
IN THE APPELLATE COURT OF ILLINOIS
FOR THE FIRST JUDICIAL DISTRICT

ANTONIO GALVAN, individually and on behalf of all others similarly situated,)	On Appeal from the Circuit of Cook County, County
)	
Plaintiff-Appellant,)	No. 05 CH 01800
)	
v.)	
)	
NORTHWESTERN MEMORIAL HOSPITAL, individually and on behalf of all others similarly situated,)	The Honorable Thomas P. Quinn, Judge Presiding
)	
)	
Defendant-Appellee.)	

**BRIEF OF AMICUS CURIAE ILLINOIS HOSPITAL ASSOCIATION IN
SUPPORT OF NORTHWESTERN MEMORIAL HOSPITAL**

STATEMENT OF INTEREST

The Illinois Hospital Association (IHA), on behalf of its member institutions, submits this *amicus* brief in support of the defendant-appellee, Northwestern Memorial Hospital (the Hospital). The IHA is a statewide non-profit association with a membership of approximately 200 Illinois hospitals. For over seventy-five years, the IHA has served as representative and advocate for its members, addressing the social, economic, political and legal issues affecting the delivery of high quality health care in Illinois. As the

representative of almost every hospital in Illinois, IHA has a profound interest in this case.

The IHA respectfully offers this brief *amicus curiae* because it believes that it has a unique perspective and information not addressed by the litigants in this case. In particular, the IHA believes that this brief will offer necessary counterpoints to certain factual contentions made in the brief of plaintiff's *amicus*, the Service Employees International Union (SEIU). The IHA wishes to offer this Court its own perspective on the way hospitals are reimbursed for treating patients.

The practices described in this brief are based on years of IHA's advocacy for hospitals regarding health care payment reform and regulation. The IHA offers its views in the good faith belief that they accurately reflect the realities of hospital economics. The Court should have the opportunity to appreciate the complexities of how hospitals treat patients and then seek payment from them.

The system of list prices and discounts, about which plaintiff's *amicus* complains, came into existence, and remains in existence, for reasons having nothing to do with uninsured patients. The discounts hospitals provide to governmental health programs and to some private insurance companies reflect the volume and certainty of payments that hospitals receive from those payers. Plaintiff's *amicus* complains that such volume discounts are not reflected in *charges* to uninsured patients, but the truth is that, as a group, the uninsured *pay the least*, not the most, of any class of hospital patients. Moreover, virtually all hospitals provide discounts, up to 100% of charges, to uninsured patients based on financial need, so it is wrong to claim that the poor and uninsured patients are charged more than insured patients, which implies that hospitals collect those

amounts from the uninsured. Further, efforts to provide assistance to the uninsured beyond the substantial assistance that hospitals already offer them should be undertaken through legislation, not through litigation.

In Section I of this brief, the IHA will describe the basic facts of Illinois hospitals' economics. The purpose of this discussion is to show how hospitals raise the revenue that enables them to provide service to uninsured patients and patients with Medicare or Medicaid coverage, where reimbursement is, on average, substantially below hospitals' costs. Section I discusses the different payers that fund hospital care; the "charge master" system of prices and discounts by hospitals; the need for hospitals to find alternative funding for care provided to patients for free or below-cost; and the financial assistance policies of Illinois hospitals.

Section II argues against imposing *ad hoc* judicial solutions, advocated by the plaintiff, to the problems faced by uninsured patients. As IHA will discuss, the state legislature has been, and continues to be, actively engaged in this area through the enactment of the Community Benefits Act, the Health Care Justice Act, and the Fair Patient Billing Act, and pending legislation on charity care.

ARGUMENT

I. HOSPITALS MUST FIND ALTERNATIVE REVENUE TO SERVE PATIENTS WHOSE PAYMENT OR COVERAGE DOES NOT COVER THE FULL COST OF TREATMENT.

A. Hospitals Serve Uninsured and Government-Sponsored Patients at a Substantial Loss.

Hospitals in Illinois essentially serve three groups of patients: (1) those with private health insurance; (2) those insured by government programs, such as Medicare

and Medicaid; and (3) the uninsured. To survive financially, a hospital must collect enough revenue from these groups to pay the substantial and growing costs of running the hospital and treating patients. The costs of providing hospital service have continued to rise, due to rising labor costs, an aging population, higher malpractice insurance costs, the costs of drugs and supplies, and many other factors, including an acute health care workforce shortage. Moroney, Sheila D., *Understanding Health Care Cost Drivers*, 2003 National Institute of Health Policy.

Hospitals are economically unique among private providers of services in that they give very expensive service to persons who need it, most often without advance payment, and generally, without proof of ability to pay. This is particularly true of emergency room patients, where state law requires that hospitals provide emergency treatment to any person who needs it regardless of his or her ability to pay. Emergency Medical Treatment Act, 210 ILCS 70/1. Federal law requires hospitals to assess and stabilize emergency patients without regard to their ability to pay. Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd (West 2000)(EMTALA). The United States Department of Justice and the Federal Trade Commission acknowledge that hospitals bear the “biggest financial burden” of caring for the uninsured population because of the EMTALA obligation. Department of Justice/Federal Trade Commission, *Improving Health Care: A Dose of Competition*, July 2004, at page 27.

Hospitals have long served and will continue to serve all kinds of patients despite losing substantial amounts of money in the process. Three groups in particular stand out: (1) the uninsured, or “self-pay” patients, (2) Medicaid patients, and (3) Medicare patients.

1. Uninsured Patients Rarely Pay Hospitals' Charges.

Hospitals receive less reimbursement from uninsured patients than they do from patients on Medicare or Medicaid, which, on average, reimburse hospitals for less than their costs. Several sources cite to studies that indicate uninsured patients pay only seven to ten percent on average of their hospital expenses. Institute of Medicine, *Insuring America's Health*, National Academies Press, 2004, at page 50; Prottas, Costs, Charges, and Medical Debt: What is the Real Goal? 3 *Am.Heart Hosp. J.* 39, 109 (2005). Hospitals lose substantial amounts of money serving this group. In one year alone, Illinois hospitals provided \$1.2 billion in uncompensated care, measured at cost, to their patients. *2003 AHA/Health Forum Annual Survey of Hospitals*. The losses from providing uncompensated services are likely to grow, since employers are under pressure to decrease or drop health benefits for their employees. See Jeanne M. Lambrew et al., *Changes in Challenging Times: A Plan for Extending And Improving Health Coverage*, 2005 at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.119v1.pdf>

As described in more detail below, hospitals typically have financial assistance policies that offer needy uninsured persons the opportunity to obtain a complete or partial write-off of their charges. Under the newly enacted Fair Patient Billing Act, a consumer information bill which was recently passed by the Illinois General Assembly, hospitals must advertise the availability of financial assistance and offer a reasonable payment plan for qualified patients. Public Act 94-0885. While the Act standardizes the procedures for hospitals to follow, such financial assistance programs have been a long-standing feature in all hospitals for years.

Hospitals may initiate reasonable collection efforts for those people who make too much income to qualify for full or partial financial assistance under the hospitals' policies. However, in many cases, the hospitals ultimately determine that collection is not feasible. In those cases, hospitals write off the uncollected portion of the bill as "bad debt." Either way, whether the write-off comes through officially granted financial assistance or as bad debt -- the economic effect on hospitals is the same: hospitals serve the uninsured at a substantial loss.

2. State Medicaid Reimbursement Does Not Cover the Cost of Care.

On average, Illinois hospitals lose money when they treat a Medicaid patient. The Illinois Medicaid program pays for the health care of low-income and disabled persons based on rates for each particular diagnosis, regardless of what it costs a hospital to treat the patient. Illinois Public Aid Code, 305 ILCS 5/14-8. Medicaid payments have not kept pace with the costs of caring for the poor and at this time, Medicaid pays, on average, 73 cents for every dollar of *cost* at hospitals in Illinois. Metropolitan Chicago Health Council and Illinois Hospital Association, *Caring for Their Communities, A Comprehensive Report on the Community Benefits Provided By Tax-Exempt Hospitals in Cook County*, May 2006. As a result, the majority of hospitals lose money treating patients covered by the state Medicaid program.

3. For the Average Illinois Hospital, Federal Medicare Reimbursement Does Not Cover the Cost of Care.

On average, Illinois hospitals lose money when they treat a Medicare patient. The federal Medicare program is similar to the Illinois Medicaid program in that hospitals are paid according to the patient's particular diagnosis, regardless of the hospital's cost of

treating that patient. 42 U.S.C.A. 1395ww, 42 CFR § 412.2 (2004). So, in addition to the Medicaid shortfall, federal Medicare payments in Illinois underpay hospitals for their services. On average, Medicare reimburses hospitals 92 cents of every dollar spent on cost. Metropolitan Chicago Health Council and Illinois Hospital Association, *Caring for Their Communities, A Comprehensive Report on the Community Benefits Provided By Tax-Exempt Hospitals in Cook County*, May 2006. As sources of revenue, Medicare constitutes 40.7% of gross revenue and Medicaid constitutes about 13.5% of gross revenue in Illinois hospitals. *2004 AHA/Health Forum Annual Survey of Hospitals*. Thus, for the average Illinois hospital, over half of its revenue comes from state and federal programs that pay less than the hospital's actual costs of providing care to those patients.

B. The Current System for Healthcare Reimbursement Is the Result of Government Regulations and Third Party Reimbursement

1. Medicare Rules Require All Hospitals to Maintain a “Charge Master” List of Uniform Pricing.

Medicare regulations define customary charges as charges “imposed uniformly on most patients.” Health Care Financing Admin., U.S. Department of Health & Human Services, Provider Reimbursement Manual § 2203 (1997). As a result, all Illinois hospitals maintain a uniform and detailed list of charges for each service. This so-called "charge master" contains a specific price for every specific service and supply the hospital provides, often containing tens of thousands of different prices. The charge master list provides the starting point when calculating the amount a patient may owe for services received. While this federal regulation permits hospitals to provide discounts to various classes of patients, including uninsured patients, and to accept less than the

uniform charge master rate as payment in full, the regulation certainly played a role in structuring the current hospital billing practice of using a charge master.

For those insured patients whose insurance company has contracted with the hospital, the charge master rate gets negotiated down to some discounted amount during contract negotiations between the hospital and the insurer. In the case of the uninsured patient, who does not have the opportunity to negotiate a discount before an encounter with the hospital, the initial charge is the charge master rate, but in most cases, the hospital offers discounts, up to and including free care, based on financial need. As a result, while an uninsured patient might receive a bill reflecting charge master rates, if the patient has an inability to pay that bill, he or she is most likely going to qualify for discounts, and in the end, the average uninsured patient actually pays substantially less than the average insured patient for the same care.

American Hospital Association, *Hospital Charges Explained*, at www.caringforcommunities.org/caringforcommunities/content/031209hosp_charges_explained.pdf.

2. Competition for Insured Patients Force Hospitals to Discount Their Charges from the Charge Master.

Health insurers have insisted that hospitals provide discounts from the charge master prices for the patients that they cover because they can provide a reliable patient volume and prompt lump sum payments. Lawrence O. Gostin & Peter D. Jacobson, *Law and the Health System*, Foundation Press, 2006, page 344. Sometimes, private insurance payers insist on a specified percentage discount from charges; sometimes they simply dictate the dollar amounts that they will pay for a given service. The particular rates that

hospitals agree on depend on the size and market strength of the hospital and the size and market strength of the insurance company. Gostin & Jacobson, pages 343-344.

The result is a highly complex set of rates. For instance, a given hospital or hospital system will typically have a separate contract with each major private payer. A contract with a large, powerful payer, like Blue Cross, will typically have very large discounts from charge master rates; a contract with a smaller payer may have smaller discounts. Moreover, different hospitals will achieve different rates with the same insurance company. An insurer anxious to include a particular hospital in its "network" may well agree to a higher reimbursement rate to that hospital, while a smaller hospital with less market power may have to accept a lower rate from the same insurer.

Not all privately insured patients get discounts from the charge master rates. If a patient is insured by a managed care organization that has no contract with the hospital, the care is known as "out of network" and the insurer will be billed for the full charges. Thus, the notion that only the uninsured are charged at full charges is not correct. In some cases, an insurance company called upon to pay for "out of network" care for its insured patient will negotiate some sort of discount from charges in exchange for a prompt payment, but payments of full charges for out-of-network care is common.

Hospitals did not create this fragmented system with private payers paying different rates for different patients depending on which insurance covers them. But, all hospitals rely on revenue from these payers in order to make up for Medicare, Medicaid and uncompensated care shortfalls. So long as payers embrace the charge master and discounting system, individual hospitals are not free to, unilaterally, change the practice,

especially since Medicare reimbursement regulations were the original impetus for the charge master system in the first place.

3. The Current System Forces Hospitals to Reconcile Being Competitive While Maintaining the Health Care Safety Net.

Government and private payers of health care services embrace a market-based, competitive model for the delivery of health care. For example, the growth in managed care during the 1990s was an attempt to use market forces to contain health care costs. At the same time, those without the ability to pay for health care need access to quality health care. Consequently, hospitals are caught in the middle. On the one hand, they are told to operate more efficiently, cut costs, and compete in the marketplace by the health care payers. At the same time, hospitals serve as the health care safety net, providing 24/7 access to care, treating a growing number of uninsured and under-insured patients, and providing the resources to care for the ill and injured during disasters. The Chartis Group/American Hospital Association, *Prepared to Care: The 24/7 Role of America's Full-service Hospitals*, August 2006. And while most hospitals provide substantial amounts of service for free, the service must necessarily be cost-shifted somewhere else.

4. By Necessity, Hospitals Shift Costs to Those With An Ability to Pay.

Hospitals that serve groups on which it loses substantial amounts of money must make that money up from the other groups it serves, or they will eventually have to close. As indicated above, most hospitals lose large amounts treating Medicaid and uninsured patients, and lose lesser sums, or barely break even, on Medicare patients. Most hospitals make up these losses through reimbursement from patients with private insurance. Wing, Jacobs, & Kuszler, *The Law and American Health Care*, Aspen Law & Business, 1998,

at page 354. A hospital must have a positive operating margin on patients with the ability to pay, or it will be unable to keep operating.

However, it has become increasingly difficult to cost-shift losses to paying patients with insurance. Wing, at page 356. Insurance companies and employer health care plans are powerful negotiators seeking the lowest rates they can get. A hospital may have little to negotiate with a dominant insurer covering most of the patients in the market. As a result, while cost-shifting allows a hospital to survive, there are severe limitations on the amount that can be cost-shifted in this fashion. Notwithstanding the fact that they must operate within this system, hospitals have succeeded surprisingly well in finding ways to provide free and discounted care to needy patients.

The interplay between charges, discounts, and cost shifting shows that the charge master system was not designed by hospitals to “gouge the poor.” There are too many other factors at play to simply blame hospitals. Furthermore, outlawing the charge master system would not solve the problem of how to finance health care for the uninsured. The solution must come from legislation.

II. SOLUTIONS TO THE PROBLEM OF THE UNINSURED REQUIRE THE DELIBERATIVE LEGISLATIVE PROCESS

The Plaintiff is asking this Court to solve a complex societal problem, on an *ad hoc* basis, by requiring hospitals to provide discounted rates to all uninsured, regardless of financial need. Establishing the terms and conditions of financing care for the uninsured, however, involves the consideration of many factors that must be addressed through the deliberative legislative process, not the adversarial process of the courts. Indeed, the Illinois General Assembly has been addressing this issue over the last few

years, attempting to find a way to make health care affordable to all. The General Assembly has considered, and passed, the Community Benefits Act, the Health Care Justice Act, and the Fair Patient Billing Act, to name a few. It also will be considering legislation mandating hospitals provide free and discounted care to low income uninsured patients.

A. Recent Legislation Demonstrates that the Illinois General Assembly Has Been Actively Engaged in Addressing The Uninsured Patient Population.

Rather than attempting to restructure the current hospital financing system, the Illinois General Assembly, at the initiative of the Office of the Attorney General, passed the Fair Patient Billing Act, Public Act 094-0885 (2006). This Act requires hospitals to provide all uninsured patients, regardless of assets or income, with information about the hospitals' financial assistance and payment plan policies. The new law also specifies when collection efforts, if any, may proceed against an uninsured patient. The new law is silent on the industry-wide practice of billing the uninsured patients the full charge master rate. Instead, the law requires hospitals to offer financial assistance to patients who indicate an inability to pay the charge master rate. P.A. 094-0885 at Section 30(a)(2).

The most common kind of financial assistance policy that hospitals offer specifies that a family whose annual income is lower than a certain multiple of the "federal poverty level" (FPL) for a family of that size will be eligible for free care. Above that multiple, and up to a certain higher level of the FPL, some type of discount from the charge master rates is offered. Most Illinois hospitals meet or exceed the guidelines jointly adopted by the Illinois Hospital Association and the Metropolitan Chicago Healthcare Council in

providing free care for patients at 100% of the FPL and discounted rates for patients between 101% and 200% of the federal poverty level. See <http://www.ihatoday.org/issues/payment/uninsured/charitycare.pdf>.

Under these financial assistance policies, a person who is eligible for Medicare or Medicaid is not eligible for assistance, since Medicare and Medicaid require hospitals to write off any patient balance remaining after reimbursement is received. 305 ILCS 5/11-13. Likewise, most hospitals' policies do not extend eligibility to persons who, like the Plaintiff, have funds from a personal injury lawsuit or workers compensation claim available to pay the bill. Indeed, as the present case illustrates, Illinois law specifically allows hospitals the right to file statutory liens on patients' personal injury lawsuits in order to obtain payment for services. Health Care Services Lien Act, 770 ILCS 23/1 *et seq.* It seems unreasonable to accuse a hospital of fraud and deception for merely exercising its rights under this law.

Just prior to passing the Fair Patient Billing Act, the Illinois General Assembly passed the Health Care Justice Act, 20 ILCS 4045/1 *et seq.* (West 2004), which the IHA and hospitals actively supported. Under this Act, a Task Force of experts was appointed to hold public hearings throughout the state to solicit input from the public about access to quality, affordable health care. The focus of the Task Force has now turned to reviewing specific benefit access plans. Recently, both the IHA and the SEIU submitted plans designed to reduce the problems of the uninsured/underinsured, which will be considered along with four or more other plans. The Task Force must submit a health care access plan to the General Assembly by October 2006. The General Assembly will

be urged to enact a plan by December 31, 2006 and implement it by July 1, 2007. 20 ILCS 4045/35.

The Illinois General Assembly also passed the Community Benefits Act, 210 ILCS 76/1, *et seq.*, which has been effective since 2003. This Act requires larger not-for-profit hospitals to file an annual report with the Office of the Attorney General detailing the benefits it has provided to its community, including the amount of charity and uncompensated care the hospital has provided. Instead of imposing mandates on all hospitals throughout the state, this Act reflects a policy of encouraging dialogue at the local level between the hospital and its community for how the hospital can best meet local health needs. Again, the IHA and its member hospitals supported the passage of the Community Benefits Act.

Before enacting any new mandate requiring hospitals to provide more free or discounted care than they already do voluntarily, policymakers will have to consider many factors, including: the impact on hospitals' financial condition; the potential impact on the community's access to a variety of health care services; and the impact on the cost and availability of health insurance. These are legislative, not judicial, issues.

B. Recent Legislative Debate Demonstrates the Complexity of Imposing New Requirements on Hospital Pricing Practices.

The General Assembly has considered legislation in its last two sessions that would have mandated hospitals provide free care and various discounts to low income uninsured. (S.B. 2579, 93rd Gen. Assemb., Reg. Sess. (Ill. 2004) and H.B. 5000, 94th Gen. Assemb., Reg. Sess. (Ill. 2006). Both bills triggered substantial discussion because legislation on this issue must be carefully designed to avoid unintended consequences for the health care system. Fortunately, the legislative process allows for all affected

persons, parties, and interests to review and assess such proposals. On the other hand, the judicial process lacks systematic input from all of the various stakeholders. Further, the courts are not well-positioned to overhaul the health care payment system one patient claim at a time.

As legislative proposals mandating the level of free or discounted care move forward, they are likely to take into account factors such as (a) whether the hospital is urban or rural, (b) whether it is large or small, (c) whether it is in a prosperous area with a high percentage of people with private health insurance, or in a depressed area where most people are on Medicare or Medicaid, or are uninsured; (d) whether it is an academic teaching hospital with an expensive educational mission to support financially, or a non-teaching community hospital; and (e) whether it is part of a network with economically healthy sister institutions that can subsidize any of its losses, or instead, stands on its own and has no help to tide it over during difficult periods. Legislation can consider and differentiate between hospitals in these differing categories. In contrast, judicial intervention, one judge at a time, one patient claim at a time, cannot consider these distinctions.

In the end, finding a solution that allows all uninsured Illinoisans access to quality, affordable health care is a complex question of social policy. This social policy question raises significant practical implementation questions to which the courts have no law to apply. Certainly, the Consumer Fraud and Deceptive Practices Act, 815 ILCS 505/1 *et. seq.*, on which the Plaintiff's Complaint is based, is of no help on this question, because it cannot establish rates, nor define qualifications, nor make distinctions among health care providers. The extreme complexity of hospital economics, and the need to

make sure that losses on charity care and Medicaid or Medicare are made up by positive operating margins on patients with an ability to pay, argues strongly for a legislative rather than a judicial solution to the question of access to care for the uninsured.

CONCLUSION

Class action lawsuits such as this one make implicit assumptions about hospital economics that have no grounding in reality. To judge the validity of the Plaintiff's legal arguments, this Court needs to take into account (1) the realities of how hospitals raise the revenue needed to serve uninsured patients at a loss; (2) the origins of the system of "charge master" list prices and discounts from those prices, (3) the fact that this system cannot be abolished or effectively reformed by court decrees, and (4) the fact that the problem of paying for health coverage for the uninsured will require legislation, not *ad hoc* judicial price control on those hospitals who happened to be sued. For these reasons, the *amicus curiae* supports the Defendant-Appellee in its brief and urges that the judgment of the trial court dismissing the Complaint be affirmed.

Respectfully submitted,

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