanying text.


305. See Fairview Health Services, Minnesota AG Reach Deal on Charity Care, Debt Collection, supra note 304, at 514.

306. See id.
the most revenue to the hospital. The settlements also require the hospitals to offer free or discounted care to eligible patients, to offer payment plans to patients who cannot pay the entire bill at once and to soften collections practices.

Most recently, uninsured patients and the Providence Health System reportedly reached a settlement in a charity class action, announced on November 1, 2005. Providence has reportedly agreed to discount its billings to all uninsured patients to equal its average insured rates. Providence also will give additional discounts ranging from 100% (to uninsured patients who earn 200% or less of the federal poverty level) to 10% (to uninsured patients who earn up to 400% of the federal poverty level). Providence has agreed to apply the discounts to patients who received services at Providence for the past four years, and to patients who receive services for the next two years.

XI. CONCLUSIONS

The changes that have recently taken place regarding hospitals’ indigent billing and collections practices are so obviously rooted in common sense, it is a wonder they have not occurred before this time. Obviously, hospital rates for the uninsured should not be the highest rates the hospitals bill to all payors. Once indigency is determined, either on a case by case basis or more globally using the federal poverty level as a benchmark, the uninsured should be billed at rates that are at least on par with those paid by governmental programs and private insurers. It is likely that


308. See Press Release, Agreement Between Attorney General and Minnesota Hospitals, supra note 304 (delineating specifics of agreement that State Senator Ann Rest describes as “overall system of fairness”). A settlement has also been reached in Servedio v. Our Lady of the Resurrection Medical Center, but the terms of the settlement are confidential. See Settlement of Uninsured Lawsuit in Illinois Against Resurrection Health Care Confirmed, 14 Health L. Rep. (BNA) 760, 760 (2005).


310. See id. at 1433 (reporting average discount for preferred provider rate as thirty-one percent).

311. See id. (reporting sliding scale discounts).

312. See id. at 1433-34 (announcing application of agreement both retroactively and prospectively).

313. Health policy expert Uwe Reinhardt has termed this type of pricing “brutal and inhumane.” See WORKING POOR, supra note 73, at 7. New York Legal Aid Society attorney Elisabeth Benjamin called it “the secret shame of the U.S. health-care system.” See Lagnado, House Panel Begins Inquiry into Hospital Billing Practices, supra note 138 (quoting Elisabeth Benjamin).

314. Some suggestions are that the uninsured should be billed at a rate that is higher than the rates paid by insurers and managed care plans, so that the marketplace will not be disrupted, such as the Medicare DRG rate plus twenty-five percent, or the highest rate the hospital charges to any insurer or managed care plan.
reducing rates (and interest rates on unpaid bills) for the uninsured will not even have a substantial fiscal impact on hospitals, because as the hospitals themselves insist, they were rarely able to collect full charges from the uninsured anyway. 315

For hospitals that utilized aggressive collections tactics for this population, it is obvious that the collections should be conducted in a more humane manner. As many commentators have observed, medical debt is not like other debt, as it is not voluntarily assumed, and as the Journal articles pointed out, tens of thousands of dollars in hospital bills may be incurred suddenly, without warning and after only a few days of inpatient care. 316 Obviously, if a hospital has a charity care policy that offers free or discounted care to indigents, the hospital should tell qualified patients about it and make that assistance available to them. Hospital staffers should be schooled about their institution’s charity care policy, and should be helpful and sympathetic in assisting patients with their applications. Once indigency is determined, collections should not be effected by means of residential foreclosures, wage garnishments that leave the working poor unable to meet their basic needs or body attachments. To quote Ray Sweeney of HANYS, the only sensible rule is: “Don’t try to get blood from a stone.” 317

See Hearing, supra note 1, at 16 (statement of Gerard F. Anderson, Director, Johns Hopkins Center for Hospital, Finance and Management) (suggesting rate methodologies for indigent patients). 315. See id. at 4 (statement of Rep. James C. Greenwood, Member, Comm. on Energy and Commerce, Chairman, Subcomm. on Oversight and Investigations) (referring to December 2002 remarks by Trevor Fetter, CEO of Tenet Healthcare, noting that seventy percent of uninsured patients do not pay their bills); id. at 98 (statement of Herbert Pardes, President and CEO of New York Presbyterian Hospital) (remarkling that New York Presbyterian Hospital collects only twelve to thirteen percent of charges for services furnished to uninsured patients); Tenet Announces Proposed Settlement of Suits Alleging Overcharging of Uninsured, supra note 299, at 354 (“If the uninsured as a class were not paying the managed care prices in the aggregate, then a reduction in rates would probably have little impact on the bottom line.” (quoting J. Mark Waxman, General Counsel of Caregroup, Boston)); see also CTR. FOR STUDYING HEALTH SYS. CHANGE, BALANCING MARGIN AND MISSION: HOSPITALS ALTER BILLING AND COLLECTION PRACTICES FOR UNINSURED PATIENTS 5 (2005), available at http://hschange.org/CONTENT/788/788.pdf (confirming that “changes in billing and collection policies have had negligible impact on hospital finances to date”). 316. See, e.g., Lagnado, Taming Hospital Billing, supra note 283 (stating that “hospital bills are by nature different from other consumer debt—such as bills for washing machines—because most patients didn’t choose to incur them”). Other sources support this proposition by stating:

Health care is a business unlike most others. . . . Their product is essential and often life saving. . . . Purchases are often sudden and unplanned and, particularly for people without health insurance, may bring large financial burdens that are involuntary in the sense that they are not the result of a traditional consumer choice.

Consequences of Medical Debt, supra note 76, at 2. 317. See Lagnado, Cold-Case Files: Dunned for Old Bills, Poor Find Some Hospitals Never Forget, supra note 98.
While the focus of uninsured charges has been almost exclusively on hospitals, we should also bear in mind that the same system of charges for the uninsured can occur with regard to other types of healthcare providers as well, including physicians, dentists, medical device suppliers, pharmacies, etc.\textsuperscript{318} Relief from charges should be broadened to include the full range of providers who charge the uninsured at the uppermost limit of the providers' rates.\textsuperscript{319}

The exposé on hospital billing and collections practices for the uninsured has not been a proud chapter in healthcare history. Had it not been for a single reporter at the \textit{Journal}, it is possible that the issue of hospital charges for the uninsured might still remain largely hidden from public view.\textsuperscript{320} While it is understandable that hospitals legitimately may have believed that tampering with their charge schedules to give rate relief to the uninsured would have exposed them to anti-kickback risk and threatened them with lower Medicare reimbursements, this does not excuse hospitals for their silence.\textsuperscript{321} Nor could regulatory concerns ever justify practices like those by the Carle Foundation, which first treated an uninsured patient for attempted suicide and then later had him arrested for not paying his bill.\textsuperscript{322}

The government and the private insurance industry also are not free from blame. They too were certainly aware that a substantial segment of middle America was being victimized by exorbitant hospital charges, but failed to take action to publicize the issue or lobby for change. While the class action lawyers may assert that they acted swiftly to attempt to right this wrong, in fact they flooded into the federal courts with legal theories...
that were plainly unsupportable under current law.\textsuperscript{323} The \textit{Kolari} court aptly described the federal claims as “bootless” and “without basis in law,” and referred to the plaintiffs as “hav[ing] lost their way.”\textsuperscript{324} So far, all that the class actions have accomplished is to drain thousands of dollars out of hospitals for defense costs that could have been allocated to charity care.\textsuperscript{325}

Finally, even with the changes that are now occurring to make hospitals a kinder and gentler place for the uninsured, the basic problems that the uninsured face in obtaining necessary medical care have not changed much. Hospital bills, even at prevailing managed care rates, will probably continue to be beyond the means of the working poor or the unemployed to pay. This population will continue to be subject to collections, albeit of discounted amounts, with only the most aggressive collections tactics being abandoned.\textsuperscript{326} As some healthcare experts have observed, the only real answer is to make basic coverage health insurance available for everyone.\textsuperscript{327}

\begin{itemize}
\item \textsuperscript{323} For a further analysis of legal arguments asserted by class action attorneys against hospitals that were rejected by federal courts, see \textit{supra} notes 205-43 and accompanying text.
\item \textsuperscript{324} \textit{See} Kolari \textit{v. N.Y.-Presbyterian Hosp.}, 382 F. Supp. 2d 562, 566 (S.D.N.Y. 2005).
\item \textsuperscript{325} For example, Tenet has agreed to pay $11 million for plaintiffs’ attorneys fees to settle the charity care class actions against it. \textit{See} Proposed Tenet Settlement, \textit{supra} note 299 (presenting terms of agreement). Further, the administrative burden of the class actions is evident, as Tenet produced 1.2 million pages of documents during negotiations over the settlement. \textit{See id.} (commenting on voluminous documents produced during negotiations).
\item \textsuperscript{326} \textit{See}, \textit{e.g.}, Lucette Lagnado, \textit{New York State Hospitals Agree to Cut Prices for Uninsured}, \textit{Wall St. J.}, Feb. 2, 2004, at B1 (criticizing Healthcare Association of New York State’s charity care guidelines because hospitals “can still charge 9% interest, they can still grab your paycheck, they can still sue you, [and] they can put liens on your house” (quoting Elisabeth Benjamin, healthcare attorney with New York Legal Aid Society)).
\item \textsuperscript{327} \textit{See}, \textit{e.g.}, \textit{Hearing, supra} note 1, at 92 (remarking that "[t]he problem is how are we as a society going to guarantee that every American has some form of health insurance" (quoting Jack O. Bovender, Jr., Chairman and CEO, Hospital Corporation of America)).
\end{itemize}