

Analysis & Perspective

What May Arrive in Tomorrow's Mail?: An Analysis of Class Action Lawsuits Concerning Hospital Billing of Uninsured Patients

BY LISA W. CLARK, KATHERINE M. KELTON, AND
DAVID FLYNN

Many nonprofit hospitals were caught off guard last month when 13 coordinated class action lawsuits were filed in federal courts against nonprofit hospitals in seven states alleging unlawful billing practices for services rendered to the uninsured (the Hospital Class Action Litigation).¹ Since then, a growing list of plaintiffs' firms that specialize in national complex, mass tort, class action litigation, have filed in federal court subsequent waves of similar litigation in additional states. We are also beginning to see copycat cases filed by firms that are not part of the coordinated effort. (See fn. 1 for a list of states in which actions have been filed to date.)

Not surprisingly, nearly every nonprofit hospital that has not been sued is wondering what may arrive in tomorrow's mail. Yet apart from those already named as defendants, few other hospitals or their counsel have actually read the complaints and analyzed the claims. To assist those hospitals that have not been sued in un-

¹ As of the date of this writing, over 35 cases have been filed. While these cases are too numerous to list here individually, perhaps more significant are the number of states in which these actions have been filed, which now number 20: Alabama, Arizona, California, Colorado, Florida, Georgia, Illinois, Louisiana, Michigan, Minnesota, Mississippi, Missouri, New Mexico, Ohio, Oklahoma, Pennsylvania, New Jersey, New York, Tennessee and Texas. In addition, plaintiffs' counsel has developed a Web site, www.nfplitigation.com, which provides an updated list of cases, an archive of press releases and other information relating to the Hospital Class Action Litigation, as well as solicits potential plaintiffs' statements for purposes of developing the litigation. Some litigation, which appears to have been brought by law firms that are not part of the coordinated group, is not included on the Web site. See e.g., *Amato et al. v. UPMC et al.*, W.D. Pa. No. 04-1025, filed 7/14/04; *Amato et al. v. Allegheny General Hospital et al.*, W.D. Pa. No. 04-1038, filed 7/15/04. These copycat actions are best followed through news reports.

Lisa W. Clark and David Flynn are partners and Katherine M. Kelton is an associate in the national Health Law Practice Group of Duane Morris LLP, Philadelphia. Clark practices in the areas of administrative and health care law, with an emphasis on Medicaid, managed care contracting, HIPAA, EMTALA, and general regulatory compliance. She can be reached at lclark@duanemorris.com. Flynn focuses his practice on tax-exempt organizations, nonprofit corporations, and corporate governance issues.

derstanding this new legal development and to weigh the impact of possible litigation on their institutions, this article provides a primer on the claims raised in the Hospital Class Action Litigation and possible steps to take now in order to be best positioned in the event of litigation.

I. General Background

To understand fully the Hospital Class Action Litigation, one must consider the general landscape. The issue of whether and how hospitals should bill for services rendered to the uninsured has been looming for some time, particularly as the population of uninsured and underinsured individuals increased during the economic downturn of the last several years. In 1999, an organization called Community Catalyst spearheaded the Free Care Monitoring Project, in which grassroots organizations in nine states began investigating the availability of information on free or reduced-price hospital care.² The result of this investigation is a white paper, *Not There When You Need It: The Search for Free Hospital Care*, (October, 2003), that provides a template for the kinds of claims raised in the Hospital Class Action Litigation.³

Also in the summer of 2003, the Oversight and Investigations subcommittee of the House Energy and Commerce Committee, chaired by Rep. Jim Greenwood (R-Pa.), began a nationwide investigation into hospital pricing, specifically regarding hospital charges. This effort, which targeted 20 major hospital systems across the country and focused on billing practices relating to uninsured patients, led to congressional hearings that began last month. On June 22, 2004, the Subcommittee on Oversight of the House Committee on Ways and Means held the first of a proposed series of hearings on hospital pricing to "examine the current hospital pricing system and focus on the lack of transparency in hospital charges, which hinders consumers from making informed choices about where they get care and the op-

² Community Catalyst Inc., *Not There When You Need It: The Search for Free Hospital Care* (October, 2003), p. 9. See www.communitycatalyst.org.

³ Based on its investigations, Community Catalyst concludes that the obligation of nonprofit hospitals to provide charity care, or free care, arises from these hospitals' tax-exempt status and statutory and regulatory requirements, including federal obligations under the Hill-Burton Act and state and county laws that address the availability of free care. pp. 37-46. Community Catalyst also cites the Emergency Medical Treatment and Active Labor Act (EMTALA) for creating an illusion of a safety net for the uninsured: EMTALA prohibits all Medicare-participating hospitals from refusing to screen, treat and stabilize any person who seeks emergency treatment, but does not require that those hospitals cover the cost of treatment or any post-stabilization treatment. 42 U.S.C. § 1395dd.

tions for increasing information about hospital pricing."⁴

The hospital community has closely followed these developments. In December 2003, the American Hospital Association (AHA), the national trade association for hospitals, sent a formal request to the federal Department of Health and Human Services (HHS), asking the agency to clarify or amend Medicare pricing regulations to permit hospitals to give discounts to uninsured patients. The AHA stated that Medicare pricing policies, which require that hospitals bill all patients the same charge for each service, can be interpreted to require the uninsured to pay full price for their care and preclude the use by hospitals of discounts or other means of financial assistance for patients. In a February 2004 response to the AHA, HHS Secretary Tommy Thompson stated that Medicare pricing policies do not prohibit hospitals from providing discounts to uninsured patients.⁵

Finally, as these legislative and regulatory events were taking place, plaintiffs' lawyers were beginning to mobilize against both nonprofit and for-profit hospitals. As early as February 2003, a proposed class action was filed in Los Angeles County against Tenet Healthcare Corp., Tenet Healthsystem Hospitals Inc. and related entities on behalf of individuals residing in the United States who received treatment at a Tenet hospital and who were uninsured, self-insured or covered by Medicare or Medicaid and required to pay copayments based

⁴ See Advisory from the Committee on Ways and Means Subcommittee on Oversight, "Houghton Announces First Hearing in a Series on Tax Exemption: Pricing Practices of Hospitals," June 15, 2004, available at <http://waysandmeans.house.gov/hearings.asp?formmode=view&id=1673>. On that same day, the Senate Committee on Finance held a concurrent hearing on charity oversight and reform, which resulted in the release of a staff discussion draft outlining proposed reforms in the area of Section 501(c)(3) tax-exempt organizations. "Charity Oversight and Reform: Keeping Bad Things From Happening to Good Charities," June 22, 2004. See <http://finance.senate.gov/sitepages/hearing062204.htm>.

⁵ At the Secretary's direction, CMS and the OIG issued guidances on outlining suggested policies that hospitals can utilize to assist the uninsured and underinsured. The CMS guidance document, in the form of a set of questions and answers on charges for the uninsured, stated that Medicare regulations and program instructions do not prohibit a hospital from waiving collection of charges to any patient if it is done as part of the hospital's "indigency policy," which CMS defines as a policy developed and utilized by a hospital to determine a patient's financial ability to pay for services. See "Questions on Charges for the Uninsured," Feb. 17, 2004, available at http://www.cms.hhs.gov/FAQ_Uninsured.pdf. The OIG guidance document, "Hospital Discounts Offered to Those Who Cannot Pay Their Hospital Bills," dated February 2, states specifically that the anti-kickback statute does not prohibit discounts to uninsured patients who are unable to pay their hospital bills. <http://oig.hhs.gov/fraud/docs/alertsandbulletins/2004/FA021904hospitaldiscounts.pdf>. The OIG guidance further indicates that such discounts are not prohibited by a separate statute that authorizes the exclusion from Medicare and Medicaid of a provider submitting bills or payment requests to these programs for amounts "substantially in excess" of the provider's "usual charges." 42 U.S.C. § 1320a-7(b)(6). In response to Thompson's letter, both Tenet Healthcare Corp. and HCA Inc. announced that they would begin discounting care to uninsured and underinsured patients.

on a percentage of charges.⁶ Then in December 2003, Service Employees International Union 1199-New England filed a proposed class action against Yale New Haven Hospital and Bridgeport Hospital in Connecticut, alleging that the hospitals held in reserve millions of dollars in free care funds that were not utilized to pay the bills of uninsured patients, in violation of state law.⁷ These hospitals had also been the target of a well-publicized campaign by patient advocacy groups.

The litigation in its current form began with the first filings in mid-June. As of this writing, the Hospital Class Action Litigation consists of 39 actions filed in four clear waves, on June 15, June 22, July 8, and July 21, with some individual actions filed in between. The press releases issued by the Scruggs Law Firm promise that "cases of a similar nature are expected to be filed in the near future against additional major hospitals in other states." We also anticipate the filing of individual actions, including suits filed by firms that are not part of the coordinated group. In addition, the Hospital Class Action Litigation will undoubtedly garner the attention of state regulators,⁸ including state attorneys general.⁹

II. Overview of Complaint

Given this background, the Hospital Class Action Litigation is noteworthy not because it proposes changes to the charity care practices of nonprofit hospitals, but because it does so through the vehicle of national, coordinated consumer-based class action litigation. The complaints in the actions that constitute the litigation to date follow the same general model. Understanding this model, and in particular the claims therein, is best accomplished by analyzing one of the earlier complaints filed in the litigation, with reference to later complaints that add or amend the basic claims. The following analysis focuses on the complaint against East Texas Medical Center Regional Healthcare System et al., which was one of the first complaints filed on June 16, 2004. The analysis does not address defendants' responses, which are only now beginning to be filed.¹⁰

⁶ *DelGadillo v. Tenet Healthcare Corp. et al.*, Cal. Super. Ct., No. B290056, filed 2/7/03. That case was consolidated with other similar actions into *Tenet Healthcare Cases II*, J.C.C.P. No. 4289, and was followed by an additional class action filed in Florida.

⁷ In that action, plaintiffs sought to vacate all previous judgments against the plaintiffs and other members of the class, to release them from the obligation to pay charges, and to award compensatory as well as punitive damages and attorneys' fees and costs. The plaintiffs also sought a court-appointed independent board of trustees to oversee all free bed funds administered by the defendant hospitals.

⁸ For example, earlier this year, the Illinois Department of Revenue revoked the tax-exempt status of Provena Covenant Medical Center (Urbana) reportedly for, among other reasons, failing to meet its charitable care requirement under state law. See Lucette Lagnado, "Hospital Found 'Not Charitable' Loses Its Status As Tax Exempt," *Wall Street Journal*, Feb. 19, 2004, at B1.

⁹ State law typically requires the participation of the attorney general in litigation against a nonprofit or charitable organization.

¹⁰ As of the date of this writing, several responses have been filed. At first glance, they appear to raise many of the points of contention noted in this article.

A. Parties

In *East Texas*, plaintiffs Crystal Lynn McCoy and Cora May Edison are uninsured, indigent persons who claim that after being treated at defendants East Texas Medical Center–Jacksonville and East-Texas Medical Center for urgent conditions, they were subject to numerous bills and demands for payment from the hospitals and debt collectors despite their representations that they were unable to pay. Plaintiffs in the other complaints are also uninsured persons with similar experiences—no insurance, costly and necessary medical treatment, no or inadequate information from the hospital regarding financial assistance, payment plans or free care, and aggressive billing and collection efforts by the hospital and/or a debt collector.

In addition to the hospitals, defendants in *East Texas* include the hospitals' parent corporation, East Texas Medical Center Regional Healthcare System. Some of the complaints also name as defendants "John Does" to represent those agents, employees, affiliates or subsidiaries of the defendant hospital that engaged in debt collection and other unlawful conduct against the plaintiffs.¹¹

Moreover, some complaints include the AHA as a co-conspirator for having drafted guidelines and provided advice to hospitals that allegedly advanced discriminatory billing practices against the uninsured. The AHA is named as a defendant in all of the actions filed on July 21; in addition, according to a press release issued by the coordinated team of plaintiffs' attorneys on that same date, all previous lawsuits will be amended to add the AHA as a defendant.¹²

B. Request for Class Action

Plaintiffs also request class certification pursuant to Federal Rule of Civil Procedure 23.¹³ As stated in *East Texas*, the proposed class consists of "all uninsured patients of ETMC on the dates described herein who were charged an amount for medical care in excess of the amount charged to Defendants' Medicaid patients, and/or were pursued for such debt through collection efforts and lawsuits."¹⁴ Similarly, the other complaints define the class to include uninsured patients that received services at the respective defendant hospitals. However, on the first prong of the definition of the class (uninsured patients who were charged an amount for services in excess of the Medicaid rates), there is some

¹¹ See *Duane Darr v. Sutter Health, and Does 1-50*, N.D. Cal. No. 3:04-CV-02624, filed 6/30/04; *Wright v. St. Dominic Health Services Inc., St. Dominic-Jackson Memorial Hospital, and John Does A Through Z*, S.D. Miss. No. 04-CV-521, filed 7/7/04; *Lorens v. Catholic Healthcare Partners, Community Health Partners, Community Health Partners Hospital Surgical Center and John Does 1 Through 10*, N.D. Ohio No. 1:04CV1151, filed 6/16/04; *Cargile et al. v. Baylor Health Care System*, N.D. Dallas, Tex. No. 3-04CV-1365M, filed 6/22/04.

¹² See www.nfplitigation.com.

¹³ F.R.C.P. 23 provides that: One or more members of a class may sue or be sued as representative parties on behalf of all only if (1) the class is so numerous that joinder of all members is impracticable, (2) there are questions of law or fact common to the class, (3) the claims or defenses of the representative parties are typical of the claims or defenses of the class, and (4) the representative parties will fairly and adequately protect the interests of the class. Additional conditions must also be present.

¹⁴ *East Texas* Complaint at 8.

variation among the complaints. Instead of comparing the rates charged to the uninsured against Medicaid rates, some complaints define the class as those persons who were charged rates in excess of the Medicare rates, and/or in excess of amounts charged to insured patients.¹⁵ Should these actions reach the discovery phase, the issue of how similar—or divergent—the experiences and treatment of the plaintiffs have been could become an obstacle for class certification.

The Hospital Class Action Litigation Web site seeks claimants to add to the proposed classes.

C. Claims and Jurisdiction

1. Third-Party Breach of Contract. *East Texas* and the other complaints in the litigation share in common the principal claim that plaintiffs are third-party beneficiaries of "agreements" entered into between the defendants and the government taxing authorities whereby defendants do not pay federal, state and/or local income taxes and in return promise to perform certain functions, as listed in *East Texas*:

[to] operate exclusively for charitable purposes; provide emergency room medical care to the Plaintiffs and the Class without regard to their ability to pay for such medical care; provide mutually affordable medical care to the Plaintiffs and the Class; and not to pursue outstanding medical debt from the Plaintiffs and the Class by engaging in aggressive, abusive, and humiliating collection practices.¹⁶

Additionally, other complaints state that these agreements prohibit defendant hospitals from engaging in any activity that is related to profit-making.¹⁷

According to the complaints, the legal authority that governs these tax agreements includes § 501(c)(3) of the Internal Revenue Code (IRC). Under § 501(c)(3), entities are eligible for exemption from federal income taxes if: 1) they are organized and operated "exclusively" for one or more exempt purposes, including "charitable," religious, educational, scientific or literary; and 2) no part of their net earnings inure to the benefit of "insiders," including members of the board, officers, managers and possibly staff, employees or other individuals associated with the enterprise.¹⁸ State tax law is also cited as authority for the tax agreements discussed above.

Plaintiffs generally allege that defendant hospitals have violated the provisions of the so-called agreements cited above. In addition, in some complaints plaintiffs allege that defendants have violated the IRC prohibition on private inurement by providing "substantial discounts off the gross charges to entities owned, controlled or connected to their Board of Directors, and by allowing for-profit physician groups and others to use

¹⁵ See *Sabeta v. Baptist Hosp. of Miami et al.*, S.D. Fla. No. 04-CV-21437, p. 19 (referencing Medicare rates); *Woodrum v. Integris Health*, W.D. Okla. No. 5:04-CV-00835, filed 7/7/04, p. 11 (referencing insured rates); *Campbell v. St. Barnabas Corp.*, D. N.J. No. 2:04-CV-03201, filed 7/7/04 (referencing Medicare, Medicaid and/or insured rates).

¹⁶ *East Texas* Complaint at 12-13.

¹⁷ See *Lively v. MCG Health Inc.* S.D. Ga. No. 04-CV-113, filed 7/7/04, pp. 13, 58; *Wright, supra*, p. 2.

¹⁸ 26 U.S.C. § 501(c)(3).

the hospital to derive profits based on services provided at the hospital.”¹⁹

Significantly, plaintiffs’ third-party breach of contract claim provides the basis for their allegation of federal court jurisdiction. The *East Texas* plaintiffs argue that the federal court has subject matter jurisdiction under 28 U.S.C. §§ 1331, 1340 and 1367 because plaintiffs’ claims arise out of the tax agreement described above pursuant to § 501(c)(3). (As discussed below, other claimants cite additional federal laws as the basis for federal court jurisdiction.)

The theory that plaintiffs are third-party beneficiaries to agreements between a hospital and a taxing authority raises interesting issues that undoubtedly will be the subject of extensive motions by the parties. Some of these issues include whether the federal and state tax laws create express or implied agreements with tax-exempt entities, and whether, if such agreements exist, consumers have standing to enforce them as third-party beneficiaries to such agreements. Although the tax-exempt status of hospitals has been litigated in numerous tax cases brought by government entities,²⁰ including cases that involve patient billing,²¹ the concept that a consumer has standing, through a contractual theory or otherwise, to challenge a hospital’s tax-exempt status and to obtain damages if the hospital is in violation of applicable tax-exemption law is novel.²²

2. Breach of Contract Between Plaintiff and Hospital.

East Texas also shares with the other actions in the Hospital Class Action Litigation a second contract-based claim. Plaintiffs argue that upon admission, they entered into form contracts with the hospital that “imputed” an express and/or implied promise that plaintiffs would be billed “no more than a fair and reasonable charge for such medical care.”²³ Moreover, plaintiffs allege, by simply accepting or admitting the plaintiffs for treatment, the defendants undertook an express and/or implied contractual obligation to bill no more than a fair and reasonable charge for care.

The contractual claim goes directly to the heart of the litigation: the amount charged to uninsured hospital patients for medical care. Plaintiffs assert that the defendant hospitals charged the plaintiffs and the class the “highest and full undiscounted cost” of care, thereby breaching a contractual obligation to provide “mutually

affordable medical care” to the plaintiffs.²⁴ Determining the extent of this alleged obligation will necessitate an examination of Medicare pricing regulations which, as the AHA raised in its correspondence to Secretary Thompson, had been interpreted by hospitals nationwide as a prohibition on the use of discounts and/or the waiver of copayment amounts as a means of financial assistance.

The challenge in all the actions will thus be how to define a “fair and reasonable charge” for services, or alternatively, “mutually affordable health care,” rendered to uninsured patients, particularly given the complexity of the health care payment system. This complexity is likely to appear as a theme in pleadings filed by the parties, particularly the intersection of free or charity care and bad debt, and how hospitals report these relative costs for the purpose of reimbursement. The accounting practices of hospitals will undoubtedly be the focus of plaintiffs’ attorneys, who have accused the defendants of using “Hollywood accounting” to inflate the amount of free care already being provided.²⁵ Further, defining what is fair and reasonable or mutually affordable with respect to health care for a particular plaintiff (or class of plaintiffs if the request for class action certification is successful) and a particular hospital will likely depend heavily upon expert opinion on health care financing, plus an analysis of federal poverty levels, existing state charity care law, and the charity care policies of individual hospitals.

3. Breach of Good Faith and Fair Dealing. Plaintiffs’ claim of breach of good faith and fair dealing builds on the breach of contract claims outlined above. As alleged direct or indirect contract beneficiaries, plaintiffs contend that the defendants owed them a duty of good faith and fair dealing to provide emergency room treatment without consideration of their ability to pay; not bill them at full, undiscounted charges; not bill them in amounts higher than amounts charged for insured patients for similar services; and not to use aggressive collection practices, including lawsuits, liens and garnishments.

According to the Restatement of the Law 2d of Contract, parties to a contract have a duty to perform and enforce the agreed-upon terms honestly, in “observance of reasonable commercial standards of fair dealing in the trade,” and “with faithfulness to an agreed common purpose and consistency with the justified expectations of the other party.”²⁶ The Restatement also recognizes that how this duty applies, and appropriate remedies for breach of this duty, vary based on the circumstances. It is expected that issues such as the definition of “standards of fair dealing in the trade” and the “justified expectations of the other party” will be hotly contested.

4. State Law Consumer Protection Violations. In the *East Texas* complaint, the next claim alleges violations of Texas’ Deceptive Trade-Consumer Protection Act, which protects Texas citizens from “deceptive, fraudulent and unfair conduct.”²⁷ Plaintiffs highlight the defendants’ alleged practice of billing charges to plaintiffs

¹⁹ *MCG Health, supra*, pp. 13, 58.

²⁰ See, e.g., *St. David’s Health Care System v. United States of America*, 349 F.3d 232 (5th Cir. 2003) concerning whether a nonprofit hospital’s tax-exempt status should be revoked because it “ceded control” over its charitable assets, that had been contributed to a 50/50 limited partnership, to its for-profit partner. The hospital won a favorable ruling on a motion for summary judgment at the trial court level. *St. David’s*, Civil No. A-01-CA-046 JN (W.D. Tex. 2002) (including significant discussion on whether the hospital fulfilled its charitable purpose). Following remand by the Fifth Circuit on whether summary judgment was appropriate, the federal government eventually lost its challenge. *St. David’s* (W.D. Tex. March 5, 2004).

²¹ See *infra* n. 8.

²² For a discussion of consumer standing to challenge the tax-exempt status of hospitals as charitable organizations under Section § 501(c)(3), see *Eastern Kentucky Welfare Rights Org. v. Simon*, 426 U.S. 26 (1976) (class of uninsured patients had no standing to challenge IRS revenue ruling granting hospital tax-exempt status).

²³ Complaint at 14.

²⁴ *East Texas*, Complaint at 13.

²⁵ See www.nfplitigation.com.

²⁶ Restat. 2d of Contracts, § 205.

²⁷ *East Texas* Complaint at 16.

and of using aggressive debt collection techniques as discriminatory and against public policy.

Other complaints include similar claims based on the consumer protection laws of the state in which the defendant hospital is located. At least two complaints contend that the defendant hospital "knowingly induced" consumers to use its facilities under the belief that such facilities operated as a charity care provider, or similarly, that the defendant hospital publicly misrepresented its charitable mission.²⁸ The strength of these claims will depend on the particulars of the facts and applicable state law.

5. Unjust Enrichment/Constructive Trust. Similar to the breach of contract claim, plaintiffs' unjust enrichment claim also strikes at the underlying issue of the Hospital Class Action Litigation, the amount charged to uninsured patients for hospital care. This claim, which is raised in all of the complaints, asserts that the defendant hospitals' practice of allegedly over-billing the uninsured despite their nonprofit status, has resulted in significant windfalls in the form of million dollar tax exemptions. Plaintiffs allege they have been injured by this practice because the hospitals have allegedly failed to provide affordable medical care despite their substantial net assets and revenues, and have realized profits by billing the uninsured at rates that are higher than those billed to insured patients.

The significance of this claim is the remedy requested by plaintiffs, the imposition of a "constructive trust" in the amount equal to a) the hospitals' federal, state and local tax-exempt savings; b) all profits obtained by billing plaintiffs for charges; c) the difference between the amount charged to plaintiffs and the amount charged to insured patients; and d) the cost to provide "mutually affordable medical care" in accordance with the hospitals' tax-exempt status.

A constructive trust is a trust by operation of law; it is remedial in character and is imposed by a court of equity, typically to prevent unjust enrichment. Generally, the common law theory behind the remedy of constructive trust is that such a trust exists whenever one holding title to property is subject to an equitable duty to convey it to another on the ground that it would be unjustly enriched if it were permitted to retain the property. Courts can impose a constructive trust to prevent unfairness, bad faith, fraud, accident or a diversion of corporate property. The actual intent of the parties is immaterial. The burden of demonstrating that a constructive trust exists is on the party seeking to benefit from it.²⁹

The applicability of the unjust enrichment/constructive trust theory to a nonprofit hospital's tax-exempt status is another novel legal issue. If a constructive trust theory is applicable here, because the amount of assets and revenues held by hospitals varies widely between institutions (that is, an established, large teaching hospital may have more assets and revenues than a small community hospital), whether a particular hospital has been unjustly enriched and whether a constructive trust is the appropriate remedy will also depend on the facts of a particular action.

²⁸ Woodum, *supra*, p. 21; *Fields v. Banner Health*, Dist. Ariz. No. 04-CV-1297, filed 6/23/04.

²⁹ See Restatement 2d of Trusts § 101-111.

6. Civil Conspiracy/Concert of Action. One of the more interesting averments in the *East Texas* complaint is that the defendant hospitals entered into a "civil conspiracy" with the AHA and that the AHA aided and abetted the defendants by concealing and misrepresenting the defendants' breaches of their agreements with government taxing authorities. Other complaints cite the AHA's December 2003 letter to Secretary Thompson in which the association requested guidance on hospitals' ability to discount rates under Medicare (discussed above) as evidence that the AHA misrepresented and concealed hospitals' billing and collection practices, and charge the AHA with providing "advisory assistance" to hospitals on how to over-bill their uninsured patients and aggressively collect medical debt.³⁰

At this stage, it is difficult to assess whether and how this claim will impact the overall litigation. The recent addition of the AHA as a named defendant suggests that additional, allegedly more concrete links will be drawn between the billing practices of the individual defendant hospitals and the AHA. On the one hand, it can be presumed that, like any trade association, the AHA's advice on hospital billing and collections practices was general and not specific to any one institution. On the other hand, it is conceivable that, at least at this stage of the litigation, a court could find that the AHA's advice supported and unduly influenced a particular hospital's billing and collection activities. At a minimum, the claim against the AHA appears to be an attempt to transform the individual cases into litigation that can address a larger claim that the issue of hospitals' billing and collections practices for the uninsured is industry-wide.

7. Breach of Charitable Trust. An additional substantive claim that is included in a number of complaints other than *East Texas* alleges a breach of charitable trust.³¹ In the action against MGH Health Inc., for instance, this claim is fashioned on the assumption that by accepting federal, state and local tax exemptions, defendant hospitals entered into a "charitable trust to provide mutually affordable medical care to its uninsured patients," and that, importantly, plaintiffs are beneficiaries of that trust.³² The violations of that trust include a number of specific allegations repeated throughout the complaints in support of various claims — failure to provide emergency care without regard to ability to pay, billing the uninsured for charges, charging the uninsured more than the insured for similar services, failing to use their assets and revenues to provide mutually affordable care, utilizing aggressive collection practices, and permitting for-profit entities, such as physician groups, to derive a profit based on use of the hospital.

One procedural issue raised by this claim is whether plaintiffs have standing to request the creation or enforcement of a charitable trust. The Restatement of the Law, 2d, Trusts, suggests that a charitable trust is typically enforced by a state's attorney general or other public officer.³³ According to the Restatement comments, "the mere fact that as members of the public they benefit from the enforcement of the trust is not a

³⁰ See *Patel v. Cleveland Clinic et al.* N.D. Ohio No. 1:04-CV-01330, filed 7/15/04, pp. 18-19; *Wright, supra*, p. 17.

³¹ See *Lively, supra*, p. 26.

³² *Id.*

³³ Restat. 2d of Trusts, § 391.

sufficient ground to entitle them to sue, since a suit on their behalf can be maintained by the Attorney General.”

8. EMTALA. Another notable cause of action that is raised in complaints other than *East Texas* concerns violations of EMTALA. EMTALA requires that a Medicare-participating hospital provide a medical screening examination to any individual that comes to the emergency room and, if a medical condition exists, to provide stabilization services. The complaint against Baptist Hospital, for example, argues that the hospital conditioned the provision of emergency care on a determination of the plaintiff's ability to pay for such care and agreement to sign form contracts agreeing to pay charges.³⁴ Plaintiffs in these cases cite EMTALA as an additional basis for federal court jurisdiction.

Recent EMTALA regulations have addressed a hospital's ability to register a patient and collect payment information from a patient seeking emergency services covered by EMTALA. These regulations allow a hospital to follow “reasonable registration processes,” including inquiries regarding a patient's insurance status and method of payment, as long as such processes do not result in a delay in screening or treatment.³⁵ For those actions that raise this claim, the question then will be whether the hospital's registration processes, including any information obtained or forms signed by patients, were reasonable and did not delay treatment.

9. Fair Debt Collection Practices Act/Claims Against John Does. A final, substantive claim that has appeared in more recent complaints concerns the Fair Debt Collection Practices Act and the activities of John Doe collection agencies.³⁶ Plaintiffs assert that these collection agencies have engaged in “aggressive, abusive and humiliating” debt collection practices, in violation of the Act. This claim also provides an additional jurisdictional basis for claimants.

10. Other State Statutory Claims. In addition to actions under state consumer fraud statutes, some complaints cite violations of other state statutes, for example, those that regulate the actions of nonprofit corporations.³⁷

D. Relief Requested

The complaints all seek declaratory and injunctive relief, as well as actual and special damages for plaintiffs and the proposed class. As noted, they also request the imposition of a constructive trust on hospitals' tax-exempt savings, profits, and net assets and revenues in amounts sufficient to provide “mutually affordable medical care.” Finally, they request attorneys' fees, costs, and expenses, and “such other relief as the court deems proper.”

³⁴ *Sabeta* Complaint at 15.

³⁵ 42 C.F.R. § 489.24(d)(4).

³⁶ See *Kolari v. New York-Presbyterian Hospital et al.*, S.D.N.Y., No. 04CV5506, p. 20; *Quinn v. BJC Health System d/b/a BJC Healthcare et al.*, E.D. Miss. No. ____, p. 22.

³⁷ See e.g., *Kolari, supra*, p. 22; *Sabeta et al. v. Baptist Hospital of Miami, Inc. et al.*, S.D. Fla. No. 04-21437, p. 31.

III. Beyond the Litigation

Given the newness of the Hospital Class Action Litigation, it is too early to predict how the litigation will evolve. For instance, it is uncertain whether the different actions will survive likely motions to dismiss based on jurisdiction or other grounds. It is also unknown whether class action standing will be awarded. Finally, assuming that federal jurisdiction stands, the plaintiffs or defendants, or a court on its own initiative, will seek to transfer the different cases under the federal rules³⁸ governing multi-district litigation, as was done in the national managed care litigation.

Beyond the litigation, nonprofit, as well as for-profit, hospitals should continue to address the issue of providing and financing care for the uninsured by, among other things, reviewing their policies and practices governing billing and collection from the uninsured, amending them to be more specific and explicit as necessary, and ensuring their enforcement. Specifically, hospitals should consider the following:

1. Review patient intake procedures and policies to determine who should be eligible for charity care and financial assistance;
2. Perform a community assessment of service area demographics to see if policies can be appropriately applied to an organization's patient population;
3. Consider whether the community is adequately informed about the organization's charitable care and financial assistance activities;
4. Review their agreements with third-party debt collectors to ensure that fair and appropriate debt collection practices are being followed; and
5. Review whether the charge structure and the amounts of charity care and financial assistance that the institution can provide in light of its overall financial situation should be modified.

Clearly, the last recommendation is the most difficult. As stated above, at the heart of the Hospital Class Action Litigation is the issue of how to bill the uninsured for medical care. Plaintiffs in the actions frequently refer to the need for “mutually affordable medical care,” but what does this mean within the context of the current health care payment system? And further, if it means that every uninsured person should be able to receive necessary health care, who will pay for it? The Community Catalyst initiative, which was cited above as one original source of the current interest in hospital billing practices for the uninsured, set out a number of steps that must be taken to address this issue. One step was making hospitals more responsible for providing charity care to patients. The next steps demand efforts by all interested parties – consumers, hospitals and other providers, insurers, employers and government, to address how this care should be funded. From this view, then, the Hospital Class Action Litigation takes the first step by seeking to cause hospitals to become more accountable. The more complicated next steps involving a universal solution to the problem of how to pay for medical care for the uninsured and underinsured are yet to come.

³⁸ 28 U.S.C. § 1407.