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OVERCHARGING THE UNINSURED IN HOSPITALS: SHIFTING A GREATER SHARE OF UNCOMPENSATED MEDICAL CARE COSTS TO THE FEDERAL GOVERNMENT

*James McGrath**

I. INTRODUCTION

I think there is a shared consensus that the problems with the [health care] system and the escalating costs, and the escalating dysfunctions, with more and more losing their health care insurance every month, are greater than the costs of change.¹

Since Bill Clinton spoke those words in 1993, the need for change has only increased. Articles abound critiquing our health care payment systems, offering plans to patch, restructure, or totally abandon our current scheme as it becomes less efficient and more expensive.² This article has a less expansive goal: to reveal a hidden federal cost of treating people without health insurance (the “uninsured”), and to more fully inform discussions about changing our health care payment system. The plight of the uninsured in navigating our health care system reveals

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1. HAYNES JOHNSON & DAVID S. BRODER, *THE SYSTEM: THE AMERICAN WAY OF POLITICS AT THE BREAKING POINT* 25 (1996) (statement of President William J. Clinton).

2. See, e.g., Timothy Stoltzfus Jost et al., *The Role of Competition in Health Care: A Western European Perspective*, 31 J. HEALTH POL. POL'Y & L. 687, 688 (2006); Jonathan Barry Forman, *Making Universal Health Care Work*, 19 ST. THOMAS L. REV. 137, 145 (2006); James B. Roche, *Health Care in America: Why We Need Universal Health Care and Why We Need it Now*, 13 ST. THOMAS L. REV. 1013, 1026 (2001); William P. Gunnar, *The Fundamental Law that Shapes the United States Health Care System: Is Universal Health Care Realistic Within the Established Paradigm?*, 15 ANNALS HEALTH L. 151, 155 (2006); Uwe E. Reinhardt, *Reforming the Health Care System: The Universal Dilemma*, 19 AM. J.L. & MED. 21, 31 (1993).

many of the inconsistencies and inequities that have developed throughout the evolution of our nation's health care payment schemes. The health care treatment that the uninsured receive is likely to be more expensive and of lower quality than the treatment received by people who have health care coverage.³

In addressing problems with our health care payment system, one of the most contentious debates has been whether the United States should adopt a plan of universal health care. The debate intensifies over whether this country should adopt a single payer health care system, which one commentator describes as a system "in which a federal agency would centrally administer a single, comprehensive benefits package financed through general tax dollars"⁴ Under a single payer plan, everyone in the country would receive at least some level of access to health care for which the federal government would pay.

The federal government already pays for or subsidizes health care through many commonly known as well as many indirect and hidden programs. This article explores one particular hidden federal subsidy for treatment of the uninsured: a tax subsidy that results from unpaid, uncollected, and inflated health care bills. Acknowledging this hidden burden on the federal government, the article further erodes two of the common criticisms against adopting a single payer system in this country. First, many opponents of a single payer system assume that in our current multi-payer health care system, competition is necessary to achieve efficiencies, and that market-based economic effects efficiently minimize costs and provide adequate health care.⁵ Second, opponents of a single payer system predict that a single payer plan would require excessive new federal expenditures and higher taxes to finance such a comprehensive system.⁶

3. One exception is the provision of emergency services, in which care for both the insured and uninsured is generally of high quality.

4. John V. Jacobi, *Government Reinsurance Programs and Consumer-Driven Care*, 53 *BUFF. L. REV.* 537, 551 (2005).

5. Roche, *supra* note 2, at 1026.

6. *Id.* at 1022. Much of the literature supporting a single-payer system notes that the federal government already is paying most of the health care costs in this country (through both obvious and unapparent funding programs), reducing the efficacy of a truly competitive market to control costs. In addition, efficiencies have not materialized with the conversion of many health care providers from a not-for-profit model into a profit model. Single-payer system supporters also argue that the implementation of such a plan might actually cost the government about the same, or even less, than it currently spends on health care. This argument is based on a reduction in health care subsidies, decreased administration costs, better utilization of resources, and improved preventive health care.

Arguments based upon a free market approach to health care funding do not fully address its effect on the forty-seven million people in this country currently without health insurance.⁷ Specifically, free market proponents do not fully recognize the impact of federal law requiring hospitals to treat uninsured patients, even if those patients do not have the ability to pay for hospital services.⁸ The question then arises: if uninsured patients cannot pay for services rendered, who is paying for their treatment?

The answer is that the federal government already provides some minimal “coverage” to the uninsured that are unable to pay for medical care. The government provides this coverage through various programs, including the previously mentioned hidden subsidy that begins with health care providers overcharging uninsured patients for medical services. This subsidy occurs when health care providers charge uninsured patients a rate that is substantially higher than the reimbursement the provider would receive from third party payers, such as private insurers, HMOs, and the federal government through its direct funding programs. If the uninsured patient fails to pay, the providers often write off this inflated charge at tax time.

Most hospitals, however, do not pay income tax because they qualify as charitable, not-for-profit entities.⁹ While these not-for-profit hospitals may not benefit from tax deductions, they still benefit by charging the uninsured inflated list prices. Rather than write off unpaid, uncollectible bills, not-for-profit entities report them as “charity care.”¹⁰ The ability to maintain their charitable status by overstating their

7. “The percentage [of Americans] without health insurance increased from 15.3 percent in 2005 to 15.8 percent in 2006 and the number of uninsured increased from 44.8 million to 47.0 million.” U.S. Census Bureau, Health Insurance Coverage: 2006, <http://www.census.gov/hhes/www/hlthins/hlthin06/hlth06asc.html>, last visited October 23, 2007 (last visited Nov. 7, 2007).

8. See, e.g., The Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd (2000).

9. I.R.C. § 501 (c)(3) (2000).

10. See *Kizzire v. Baptist Health Sys., Inc.*, 343 F. Supp. 2d 1074, 1074 (N.D. Ala. 2004). The plaintiff claimed the hospital overstated its provision of charity care by claiming its uncollectible debts as provision of charity care. Plaintiff complained,

Defendant BHS uses Enron-style accounting tricks to grossly distort the small amount of charity care it does provide to insured patients. Defendant BHS reports is [sic] amount of charity care as the amount of gross charges—which are grossly inflated—rather than the cost of actually providing the service. Defendant BHS further exaggerates the amount of charity care that it does by simply referring to all bad-debt writes offs [sic] as charity care.

Id. at 1078.

provision of free care is part of the calculus that allows these hospitals to be classified as not-for-profit; it may also net these hospitals great savings from property tax burdens.¹¹ The practice of claiming uncollectible debt as charity care has come under heavy scrutiny lately, as for-profit hospitals provide similar benefits to the community using this standard, leading many to question the value of not-for-profit hospitals' tax-exempt status.¹²

An example will help clarify the effect of the subsidy. When John Herson, an uninsured resident of Massachusetts, suffered a stroke, he was billed \$23,280.80 for his hospital visit (plus an additional \$23,018.10 for doctor's fees and follow-up care over the next nine months).¹³ If he had been a Blue Cross member, the hospital would have been reimbursed \$7000 for his visit.¹⁴ If he had been on Medicaid, the hospital would have been reimbursed about \$5400 for the same services.¹⁵ If John had been unable to pay for his visit, the hospital would have written off the entire hospital visit at its list price, a price three to four times the amount it normally would receive for the same services.¹⁶ Writing off an inflated charge, in this example \$23,000, for a procedure for which the hospital usually would receive no more than \$7000 may reduce the hospital's tax burden, perhaps by as much as its actual or usual reimbursement for that procedure. In these extreme cases, hospitals may effectively shift to the federal government the entire cost of treatment for an uninsured patient.

The federal government, in other words, has become the unwitting insurer for many who do not actually have either private or government health insurance, and are unable to pay for health care out-of-pocket.

11. *E.g.*, WIS. STAT. ANN. § 70.11(4m)(a) (West 2007) ("The property described in this section is exempted from general property taxes . . . (4m) Nonprofit hospitals. (a) Real property owned and used and personal property used exclusively for the purposes of any hospital of 10 beds or more devoted primarily to the diagnosis, treatment or care of the sick, injured, or disabled, which hospital is owned and operated by a corporation, voluntary association, foundation or trust . . .").

12. *See* CONGRESS OF THE UNITED STATES, CONGRESSIONAL BUDGET OFFICE, NONPROFIT HOSPITALS AND THE PROVISION OF COMMUNITY BENEFITS 9 (December 2006), available at <http://www.cbo.gov/ftpdocs/76xx/doc7695/12-06-Nonprofit.pdf>.

13. Liz Kowalczyk, *Uninsured Caught in Costly Twist*, BOSTON GLOBE, Nov. 7, 2004, at A1.

14. *Id.*

15. *Id.*

16. John struck a deal with the hospital to make payments of \$700 per month. The hospital was gracious enough to not charge him interest on the debt. He was also charged an additional \$594.78 surcharge that benefits a statewide pool for people who do not have insurance. *Id.*

Some of the uninsured end up being “covered” by the federal government through this hidden tax subsidy. The odd system that has evolved for paying for the treatment of the uninsured, however, was unintended and unplanned. As a result, it has evolved into a grossly inefficient and inequitable system that is not easily navigated by the uninsured in need of medical treatment.

First, the system of covering the uninsured is expensive, and, through the hidden and transparent subsidies provided by the federal government, the costs ultimately are borne by taxpayers. Many hospitals take advantage of tax laws to pass on the costs of treating the uninsured to the federal government. Charging uninsured patients an inflated price permits hospitals to accrue excess profit from those least able to pay, and allows hospitals to take advantage of the ability to write off an amount excessive to their normal billing rate for a given procedure. Moreover, many of the uncollectible debts arising from treatment of the uninsured are then discharged through bankruptcy. These bankruptcies, precipitated by catastrophic health care costs, also add to society’s expense for treatment of the uninsured because additional health care debt (along with other unsecured debt unassociated with the provision of health care) will likely be written off as bad debt in the wake of the patient’s personal bankruptcy.

Second, health care treatment for the uninsured is likely to be untimely, delayed by lack of access to preventive and primary care available to those who have health care coverage. The uninsured are forced to visit hospital emergency rooms for ordinary care. The use of expensive emergency facilities to provide ordinary care to the uninsured also squanders precious health care dollars in the most expensive and often least efficient method of treatment. Because of their lack of access to routine health care options, uninsured patients may also delay treatment until a routine medical problem actually becomes an emergency medical condition.

Providing at least minimal coverage for the health care of everyone could help utilize our precious health care dollars more efficiently. One of the criticisms of a single payer health care system is that it would require taxpayers, through the federal government, to pay for the health care of all Americans.¹⁷ The problem with this critique, however, is that the federal government is already paying for much of the treatment of

17. Jennifer Prah Ruger, *Health, Health Care, and Incompletely Theorized Agreements: A Normative Theory of Health Policy Decision Making*, 32 J. HEALTH POL. POL’Y & L. 51, 73 (2007).

the uninsured, in a way that is inefficient, inequitable, and ineffective. Whatever the problems with a single payer plan, any benefit from market competitiveness that exists in our current health care payment system is cancelled by its gross systemic inefficiencies.

Part II of this article provides a brief history of the health care funding system and examines our current pricing scheme. Part III analyzes the current hospital pricing scheme in light of its effects on the uninsured. Part IV examines the adoption of a single payer system while recognizing less sweeping approaches that some commentators have advanced to address the immediate concern of paying for the uninsured.

The mechanics of shifting our current system to that of a single payer system, or implementation of any other plan to overhaul our health care payment system, is a topic beyond the scope of this article. Such a massive structural change would be onerous, but preferable to forced change in the event of the current system's eventual collapse. Quoting Bill Clinton once again, "[t]he general point I want to make is that I think profound change has happened in societies when essentially people understand that the cost of staying with the present course of action is greater than the cost of change; that the risks of staying with the present course of action are greater than the uncertain risks of change."¹⁸ Although additional federal funding or some stopgap state response could address disparate treatment of the uninsured, this would merely ameliorate a symptom in the short term, while preventing treatment for the underlying systemic failure.

II. THE HEALTH CARE PAYMENT SYSTEM WAS NOT DESIGNED, IT EVOLVED

Our health care funding system was not developed in a planned, rational manner, but evolved over time to an incredibly complex and inefficient form.¹⁹ The overcharging of uninsured patients was not a planned occurrence, but developed through this evolution. Some of the legislative reforms that have taken place in the past two decades address issues such as access to emergency care for people unable to pay for their treatment,²⁰ and health insurance portability.²¹ Although these

18. JOHNSON, *supra* note 1, at 24 (statement of President William J. Clinton).

19. *See generally*, PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* (1982).

20. The Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd (2000).

efforts have ameliorated certain immediate health care access issues, they do not address other systemic issues that have developed. Our current system has been built upon a foundation ill equipped to support the end result, and now operates not unlike a Rube Goldberg machine.²² As one scholar put it, “[t]he current reform trend we have undertaken is like putting a band aid on a gun shot wound.”²³ Following is a brief history of the evolution of our health care payment system followed by an examination of some of the inefficiencies that have developed.²⁴

A. *History of our Current Payment System*

Health care insurance in the United States has a relatively short history.²⁵ Prior to the development of private health insurance, Americans paid for health insurance out-of-pocket or with bartered goods.²⁶ The structure and evolution of our health care system in

21. The Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. § 1320a-7(c) (2000).

22. Rube Goldberg was a famous cartoonist who is best remembered for his “Rube Goldberg machines,” excessively complex machines that perform simple tasks in an indirect and tortuous manner. WEBSTER’S NINTH NEW COLLEGIATE DICTIONARY 1028 (1988). A more generous description of the intricacies of our health care financing systems describes any changes in regulating it as

tricky because of the dual markets for medical care. Health care is paid for by both private dollars, through employer health plans and private insurance, and government dollars, through programs like Medicare and Medicaid. An intricate web of regulations and incentives define the government health care programs. Tugging on a strand to close one loophole risks unraveling another strand of regulations and private market incentives elsewhere in the system, compromising the overall scheme. Program changes must be made deliberately, not reactively, to avoid unintended results that endanger the nation’s overall health care system.

Elizabeth A. Weeks, *Gauging the Cost of Loopholes: Health Care Pricing and Medicare Regulation in the Post-Enron Era*, 40 WAKE FOREST L. REV. 1215, 1219-20 (2005).

23. Roche, *supra* note 2, at 1038.

24. Atul Gawande, a surgeon and *New Yorker Magazine* staff writer, weighed in on this subject in an op-ed piece in the *New York Times*. Dr. Gawande notes that most Americans are somewhat satisfied with their health care coverage and would not be enthusiastic about the costs and inconvenience associated with rehabilitating our system. Dr. Gawande is concerned that our nation will wait until the system’s eventual collapse, as we had done with the problems inherent in our banking schemes which precipitated the Great Depression. Atul Gawande, Op-Ed., *Can this Patient be Saved?*, NEW YORK TIMES, May 5, 2007, at A13.

25. The history of medicine in this nation is also an interesting story. The development of the profession and our hospital system is a surprising story, revealing that both are well respected notwithstanding their relatively short history. See STARR, *supra* note 19.

26. Lewis D. Soloman & Tricia Asaro, *Community-Based Health Care: A Legal and Policy Analysis*, 24 FORDHAM URB. L. J. 235, 237 (1997). Long ago, dispensaries provided free health care in an era where medicine was not nearly as an exacting science, before the

general had much to do with economics in the development of our hospital-based system. In an effort to protect the economic interests of the medical profession, originally there was a split between the efforts of physicians and public health departments in the treatment of disease.²⁷ In response to the Great Depression, which left many Americans unable to pay for medical services, and left hospitals facing financial difficulties, several hospitals developed plans to provide “a more predictable flow of revenue.”²⁸ One of these plans was Blue Cross, which began operating in 1929 in Dallas, Texas.²⁹

Under the Blue Cross plan, the Baylor University Hospital initially agreed to provide teachers with twenty-one days of hospital care a year for \$6 per person.³⁰ The Blue Cross plan expanded to allow any person or group to purchase insurance regardless of their medical history.³¹ These plans were tax-exempt because they provided medical coverage to the general population.³² Other hospitals began to implement similar plans, and eventually hospitals joined to form many different plans.³³ Around this same time, private health insurance plans were also developed.³⁴ These early private health plans limited their financial risks by offering three general kinds of medical benefits: indemnity benefits, service benefits, and direct services.³⁵

Indemnity benefits reimbursed the subscriber for medical expenses but usually did not include the entire medical bill.³⁶ Under this type of plan, the subscriber would submit their medical claims for

“germ theory” of disease was developed. Students from medical schools volunteered and provided free care in exchange for an opportunity to practice their diagnostic skills. Patients in dispensaries faced incredibly long lines to see a practitioner and then more lines to have any resulting prescription filled. Critics of the system at the time were outraged that the mostly poor people seeking care were getting “something for nothing.” The dispensary system seems to have been replaced as the provider of last resort with the current use of emergency rooms as places for “free treatment.” See STARR, *supra* note 19, at 182-83.

27. Public health efforts were restricted during this period to their “sanitarian” role of protecting the public’s health from filth and not becoming involved with treatment of any resulting disease, so as not to interfere with the income of physicians. STARR, *supra* note 19, at 195-97.

28. *Id.* at 295.

29. *Id.*

30. *Id.*

31. Soloman & Asaro, *supra* note 26, at 237.

32. *Id.*

33. See, e.g., *id.*; STARR, *supra* note 19, at 296.

34. STARR, *supra* note 19, at 297.

35. *Id.* at 291.

36. *Id.*

reimbursement.³⁷ This greatly limited the amount of contact between the hospital and the insurer, which resulted in the insurer having no responsibility for the quality of medical services the insured received.³⁸ Indemnity plans limited their liability by requiring the insured to pay an initial deductible and a share of the costs, thus providing incentive to reduce the insured's use of services.³⁹

Service benefits guaranteed payment for services directly to the physician or hospital, and usually covered the bill completely.⁴⁰ Under these plans, the treating physician or hospital submitted a claim for reimbursement directly to the insurance provider.⁴¹ This also resulted in the insurance provider and the medical provider entering into periodic negotiations.⁴² Insurance providers also used these periodic negotiations as a way to control their costs and liabilities.⁴³

Around the time that the imposition of the doctrine of informed consent changed the manner in which physicians began interacting with their patients, direct services plans created more involvement between the medical provider and the insurance provider than did indemnity benefit plans or service benefit plans.⁴⁴ Direct services plans are "the provision of health services to the [insured party] by the organization receiving prepayment."⁴⁵ This type of organization is responsible for the quality of services provided because the doctors are integrated with the same organization that enrolls the insured parties.⁴⁶

Blue Shield was later established to compete with these commercial health plans.⁴⁷ Blue Shield created plans to pay for physician care by Blue Cross, which provided for hospital coverage. Blue Shield originally reimbursed physicians for the full cost of services.⁴⁸ Group practice associations also began to evolve around this time.⁴⁹ A group-practice association consisted of several physicians who banded together

37. *Id.*

38. STARR, *supra* note 19, at 291.

39. *Id.* at 291-92.

40. *Id.* at 291.

41. *Id.* at 292.

42. STARR, *supra* note 19, at 292.

43. *Id.*

44. *Id.*

45. *Id.* at 291.

46. STARR, *supra* note 19, at 292.

47. Solomon & Asaro, *supra* note 26, at 238.

48. *Id.* at 238-39.

49. *Id.* at 239.

and agreed to provide care to certain people for a pre-arranged fee.⁵⁰ Before World War II, Blue Cross and Blue Shield plans were the dominant type of health insurance.⁵¹ After World War II, commercial insurers began using better marketing techniques and more competitive pricing.⁵² Soon, during the post-war period, commercial insurers began to control the industry.⁵³

Today, there are three basic health insurance models: the fee-for-service model (FFS), the preferred provider organization (PPO), and the health maintenance organization (HMO). In the FFS model, which is the rarest of the three,⁵⁴ health care providers receive a fee for each service they provide.⁵⁵ A PPO, on the other hand, "integrates the health care financing function with the health care delivery system."⁵⁶ Subscribers to a PPO must choose from a limited list of medical providers, making it more effective for a PPO to oversee its providers.⁵⁷ Finally, an HMO is a "risk-bearing managed plan which further integrates health care financing and health care delivery."⁵⁸ HMOs often pay providers on a fixed payment basis rather than each time a patient visits the doctor's office.⁵⁹ HMOs may be for-profit or not-for-profit.⁶⁰

With the transition of many major health care insurers to for-profit organizations, there have been corresponding changes in our health care payment system. Using a profit model, and through consolidation and merger of larger patient bases, insurers can theoretically negotiate contracts with hospitals and hospital systems using their large patient base to negotiate the lowest possible payments. As discussed below, these potentially lower payments have not resulted in lower health care costs in general or lower prices to the consumer. Lower payments by third party payers might have even exacerbated the need of health care providers to seek greater payment return from patients who have no power to bargain in advance for a discount from a hospital's list price.

50. *Id.*

51. Solomon & Asaro, *supra* note 26, at 239.

52. *Id.*

53. *Id.*

54. *Id.* at 240.

55. Solomon & Asaro, *supra* note 26, at 240.

56. *Id.* at 241.

57. *Id.*

58. *Id.*

59. Solomon & Asaro, *supra* note 26, at 241.

60. *Id.* at 242.

B. *The Hospital List Price and Pricing Disparities*

Disparate pricing for the uninsured has been well documented and rigorously challenged by consumer advocates, litigators, and scholars.⁶¹ The price paid by the uninsured has often been so inflated, as compared to the bulk of the payments received from third-party payers, that this disparity has been deemed both medically and legally unethical.

The phenomenon of the uninsured patient paying so much more than is typically reimbursed by third-party payers comes from the practice of hospitals maintaining a list price. One commentator compared hospital list prices to hotel “rack rates,” usually displayed on a chart on the back of each hotel room’s door.⁶² These rates almost always reflect a rate much higher than what any customer actually pays for the room. Hospitals usually bill all patients at the list price for the same service, and then significantly discount these rates for third-party payers who contract with the hospital.⁶³ Uninsured patients and third-party payers who do not contract with the hospital may or may not receive a discount from this price.⁶⁴ In any event, the uninsured are far more likely to pay the list price than patients who have insurance coverage, and, on the average, the uninsured pay more than all other patients.⁶⁵

A self-paying patient, the patient who is most likely unable to afford medical insurance, might pay as much as four times more for the same procedure as compared to third-party payers.⁶⁶ Nationwide, the

61. See, e.g., George A. Nation III, *Obscene Contracts: The Doctrine of Unconscionability and Hospital Billing of the Uninsured*, 94 KY. L.J. 101 (2005); Hugh F. “Trey” Daly III et al., *Into the Red to Stay in the Pink: The Hidden Cost of Being Uninsured*, 12 HEALTH MATRIX 39 (2002); Beverly Cohen, *The Controversy over Hospital Charges to the Uninsured – No Villains, No Heroes*, 51 VILL. L. REV. 95 (2006).

62. *Hospital Pricing and the Uninsured: Hearing Before the Subcomm. on Health of the H. Comm. on Ways & Means*, 108th Cong. 50 (2004) (statement of Glen Melnick, Ph.D., Director, Center for Health Financing, Policy and Management, University of Southern California) [hereinafter Melnick Statement].

63. *Id.*

64. Although some of the uninsured do not pay the list rate, they usually pay significantly more than any other patient. If uninsured patients are offered discounts, it is usually on an ad hoc basis and varies by hospital, or even within hospitals. Exhibit 1 of Glenn Melnick’s testimony, see *id.*, compares the average list price for an appendectomy in California hospitals with the amounts actually paid by patients with various levels of insurance.

65. *Id.*

66. Randy Suttles & Merrill Matthews, *Hospital Pricing: Separate and Unequal*, HEALTH CARE NEWS (Heartland Inst., Chicago, Ill.), Sept. 1, 2003, available at <http://www.heartland.org/Article.cfm?artId=12775>.

uninsured paid on average over three times as much as the federal government pays to reimburse hospitals for the same treatment.⁶⁷ The amount charged to the uninsured patient varies depending on several factors, including region of the nation, whether the hospital is in an urban or rural area, the size of the facility, and whether the hospital is for-profit or not-for-profit.⁶⁸

Patients arriving at hospitals are not usually apprised of the charges for various procedures, but are billed later at the hospital's list price. This does not present as much of a problem for insured patients, as health insurance providers usually have already negotiated a discount from the list price. Hospitals simply bill third party payers at that discounted rate; but, too often, hospitals directly bill uninsured patients at the full list price.

Hospital list prices have been rising faster than inflation.⁶⁹ The rapid rise of the list price can affect prices paid by third-party payers, as the list price is usually the basis for their discounted rate.⁷⁰ Other than acting as a reference for the discounted rates, which make up the bulk of the actual payments to a hospital, these prices do not reflect the reality of what a hospital expects to recover from these over inflated charges. Reimbursement rates for the overwhelming majority of hospital services are significantly discounted. For example, in California, Medicare pays a discounted rate of about 27% of the list prices.⁷¹ Medicare's target is to pay hospitals 1% above their actual costs, but the national average is currently closer to 3.9%.⁷² Comparatively, managed care payers on

67. Gerard F. Anderson, *From 'Soak The Rich' To 'Soak The Poor': Recent Trends In Hospital Pricing*, 26 HEALTH AFFAIRS 780, 781 (2007). This study also notes that the disparity in the charges to uninsured patients versus third party payers actually widened from 1984 through the period of study in 2004.

68. See *infra* Section III.B describing demographics of the uninsured.

69. Larry Grudzien, *Can Consumer-Driven Health Care, Health Reimbursement Arrangements and Health Savings Accounts Save Employer Sponsored Health Care From Ruin?*, 19 ST. THOMAS L. REV. 39, 40 (2006) (citing GARY CLAXTON ET AL., THE KAISER FAMILY FOUNDATION EMPLOYER HEALTH BENEFITS SURVEY: 2005 ANNUAL SURVEY 1 (2005), <http://www.kff.org/insurance/7315/upload/7315.pdf>).

70. Cohen, *supra* note 61, at 108-09. Although Medicare reimbursement is largely by fixed rate, the fixed rate may be influenced by hospitals' list prices. Medicare reimbursement for extraordinary patient cases ("outlier cases") is in proportion to the hospital's list price. *Id.* at 109. See also Diane Miller Wolman & Wilhelmine Miller, *The Consequences of Uninsurance for Individuals, Families, Communities, and the Nation*, 32 J.L. MED. & ETHICS 397, 400 (2004).

71. Melnick Statement, *supra* note 62.

72. Suttles & Matthews, *supra* note 66.

average pay a discount rate of about 35% of the list prices.⁷³ As over 90% of the payers for hospital services are paying significantly discounted rates, charging uninsured patients the list price is not only on its face unfair, but it also serves to grossly overstate the amount of bad debt written off when these bills are uncollected, or in the case of not-for-profit charitable hospitals, greatly inflates their provision of free care to the community.⁷⁴

The evolution of the nation's health care payment systems, integrated with the ever-increasing federal share of providing health care through direct and indirect federal subsidies, has evolved into a system where a hospital's list price is relatively meaningless. The list price continues to rise, expanding the share paid by governments and other third party payers, but the list price itself grows at a rate much faster in real dollars than these discount rates, further penalizing the uninsured.

The list price is paid by only a small fraction of a hospital's payers: the uninformed and/or the uninsured. The rates are so high that they have spawned litigation and both federal and state legislative efforts to alter this pricing inequity. The inequities inherent in this pricing scheme should be of concern for all citizens, as the largest share of the burden of providing this care falls to the federal government, and ultimately the taxpayer.

C. Federal Health Care Expenditures

The federal government is already, by far, the largest provider of health care funding through its many insurance programs and tax incentives. Most people are familiar with some of the programs through which the federal government pays for medical treatment, such as the Medicare and Medicaid programs, but there are also other indirect federal subsidies.⁷⁵

The federal government is the largest funding source for health care in the United States as a direct third-party payer. Of the approximately

73. Melnick Statement, *supra* note 62.

74. One district court examined such issues in *Kizzire v. Baptist Health Sys., Inc.*, 343 F. Supp. 2d 1074, 1075 (N.D. Ala. 2004).

75. Laura D. Hermer, *Private Health Insurance in the United States: A Proposal for a More Functional System*, 6 HOUS. J. HEALTH L. & POL'Y 1, 16-17 (2005). Note that the employees are also not taxed for this valuable benefit. See also KAISER COMM'N ON MEDICAID AND THE UNINSURED, THE UNINSURED: A PRIMER, KEY FACTS ABOUT AMERICANS WITHOUT HEALTH INSURANCE, 2-3 (2006), available at <http://kff.org/uninsured/upload/7451.pdf> [hereinafter KAISER COMM'N PRIMER].

84.4% of the American population (243.3 million people) who had health insurance in 2003, 31% were insured by the federal government.⁷⁶ Approximately 76.8 million people were covered directly by government-paid health insurance programs.⁷⁷ Medicare is the federal program which helps pay health care costs for people age sixty-five and older and for certain people under the age of sixty-five with disabilities.⁷⁸ Medicare alone covers more than 39.5 million people.⁷⁹ Medicaid is a program funded jointly by federal and state governments, and is administered at the state level to provide medical assistance to the needy.⁸⁰ Medicaid covered about 35.6 million Americans in 2003.⁸¹

Federal dollars for health care are not spent exclusively on the poor or retired. Private health insurance, such as coverage purchased by an individual from a private health insurance company or coverage from a health plan provided through an employer or union,⁸² is also heavily subsidized through the employment tax exclusion for insurance premiums paid by employers.⁸³ Employment-based health insurance is coverage offered through a relative's or one's own employment.⁸⁴ About 60.4% of the people with private insurance were covered by

76. CARMEN DENAVAS-WALT, BERNADETTE D. PROCTOR & ROBERT J. MILLS, U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2003, at 14 (2004), available at <http://www.census.gov/prod/2004pubs/p60-226.pdf>. This 31% included individuals insured by Medicare, Medicaid, and veterans and military health care.

77. *Id.*

78. The Third Circuit describes Medicare as follows:

The federal Medicare program, administered by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services, is the largest public program financing health care services for the aged and disabled. Hospitals that provide services to Medicare patients are reimbursed for their expenses under Title XVII of the Social Security Act (the "Medicare Act"), 42 U.S.C. § 1395 *et seq.* Part A of the Medicare Act authorizes payment to participating hospitals ("providers") for their direct and indirect costs of providing inpatient care to beneficiaries. 42 C.F.R. § 413.9(a), (b). Medicare also reimburses teaching hospitals for the costs of graduate medical education, including physician time for instructing and supervising interns and residents. 42 U.S.C. § 1395ww(h).

Mercy Catholic Med. Ctr. v. Thompson, 380 F.3d 142, 144 (3d Cir. 2004).

79. DENAVAS-WALT ET AL., *supra* note 76, at 14.

80. Richard L. Kaplan, *Retirement Planning's Greatest Gap: Funding Long-Term Care*, 11 LEWIS & CLARK L. REV. 407, 422 (2007).

81. DENAVAS-WALT ET AL., *supra* note 76, at 14.

82. *Id.* at 14.

83. Hermer, *supra* note 75, at 17. Note that the employees are also not taxed for this valuable benefit. See also KAISER COMM'N PRIMER, *supra* note 75, at 2-3.

84. *Id.*

employment-based health insurance in 2003,⁸⁵ while others chose to provide their own coverage through direct-purchase plans. Direct-purchase health insurance is coverage through a plan purchased by an individual from a private company.⁸⁶ In 2003, 9.2% of the privately insured were covered by direct-purchase insurance.⁸⁷

Federal income tax subsidies, which allow individuals to deduct health benefit contributions⁸⁸ and health care expenses exceeding 7.5% of their adjusted gross income,⁸⁹ totaled approximately \$188.5 billion in 2004, more than was spent on the Medicare program that year.⁹⁰ Over one-fourth of these tax benefits inured to families with annual incomes of \$100,000 or more, who account for about 14% of the population.⁹¹ Although the federal government does not actually pay for this care, it permits the above deductions and hence a reduction in these taxpayers' tax bills, effectively shifting the cost to the federal government. Most people recognize that health care is government subsidized for the very poorest, but many do not realize that the federal government also subsidizes health care for people with greater than average incomes.

Federal and state governments are also the primary source for funding uncompensated care through a variety of programs.⁹² In 2004,

85. DENAVAS-WALT ET AL., *supra* note 76, at 14 fig.5.

86. *Id.* at 14.

87. *Id.* at 16 fig.5.

88. An employee is not subject to tax on the value of health insurance benefits provided by an employer. I.R.C. §§ 105(b), 105(g), 106(a) (2000). Internal Revenue Code § 106 excludes employer provided health care insurance from employer's income.

89. *See* I.R.C. § 213 (2000) (providing for a deduction of medical expenses not compensated for by insurance if the expenses exceed 7.5% of a person's adjusted gross income).

90.

The tax expenditure for health benefits is the amount of revenues that the federal government forgoes by exempting health benefits and spending from the federal income and Social Security taxes, including (1) employer health benefit contributions for workers and retirees, (2) health benefit deductions for the self-employed, (3) health spending under flexible spending plans, and (4) the tax deduction for health expenses . . . Families with incomes of \$100,000 or more (14 percent of the population) account for 26.7 percent of all health benefit tax expenditures.

John Sheils & Randall Haight, *The Cost of Tax-Exempt Health Benefits in 2004*, HEALTH AFFAIRS W4-106, W4-106 (Web Exclusive, Feb. 25, 2004), <http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.106v1.pdf>.

91. *Id.*

92. JACK HADLEY & JOHN HOLAHAN, KAISER COMM'N ON MEDICAID AND THE UNINSURED, *THE COST OF CARE FOR THE UNINSURED: WHAT DO WE SPEND, WHO PAYS, AND WHAT WOULD FULL COVERAGE ADD TO MEDICAL SPENDING?* 3 (2004), <http://www.kff.org/uninsured/upload/The-Cost-of-Care-for-the-Uninsured-What-Do-We->

the federal government paid for roughly 85%, or \$34.6 billion, of uncompensated care provided by hospitals.⁹³ In one such program, the federal Medicaid Disproportionate Share Hospital Payment Program (“DSH”), payments totaled \$17.4 billion in 2004.⁹⁴ DSH payments are paid to hospitals that serve a disproportionate number of Medicaid patients because of the areas in which the hospitals are located. DSH payments aim to offset the low, discounted rates that these hospitals receive for treating Medicaid patients. State Medicaid DSH payments totaled \$1.8 billion for the same year.⁹⁵ Payments totaling \$7.9 billion were also made to hospitals from state and local tax appropriations for their provision of charity care.⁹⁶

Direct service programs on the federal level also funded care for the uninsured, paying \$6.1 billion to health care providers for uncompensated medical care, and state direct service programs paid \$1.4 billion in 2004.⁹⁷ Medicare also ensures that health care providers are credited for unpaid, uncollectible Medicare deductibles or co-insurance, if providers make reasonable collection efforts.⁹⁸

The value of the uncompensated care that is federally subsidized through direct programs, such as DSH, and through hidden subsidies calls into question the level of discount hospitals offer to governmental and private insurers. Artificially high list prices could not have been designed merely to overcharge the uninsured. Some authors postulate that hospitals purposely inflate these fee schedules to maximize returns not only from the uninsured, but also on all discounted rates.⁹⁹ One hospital’s chief financial officer commented:

For some payors and for some services, “usual, customary, and reasonable” limits do not exist. Often an insurer that does not have a contract with a

Spend-Who-Pays-and-What-Would-Full-Coverage-Add-to-Medical-Spending.pdf.

93. *Id.*

94. *Id.* The fact that a high percentage of Medicare patients require additional funding for hospitals lends support to the idea that the reimbursement rates by these Medicare and Medicaid funding may be too low. Hermer, *supra* note 75, at 74 (citing Theresa A. Coughlin et al., *States' Use of UPL and DSH Financing Mechanisms*, 23 HEALTH AFFAIRS, 245, 246-47 (2004), available at <http://content.healthaffairs.org/cgi/content/full/23/2/245>).

95. HADLEY & HOLAHAN, *supra* note 92, at 3 fig.3.

96. *Id.*

97. *Id.*

98. Nation III, *supra* note 61, at 121 (citing 42 C.F.R. § 413.80(e)(2)).

99. See, e.g., Mark A. Hall, *Paying for What You Get and Getting What You Pay for: Legal Responses to Consumer-Driven Health Care*, LAW & CONTEMP. PROBS., Autumn 2006, at 159; Barry F. Rosen & Christopher D. Scott, *Back to the Future – Are Tax-Exempt Hospitals Headed for the Good Old Days?*, MD. BAR J., March/April 2006, at 35.

provider or that pays a percentage of charges will have to pay the hospital in proportion to its charges. Therefore, the higher the hospital's charge, the higher the payment. Because of this reality, charges for many hospitals are irrationally high and not based on underlying costs, relative value units or a reasonable multiple of a standard fee schedule, such as Medicare. Charges are set artificially high to maximize payments.¹⁰⁰

The fact that the federal government offers incentive payments to hospitals that care for a disproportionate share of Medicare and Medicaid patients is some evidence that the discount rate is too low.

Our current health care payment scheme has evolved to a point where the federal government is responsible for protecting the health of the elderly through Medicare and the very poor through Medicaid. The federal government also provides tax incentives to employers that offer health insurance to their workers, helping to ensure coverage for a majority of workers. Other laws prohibit denying an uninsured at least some minimal form of emergency treatment if needed.¹⁰¹

III. THE CURRENT HEALTH CARE PAYMENT SYSTEM'S INEQUITIES AND INEFFICIENCIES

The inequities of the list price, in combination with other anomalies in our health care payment system, place the most substantial burden on the uninsured. So who are the ones left without health care coverage in the United States? The uninsured are not likely to be the poorest, and are not divided evenly by age, race, or geographic location. They are most likely to be the young and the working poor. The lack of access to health care, and the exorbitant prices often charged when they access the health care system, point to the system's inequities. The inefficiencies of the system were caused, in many cases, by efforts to help solve the inequities. In addition, promised efficiencies stemming from open competition in the health care system have not been realized.

A. Inequities of the List Price

Charging patients who are least likely to be able to pay many times the cost of what is normally expected for the same service is, on its face, unethical. It is well documented that much of this debt remains

100. Ray B. Lefton, *What's It Worth?*, HEALTHCARE FIN. MGMT., Dec. 2003, at 61.

101. See discussion of EMTALA *infra* Part III.C.

uncollected.¹⁰² According to the American Hospital Association, debt from un-reimbursed care totaled \$22.3 billion at 4927 United States hospitals in 2002.¹⁰³ According to a leading health care lawyer, “[h]ospitals typically write off 70% of self-pay revenue to bad debt, and collect only 30%. . . . If they do it right, they can flip those numbers.”¹⁰⁴ Other sources report that as little as 10% of this debt is collectible.¹⁰⁵

Hospitals also report, however, that self-paying patients, a tiny portion of their total patients, account for a disproportionate amount of their “profits.”¹⁰⁶ Counting on the uninsured to support the bottom line by paying the highest rate of any patients serves to make access to health care even more difficult, and ultimately less effective, for people who cannot afford health insurance. Uninsured people often can afford less treatment, and may defer treatment until later stages of a disease’s progression, often resulting in the most expensive and least efficient way to treat health care problems.¹⁰⁷

The inflated bills to the uninsured are not the only debts that may be uncollected and written off by health care providers. Adding in other forms of payment made directly by patients, including insured patients’

102. See, e.g., Edward J. Larson & Marc Dettmann, *The Impact of HSAS on Health Care Reform: Preliminary Results After One Year*, 40 WAKE FOREST L. REV. 1087, 1121 (2005); Nina J. Crimm, *Do Fiduciary Duties Contained in Federal Tax Laws Effectively Promote National Health Care Policies and Practices?*, 15 HEALTH MATRIX 125, 142 n.66 (2005); Robin Locke Nagele & Catherine A. Pajakinas, *Charity Care Class Action is Denied Federal Status*, HEALTH LAW., Mar. 2005, at 1, 3.

103. AHC Media LLC, *Are Nonprofit Hospitals Preying on the Uninsured?*, MED. ETHICS ADVISOR, Dec. 2004, available at http://www.ahcpub.com/hot_topics/?htid=1&htid=1610.

104. Chris Rauber, *Chain Reactions*, HEALTHLEADERS, Aug. 2003, (quoting Michael Zimmerman, the “CEO of Hales Corners . . . , a revenue-cycle-management consulting, research and publishing company”) available at http://www.healthleadersmedia.com/magazine/view_magazine_feature.cfm?content_id=4730 2.

105. Jonathan Maze, *Hospitals Under Assault over Billing of Uninsured Patients*, THE POST & COURIER (Charleston, S.C.), Sept. 11, 2004, at 1A.

106. Both for-profit and not-for-profit hospitals appear to count on self paying patients for their “profits,” simply meaning the amount of funds remaining after all expenses have been paid. “Data from one California hospital system showed that, although uninsured and walk-in patients accounted for less than two percent of the patient population, they accounted for as much as thirty-five percent of the chain’s total profits.” E. Haavi Morreim, *Consumer-Defined Health Plans: Emerging Challenges from Tort and Contract*, 39 J. HEALTH L. 307, 342 (2006).

107. Wolman & Miller, *supra* note 70, at 399. This is likely due to their ability to access health care professionals without providing proof or ability to pay because the federal law forbids hospitals turning away patients in certain emergency situations. Gunnar, *supra* note 2, at 155.

deductibles and bills exceeding a patient's coverage, hospitals wrote off approximately \$22 billion in 2003.¹⁰⁸ The remarkably high default rate alone reveals that our health care payment system has serious structural issues.

B. Who are the Uninsured?

In 2004, 45.8 million people in the United States (15.7% of the population) did not have health insurance for the entire year.¹⁰⁹ This is an increase from 2002, when 43.6 million Americans were without health insurance.¹¹⁰ Many of these uninsured people sought and received some form of medical treatment.

In 2004, a total of \$1.5 trillion was spent on health care.¹¹¹ Uncompensated medical care represented 2.7% of the total amount spent on health care.¹¹² This uncompensated care makes up over \$40 billion, or one-third, of medical care provided to the uninsured.¹¹³ Adults who were uninsured for the full year received 65%, or \$26.3 billion, of uncompensated care.¹¹⁴ Children who were uninsured for the full year received \$3.6 billion in uncompensated medical care.¹¹⁵

1. Demographics of the Uninsured

If so many U.S. citizens of limited means have some access to health care through a federal, state, or local program, then who are the uninsured? Health care coverage is not equally distributed among the various racial and cultural groups in the United States. Many scholars have reported on the disparities in medical treatment in the United States based on race; access to health care insurance is only one small part of this problem.¹¹⁶ In 2003, Hispanics were more likely to be uninsured

108. Rauber, *supra* note 104. The underinsured may be insured, but may have used up the extent of their benefits; or, alternatively may be insured at the outset of an illness, but may lose coverage due to their inability to work and then become uninsured. Mary Crossely, *Discrimination Against the Unhealthy in Health Insurance*, 54 U. KAN. L. REV. 73, 147-48 (2005).

109. DENAVAS-WALT, ET AL., *supra* note 76, at 16.

110. *Id.* at 14.

111. HADLEY & HOLAHAN, *supra* note 92, at 2.

112. *Id.*

113. *Id.*

114. *Id.*

115. HADLEY & HOLAHAN, *supra* note 92, at 2 fig.2.

116. See, e.g., Lisa C. Ikemoto, *In the Shadow of Race: Women of Color in Health*

than any other racial group.¹¹⁷ Approximately 13.2 million Hispanics were without health insurance in 2003.¹¹⁸ This is an increase from 2002, when 12.8 million Hispanics were without health insurance.¹¹⁹ Approximately 32.7% of Hispanics were uninsured, as opposed to 19.6% of blacks¹²⁰ and 14.6% of whites.¹²¹

Younger Americans are more likely to be uninsured than other Americans. More people ages 18-24 were uninsured than any other age group;¹²² 30.2% of the people in this age group were uninsured in 2003.¹²³ People aged 25-34 are also highly likely to be uninsured, with about 26.4% having no coverage in 2003.¹²⁴ Children under the age of 18 are also more likely to be uninsured, even in spite of the many federal and state programs created to provide health care coverage for children;¹²⁵ about 11.4% of children under the age of 18 were uninsured in 2003.¹²⁶ It is difficult to calculate how many people could have afforded health insurance but chose to remain uninsured. This practice appears to be more common among younger Americans, who may have more of a sense of invulnerability to disease and age.

The number of uninsured people also varies according to geographic region of the nation. The South had the highest proportion

Disparities Policy, 39 U.C. DAVIS L. REV. 1023 (2006); Mary Crossley, *Infected Judgment: Legal Responses to Physician Bias*, 48 VILL. L. REV. 195 (2003); Michael S. Shin, *Redressing Wounds: Finding a Legal Framework to Remedy Racial Disparities in Medical Care*, 90 CAL. L. REV. 2047 (2002); M. Gregg Bloche, *Race and Discretion in American Medicine*, 1 YALE J. HEALTH POL'Y L. & ETHICS 95 (2001); René Bowser, *Racial Profiling in Health Care: An Institutional Analysis of Medical Treatment Disparities*, 7 MICH. J. RACE & L. 79 (2001); Barbara A. Noah, *Racial Disparities in the Delivery of Health Care*, 35 SAN DIEGO L. REV. 135 (1998).

117. DENAVAS-WALT ET AL., *supra* note 76, at 15.

118. *Id.*

119. *Id.*

120. These are the terms used to identify these populations in the original sources.

121. DENAVAS-WALT ET AL., *supra* note 76, at 15.

122. *Id.*

123. *Id.*

124. *Id.* Of course, some of these people can afford health insurance and choose instead not to pay for it. This phenomenon is especially prevalent among young adults.

125. For example, the State Children's Health Insurance Program provides matching federal funds to states that provide health insurance coverage for uninsured children. The Balanced Budget Act provided \$40 billion over ten years to help states expand health care to children. 42 U.S.C. § 1397dd (2000) (amended by Pub. L. No. 106-554, 114 Stat. 2763 (2000)), *cited in* Sean A.C. Courtney, *Children's Health Insurance Program in Mississippi: Enrollment Barriers and Opportunities for Increased Access*, 70 MISS. L.J. 983, 984-85 (2001).

126. DENAVAS-WALT ET AL., *supra* note 76, at 15.

of uninsured in 2003, with 18% of people lacking health insurance.¹²⁷ The Midwest, with 12% of its population uninsured, had the lowest rate of uninsured people.¹²⁸

Economics are also an indicator of who is likely to be uninsured. Households with less than \$25,000 in annual income were less likely to have health insurance than any other income bracket; approximately 24.2% of people making \$25,000 a year or less were uninsured in 2003.¹²⁹ Surprisingly, more than eight out of ten uninsured come from working families with one or more full time workers.¹³⁰ Families with part-time workers made up about 12% of the uninsured, and families with no working members made up about 19% of the uninsured.¹³¹ The people most likely to be without health insurance are also less likely to be politically powerful. People who lack health coverage, or lack consistent health coverage, not only receive worse health care, but also as a group have poorer health.¹³²

2. *Bankruptcy Issues of the Uninsured*¹³³

Although they may not qualify for a government-funded health insurance plan, many uninsured families of limited means also have financial difficulty paying other monthly bills.¹³⁴ The addition of medical bills to these families' debts may create serious financial constraints for them. When medical bills are not paid, hospitals and doctors often turn the debt over to a collection agency, which may harm a person's credit history.¹³⁵ This damage to their credit will further interfere with their ability to pay, as he or she will then likely pay higher interest rates in the unlikely event they are able to secure financing to pay these debts. About 23% of uninsured people in 2003 reported they were contacted by a collection agency.¹³⁶

127. *Id.*

128. *Id.*

129. *Id.*

130. KAISER COMM'N PRIMER, *supra* note 75, at 4.

131. *Id.* at 19.

132. Hermer, *supra* note 75, at 2-3.

133. The academic discussion of health care costs and bankruptcies is largely based upon the pre-2005 Bankruptcy Code analysis and issues. Prospectively, these problems may be further exacerbated by changes in the laws that make individual Chapter 7 bankruptcy more difficult.

134. KAISER COMM'N PRIMER, *supra* note 75, at 8.

135. *Id.*

136. *Id.*

Uninsured and underinsured patients make up a substantial portion of the many people who seek protection of the bankruptcy laws in the United States.¹³⁷ In 2001, approximately 1.5 million bankruptcy petitions were filed.¹³⁸ Medical reasons contributed to roughly half of all personal bankruptcies filed in the United States in 2001, according to a study by Harvard University's law and medical schools.¹³⁹ This represented a substantial increase from just two years prior, when a similar 1999 study revealed that only 25% of the respondents had indicated that medical reasons led to their bankruptcy.¹⁴⁰

In another 2001 study, 1771 personal bankruptcy filers in five federal courts answered a questionnaire regarding their reasons for filing bankruptcy.¹⁴¹ Almost half of them indicated that medical problems led to their bankruptcy.¹⁴² More than one-fourth said illness or injury was the specific reason for filing bankruptcy.¹⁴³ A lapse of insurance during a medical problem was also responsible for many bankruptcy filings; slightly over 38% of those who filed bankruptcy because of major medical problems experienced a lapse in their medical insurance.¹⁴⁴

Other uninsured patients who cannot pay their medical bills may not file for bankruptcy, but may be deemed "judgment-proof" and may not be pursued for payment.¹⁴⁵ These losses might also be written off by a hospital. The greater these patients' hospital bills are inflated, the greater the benefit will be to the hospital at tax time, or when calculating a hospital's charitable contributions to the community.

People forced into bankruptcy after suffering an injury or illness are likely to default not only on their obligations to pay their medical bills,

137. The effect of being uninsured and the interaction between hospital charges and bankruptcy is not clear. Multiple other factors must be considered in attempting to establish any causal connection. A recent empirical study revealed that there are factors beyond hospital overcharging that contribute to the intersection of these issues. See Melissa B. Jacoby & Elizabeth Warren, *Beyond Hospital Misbehavior: An Alternative Account of Medical-Related Financial Distress*, 100 NW. U. L. REV. 535 (2006).

138. David U. Himmelstein et al., MarketWatch: Illness and Injury as Contributors to Bankruptcy, HEALTH AFFAIRS W5-63, W5-63 (Web Exclusive, Feb. 2, 2005), <http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.63v1.pdf>.

139. *Id.*

140. Elizabeth Warren et al., *Medical Problems and Bankruptcy Filings*, Norton Bankruptcy Law Adviser (May 2000).

141. See Jacoby & Warren, *supra* note 137, at 545.

142. Himmelstein et al., *supra* note 138, at W5-63.

143. *Id.* at W5-67.

144. *Id.*

145. It may make little sense for judgment proof debtors to file bankruptcy at all. Susan Kovac, *Judgment-Proof Debtors in Bankruptcy*, 65 AM. BANKR. L.J. 675, 751 (1991).

but on their other unsecured obligations as well. Unsecured creditor debts are likely to be scheduled in bankruptcy filings precipitated by a person's lack of health insurance, adding additional costs to society due to his or her lack of healthcare coverage. Creditors usually write off these additional debts, further increasing indirectly the federal government's burden for costs accrued by the uninsured due to their lack of health care coverage.

C. Competition in the Health Care System has not Produced a More Efficient System

Conversion of many health care insurers and providers from not-for-profit to for-profit entities was implemented in part to realize the benefits and cost savings inherent in a free market system. The economies of scale and other efficiencies of large for-profit health care providers apparently have not driven down the cost of health care. Health care premiums have continued to rise faster than the rate of inflation.¹⁴⁶ The effects of an invisible hand controlling the costs of health care have not been realized in this nation's health care payment systems.

1. System-Wide, Cost Control has not Benefited from Competition.

The consumer price index rose 26% between the years of 1992 and 2001; during that same period, the increase for medical services increased by about 47%.¹⁴⁷ While that comparison alone is intriguing, during that same time, the cost of cosmetic surgery, largely excluded from third party payer benefit plans and of limited availability, increased by only 16%.¹⁴⁸ The laws of supply and demand do not appear to be functioning efficiently among third-party payers in our current health care payment system.

In spite of concerns about the financial health of our health care system and concern over rapidly rising prices, it may be surprising to learn that the profits for health insurance providers and HMOs actually have risen in recent years. In 2004, six of the seven largest health

146. Hermer, *supra* note 75, at 29.

147. DEVON HERRICK, NATIONAL CENTER FOR POLICY ANALYSIS, WHY ARE HEALTH COSTS RISING? 1 (2003) <http://www.ncpa.org/pub/ba/ba437/ba437.pdf>.

148. *Id.*

insurers experienced an increase in profits.¹⁴⁹ CIGNA and Aetna, two of the largest providers, saw increases of 128% and 136%, respectively.¹⁵⁰ Highmark, Inc., a leading health insurer in the Pittsburgh area, saw its profits nearly triple that same year.¹⁵¹ Highmark's overall profits reached \$310.5 million in 2004.¹⁵²

According to Weiss Ratings, Inc., a consumer advocacy organization, HMOs also experienced an increase in their profits. In the first half of 2004, HMOs earned \$5.8 billion.¹⁵³ This represents a 31.9% increase over their profits in the first half of 2003.¹⁵⁴

Of all the uninsured patient costs to hospitals, 35% are paid by the uninsured patients out-of-pocket.¹⁵⁵ Services for which payment has not been received are then labeled as uncompensated care. It is estimated that government spending already covers about 85% of these costs, or \$34.6 billion, through the various direct and indirect programs mentioned previously.¹⁵⁶ This share is likely to increase as more uninsured Americans utilize the nation's emergency rooms as their only access to a health care provider.¹⁵⁷

In 2001, over 60% of uncompensated care was provided in hospitals.¹⁵⁸ The remaining care was provided almost equally by office-based physicians and direct care programs and clinics.¹⁵⁹ Direct service programs provided roughly 19% of uncompensated care and are partly supported by government funds, but not to the same extent as hospitals.¹⁶⁰ They received less than \$8 billion in 2004.¹⁶¹

149. Robert Kazel, *Managed Care Profits Up, Optimism for 2005 Strong*, AMER. MED. NEWS, Feb. 28, 2005, available at <http://www.ama-assn.org/amednews/2005/02/28/bisc0228.htm>.

150. *Id.*

151. Christopher Snowbeck, *Health Insurer Profits Triple: Highmark's Higher Returns Accompanied Higher Health Costs for Many Consumers*, PITTSBURGH POST-GAZETTE, Mar. 24, 2005, at A1, available at <http://www.post-gazette.com/pg/05083/476795-28.stm>.

152. *Id.*

153. Weiss Ratings Inc., *50% of HMOs Financially Strong as Profitability Continues*, http://www.weissratings.com/News/Ins_HMO/20050207hmo.htm (last visited Nov. 1, 2007).

154. *Id.*

155. KAISER COMM'N PRIMER, *supra* note 75, at 8.

156. *Id.* at 9.

157. Most hospitals are prohibited from turning away a patient who presents with an emergency condition but is unable to pay for medical care. Stephanie B. Livesay, Note, *The New EMTALA Regulations: The Wrong Prescription for Emergency Department Congestion*, 3 APPALACHIAN J. L. 139, 139 (2004).

158. HADLEY & HOLAHAN, *supra* note 92, at 3.

159. *Id.*

160. *Id.*

161. *Id.*

The fact that many uninsured patients start out insured, and later must personally pay for health care if they lose their job or reach the limits of their policy coverage, makes calculating the payment inequity for uninsured patients difficult.¹⁶² Often a catastrophic illness will result in the loss of a job, which then results in the loss of health insurance coverage. Despite the opportunity to maintain continuous coverage while employed, pursuant to HIPAA,¹⁶³ and after the loss of employment, pursuant to COBRA,¹⁶⁴ many are still financially unable to take advantage of such an opportunity, especially those who are unemployed for an extensive period.

2. *Delays in Treatment Result in an Inefficient Use of Health Care Funds*

Many uninsured patients with minor medical problems delay treatment, hoping that their medical needs will disappear, or they may wait until the condition is emergent.¹⁶⁵ Non-elderly insured people generally had more than twice the amount of medical bills as uninsured people in 2004.¹⁶⁶ Per capita, insured patients incurred \$2975 in medical care costs while uninsured people incurred \$1629. People without health care are either remarkably healthy as a group, or are foregoing or delaying treatment.

The federal statute prohibiting most hospitals from turning away patients who lack an ability to pay but present at emergency rooms makes these facilities the only available health care provider for many uninsured.¹⁶⁷ Many of these emergency room patients will never pay

162. Insured patients may also exhaust the limits of their coverage, making a portion of their expenses uninsured. Melnick Statement, *supra* note 62.

163. "The Health Insurance Portability and Accessibility Act (HIPAA) bans outright refusal of coverage to those seeking coverage in a group plan and significantly curtails the use of preexisting condition restrictions." Hermer, *supra* note 75, at 12 (citing 42 U.S.C.A. § 300gg-41(a)(1) (West 2005)).

164. The Consolidated Omnibus Budget Reconciliation Act, commonly referred to as COBRA, is federal legislation that mandates continuation of coverage under group health plans for employees and their dependents who lose coverage by termination of employment or otherwise. André Hampton, *Markets, Myths, and a Man on the Moon: Aiding and Abetting America's Flight from Health Insurance*, 52 RUTGERS L. REV. 987, 1004 n.75 (2000).

165. Gunnar, *supra* note 2, at 155.

166. *Id.* at 154.

167. The Emergency Medical Treatment and Active Labor Act (EMTALA) was enacted by Congress in 1986 as an attempt to reduce patient dumping, the practice of refusing to treat uninsured patients. Under EMTALA, a hospital must provide any patient presented to the emergency department with an appropriate medical screening, stabilizing treatment if any, and

their resulting medical bills, as they may be judgment proof and refuse to pay, or will be forced into bankruptcy by impossibly high debt.¹⁶⁸ There is little incentive for hospitals to reduce the list price of treatments for which they will never receive payment, yet these prices are not grounded in any real sense of the actual cost or prevailing market rate of these treatments. The ability to write off these debts, however, does provide incentive to further inflate the list prices and hence the uncollectible bills. Although it may seem that the inflation of these bills is relatively harmless, as these debts will not likely be collected, this shifts the cost for this highly inefficient care to the federal government.¹⁶⁹

Patients who utilize emergency rooms in this manner either squander the resources of an expensive treatment facility for less than emergent conditions, or perhaps have waited until a condition that could have been treated in a prophylactic manner by a primary care physician becomes an actual emergency.¹⁷⁰ Either use is a waste of the nation's health care resources.

People without health insurance also receive less preventive care than those with insurance. These people are often diagnosed later, at a time when a disease is at a more advanced stage.¹⁷¹ Once diagnosed, those without insurance receive less therapeutic care and have higher mortality rates than those with insurance.¹⁷² EMTALA might have been effective in stopping the practice of "patient dumping," but a more

an appropriate transfer under certain circumstances.

An appropriate medical screening must be provided to determine whether an emergency medical condition exists. A hospital fulfills this requirement if it provides the same treatment to one patient as it would to any other patient similarly situated. If an emergency medical condition is found, the hospital must provide the patient with stabilizing treatment. Stabilizing treatment must assure, within a reasonable medical probability, that further deterioration of the emergent condition is prevented. Finally, a hospital may transfer the patient to another medical facility if the transfer is approved by the accepting facility and all necessary medical records are sent to the accepting facility. Qualified personnel with appropriate medical equipment reasonably necessary for a safe transfer must conduct the transfer. Unfortunately, many people without health insurance misuse hospital emergency departments and EMTALA. Because hospitals are required to provide them with a basic amount of medical care, uninsured people misuse the hospital emergency department to receive primary care and not emergency care. See Livesay, *supra* note 157, at 139-43.

168. See Jacoby & Warren, *supra* note 137, at 535.

169. This practice may also shift these debts to the various state and local governments that offer tax incentives to health care providers that render charitable services.

170. For a physician's perspective, see Gunnar, *supra* note 2, at 152-54.

171. HADLEY & HOLAHAN, *supra* note 92, at 4.

172. *Id.*

efficient method of providing basic health care for the uninsured could save the government significant money, considering the cost of treating patients in an emergency room.¹⁷³

IV. FIXING THE IMMEDIATE CONCERN OR THE UNDERLYING PROBLEM

Adoption of a single payer system would be the optimal approach for solving not only the problems of the uninsured, but for realizing greater efficiency, cost savings, and fair access to health care. Although other countries have managed to move from a private system to a single payer system, this is unlikely to occur in the United States until our current system suffers nearly complete collapse.¹⁷⁴ In the meantime, many patches to our current system have been instituted with various degrees of success, but we are only prolonging the eventual collapse with temporary fixes.

A. *Is Any Plan of Universal Health Care Possible in the United States?*

Until recently, hospitals have been unwilling to adjust their list rates to reflect the actual value of services rendered to uninsured patients. Recent bad press about this practice has given many Americans pause to consider the inequities in our entire health care payment system.¹⁷⁵ Many scholars believe the best solution would be to create a national health insurance plan.¹⁷⁶ One commentator estimates that, by providing health care coverage to people who had been without

173. There were cases of seriously hurt people being turned away from hospitals for their lack of ability to pay; Congress quickly passed EMTALA in response to these horrible stories of people being allowed to die, or of women in labor forced to travel great distances to find help for their immediate needs. *Baber v. Hosp. Corp. of Am.*, 977 F.2d 872, 879-80 (4th Cir. 1992). This need might have coincided with the end of many hospitals obligations to provide free health care under the Hill-Burton Act, which provided financing for the construction of hospitals with an obligation to provide health care services for the needy. See David E. Mitchell, Recent Decision, *EMTALA's Stabilization Requirement Does not Require Proof of Improper Motive: Roberts v. Galen of Virginia*, 38 DUQ. L. REV. 163, 167-68 (1999).

174. See Gawande, *supra* note 24.

175. See, e.g., MSNBC.com, *Uninsured Patients Pay More for Care: Hospitals Charge Up to Four Times More for Services, Experts Say*, <http://www.msnbc.msn.com/id/5290172/> (last visited Nov. 1, 2007); David Lazarus, *Uninsured Patient Billed More than \$12,000 for Broken Rib*, S.F. CHRON., Mar. 30, 2007, at C1.

176. See TIMOTHY STOLTZFUS JOST, *DISSENTLEMENT? THE THREATS FACING OUR PUBLIC HEALTH-CARE PROGRAMS AND A RIGHTS-BASED RESPONSE* (2003); Hampton, *supra* note 164, at 987; M. Gregg Bloche, *Trust and Betrayal in the Medical Marketplace*, 55 STAN. L. REV. 919 (2002).

insurance for a full year, the average spending per person on health care would increase by approximately 70%, from \$1629 to \$2768.¹⁷⁷ This would increase medical care spending by a total of \$48 billion.¹⁷⁸ It is unclear how much of the uncompensated medical care is already written off without being added to these estimates of the federal government's current burden for such costs. Other savings could be realized by encouraging treatment in primary care clinics instead of emergency rooms.

Universal access to health care can improve the population's health by providing preventive care and early diagnosis of disease.¹⁷⁹ This could avoid having to spend greater amounts of money to treat a condition that has advanced to a more severe and costly stage. In turn, patients would receive therapeutic care, possibly lowering mortality rates. Conservative estimates indicate that nationwide health insurance could offer a 5-15% reduction in mortality rates.¹⁸⁰

Spending the additional \$48 billion needed to provide nationwide health insurance is a small amount compared to the amount the federal government already spends on health care. Medicare cost approximately \$266.4 billion in 2004, and Medicaid cost \$280.7 billion.¹⁸¹ As previously stated, the tax subsidy for private insurance cost the federal government an estimated \$188.5 billion in 2004.¹⁸² Putting these dollar figures into perspective, the additional \$48 billion would increase the share of the GDP already going to health care by only 0.4%.¹⁸³

Proponents of universal health care look to existing models in Canada and in Europe to support adoption of such a system in the United States. In Germany, the government achieves universal healthcare by obligating its citizens to secure public insurance coverage, typically provided for by a deduction from their earnings, based on their income and not on their health risk or family size. People whose income falls below a certain range must purchase this insurance. People with higher incomes may elect a private insurance plan, although about 60% of them still choose the public plan anyway.¹⁸⁴ Health expenditures in European

177. HADLEY & HOLAHAN, *supra* note 92, at 5.

178. *Id.*

179. Hermer, *supra* note 75, at 3.

180. HADLEY & HOLAHAN, *supra* note 92, at 6.

181. *Id.*

182. *Id.* (citing Sheils & Haught, *supra* note 90, at W4-106).

183. HADLEY & HOLAHAN, *supra* note 92, at 6.

184. Timothy Stoltzfus Jost, *Why Can't We Do What They Do? National Health Reform Abroad*, 32 J.L. MED & ETHICS 433, 433-34 (2004).

countries are about half of what is spent on health care in the United States per capita (as expressed as a percentage of GDP), yet life expectancy in the United States is lower than in the United Kingdom, Sweden, Germany, and the Netherlands. Infant mortality rates in the United States also exceed those in the countries mentioned above.¹⁸⁵

Those who claim that Americans would be unwilling to give up the “best health care” available to adopt universal health care may be making such a claim under a false premise. Although Americans with limitless resources may be able to get the best care available, the health care that most Americans receive is actually inferior in many respects to that of other countries, notwithstanding that the United States spends about twice as much as any other nation per capita on health care.¹⁸⁶ In spite of our willingness to spend more per capita on health care, we rank poorly as measured against other leading nations on factors such as quality of care, access to care, efficiency, and equity.¹⁸⁷ In 2000, the World Health Organization’s World Health Report ranked U.S. health care thirty-seventh in the world.¹⁸⁸

Creating a universal health care scheme that provides coverage for the uninsured may further distort the current scheme by reducing the need for people to self insure or to provide insurance for their employees. This would be another temporary fix to our health care

185. *Id.* at 435. Per capita health care spending in 1992 was between 69% and 174% higher than that of other “developed” nations, when the United States ranked eighteenth for life expectancy for females and twenty-third for males. Roche, *supra* note 2, at 1014. In 2000, the United States ranked twenty-fourth according to the World Health Organization. Press Release, World Health Org., WHO Issues New Healthy Life Expectancy Rankings: Japan Number One in New ‘Healthy Life’ System (June 4, 2000), *available at* <http://www.who.int/inf-pr-2000/en/pr2000-life.html>.

186. The countries compared were Australia, Canada, Germany, New Zealand and the United Kingdom, countries that all have a form of universal health care coverage. KAREN DAVIS ET AL., MIRROR, MIRROR ON THE WALL: AN INTERNATIONAL UPDATE ON THE COMPARATIVE PERFORMANCE OF AMERICAN HEALTH CARE, 5 (2007) *available at* http://www.commonwealthfund.org/usr_doc/1027_Davis_mirror_mirror_international_update_final.pdf?section=4039.

187. *Id.*

188. WORLD HEALTH ORGANIZATION, THE WORLD HEALTH REPORT 2000—HEALTH SYSTEMS: IMPROVING PERFORMANCE 155 (2000) *available at* http://www.who.int/whr/2000/en/whr00_en.pdf. One author describes rationing as “an action undertaken where there is: (a) a recognition that resources are limited, and (b) when faced with scarcity, a method that must be devised to allocate fairly and reasonably those resources. Rationing is the effort to distribute equitably scarce resources.” Daniel Callahan, *Symbols, Rationality, and Justice: Rationing Health Care*, 18 AM. J.L. & MED. 1, 3 (1992). This definition certainly covers the efforts of managed care organizations to contain costs some fifteen years after this article was written.

payment scheme, as the economics would shift with the unwillingness of some people to pay for their own insurance. A more sensible approach is the adoption of a single payer system.

Critics of single payer plans note that rationing of health care occurs in countries using single payer systems, and that people in the United States will not tolerate such a practice.¹⁸⁹ Other critics observe that, with the limited health care resources available, rationing in the United States is already occurring based on one's ability to pay.¹⁹⁰ Payment for health care in a single payer system is generally based on cost effectiveness of the treatment. With about 95% of United States citizens receiving health care as an employment benefit, Americans are already experiencing medical care rationing.¹⁹¹ Managed care plans routinely limit a patient's access to drugs, medical tests, medical procedures, levels of mental health treatment, and other treatment based on its cost, not on a particular patient's treatment choice.

B. Efforts to Address the Disparate Pricing Scheme in the Interim

Although emblematic of a deeper issue, some people have recently begun to address the inequitable treatment of the uninsured through litigation and legislation. Lawyers have challenged the practice of billing the uninsured at inflated rates, states have passed laws to curtail the practice, and some hospital chains have changed their pricing structure in response to condemnation of the practice. Although adoption of a single payer universal health care system would remedy this issue, as well as the systematic problems, the efforts to remedy the immediate issue also highlight the problems inherent in the system.

1. Lawsuits Challenging Uninsured Inequalities

Creative lawyers have directly challenged, with little success, the practice of overcharging uninsured patients based upon a hospital's not-for-profit status. Most of these claims in federal courts have been dismissed. Most of this litigation has centered on the failure of not-for-

189. Kimberly A. Jones & Tricia M. Smith, *Health Care Reform: An Analysis of Potential Models*, 3 KAN. J.L. & PUB. POL'Y 63, 68-69 (1993).

190. Posting of Jonathan Cohn to TPMCafe, <http://www.tpmcafe.com/node/26805> (Feb. 27, 2006, 11:00 EST) ("Try getting a colonoscopy at County Hospital in Los Angeles if you have no insurance.").

191. People who pay for care themselves, as well as those beneficiaries of government health care plans, also are experiencing medical care rationing. Hermer, *supra* note 75, at 29.

profit hospitals to provide adequate, or sometimes any, charitable care for those in their community unable to pay for health care.¹⁹² Not-for-profit hospitals gain their tax-exempt status for serving a public interest rather than a private interest.¹⁹³ Merely being not-for-profit is insufficient to attain and maintain tax-exempt status, as “the status of each nonprofit hospital is determined on a case-by-case basis by the IRS.”¹⁹⁴ The lawsuits claim, in part, that the hospital has a duty to perform work in the community interest, including treating uninsured patients for reasonable fees.¹⁹⁵

Since June of 2004, attorneys all over the country have initiated lawsuits against not-for-profit hospitals, alleging that they have overcharged uninsured patients, violating their tax-exempt status.¹⁹⁶

192. Leah Snyder Batchis, Comment, *Can Lawsuits Help the Uninsured Access Affordable Hospital Care? Potential Theories for Uninsured Patient Plaintiffs*, 78 TEMP. L. REV. 493, 505-06 (2005).

193. I.R.C. § 1.501(c)(3)-1(d)(1)(ii) (2000); Restatement (Second) of Trusts § 372 cmt. b (1959).

194. *Simon v. E. Ky. Welfare Rights Org.*, 426 U.S. 26, 29 (1976).

195. Batchis, *supra* note 192, at 523-24.

196. For cases dismissing federal claims, see *Grant v. Trinity Health-Mich.*, 390 F. Supp. 2d 643, 658 (E.D. Mich. 2005); *Hutt v. Albert Einstein Med. Ctr.*, No. 04-03440, 2005 U.S. Dist. LEXIS 21548, at *6 (E.D. Pa. Sept. 28, 2005); *Feliciano v. Thomas Jefferson Univ. Hosp.*, No. 04-CV-04177, 2005 U.S. Dist. LEXIS 21565, at *21 (E.D. Pa. Sept. 28, 2005); *McCoy v. E. Tex. Med. Ctr. Reg'l Healthcare Sys.*, No. 2:04-CV-223, 2005 U.S. Dist. LEXIS 19416, at *29-30 (E.D. Tex. Aug. 31, 2005); *Nash v. Lee Mem'l Health Sys.*, No. 204CV369FTM29DNF, 2005 WL 2043642, at *8 (M.D. Fla. Aug. 25, 2005); *Kabeller v. Orlando Reg'l Healthcare Sys., Inc.*, No. 6:04-cv-1106-Orl-19DAB, 2005 U.S. Dist. LEXIS 20219, at *5 (M.D. Fla. Aug. 11, 2005); *Cygan v. Resurrection Med. Ctr.*, No. 04C4168, 2005 U.S. Dist. LEXIS 19867, at *5 (N.D. Ill. July 27, 2005); *Gardner v. N. Miss. Health Servs.*, No. 1:04cv235, 2005 WL 1312753, at *5 (N.D. Miss. May 31, 2005); *Amato v. UPMC*, 371 F. Supp. 2d 752, 759 (W.D. Pa. 2005); *Ellis v. Phoebe Putney Health Sys., Inc.*, No. 1:04-CV-80(WLS), 2005 U.S. Dist. LEXIS 19935, at *15 (M.D. Ga. Apr. 8, 2005); *Corely v. John D. Archibald Mem'l Hosp., Inc.*, No. 1:04-CV-110(WLS), 2005 U.S. Dist. LEXIS 8057, at *20 (M.D. Ga. Mar. 31, 2005); *Watts v. Advocate Health Care Network*, No. 04C4062, 2005 U.S. Dist. LEXIS 7418, at *14-15 (N.D. Ill. Mar. 30, 2005); *Valencia v. Miss. Baptist Med. Ctr., Inc.*, 363 F. Supp. 2d 867, 873-76 (S.D. Miss. 2005); *Fields v. Banner Health*, No. CIV-04-1297-PHX-SRB, 2005 U.S. Dist. LEXIS 13481, at *22-23 (D. Ariz. Mar. 23, 2005); *Jellison v. Fla. Hosp. Healthcare Sys., Inc.*, No. 6:04-cv-1021-Orl-28KRS, 2005 U.S. Dist. LEXIS 8036, at *26 (M.D. Fla. Mar. 15, 2005); *Quinn v. BJC Health Sys.*, 364 F. Supp. 2d 1046, 1057 (E.D. Mo. 2005); *Wright v. St. Dominic Health Servs., Inc.*, No. 3:04CV521LN, 2005 U.S. Dist. LEXIS 8086, at *3 (S.D. Miss. Mar. 1, 2005); *Schmitt v. Protestant Mem'l Med. Ctr., Inc.*, No. 04-CV-00577-DRH, 2005 U.S. Dist. LEXIS 7449, at *28 (S.D. Ill. Feb. 23, 2005); *Sabeta v. Baptist Hosp. of Miami, Inc.*, No. 04-21437-CIV-JORDAN, 2005 U.S. Dist. LEXIS 6132, at *59 (S.D. Fla. Feb. 23, 2005); *Hagedorn v. St. Thomas Hosp., Inc.*, No. 3:04-0526, 2005 U.S. Dist. LEXIS 7259, at *8 (M.D. Tenn. Feb. 7, 2005); *Peterson v. Fairview Health Servs.*, Nos. 04-2973 ADM/AJB, 04-2974 ADM/AJB, 2005 U.S. Dist. LEXIS 1962, at *10 (D. Minn. Feb. 1, 2005); *Daly v. Baptist Health*, No. 4:04CV789GH, 2005 U.S. Dist.

These suits have been filed in twenty-six states in both federal and state court. The cases allege that not-for-profit hospitals have failed in their duty to provide a charitable service to the community, which is required to maintain their favored tax status. The suits also claim, “non-profit, tax-exempt hospitals are overcharging uninsured patients while conspiring with the American Hospital Association (AHA) to profit and hoard billions of dollars while suing the uninsureds to collect medical charges.”¹⁹⁷ Attorney Richard Scruggs, famous for his efforts in litigating class action lawsuits against the tobacco and asbestos industries, has spearheaded the suits against over three hundred not-for-profit hospitals.¹⁹⁸

Some lawsuits have even named the AHA as a defendant. The AHA has responded, “the lawsuits we have seen to date are baseless and don’t begin to help solve the very real problem of the uninsured.”¹⁹⁹ The president of the AHA has further stated, “[t]his assault on community hospitals is misdirected—diverting focus away from the real issue of how we as a nation are going to extend health care coverage to all Americans.”²⁰⁰

The AHA contemporaneously began efforts to ameliorate the problem of billing of the uninsured by recommending to its members that they alter their billing practices. One commentator suggested that

LEXIS 6270, at *14 (E.D. Ark. Jan. 31, 2005); *Washington v. Med. Ctr. of Cent. Ga., Inc.*, No. 5:04-cv-185(CAR), 2005 U.S. Dist. LEXIS 2614, at *26 (M.D. Ga. Jan. 21, 2005); *Shriner v. ProMedica Health Sys., Inc.*, No. 3:04CV7435, 2005 U.S. Dist. LEXIS 894, at *2 (N.D. Ohio Jan. 21, 2005); *Hudson v. Cent. Ga. Health Servs.*, No. 5:04CV301(DF), 2005 U.S. Dist. LEXIS 2613, at *28 (M.D. Ga. Jan. 13, 2005); *Lorens v. Catholic Health Care Partners*, 356 F. Supp. 2d 827, 835 (N.D. Ohio 2005); *Ferguson v. Centura Health Corp.*, 358 F. Supp. 2d 1014, 1021 (D. Colo. 2004); *Burton v. William Beaumont Hosp.*, 347 F. Supp. 2d 486, 501 (E.D. Mich. 2004) (dismissing all federal claims except for those based on the Emergency Medical Treatment Act and Active Labor Act); *Kizzire v. Baptist Health Sys., Inc.*, 343 F. Supp. 2d 1074, 1085 (N.D. Ala. 2004); *Darr v. Sutter Health*, No. C04-02624WHA, 2004 WL 2873068, at *6 (N.D. Cal. Nov. 30, 2004); *see also* *Burton v. William Beaumont Hosp.*, 373 F. Supp. 2d 707, 713-24 (E.D. Mich. 2005) (dismissing federal claims under the Emergency Medical Treatment Act and Active Labor Act and state law claims). List compiled in Cohen, *supra* note 61, at 128 n.209.

197. *Are Nonprofit Hospitals Preying on the Uninsured?*, MEDICAL ETHICS ADVISOR, Dec. 2004, (internal quotation marks omitted), available at http://www.ahcpub.com/hot_topics/?htid=1&htid=1610 [hereinafter *Preying on the Uninsured*].

198. Kaisernetwork.org, *Charity Care: Philadelphia Inquirer Looks at Lawsuits Against Hospitals* (Aug. 9, 2004.), http://www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=25172&hint=3.

199. *Id.*

200. *Preying on the Uninsured*, *supra* note 197.

hospitals had “got[ten] caught with their hands in the cookie jar,” and once “they smelled litigation, they started changing their [billing and collection] practices.”²⁰¹ Hospitals, however, have claimed that they were unaware they could legally offer discounts to uninsured patients who could not pay their hospital bills, as this practice might violate federal anti-kickback laws.²⁰² “The Federal anti-kickback statute prohibits a hospital from giving or receiving anything of value in exchange for referrals of business payable by a federal health care program, such as Medicare or Medicaid.”²⁰³ Although it seems absurd that offering uninsured a discount off the hospital’s list price would violate anti-kickback laws, surprising past applications of the statute prompted the request for an opinion letter from the Office of the Inspector General (OIG).²⁰⁴ The opinion letter clarified the issue, stating unequivocally that “no OIG authority prohibits or restricts hospitals from offering discounts to uninsured patients who are unable to pay their hospital bills.”²⁰⁵

Specifically, the OIG has determined that section 1128 of the Social Security Act permits the OIG “to exclude from participation in the Federal health care programs any provider or supplier that submits bills or requests for payment to Medicare or Medicaid for amounts that are substantially more than the provider’s or supplier’s usual charges.”²⁰⁶ The OIG letter stated that it “has never excluded or attempted to exclude any provider or supplier for offering discounts to uninsured or underinsured patients.”²⁰⁷ Furthermore, the OIG stated that it fully

201. *Id.*

202. Social Security Act of 1935 § 1128(b)(6)(A), 42 U.S.C. § 1320a-7b(b) (2000); *see also* Kowalczyk, *supra* note 13.

203. Letter from the Office of Inspector General, Department of Health & Human Services, Hospital Discounts Offered to Patients Who Cannot Afford to Pay Their Bills (Feb. 2, 2004) (citing 42 U.S.C. § 1320a-7b(b) (2000)), *available at* <http://www.oig.hhs.gov/fraud/docs/alertsandbulletins/2004/FA021904hospitaldiscounts.pdf>.

204. “Proposed regulations were issued in September, 2004 confirming the OIG’s position that providing discounts to the uninsured would not create liability exposure.” Medicare and Federal Health Care Programs: Fraud and Abuse; Clarification of Terms and Application of Program Exclusion Authority for Submitting Claims Containing Excessive Charges, 68 Fed. Reg. 53939 (Sep. 15, 2003) (to be codified at 42 C.F.R. pt. 1001), *cited in* Robin Locke Nagele & Catherine Pajakinas, *Charity Care Class Action Litigation is Denied Federal Status*, 17 HEALTH LAW. 1, 3 (March 2005).

205. Office of Inspector General, *supra* note 203, at 1.

206. *Id.* at 1-2.

207. *Id.* at 2.

supports the hospital industry's efforts to lower health care costs for those unable to afford care.²⁰⁸

Other causes of action have been filed in attempts to redress the problem of excessively high hospital rates for the uninsured. One approach has been to claim unjust enrichment as a cause of action against hospitals that bill uninsured patients at an exorbitant rate.²⁰⁹ One case failed because the court found that the admission form was a legal contract.²¹⁰ In another case, hospital officials defended the practice of charging uninsured patients higher rates than any third party payer. Sally Mason Boemer, Massachusetts General Hospital's vice president of finance stated, "If I didn't have payers paying charges to make up for Medicaid and free care, an institution this size would be in trouble."²¹¹

Breach of contract has been another cause of action against hospitals that bill uninsured patients at exorbitant rates. "The lawsuits claim that because no price is listed in the contract patients sign when they are admitted, the hospitals should be required to charge a fair and reasonable value for their services."²¹² It is interesting to note that unconscious patients brought to a hospital may actually be able to challenge the list price under this claim, as they are held liable to the reasonable value of services provided when emergency care is rendered.²¹³ When there is no express agreement to pay, the law implies a promise to pay a reasonable fee for a health provider's services.

208. *Id.* at 1.

209. *See Pitts v. Phoebe Putney Health Sys., Inc.*, No. 04CV1991-3, 2005 WL 5176797 (Ga. Super. Jun 23, 2005). In *Pitts*, the plaintiffs actually alleged numerous causes of action: third party breach of contract, breach of contract, implied right of action, breach of duty of good faith and fair dealing, violation of Georgia Uniform Deceptive Trade Practices Act, unjust enrichment/constructive trust, fraud, constructive fraud, negligent misrepresentation, breach of fiduciary duties, and negligence. The court defined unjust enrichment as a doctrine which provides "that a benefited party should either return or compensate for benefits conferred when there is no legal contract to pay." *Id.* at *3.

210. *Id.* *See also* Kowalczyk, *supra* note 13, at A1; Maze, *supra* note 105.

211. Kowalczyk, *supra* note 13.

212. *See* Maze, *supra* note 105.

213. *Temple Univ. Hosp., Inc. v. Healthcare Mgmt. Alternatives, Inc.*, 832 A.2d 501, 508 (Pa. Super. Ct. 2003) ("Thus, in a situation such as this [when an unconscious patient receives medical treatment], the defendant should pay for what the services are ordinarily worth in the community. Services are worth what people ordinarily pay for them. Whether the amount charged is unconscionable and whether it shocks the conscience is irrelevant. While the Hospital's published rates for services may be the same or less than rates at other Philadelphia hospitals, the more important question is what health care providers actually receive for those services." (internal citations omitted) (citing *Eagle v. Snyder*, 604 A.2d 253 (Pa. Super. Ct. 1992))). For a thorough discussion on the unconscionability of billing of the uninsured, see Nation III, *supra* note 61.

2. Legislative Response to Disparate Pricing for the Uninsured

Several states and Congress have attempted to correct the inequities of hospital billing practices. The “Hospital Billing Fairness Act” was introduced during the 108th Congress.²¹⁴ This act attempted to require hospitals to certify that the hospital would not bill or collect from an uninsured patient an amount that exceeds 125% of the full payment amount permitted under title XVIII of the Social Security Act.²¹⁵ A hospital found to be in violation of this act would be subject to a civil penalty of up to three times the amount charged in excess.²¹⁶ Two states have passed laws that forbid excessive charging of the uninsured: New York and California. In New York, hospitals cannot charge patients more for medical care than the hospital would charge their highest volume payer, Medicare, or Medicaid. The same law also provides protection from harsh collection practices for unpaid hospital bills, such as foreclosing on one’s home.²¹⁷

In California, Governor Schwarzenegger signed a bill into law that made it the second state to protect uninsured and low-income patients from overcharging by hospitals.²¹⁸ His approval of the law was somewhat of a surprise, as a few years earlier he had vetoed legislation requiring screening of self-pay patients to determine their eligibility for public health insurance programs or hospital charity care.²¹⁹ The previous bill would also have required the self-pay patients to receive

214. Hospital Billing Fairness Act of 2004, H.R. 4092, 108th Cong. (2004). The Act never became law.

215. *Id.*

216. *Id.*

217. N.Y. PUB. HEALTH LAW § 2807-k (McKinney 2007).

218. Laura B. Benko, *California Governor Signs Pricing Bill: Law Aims to Protect Patients From Aggressive Billing*, MODERN HEALTHCARE, October 9, 2006, at 10. This occurred one week after the governor vetoed a bill that would have created a single payer health insurance system in California. *Id.* See also Press Release, Health Access California, Uninsured and Overcharged: New Consumer Protections for Hospital Patients (Oct. 2006), available at <http://www.health-access.org/providing/ab774.htm> (“AB 774 (Chapter 775, Statutes of 2006), by Assemblywoman Wilma Chan and sponsored by Health Access California, would prevent hospitals from overcharging and [engaging in] other unfair billing practices. This new law, which takes effect January 2007, will curb the common practice of hospitals overcharging the uninsured and underinsured, in many cases charging three to ten times what insurance companies and government programs would pay for exactly the same service.”).

219. 2004 *Immigrant Rights Legislation: The Final Picture*, CALIFORNIA UPDATE (Cal. Immigrant Welfare Collaborative), Nov. 8, 2004, at 2, available at <http://www.nilc.org/ciwc/nwsltr/caupd6-04.pdf> [hereinafter 2004 *Immigrant Rights Legislation*]. See also Benko, *supra* note 218, at 10.

notice about their rights and financial options at the hospital, and would have protected patients from having their bills sent to collections prematurely.²²⁰

Other states have sought to ameliorate the disparate pricing scheme's effect by enacting laws to make hospital pricing more transparent. In Maine, hospitals and physicians were originally required to make available to patients a list of their prices for the fifteen most common in-patient and the twenty most common outpatient procedures.²²¹ Maine also required posting of the state's average charges for the in-patient procedures.²²²

3. *Revising the Tax Code*

In the short term, to curtail the practice of subsidizing health care by permitting the write-off of unpaid, inflated hospital bills to the uninsured, there could be immediate revision of the federal tax code. Although the tax code permits the write-off of bad debts,²²³ two criteria must be met.²²⁴ First, there must be a valid and enforceable obligation to pay a fixed or determinable sum of money.²²⁵ Admission forms have been found to be valid contracts, and challenges to the validity of these contracts have not fared well in the courts.²²⁶ Next, there must be a reasonable expectation of repayment.²²⁷ Although much of the care provided for the uninsured ends up being uncollected, some of the uninsured, like Mr. Hernon,²²⁸ actually do pay the list price. It is arguable that the tax code already prohibits deducting these inflated accounts, as they would be unlikely to pass the "economic reality test."²²⁹ The economic reality test considers whether an objective,

220. 2004 *Immigrant Rights Legislation*, *supra* note 219, at 2.

221. Kenneth T. Bowden II, *Determining a Reasonable Price for Health Care in the United States: Is this Possible?*, 34 BRIEF 26 (2005) (citing An Act to Provide Affordable Health Insurance to Small Businesses and Individuals and to Control Health Care Costs, 2003 Me. Pub. L. No. 469).

222. ME. REV. STAT. ANN. tit. 22, § 1718 (2005).

223. 26 U.S.C. § 166 (2000).

224. *Davis v. Comm'r*, 88 T.C. 122, 142-43 (1987).

225. Treas. Reg. § 1.166-1(c) (1998).

226. *See, e.g., Pitts v. Phoebe Putney Health System, Inc.*, No. 04CV1991-3, 2005 WL 5176797 (Ga. Super. Jun 23, 2005).

227. Treas. Reg. § 1.166-1(c) (1998).

228. *See supra* Part I.

229. *See Fin Hay Realty Co. v. United States*, 398 F.2d 694, 697 (3d Cir. 1968).

“outside” party would advance the funds.²³⁰ This test would be difficult to apply for the provision of medical services. A new provision in the tax code, however, could deem any overcharging of patients, at a rate higher than 110% of a provider’s reimbursement from their most used third party payers, to be prima facie evidence of fraud if that provider attempts to claim a tax write-off.

4. Other Approaches

Other approaches for health care reform include extending government reinsurance programs to make private health care available universally.²³¹ These programs have the effect of underwriting individuals and small groups of people by placing them into a larger pool, realizing the lower cost of the larger population. The Federal Trade Commission issued a report in 2004 which predicted that more economic competition should be part of the cure for our country’s health care problems.²³² Other patches to the health care system include reducing direct care funding for some low-income populations, and instead offering a refundable tax credit, or some fixed amount of money, to assist low and middle income people to pay for private health insurance.²³³ The New America Foundation’s plan would guarantee access to insurance for everyone; in return, each citizen would be

230. Charles Herbst & Giles B. Sutton, *When Debts Turn Sour: Clarifying the Process of Claiming a Bad-Debt Deduction*, 42-Mar RES GESTAE 8, 9 (1999).

231. Through reinsurance programs, many state programs already attempt to make private health care insurance more affordable to individuals and small groups who may otherwise be unable to secure coverage. Jacobi, *supra* note 4, at 538.

232. See FEDERAL TRADE COMM’N & DEP’T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION 4 (2004), available at http://www.usdoj.gov/atr/public/health_care/204694.pdf. Professor Jost compares the role of competition in the FTC approach, with that of the provision of health care in European universal health care systems. Instead of relying on the invisible hand to straighten out issues of access, price and quality, the European approach is one based upon the principle of health care as a right, that “all members of society must have access to health care regardless of their ability to pay.” Timothy S. Jost, Diane Dawson & André den Exter, *The Role of Competition in Health Care: A Western European Perspective*, 31 J. HEALTH POL. POL’Y & L. 687, 688 (2006). Note also that critics of the failed 1993 Clinton plan to reform the United States health care system predicted that the system would reform itself through free-market competition. Rory Weiner, *Universal Health Insurance Under State Equal Protection Law*, 23 W. NEW ENG. L. REV. 327, 327 (2002). Actually since that time, the number of uninsured has continued to increase, prices have risen dramatically, and quality of care has worsened. *Id.* at 327-28.

233. Hermer, *supra* note 75, at 4.

responsible for acquiring and maintaining a health care policy with assistance of his or her employer and the federal government.²³⁴

Because of powerful insurance lobbying and other economic concerns, some commentators are less than optimistic about any approach to overhauling our current health care payment system. In his recent analysis of our system, Dr. William P. Gunnar flatly concluded, “[u]niversal health care cannot be achieved in the United States due to the strength and complexity of the current health care system.”²³⁵

Radical changes to our health care payment systems may seem impossible. Even if they are possible, some believe changes of such magnitude can only evolve over time. In the past century, however, many of the European nations adopting a single payer system made abrupt changes to a system of government-centered universal care.²³⁶ Massachusetts, Pennsylvania, Maine, and California have also enacted legislation in efforts to provide universal health care for their citizens.²³⁷

CONCLUSION

A hospital payment system that charges uninsured patients a rate easily characterized as over-inflated is one small but indefensible anomaly in the management of health care costs in the United States. Overcharging uninsured patients, who will then likely default on their payment obligations, serves to inflate the value of services for which the hospital has not received payment. This in turn inflates the amount that a hospital can write off, or the amount of charity care provided by a hospital seeking to maintain its not-for-profit status.

In some instances, hospitals admittedly take advantage of high profit margin payers to help subsidize their indigent patients and otherwise assist the hospital to operate in the black.²³⁸ Although the practice of overcharging the uninsured could be curtailed considerably

234. Jonathan Barry Forman, *Making Universal Health Care Work*, 19 ST. THOMAS L. REV. 137, 145 (2006). Professor Forman also suggests a taxing and funding scheme to transition the United States to a country with universal health care access.

235. His article is a review of legal issues of access to health care in the United States from a physician’s point of view. Gunnar, *supra* note 2, at 179.

236. Robert G. Evans, *Fellow Travelers on a Contested Path: Power, Purpose, and the Evolution of European Health Care Systems*, 30 J. HEALTH POL. POL’Y & L. 277, 281-82 (2005). The author notes that many people believe that Europeans have always had universal health care, but points out that many changed their systems quickly in response to economic, social, and political pressures.

237. Forman, *supra* note 234, at 146.

238. Kowalczyk, *supra* note 13.

by revising the tax code, it is becoming more evident that larger scale reform is in order. Legislative approaches to regulating hospital list prices may be an effective way to fix the immediate problem for uninsured patients, but this is only treating the symptoms of a systemic failure.

This system that, to some degree, has relied upon overcharging uninsured patients has been effectively shifting the additional cost of providing health care onto the federal government. Medicare reimbursements under Medicare and Medicaid are, by law, close to the break-even point; but, if the system is only profitable by writing off over-inflated hospital bills, perhaps even the discount rate for third party payers is artificially low and subsidized to some degree by the taxpayer. The hospital list rates are arbitrarily established and should either be abandoned or discounted in a more fair and equitable way that does not penalize the uninsured and, by default, the federal government. The problem of the entire structure of this nation's health care system being based upon imaginary costs and outdated modes of payment should really be addressed in a comprehensive manner, whether through implementation of universal health care or by an innovative and complete restructuring of our health care payment system.

