

# NONPROFIT HOSPITAL BILLING OF UNINSURED PATIENTS: CONSUMER-BASED CLASS ACTIONS MOVE TO STATE COURTS

David L. Nie\*

## TABLE OF CONTENTS

I.	INTRODUCTION .....	173
II.	A REVIEW OF NONPROFIT HOSPITALS AS TAX- EXEMPT ORGANIZATIONS.....	178
	<i>A. Tax-Exempt Hospitals and the Provision of Charity Care</i> .....	179
	<i>B. State and Local Interpretations of Competing Federal Standards for Tax-Exemption</i> .....	182
	<i>C. State Recognition of the Community Benefit Standard</i> .....	183
III.	RECENT SCRUTINY FROM THE EXECUTIVE AND LEGISLATIVE BRANCHES AND GRASSROOTS ORGANIZATIONS .....	186
	<i>A. Congressional Hearings Regarding the Tax-Exempt Health Sector</i> .....	186
	<i>B. State Legislatures Address the Charity Care Practices of Hospitals within Their Borders</i> .....	188
	<i>C. State Attorneys General Act on Their Role of Supervising Charitable Organizations</i> .....	189
	<i>D. Advocacy Groups Acting on behalf of Uninsured Patients</i> .....	190
IV.	THE CONSUMER PROTECTION CLAIMS OF THE SUTTER HEALTH NONPROFIT HOSPITAL PRICING CLASS ACTION.....	193
	<i>A. California's Consumers Legal Remedies Act</i> .....	194
	<i>B. California's Unfair Competition Law</i> .....	196
V.	THE SUTTER HEALTH SETTLEMENT .....	202
VI.	CONCLUSION.....	203

## I. INTRODUCTION

During a visit to a local grocery store, California resident Duane Darr was injured after he slipped and fell.<sup>1</sup> Mr. Darr was subsequently transported by

---

\* J.D. Candidate, 2007, Indiana University School of Law, Indianapolis, Indiana; B.A., 1999, DePauw University, Greencastle, Indiana. I would like to thank Leeanne Coons of Krieg Devault LLP and Kristen Heath for their feedback and guidance in writing this Note. In addition, I thank my wife, Jennifer, for her unwavering support and encouragement.

<sup>1</sup> Sutter Health Uninsured Pricing Cases, J.C.C.P. No. 4388, at 13 (Cal. Super. Ct. filed

ambulance to the emergency room of a local nonprofit hospital.<sup>2</sup> Despite lacking health insurance, Mr. Darr underwent basic testing at the hospital which included blood tests, a hip x-ray, and even an EKG.<sup>3</sup> His injury did not require invasive treatment so Mr. Darr was given a pharmaceutical and discharged to return home.<sup>4</sup> For his short visit, however, the hospital billed Mr. Darr, who had no health insurance and was not enrolled in a government plan, \$4,599.10.<sup>5</sup> This amount far exceeded what he could personally afford, and, what some allege is estimated to be two to four times higher than the amount private health insurance companies have negotiated on behalf of their participants.<sup>6</sup> Based on Mr. Darr's situation, it would appear that a nonprofit, charitable hospital was expecting a patient who can least afford the high cost of health care to pay the list price for the services the hospital provided.<sup>7</sup> Plaintiffs across the country have brought claims on this very issue by asserting that private insurance companies and governmental payors like Medicare and Medicaid are receiving significant discounts for services rendered by nonprofit hospitals while uninsured patients are being billed the full list prices.

For many uninsured Americans, obtaining access to affordable medical services is a daunting, if not impossible, task. Although many of these individuals may find charitable organizations to provide them with free or discounted medical care, there exists a contingent of low-income uninsured patients whose trouble does not end with the medical treatment they receive. Rather, what may have appeared to these patients to be a charity hospital, or one perhaps founded on religious principles, proved in actuality to provide very little charity care. Stories of these patients' financial burdens, combined with allegations of nonprofit hospital surpluses, excessive hospital expenditures, and aggressive debt collection practices, have permeated the media for the last several years. Private health insurers typically negotiate discounts on behalf of their customers and Medicare and Medicaid enrollees benefit from government dictated prices. As a result, a segment of patients who do not benefit from either of these subsidies fall within a coverage gap so these persons, for purposes of this Note, will generally be referred to as the "uninsured." As recent litigation has alleged, these uninsured, often low-income, patients are being asked by hospitals to pay the list price, which some also allege is an inflated price, for the medical services they received.<sup>8</sup>

---

Jul. 22, 2005) [hereinafter Complaint].

<sup>2</sup> *Id.*

<sup>3</sup> *Id.* at 14.

<sup>4</sup> *Id.*

<sup>5</sup> *Id.*

<sup>6</sup> Associated Press, *Uninsured patients pay more for care*, MSNBC.COM, June 24, 2004, <http://www.msnbc.msn.com/id/5290172/>.

<sup>7</sup> Complaint, *supra* note 1, at 14 ("Plaintiff Darr was unable to pay his bill and no one from [the hospital] provided him with any information regarding payment plans, charity care or the [hospital administered charity care program].")

<sup>8</sup> Leo T. Crowley, *Hospitals Prevailing in Charity Care Cases*, N.Y. L.J., Dec. 28, 2004, at 3 [hereinafter Crowley I]. In reviewing the patients' claims made in the nonprofit liti-

Many hospitals have not adopted, nor are they required by law to adopt, a standard policy or method for providing charity care, in the sense of free or discounted medical services.<sup>9</sup> Any policies on charity care that exist tend to be developed internally by a hospital and can be a complicated consideration of multiple factors that include, but are not limited to, the applicant's personal, family, medical, and financial history to determine a patient's eligibility.<sup>10</sup> Even so, some uninsured patients never have an opportunity to receive the charity care for which they may qualify because information regarding the hospital's charity care options is never delivered to the patient or is otherwise presented in a confusing manner.<sup>11</sup> In addition to the complexities of administering hospital billing, patients in need of emergency medical attention often lack the incentive or time, at least during their medical crisis, to research and make crucial decisions about the costs of the services they are about to receive. Nevertheless, some hospitals contend that individuals have a responsibility to research the financial costs of their impending treatment as well as their payment options. The reality, however, is that most patients never bother pursuing the charity care policies for which they may qualify.<sup>12</sup> Hospitals further posit that they are victims "of unions that have spread misinformation to embarrass the hospital industry, and of a society that has made impossible demands of financially beleaguered health care providers."<sup>13</sup>

Regardless of the reasons for the problems associated with the charity care practices in the United States, multiple lawsuits have been filed, starting in 2004, against nonprofit hospitals in several federal courts alleging unlawful hospital billing practices for medical services rendered to the uninsured.<sup>14</sup> Renowned Mississippi plaintiffs' attorney Richard Scruggs<sup>15</sup> coordinated the ini-

---

gation discussed in this Note, the focus of this Note is on those patients who lack health insurance and are not benefiting from managed care rates or government programs subsidizing their health care.

<sup>9</sup> Guy Boulton, *Wisconsin to File Complaints Against Hospitals*, MILWAUKEE J. SENTINEL, Nov. 8, 2005, at D1.

<sup>10</sup> *Id.*

<sup>11</sup> *Id.*

<sup>12</sup> *Id.*

<sup>13</sup> Jonathan Cohn, *Uncharitable?*, N.Y. TIMES, Dec. 19, 2004, § 6 (Magazine), at 51, 52.

<sup>14</sup> Crowley I, *supra* note 8. Although not discussed in this Note, similar lawsuits were filed in 2004 against for-profit hospitals alleging they made millions of dollars by charging uninsured patients inflated prices.

<sup>15</sup> Frontline Online, *Inside the Tobacco Deal: Interviews: Richard Scruggs*, <http://www.pbs.org/wgbh/pages/frontline/shows/settlement/interviews/scruggs.html> (last visited Mar. 4, 2007). Mr. Scruggs was very successful pursuing large class action cases against the asbestos industry. *Id.* Mr. Scruggs then took on the tobacco industry in the 1990s in which his relationships with long-time friend Mississippi Attorney General Mike Moore and brother-in-law Senate Majority Leader Trent Lott, likely helped to facilitate the anti-tobacco litigation. *Id.* The tobacco suits yielded over a \$200 billion settlement to be paid out to the states for health-related damages. *Id.* Mr. Scruggs's role in the litigation was later featured in the 1999 film, "The Insider." Mr. Lott currently sits on the U.S. Senate Committee on Finance, which, since 2005, has been reviewing the charity care practices of the nonprofit hospital industry. See U.S. S. Comm.

tial class action suits which have been followed by a growing list of derivative cases around the country brought under similar theories. At last count, there were over seventy suits filed in various federal courts alleging unfair hospital pricing of the uninsured.<sup>16</sup> The complaints centered around a variety of similar theories, including federal law governing tax-exempt organizations, federal law governing emergency care, state law governing charities, and state contract and tort principles.<sup>17</sup> The federal claims in the overwhelming majority of these cases consistently have been dismissed with prejudice.<sup>18</sup> With the exception of a few federal courts,<sup>19</sup> most of these courts have dismissed the state claims without prejudice. Many of these suits have since been, or soon will be, refiled in state courts in pursuit of the remaining state claims.<sup>20</sup> In at least thirteen state courts where the plaintiffs have refiled, the judges have denied the hospitals' initial attempts to have these cases dismissed.<sup>21</sup> Thus, this litigation currently appears to be most promising for those plaintiffs pursuing it at the state level because state courts are apparently willing to acknowledge the causes of action on the remaining state law theories.

The issues surrounding accessible health care are numerous and deserving of attention. This litigation concerning hospital pricing of services provided to uninsured patients is noteworthy because it attempts to alter the charity care practices of nonprofit hospitals through consumer-based class action litigation in state courts.<sup>22</sup> It may be unreasonable to expect nonprofit hospitals to provide free or discounted health care to every person lacking health insurance by voluntarily overhauling their respective charity care practices and policies; however, by drawing attention to the ongoing plight of the indigent, uninsured, and underinsured, this litigation could pressure nonprofit hospitals, as well as

---

on Fin., Comm. Members, <http://finance.senate.gov/sitepages/committee.htm> (last visited Mar. 4, 2007).

<sup>16</sup> *Nonprofit Hospital Charity Care Litigation*, HEALTH L. REP., Nov. 22, 2004, <http://healthcenter.bna.com/pic2/hc.nsf/id/BNAP-674MLV> (providing a detailed list of over seventy cases filed across the country); see also Hospital Watch, Hospital Watch Update, <http://www.hospitalpricegouging.org/main.html> (last visited Mar. 4, 2007) (providing court and settlement documents, as well as press releases regarding the nonprofit and for-profit hospital litigation).

<sup>17</sup> Crowley I, *supra* note 8.

<sup>18</sup> Press Release, Richard Scruggs, Statement from Dick Scruggs Nonprofit Hospital Litigation Status (Oct. 2005), available at <http://www.cliffordlaw.com/not-for-profit-hospital-class-action-litigation/press-releases/statement-from-dick-scruggs-nonprofit-hospital-litigation-status> [hereinafter Statement from Scruggs].

<sup>19</sup> See both *Kolari v. N.Y.-Presbyterian Hosp.*, 382 F. Supp. 2d 562, 579 (S.D.N.Y. 2005) and *Bobo v. Christus Health*, 227 F.R.D. 479, 483 (E.D. Tex. 2005), where the defendant hospitals' motions to dismiss the state claims were granted with prejudice.

<sup>20</sup> William McCall, *Hospital Settles Class-Action Claim by Uninsured*, ALBANY DEMOCRAT-HERALD, Nov. 3, 2005, at A7.

<sup>21</sup> Statement from Scruggs, *supra* note 18.

<sup>22</sup> Lisa W. Clark et al., *What May Arrive in Tomorrow's Mail?: An Analysis of Class Action Lawsuits Concerning Hospital Billing of Uninsured Patients*, 13 HEALTH L. REP. 1134, 1135 (2004).

legislators and the general public, to ask whether the hospitals are at least doing their financial part. This litigation could provoke change within an area of health care where state and federal legislatures, for-profit and nonprofit hospitals, and health insurance providers have failed in their attempts to find adequate remedies for the provision of discounted or affordable health care to all persons. Some hospital systems have already begun to act either in response to settlement agreements reached in their own litigation or simply in response to the negative attention surrounding these suits. Although most courts have indicated that the issue of nonprofit hospital pricing is more appropriate for the state legislatures to address, state consumer protection laws could be the means that brings this issue to a head in a state court.

When in need of medical care, uninsured patients are likely to look to nonprofit hospitals for medical attention because of mission statements, religious affiliations, and advertising materials that indicate helping the sick, poor, and uninsured are part of the hospital's core goals. Consequently, low-income uninsured persons are surprised when they are billed for medical services at what appear to be radically inflated rates. Although there are patients who lack health insurance, but can afford to pay the hospital bills, there are also patients who are without health insurance and lack the financial resources to pay the hospitals back. On the one hand, it is difficult to contest the price of saving a life. But if uninsured persons are expected to pay the full amount for the medical services they received then the resulting debt can be a real life financial nightmare. Whether nonprofit hospitals are to blame for not doing enough in the provision of charity care services or the patients are to blame for their own misunderstandings regarding the costs of the care they receive, the focus of this Note is on the state consumer protection laws upon which the plaintiffs are basing their claims and which could prove to be a catalyst for reform in the way hospitals administer and subsequently bill for medical services rendered to the uninsured.

The plaintiffs in the nonprofit hospital pricing litigation have generally alleged that the defendant hospitals have a duty to operate exclusively for a charitable purpose because they were granted tax-exempt status under state and federal law. Therefore, in Part II, this Note will discuss the history of nonprofit hospitals and their tax-exempt status. In Part III, this Note will explore the recent scrutiny these hospitals are under and identify the interesting connections that exist among the ongoing litigation in state courts, recent initiatives at the legislative and executive levels of government, and the impact some powerful nonprofit organizations have had in advocating for the uninsured. Finally, in Part IV, this Note will examine the California consumer protection laws serving as the basis for the claims made in a class action against California's Sutter Health network,<sup>23</sup> which is one of the suits that was refiled in a California state

---

<sup>23</sup> Complaint, *supra* note 1; see also Sutter Corporate Watch, What is Sutter Health?, <http://www.suttercorporatwatch.com/aboutsutter.php> (last visited Mar. 7, 2007).

court and showed particular promise for the plaintiffs that it would go to trial.

The California class action implicates Sutter Health which is a private, nonprofit corporation that owns and operates twenty-six hospitals in Northern California. The uninsured plaintiffs first brought suit in 2004 in the United States District Court of the Northern District of California.<sup>24</sup> The district court ultimately granted Sutter Health's motion to dismiss the patients' federal claims but dismissed the patients' state law claims without prejudice to refile in state court after declining to exercise supplemental jurisdiction over the state law claims. In July 2005, the plaintiffs refiled in the Superior Court of the State of California, County of Sacramento; however, in late 2006 the parties reached a settlement.<sup>25</sup> Despite the settlement, the California state law claims are worthy of review for at least two reasons. First, the Superior Court denied Sutter Health's initial motions to dismiss and, second, because Sutter Health countersued members of the class. These actions had the combined effect of indicating that this case might actually go to trial. Thus, a review of the two California consumer protection laws that make up two of the five causes of action<sup>26</sup> brought by the plaintiffs may prove relevant to hospital pricing cases brought in other states under similar theories. The plaintiffs in these hospital pricing cases generally allege that nonprofit hospitals have acted unlawfully, unfairly, or even fraudulently in their business with uninsured patients despite the charitable purposes for which they are supposed to operate in exchange for their tax-exempt status. Consequently, these suits have fueled the national debate regarding charity health care practices in the United States.

## II. A REVIEW OF NONPROFIT HOSPITALS AS TAX-EXEMPT ORGANIZATIONS

In the last several years, new attention has been given to the governance of nonprofit hospitals and to the way in which they are meeting their tax-exempt obligations.<sup>27</sup> There are several potential reasons for this focus, including, "financial and management scandals in both the for-profit and nonprofit sectors, the increased need for charity care in the wake of governmental cut-backs, and the changing economics of health care in general."<sup>28</sup> In effect, this attention has pressured nonprofit hospitals to examine their levels of disclosure, their methods of corporate governance, and their existing billing and debt col-

---

<sup>24</sup> *Darr v. Sutter Health*, No. C 04-02624 WHA, 2004 U.S. Dist. LEXIS 24592 (N.D. Cal. Nov. 30, 2004).

<sup>25</sup> *Sutter Health Uninsured Pricing Cases*, J.C.C.P. No. 4388 (Cal. Super. Ct. Dec. 12, 2006) (final order and judgment).

<sup>26</sup> Complaint, *supra* note 1, at 17-24. The three non-statutory based causes of action were unjust enrichment, breach of contract, and breach of duty of good faith and fair dealing.

<sup>27</sup> Thomas L. Greaney, *New Governance Norms and Quality of Care in Nonprofit Hospitals*, 14 ANN. HEALTH L. 421, 423 (2005).

<sup>28</sup> *Id.*

lection practices.<sup>29</sup> The public's expectations, statutory requirements, and judicial treatment of tax-exempt hospitals have evolved over time and vary from state to state. Thus, a national debate exists regarding the charity care practices of nonprofit hospitals and whether those practices are sufficient to satisfy the tax-exempt obligations and corresponding benefits the hospitals receive.

#### *A. Tax-Exempt Hospitals and the Provision of Charity Care*

In order for an organization to be tax-exempt, it must be organized and operated exclusively for the purposes set forth in § 501(c)(3) of the Internal Revenue Code.<sup>30</sup> Organizations meeting these requirements are commonly referred to as charitable organizations but also are considered "nonprofit" or "not-for-profit." The term "nonprofit" can be misleading because its meaning does not preclude an organization from earning a profit.<sup>31</sup> In order for an organization to be tax-exempt under the law, it is not sufficient that the organization be simply structured as a nonprofit entity, but rather it must meet specific federal statutory and regulatory requirements.<sup>32</sup> If the hospital qualifies for tax-exemption, then it is presumptively expected to meet certain standards in order for it to maintain that exemption; however, those standards are not always so easily interpreted and can be the source of confusion and controversy when the hospital is asked to justify its tax benefits.

According to the Internal Revenue Service ("IRS"), the term "charitable" as used to describe a § 501(c)(3) organization has come to mean an organization that provides for the "relief of the poor, the distressed, or the underprivileged; advancement of religion; [and] lessening the burdens of government."<sup>33</sup> Most individuals might associate "charity" or "charitable" as an activity or organization that benefits the poor or underprivileged members of society. These terms, however, have proved to be a gray area for courts when faced with deciding whether a nonprofit hospital is meeting its charitable obligations under § 501(c)(3). Specifically, the confluence of the IRS and common law interpretations of the word "charity" has evolved into the present day definition that applies to nonprofit hospitals.

---

<sup>29</sup> See *id.* at 423-28.

<sup>30</sup> 26 U.S.C. § 501(c)(3) (2000) ("Corporations, and any community chest, fund, or foundation, organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes, . . . no part of the net earnings of which inures to the benefit of any private shareholder or individual, no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation (except as otherwise provided in subsection (h)), and which does not participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of (or in opposition to) any candidate for public office.").

<sup>31</sup> BRUCE R. HOPKINS, 650 ESSENTIAL NONPROFIT LAW QUESTIONS ANSWERED 1 (2005).

<sup>32</sup> *Id.* at 40.

<sup>33</sup> Internal Revenue Serv., U.S. Dep't of the Treasury, Exemption Requirements, <http://www.irs.gov/charities/charitable/article/0,,id=96099,00.html> (last visited Mar. 7, 2007).

The general usage of the word charity means “relief of the poor.” The word “charitable” can also be traced back through common law to mean “any function promoting the general welfare of society.” Initially, the IRS subscribed to the “relief of the poor” interpretation [or charity care standard] . . . . When hospitals started serving the entire community instead of limiting themselves to the indigent, a significant source of their revenue came from paying patients. Thus, if nonprofit hospitals were going to retain their tax-exempt status, “charitable” needed to be redefined. Consequently, the common law meaning of charitable [any function promoting the general welfare of society] began to apply to the tax code.<sup>34</sup>

Thus, for purposes of federal tax-exemption as it applied to nonprofit hospitals, the meaning of “charitable” evolved from a connotation that the hospital had to provide “relief of the poor” to a legally acceptable standard that considered the general “promotion of health” to the community as sufficient justification for exemption. The competing standards are generally referred to as the “charity care standard” and the “community benefit standard.”<sup>35</sup> The charity care standard initially adopted by the IRS was first evident in a 1956 Revenue Ruling which found that in order to qualify for tax-exemption, a hospital “must be operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay.”<sup>36</sup> Thus, serving the poor became a prerequisite for exemption. This interpretation lasted until nonprofit hospitals started serving the entire community which led the IRS to adopt broader interpretations of the word charitable.

This relaxing of requirements was confirmed with Revenue Ruling 69-545.<sup>37</sup> The standard changed to one that considered the benefit a hospital pro-

---

<sup>34</sup> Jack Burns, Note, *Are Nonprofit Hospitals Really Charitable?: Taking the Question to the State and Local Level*, 29 J. CORP. L. 665, 667 & n.25, 668 (2004) (quoting A. Kay B. Roska, Comment, *Nonprofit Hospitals: The Relationship Between Charitable Tax-exemptions and Medical Care for Indigents*, 43 Sw. L.J. 759, 763-65 (1989)); see also Jack E. Karns, *Justifying the Nonprofit Hospital Tax-exemption in a Competitive Market Environment*, 13 WIDENER L.J. 383, 523 (2004). Although § 501(c)(3) does not specifically mention “hospital” or “health care,” hospitals have generally proposed two justifications for the federal tax-exemptions they receive. *Id.* First, hospitals assert that the health care services they provide have “traditionally been included implicitly with those services that are listed in the federal exemption statute.” *Id.* Second, they point to IRS administratively institutionalized exemptions, which are created by revenue rulings and have been used to justify the nonprofit hospital exemption. *Id.*

<sup>35</sup> See generally Burns, *supra* note 34, at 676-78.

<sup>36</sup> Rev. Rul. 56-185, 1956-1 C.B. 202; see generally Burns, *supra* note 34, at 667-68.

<sup>37</sup> Rev. Rul. 69-545, 1969-2 C.B. 117, 117-19 (adopting the community benefit standard over the charity care standard). The ruling held in relevant part, “[t]he promotion of health, like the relief of poverty and the advancement of education and religion, is one of the purposes in the



vides to the community as a whole even though the hospital may not provide direct benefits to indigent community members.<sup>38</sup> While this Ruling confirmed a shift of interpretations in the tax code, it likely had little effect in changing the average consumer's perceptions of the word "charity,"<sup>39</sup> which arguably are more consistent with a "relief of the poor" interpretation rather than the community benefit standard adopted by the IRS. Nevertheless, the IRS offered with Revenue Ruling 69-545 factors to assist in the assessment of a nonprofit hospital's tax-exempt status.<sup>40</sup> When the provision of charity care was dropped from a hospital's tax-exemption requirements, hospitals were granted greater flexibility to develop charity care policies and procedures that would best fit within their business plans while also ensuring the retention of their tax-exempt status.

Despite the federal shift in tax-exempt standards from a charity care approach to a community benefit assessment, issues still arise when it comes to determining whether a hospital is in fact providing an appropriate level of benefit to the community to justify its tax-exempt status.<sup>41</sup> For example, proponents of the charity care standard prefer a system where "for every dollar of taxes forgone, the public get a 100% return in the form of free hospital services" on the premise that the flexibility of the community benefit standard is not sufficiently quantifiable to justify tax-exemptions.<sup>42</sup> Without the strict guidelines of a charity care standard, some propose that the nonprofit sector has "created opportu-

---

general law of charity that is deemed beneficial to the community as a whole even though the class of beneficiaries eligible to receive a direct benefit from its activities does not include all members of the community, such as indigent members of the community, provided that the class is not so small that its relief is not of benefit to the community." *Id.*

<sup>38</sup> Rev. Rul. 69-545, 1969-2 C.B. 117, 118. See also Helena G. Rubenstein, *Nonprofit Hospitals and the Federal Tax-exemption: A Fresh Prescription*, 7 HEALTH MATRIX 381, 397 (1997); Burns, *supra* note 34, at 668 & n.37.

<sup>39</sup> WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY 378 (3d ed. 1961) ("an organization or institution engaged in the free assistance of the poor, the suffering, or the distress; public provision for the care or relief of the needy").

<sup>40</sup> Burns, *supra* note 34, at 668-69 (citing Rev. Rul. 69-545, 1969-2 C.B. 117). These factors as appearing in the Ruling include, "(1) whether a board of trustees control the hospital and, if so, whether civic leaders compose the board; (2) whether the hospital has an open medical staff and extends privileges to all qualified physicians in the area; (3) whether the hospital operates an active and accessible emergency room, regardless of patients' ability to pay; (4) whether the hospital provides medical care to all persons able to pay; and (5) whether surplus funds, when used, improve the quality of patient care." *Id.* According to the IRS, a hospital that meets these factors is operating for a public rather than private purpose. *Id.* at 669. This federal shift from a requirement of charity care to an acknowledgement of general community benefits was further supported by Rev. Rul. 83-157, 1983-2 C.B. 94, 95, which held that a nonprofit hospital could still qualify for exempt status even if it had no emergency care facilities as long as the general purposes of the hospital sufficiently benefited the community. Burns, *supra* note 34, at 669.

<sup>41</sup> Burns, *supra* note 34, at 667.

<sup>42</sup> *Id.* at 676 & n.141 (citing Mark A. Hall & John D. Colombo, *The Charitable Status of Nonprofit Hospitals: Toward a Donative Theory of Tax-exemption*, 66 WASH. L. REV. 307, 345-63 (1991) (explaining the "quid pro theory" as it applies to hospitals and assessing why this charity care standard is inadequate for the exclusive basis for tax-exemption)).

nities for [hospital] noncompliance” with even minimum community benefit standards.<sup>43</sup> Regardless of the outcome of the national debate over the competing standards, consumers without health insurance are left to assess whether the nonprofit hospital in their community will be providing them health care within the context of free or discounted care or instead within the broad parameters of the federal, community benefit definition.

*B. State and Local Interpretations of Competing Federal Standards for Tax-Exemption*

When nonprofit hospitals benefit from their tax-exempt status, many states and local governments bear a corresponding burden in the form of lost revenue.<sup>44</sup> A nonprofit corporation is not automatically exempt from federal and state taxes. Before a hospital can receive federal tax-exempt status, it must first apply for nonprofit incorporation at the state level. Once incorporated as a nonprofit, the hospital can apply to the IRS for federal tax-exemption. If granted exemption from federal income taxes, then states vary on their exemption requirements: “some states require a separate application to get a state tax-exemption; some states are satisfied with your federal tax-exempt status; and in others, [the hospital] will need to send a copy of [its] IRS determination letter” to the appropriate state agency.<sup>45</sup> It is to the state’s advantage to develop, and hold nonprofit hospitals accountable to, minimum standards for the provision of medical care to its uninsured and indigent residents when the federal prerequisite for tax-exemption is the lenient community benefit standard. The federal government is less inclined to heighten the qualifications for tax-exemption because “[t]he amount of money [it] expends through Medicare and Medicaid programs predisposes the federal government to favor efficient, business-like hospitals” rather than entities burdened with meeting the needs of charity cases.<sup>46</sup> When nonprofit hospitals adopt more commercial, profit oriented policies and operations, state and local communities tend to lose charitable health services. Consequently, it may be up to the states to take a more active role in the regulation of these organizations. Although some state legislatures have taken proactive steps toward ensuring that nonprofit hospitals are providing an adequate amount of charity care,<sup>47</sup> this Note examines whether consumer protection laws may also serve as an impetus for reform via the judiciary.

---

<sup>43</sup> Ice Miller LLP, *Survey of Recent Developments in Health Law*, 39 IND. L. REV. 1051, 1072 (2006) (quoting *The Tax-Exempt Sector Before the H. Comm. on Ways & Means*, 109th Cong. 19 (2005) (statement of Mark Everson, Commissioner, Internal Revenue Service)).

<sup>44</sup> Burns, *supra* note 34, at 679.

<sup>45</sup> Joanne Fritz, *Nonprofit Incorporation—The First Step to Forming a Tax-Exempt Nonprofit*, <http://nonprofit.about.com/od/nonprofitbasics/a/incorporating.htm> (last visited Mar. 9, 2007).

<sup>46</sup> Burns, *supra* note 34, at 678.

<sup>47</sup> See *infra* text accompanying notes 77-82.

Despite the federal shift to the community benefit standard,<sup>48</sup> some state courts have rejected the IRS's opinion that the provision of health care is inherently charitable and instead have adopted interpretations of their respective state statutes that are more consistent with the charity care standard.<sup>49</sup> When doing so, states tend to utilize one of two approaches in considering their hospitals' tax-exempt status: the "process approach" (which is closer to the community benefit standard) in states such as California,<sup>50</sup> and the "prescriptive approach" (which often requires a minimum amount of charity care) in states such as Pennsylvania and Utah.<sup>51</sup> Claims brought in states that have adopted the prescriptive approach may be more successful because courts can more readily determine whether the hospital has quantifiably satisfied its charity care mandates. This does not necessarily preclude equally successful claims in states that have adopted the process approach. The basis of the claims in the nonprofit hospital pricing litigation is not a direct challenge to a hospital's tax-exempt status. Instead, the plaintiffs alleged that hospitals are misleading the public in holding themselves out to be a charitable organization operating for the benefit of the community, but are in turn overcharging those members of the community who are in the greatest need of their fair pricing.

### C. State Recognition of the Community Benefit Standard

Although the Sutter Health pricing case has settled, a review of the California laws regarding tax-exemption may help to put the plaintiffs' consumer protection claims in the appropriate context. A nonprofit corporation exempt from federal taxes must still apply for exemption from the California tax, but the state taxation laws in California are similar to the federal laws in that they generally adopt the community benefit standard.

In Article XIII, Section 4(b) of the California Constitution, nonprofit hospitals are granted express exemption from real estate taxation. Specifically, this section provides that the legislature may exempt from taxation in whole or in part "[p]roperty used exclusively for religious, *hospital*, or charitable purposes and owned or held in trust by corporations or other entities (1) that are organ-

---

<sup>48</sup> See *supra* text accompanying note 37.

<sup>49</sup> Burns, *supra* note 34, at 674-76.

<sup>50</sup> See *infra* text accompanying notes 52-56.

<sup>51</sup> Leah Snyder Batchis, *Can Lawsuits Help the Uninsured Access Affordable Hospital Care?: Potential Theories for Uninsured Patient Plaintiffs*, 78 TEMP. L. REV. 493, 511 (2005). See also *Hosp. Utilization Project v. Commonwealth*, 487 A.2d 1306, 1317 (Pa. 1985) (finding that a hospital is charitable if it meets the following five prongs: 1) advances a charitable purpose, 2) donates or renders gratuitously a substantial portions of its services, 3) benefits a substantial and indefinite class of persons who are legitimate subjects of charity, 4) relieves the government of some of its burden, and 5) operates entirely free from profit motive); *Utah County v. Intermountain Health Care, Inc.*, 709 P.2d 265, 278 (Utah 1985) (denying state tax-exemption to two nonprofit hospitals because they were not operated for "charitable" purposes in accord with the state's interpretation of charity, which was a "gift to the community").

ized and operating for those purposes, (2) that are nonprofit, and (3) no part of whose net earnings inures to the benefit of any private shareholder or individual."<sup>52</sup> Thus, California law clearly provides the prerequisites for a hospital's tax-exempt status where federal laws do not. The California legislature added further support for a hospital's tax-exemptions in the California Revenue and Taxation Code,<sup>53</sup> which provides in relevant part:

Property used exclusively for religious, *hospital*, scientific, or charitable purposes owned and operated by community chests, funds, foundations, limited liability companies, or corporations organized and operated for religious, hospital, scientific, or charitable purposes is exempt from taxation, . . . if: (1) The owner is not organized or operated for profit. However, in the case of hospitals, the organization shall not be deemed to be organized or operated for profit if, during the immediately preceding fiscal year, operating revenues, exclusive of gifts, endowments and grants-in-aid, did not exceed operating expenses by an amount equivalent to 10 percent of those operating expenses. As used herein, operating expenses include depreciation based on cost of replacement and amortization of, and interest on, indebtedness. . . . The exemption provided for herein shall be known as the "welfare exemption."<sup>54</sup>

Although California has taken steps to include hospitals within its "welfare exemption," not every state has been so explicit.<sup>55</sup> California case law has confirmed that the benefit a hospital provides to its community is a factor to consider in justifying tax-exemption.<sup>56</sup>

<sup>52</sup> CAL. CONST. art. XIII, § 4(b) (emphasis added); *see also* Nat'l Charity League, Inc. v. County of Los Angeles, 330 P.2d 666 (Cal. Ct. App. 1958) (finding that this exemption is not a constitutional mandate, but permissive such that the legislature may extend or deny exemption to any of the organizations listed in the Constitution).

<sup>53</sup> Kellen McClendon, *What the National Health Care Debate Tells Us About Whether Hospitals are Entitled to Exemption from Real Estate Taxes*, 6 WIDENER J. PUB. L. 41, 45 (1996).

<sup>54</sup> CAL. REV. & TAX. CODE § 214(a) (West 1998) (emphasis added).

<sup>55</sup> McClendon, *supra* note 53, at 46 & n.12 (citing FLA. CONST. art. VII, § 3(a); MASS. CONST. pt.2, ch.1, 1, art. IV (amended 1978); MO. CONST. art. X, § 6; OR. CONST. art. IX, § 1; TENN. CONST. art. II, § 28; UTAH CONST. art. XIII, § 2; FLA. STAT. § 196.192 (1989); MASS. GEN. LAWS ch. 59, 5, cl. 3 (1994); MO. REV. STAT. § 137.100(5) (1988); OR. REV. STAT. § 307.130 (1995); TENN. CODE ANN. § 67-5-212 (1994); UTAH CODE ANN. § 59-2-1101 (1996)).

<sup>56</sup> *Id.* at 48 & n.16 (citing *Rideout Hosp. Found., Inc. v. County of Yuba*, 10 Cal. Rptr. 2d 141, 143 (Cal. Ct. App. 1992) (holding that "[t]he rationale for the welfare exemption is that the exempt property is being used either to provide a government-like service or to accomplish

State court interpretations of the state tax laws regarding nonprofits vary, but some common trends are identifiable in those states where the state exemption laws are similar to the federal versions. For example, Vermont granted nonprofit hospitals tax-exemption because it saw the social value and potential community benefit that can be derived from the general provision of health care.<sup>57</sup> The Supreme Court of Vermont dealt with hospital exemptions in *Medical Center Hospital v. Burlington*<sup>58</sup> where the plaintiff hospital sought a declaratory judgment that its property qualified for exemption under state tax laws<sup>59</sup> after the City of Burlington sent the hospital a notice of assessment and a tax bill. The hospital argued that its goal “of establishing and maintaining a public hospital and nursing home exclusively for charitable and educational purposes” was consistent with the community benefit standard for exemption.<sup>60</sup>

Acknowledging the changing landscape of health care facilities, as well as the change in meaning of the word “charitable,”<sup>61</sup> the court decided it was the role of the legislature to grant tax-exemptions and that, accordingly, the hospital was indeed tax-exempt because it was “a not-for-profit institution with a recognized charitable purpose whose services [were] available regardless of ability to pay and whose excess revenues [were] devoted to the maintenance of its purpose . . . .”<sup>62</sup> Although the Vermont court showed deference to the legislative mandate, if consumers continue to challenge the extent to which a hospital is benefiting the community in exchange for the tax breaks it is receiving, then the judiciary may prove to be a forum for successful challenges of the nonprofits’ business practices. As the debate surrounding the validity of hospital tax breaks moves to state courts, plaintiffs’ attorneys will likely draw on the disparity between the rates accepted for those participants in federal programs and the rates private insurance companies negotiate compared to the list prices a nonprofit hospital bills its uninsured patients. If great disparity exists, it could serve as the premise for arguments that the nonprofit hospital is not meeting its tax-exempt obligations. The more a hospital’s representations are likely to mislead or deceive patients, the more difficult it will be to downplay the inadvertent deception as insignificant when compared to the community benefit derived from the hospital’s services.

---

some desired social objective”).

<sup>57</sup> Burns, *supra* note 34, at 676.

<sup>58</sup> *Med. Ctr. Hosp. v. Burlington*, 566 A.2d 1352, 1353 (Vt. 1989).

<sup>59</sup> VT. STAT. ANN. tit. 32, § 3802(4) (1994) (exempting from taxation “[r]eal and personal estate granted, sequestered or used for public, pious or charitable uses . . .”).

<sup>60</sup> *Med. Ctr. Hosp.*, 566 A.2d at 1353.

<sup>61</sup> *Id.* at 1356 (quoting *SHARE v. Comm’r of Revenue*, 363 N.W.2d 47, 52 (Minn. 1985)) (“The term ‘charitable’ as applied to health care facilities has been broadened since earlier times, when it was limited mainly to almshouses for the poor.”).

<sup>62</sup> *Id.* at 1357; *see also* Burns, *supra* note 34, at 675-76 (discussing *Utah County v. Intermountain Health Care, Inc.*, 709 P.2d 265 (Utah 1985), *Hosp. Utilization Project v. Commonwealth*, 487 A.2d 1306 (Pa. 1985), and *Med. Ctr. Hosp. v. Burlington*, 566 A.2d 1352 (Vt. 1989), to “show that the question of granting tax-exempt status to a nonprofit hospital is a political and policy question that will be determined on a state-by-state basis.”)

### III. RECENT SCRUTINY FROM THE EXECUTIVE AND LEGISLATIVE BRANCHES AND GRASSROOTS ORGANIZATIONS

#### A. Congressional Hearings Regarding the Tax-Exempt Health Sector

The United States House of Representatives Committee on Ways and Means held a hearing on May 26, 2005, at which it received testimony that raised questions about what a hospital should be required to do to deserve exempt status.<sup>63</sup> During this hearing, David Walker, the Government Accountability Office Comptroller General of the United States, summed up his testimony by stating that

the current tax policy lacks specific criteria with respect to tax-exemptions for charitable entities, . . . including not-for-profit hospitals, in particular. If these criteria are articulated in accordance with desired public policy goals, standards could be established that would allow not-for-profit hospitals to be held accountable for providing services that benefit the public commensurate with their tax-favored status.<sup>64</sup>

In a time of increasing health care costs, the hearing was an effort to review former, as well as existing, standards and criteria, used to determine whether a hospital is eligible for tax-exempt status.<sup>65</sup> The May 26 hearing was one of several hearings regarding the tax-exempt sector, but this one in particular focused on nonprofit hospitals qualifying for tax-exempt status.<sup>66</sup> The Chairman of the Committee explained the hearing was not an attempt to “pick on” the hospitals but was necessary because the majority of revenue in the charitable sector was going to tax-exempt hospitals.<sup>67</sup> According to one account, nonprofit hospitals in the United States made up only 1.9 percent of the charitable organizations under § 501(c)(3) in 2001, but received 41 percent or \$337 billion in tax expenditures.<sup>68</sup> Moreover, less and less was being required

---

<sup>63</sup> *The Tax-Exempt Sector Before the H. Comm. on Ways & Means*, 109th Cong. *passim* (2005) [hereinafter House Hearing on Tax-Exempt Sector].

<sup>64</sup> *Id.* at 20.

<sup>65</sup> Independent Sector, Congressional Oversight: House Ways and Means Committee Holds Hearing on Tax-Exempt Hospitals, <http://www.independentsector.org/programs/gr/hospital.html> (last visited Mar. 9, 2007) (“[I]n a recent study of hospitals in five strategically selected states, the GAO found little difference between the level of uncompensated care offered by for-profit and nonprofit hospitals.”) (paraphrasing the testimony of GAO Comptroller General David Walker).

<sup>66</sup> *Id.*

<sup>67</sup> House Hearing on Tax-Exempt Sector, *supra* note 63, at 4-5.

<sup>68</sup> Batchis, *supra* note 51, at 513 & n.161 (citing Press Release, Subcomm. On Oversight, H. Comm. on Ways & Means, Houghton Announces First Hearing in a Series on Tax-

of these hospitals in order to maintain their tax-exempt status. Since this is where the money was, so to speak, the Committee considered it within its congressional responsibility to ask what it is that taxpayers are getting in return for the billions of dollars hospitals are receiving in tax subsidy.<sup>69</sup> Although no witnesses offered specific recommendations for changing the tax-exempt policies for nonprofit hospitals, witnesses did testify that legislators should proceed with caution because major policy changes had the potential “for profound negative and unintended consequences to the sector.”<sup>70</sup>

In May 2005, United States Senator Chuck Grassley issued a letter in his role as Chairman of the Committee on Finance to ten hospitals and hospital systems requesting responses to extensive questioning about their business practices as related to charitable activities, patient billing, and ventures with for-profit companies.<sup>71</sup> On September 12, 2006, the Committee released a compilation of the responses it had received from the ten nonprofit hospitals Grassley had written in 2005.<sup>72</sup> The next day, the Committee held a hearing during which Senator Grassley focused his opening statement on two issues regarding the nonprofit sector: “measurements and reporting of community benefit and also discounted charges or free care to low-income uninsured individuals.”<sup>73</sup> Senator Grassley commended one hospital system in particular for their development of best practices for measuring and reporting their activities within the community benefit context.<sup>74</sup> Testimony revealed some of the challenges nonprofit hospitals face despite well-developed policies committed to providing a community benefit.<sup>75</sup> Senator Grassley acknowledged that under

---

exemption: Pricing Practices of Hospitals (June 15, 2004), available at <http://waysandmeans.house.gov/hearings.asp?formmode=view&id=1673>).

<sup>69</sup> House Hearing on Tax-Exempt Sector, *supra* note 63, at 4.

<sup>70</sup> Independent Sector, *supra* note 65.

<sup>71</sup> Press Release, Grassley.Senate.gov, Grassley Asks Non-Profit Hospitals to Account for Activities Related to Their Tax-Exempt Status (May 25, 2005), available at [http://grassley.senate.gov/index.cfm?FuseAction=PressReleases.Detail&PressRelease\\_id=4921](http://grassley.senate.gov/index.cfm?FuseAction=PressReleases.Detail&PressRelease_id=4921) (reprinting the text of Senator Grassley’s letter to the ten hospitals and hospital systems).

<sup>72</sup> U.S. S. COMM. ON FIN., SUMMARY OF 10 NON-PROFIT HOSPITAL RESPONSES *passim* (2006), <http://finance.senate.gov/press/Gpress/2005/prg091206summary.pdf>.

<sup>73</sup> U.S. S. Comm. on Fin., Taking the Pulse of Charitable Care and Community Benefits at Nonprofit Hospitals, Opening Statement of Chairman Grassley, <http://finance.senate.gov/hearings/statements/091306cg.pdf> (last visited Mar. 27, 2007).

<sup>74</sup> *Id.*

<sup>75</sup> U.S. S. Comm. on Fin., Taking the Pulse of Charitable Care and Community Benefits at Nonprofit Hospitals, Testimony: Sister Carol Keehan, <http://finance.senate.gov/hearings/testimony/2005test/091306cktest1.pdf> (last visited Mar. 27, 2007). Sister Keehan, the President and Chief Executive Officer of Catholic Health Association of the United States, testified that some of the challenges facing nonprofit hospitals include, but are not limited to, the growing numbers of low-income uninsured persons in need of medical attention, the difficulty in distinguishing patients who will not pay their health care bills from those who unable to pay, and the challenge of identifying those patients who are eligible for financial assistance. *Id.* Sister Keehan also stressed that “community benefit is much more than providing charity care and discounted care to low-income persons. We also have a responsibility

the present system there is little common ground from which to develop policies or answer basic questions regarding the activities of tax-exempt hospitals.<sup>76</sup>

*B. State Legislatures Address the Charity Care Practices of Hospitals within Their Borders*

Recognizing that state laws regarding tax-exemption are lacking in certain respects, some state legislatures have enacted laws that set more specific standards and requirements for exemption. For example, Illinois and Connecticut adopted new legislation specifically regulating nonprofit hospital billing and collection practices.<sup>77</sup> This legislation includes the following: “notice requirements about available free care on all bills from debt collectors; prohibitions on the filing of collection lawsuits by hospitals against patients eligible for free care; setting required levels of discounts for low-income uninsured patients; and capping interest rates hospitals charge on hospital debt.”<sup>78</sup> These consumer oriented initiatives go toward imposing at the state and local level a corresponding burden on the hospitals for the significant tax benefits they receive.

In the wake of class actions brought against nonprofit hospitals in California federal court, the California legislature passed Senate Bill 379 in August 2004.<sup>79</sup> Although Governor Arnold Schwarzenegger ultimately vetoed this legislation, Senate Bill 379 would have required nonprofit hospitals

to develop charity care and reduced payment policies including requirements for discounted or free care to patients whose income is at or below 400% of the federal poverty level. [D]evelop applications for charity care, provide oral and written notices to patients of the availability of charity care and discount policies, and limit

---

to the whole community.” *Id.* at 5.

<sup>76</sup> U.S. S. Comm. on Fin., Taking the Pulse of Charitable Care and Community Benefits at Nonprofit Hospitals, Closing Statement of Chairman Grassley, <http://finance.senate.gov/hearings/statements/091306cg.pdf> (last visited Mar. 27, 2007). In his closing statement, Senator Grassley directed the Finance Committee staff to develop a staff discussion paper that would provide the Finance Committee members with proposals to consider in addressing the issues covered at the hearing with particular emphasis on those proposals consistent with the community benefit standard. *Id.*

<sup>77</sup> Batchis, *supra* note 51, at 505 & n.97 (citing The Access Project, Hospital Billing and Collection: AHA Guidelines on Providing Financial Assistance to Uninsured Low-Income Patients, <http://www.accessproject.org/hospital.html> (last visited Mar. 12, 2007)).

<sup>78</sup> *Id.*

<sup>79</sup> John P. Krave, Gerry Hinkley & Jill H. Gordon, *Schwarzenegger Vetoes Charity Care Bill – Calls for Hospitals to Implement Hospital Association’s Voluntary Charity Care Guidelines*, DAVIS, WRIGHT, TREMAINE, LLP, HEALTH L. ADVISORY BULL., Sept. 2004, at 1, available at [http://www.dwt.com/practc/healthcr/bulletins/09-04\\_CharityCare.htm](http://www.dwt.com/practc/healthcr/bulletins/09-04_CharityCare.htm).



hospital debt collection activities during the first 150 days after a patient's discharge.<sup>80</sup>

Historically, California had been a community benefit state. By comparison, this legislation seemed an attempt to move toward a charity care standard through the imposition of specific requirements on California's nonprofit hospitals. Governor Schwarzenegger, however, chose to ask for the hospitals' voluntary compliance with guidelines proposed by the California Healthcare Association rather than to require them by statute.<sup>81</sup> Senate Bill 379 was, at least in part, an acknowledgment that the nonprofit litigation discussed in this Note could potentially persuade unsympathetic juries to find in favor of the patients if nonprofit hospitals continued to appear unresponsive to the community's concern over their charitable health services.<sup>82</sup>

### C. *State Attorneys General Act on Their Role of Supervising Charitable Organizations*

Several state attorneys general brought claims against, or initiated investigations of, nonprofit hospitals regarding their charity care practices.<sup>83</sup> Generally, a state attorney general supervises charitable organizations, as well as individuals that solicit charitable funds, administer charitable assets, or both. The attorney generals for Connecticut, Minnesota, Wisconsin, and Illinois have taken investigative action, brought suit, or proposed legislation in an effort to ensure that nonprofit hospitals within their respective states were meeting tax-exempt obligations.<sup>84</sup>

For example, Illinois Attorney General Lisa Madigan proposed legislation she believed would make certain that nonprofit hospitals were meeting their

---

<sup>80</sup> *Id.*

<sup>81</sup> *Id.* ("The 'voluntary guidelines' mentioned by Governor Schwarzenegger are, in fact, the 'Voluntary Principles and Guidelines for Assisting Low-Income and Uninsured Patients' . . . adopted on Feb. 6, 2004 by CHA [the California Healthcare Association]. The Guidelines propose, among other items, that hospitals adopt and communicate policies whereby patients with incomes at or below 300 percent of the federal poverty limit be eligible to apply for financial assistance under charity care policies, and that hospitals should limit expected payments from these patients to 'amounts that do not exceed the payment the hospital would have received from Medicare, other government-sponsored health programs, or as otherwise deemed appropriate by the hospital.'") (quoting California Healthcare Association's "Voluntary Principles and Guidelines for Assisting Low-Income Uninsured Patients").

<sup>82</sup> *Id.*

<sup>83</sup> Leo T. Crowley, *Charity Care Cases: Further Developments*, N.Y. L.J., Apr. 27, 2005, at 6 [hereinafter Crowley II].

<sup>84</sup> *Id.* See also Boulton, *supra* note 9 (discussing complaints filed by the Wisconsin Attorney General "accusing nonprofit hospitals of charging uninsured patients much higher prices than they charge managed care companies.").

obligations as a tax-exempt organization.<sup>85</sup> Attorney General Madigan explained,

Hospitals, when they decide to be nonprofits, they strike a deal with the state. The deal is that you don't have to pay property taxes, you don't have to pay sales taxes, you don't pay income taxes, and you get tax-exempt bonds when you do construction. For that multibillion-dollar benefit, they have to provide charity care for people. It's not a revolutionary idea out there. The hospitals know that is the deal they have struck.<sup>86</sup>

Whether this truly is the essence of the “deal struck” is a subject for another discussion because the standards and requirements for tax-exempt status vary from state to state and are not always as simple as free or discounted medical care in exchange for tax-exempt status. Madigan's efforts were at least an attempt to ensure hospitals were doing their part even within the broader community benefit context. The Illinois Hospital Association, however, reports that hospitals in Illinois are currently providing more than one billion dollars annually in free medical care and some have even proposed that “a hospital's benefit to its community cannot simply be measured by the amount of free care (charity care) it provides.”<sup>87</sup> This disparity highlights the tension between proponents of the federally adopted community benefit standard and proponents, particularly those at the state level, of a charity care standard.

#### *D. Advocacy Groups Acting on behalf of Uninsured Patients*

Certain nonprofit organizations have been working as advocates on behalf of uninsured patients and have proved to be highly effective not only in persuading hospitals to reduce or forgive patient debt but also in keeping the issue of hospital pricing in the national spotlight. The coordinated efforts of these organizations have also pressured hospitals to examine their pricing. If a hospital assesses and consequently reduces the list prices for its services, then private health insurance companies unable to negotiate lower rates on their own can also benefit. For example, Consejo de Latinos Unidos, which is a national nonprofit organization based in Los Angeles, California, works to educate and represent uninsured Latinos and others dealing with allegedly inflated hospital

---

<sup>85</sup> Matt Adrian, *Illinois AG outlines proposal to increase hospital charity*, QUAD-CITY TIMES, Jan. 24, 2006, available at <http://www.qctimes.com/articles/2006/01/24/news/state/doc43d5b7e440e48455965111.txt>.

<sup>86</sup> *Id.*

<sup>87</sup> Aaron Chambers & Andrea Preston, *Plan seeks stepped-up charity care: Officials at Rockford's three hospitals are cool to the attorney general's proposal*, ROCKFORD REGISTER STAR, Jan. 24, 2006, at 6.

bills.<sup>88</sup> Mr. K.B. Forbes founded this group in 2001 and has been successful in assisting overcharged patients to reduce or eliminate their hospital bills. Mr. Forbes and his group have also worked closely with plaintiffs' attorneys involved in the for-profit and nonprofit hospital pricing litigation to secure settlements from defendant hospitals and generally keep this issue in the national spotlight.<sup>89</sup>

Although some commend Mr. Forbes's efforts, others note that in addition to his victories on behalf of the uninsured, at least some private insurance executives are also benefiting. One such executive is Mr. J. Patrick Rooney who has operated various successful insurance companies in Indianapolis, Indiana, while at the same time maintaining a prominent political presence in the health care sector. Mr. Rooney's company, Medical Savings Insurance, a relatively small health insurance provider, at one time benefited from Mr. Forbes's efforts. When for-profit Tenet Healthcare Corporation, the nation's second-largest hospital chain, finally yielded in 2003 to Mr. Forbes's pressure and agreed to implement discounts for the uninsured, Tenet applied the discounts to Medical Savings Insurance, which, unlike the much larger players in the industry, could not negotiate significant discounts on its own.<sup>90</sup> As a result of this pressure, Tenet forgave at least \$2 million in bills that Rooney's company had refused to pay in protest over inflated prices and additionally agreed to accept reduced payments from Rooney's company on future claims.<sup>91</sup>

In addition to his significant GOP political contributions, Mr. Rooney pledged seed money to Consejo de Latinos Unidos and hired a Washington public relations firm to draw attention to its cause.<sup>92</sup> A second national advocacy group known as the Hospital Victims Project, an effort of the Fairness Foundation, appears to have ties to Mr. Rooney as well.<sup>93</sup> The Fairness Foun-

---

<sup>88</sup> See generally Consejo de Latinos Unidos, About Us, <http://hospitalpricing.com/aboutus.asp> (last visited Mar. 12, 2007).

<sup>89</sup> Tamar Lando, *Pocket Protector: K.B. Forbes is defending uninsured patients. Never mind why*, MOTHER JONES, May 1, 2005, at 22; see also *60 Minutes: Hospitals, Is the Price Right?* (CBS television broadcast Mar. 5, 2006), available at [http://www.cbsnews.com/stories/2006/03/02/60minutes/main1362808.shtml?source=search\\_story](http://www.cbsnews.com/stories/2006/03/02/60minutes/main1362808.shtml?source=search_story).

During the House Committee on Ways and Means May 26, 2005 hearing on the tax-exempt hospital sector, Mr. Forbes submitted a statement that made the following allegation: "Although non-profit hospitals do wonderful life-saving work and give away millions in charity care and uncompensated care, the truth is after all the spin and all the public relations: the uninsured are still being charged three or four times more for the exact same care, executives are still being paid excessively, sometimes in the millions of dollars, the non-profits are still siphoning off billions in off-shore accounts." House Hearing on Tax-exempt Sector, *supra* note 63, at 136.

<sup>90</sup> Lando, *supra* note 89.

<sup>91</sup> Lorraine Woellert, *Making Hospitals Cry Uncle*, BUS. WK., June 7, 2004, at 112 (discussing how Mr. Rooney has not only used the power of his ideas and political connections to make his company profitable but also to back Consejo de Latinos Unidos, which uses hardball tactics to get hospitals to cut prices).

<sup>92</sup> *Id.*

<sup>93</sup> See generally Hospital Victims, <http://hospitalvictims.com> (last visited Mar. 12,

dation is cited as the source of statements and statistics appearing on Consejo's Web site regarding the hospital industry's alleged practice of overcharging the uninsured.<sup>94</sup> The Fairness Foundation maintains a Web site and operates out of the same address as Medical Savings Insurance in Indianapolis, Indiana.<sup>95</sup> The pressure coming from organizations like Consejo and the Hospital Victims Project is troubling for hospitals because "[n]obody wants these cases where someone was sick and the big, bad hospital is suing them [to collect payment]," says Mr. Richard Morrison, a vice president at Orlando's Adventist Health System, who also said Rooney's Medical Savings Insurance owes Adventist an estimated one million dollars.<sup>96</sup>

Despite protests to the contrary, some industry insiders view the relationship between advocacy groups and insurance companies as the means to an end that has directly benefited not only for the uninsured patients seeking relief from their hospital bills but also insurance executives wanting to challenge and reduce rates hospitals charge for their services.<sup>97</sup> "Rooney, who has led two insurance companies that specialize in selling both the health savings accounts and the catastrophic insurance policies, has lobbied hard for this 'consumer-driven solution' to health care."<sup>98</sup> The profitability of his company and the success of his initiatives depends, at least in part, on hospitals charging reasonable rates for the services they provide. Therefore, when Consejo successfully pressures a hospital to reduce its rates, other interested parties stand to receive corresponding benefits.

---

2007).

<sup>94</sup> See Consejo de Latinos Unidos, How to Defend Yourself, <http://hospitalpricing.com/uninsured/defend.asp> (last visited Mar. 12, 2007) (citing the Fairness Foundation as the source of a report containing allegations of hospital billing practices).

<sup>95</sup> See Medical Savings Insurance, <http://www.medicalsavings.com> (last visited Mar. 12, 2007); Hospital Victims, Contact Us, <http://www.hospitalvictims.com/contactus.asp> (last visited Mar. 12, 2007). Each of these Web sites lists the same mailing address for their respective headquarters.

<sup>96</sup> Robert Dreyfuss & Peter H. Stone, *Medikill*, MOTHER JONES, [www.motherjones.com/news/feature/1996/01/medikill.html](http://www.motherjones.com/news/feature/1996/01/medikill.html) (last visited Mar. 29, 2007).

<sup>97</sup> Lando, *supra* note 89.

<sup>98</sup> Lando, *supra* note 89; see also Dreyfuss & Stone, *supra* note 96. After pioneering health saving accounts with his old company, Golden Rule Insurance, Rooney sold Golden Rule to United Health Group Inc. for \$893 million and subsequently founded Medical Savings Insurance in order to sell more health savings accounts. Woellert, *supra* note 91. Rooney, his family, and employees, have donated more than five million dollars into republican causes since he developed health savings accounts in 1990. *Id.* President George W. Bush and other republicans showed their support for this proposed system of health care when in 2003, GOP lawmakers inserted a \$6.4 billion tax break for health savings accounts into a Medicare prescription-drug bill. Lando, *supra* note 89.

#### IV. THE CONSUMER PROTECTION CLAIMS OF THE SUTTER HEALTH NONPROFIT HOSPITAL PRICING CLASS ACTION

Much of the attention surrounding nonprofit hospital billing of the uninsured is currently focused, at least in part, on the outcome of several class actions brought against nonprofit hospitals in state courts. Stories of low-income uninsured persons receiving medical bills they cannot afford to pay have permeated the press. The grim reality for these individuals is that enormous or inflated hospital bills can cause severe health and consumer credit problems.<sup>99</sup> The unprecedented, albeit relative, success obtained by the plaintiffs in the Sutter Health hospital pricing class action in a California state court seemed to indicate that the plaintiffs would finally have their day in court. The plaintiffs originally alleged eight claims<sup>100</sup> in federal court, but the U.S. District Court for the Northern District of California dismissed the patients' federal claims in *Darr v. Sutter Health*<sup>101</sup> and also dismissed the state law claims for lack of jurisdiction without prejudice to refile in state court. The plaintiffs refiled a consolidated<sup>102</sup> complaint in the Superior Court of California in July 2005 and subsequently survived defendant Sutter Health's initial motions to dismiss.<sup>103</sup> Ruling against the hospital and in favor of uninsured patients, the Superior Court of California rejected the hospital's argument that uninsured patients only had recourse through the state or federal legislature and recognized that uninsured patients could seek relief directly in state court.<sup>104</sup> This ruling showed particular promise not only for the plaintiffs, but also for similarly situated plaintiffs in other states that this case would go to trial and set new precedent for the handling of these claims brought under state consumer protection statutes. Although federal courts have overwhelmingly rejected challenges of nonprofit hospitals' business practices premised on theories arising from the government's contractual relationship with tax-exempt hospitals, plaintiffs could find success under the broad language of state consumer protection laws.

Defendant hospitals in similar cases have agreed to settlements early in the litigation; however, Sutter Health took a different approach and filed a class action claim in August 2005 against former patients who failed to pay their

---

<sup>99</sup> Batchis, *supra* note 51, at 497.

<sup>100</sup> For a summary of the eight federal claims, see Crowley I, *supra* note 8.

<sup>101</sup> *Darr v. Sutter Health*, No. C 04-02624 WHA, 2004 U.S. Dist. LEXIS 24592, at \*17 (N.D. Cal. Nov. 30, 2004) (“[I]n the usual case in which all federal-law claims are eliminated before trial, the balance of the factors to be considered under the pendent jurisdiction doctrine—judicial economy, convenience, fairness, and comity—will point toward declining to exercise jurisdiction over the remaining state-law claims.”) (citation omitted); *see also* Crowley I, *supra* note 8, at 6 (listing reasons for the dismissal of these federal claims).

<sup>102</sup> Plaintiffs' attorneys consolidated the complaint with other similarly situated patients and changed the name of the case from *Darr v. Sutter Health* to “Sutter Health Uninsured Pricing Cases.” *See* Complaint, *supra* note 1.

<sup>103</sup> Statement from Scruggs, *supra* note 18.

<sup>104</sup> *Id.*

medical bills but did not qualify for the hospital chain's existing charity care program.<sup>105</sup> This unusual move came in the form of a counterclaim and seemed to add further support that the defendant hospital was prepared to defend its billing practices.<sup>106</sup> In August 2006, however, the parties in the Sutter Health litigation reached a settlement. Although these plaintiff patients did not get their day in court, this Note will explore the basis of their state law claims because it was the state consumer protection laws on which they were premised that seemed to have the greatest potential for carrying the case to trial.

There is neither a federal nor state statute nor any common law principle that requires a nonprofit hospital to charge uninsured patients the same rates it charges to other patients.<sup>107</sup> Despite provisions in the California constitution and code specifically exempting nonprofit hospitals, California case law regarding a hospital's tax-exempt status has generally supported the interpretation that "'lessening the burdens of government' is a factor that the California courts must consider when determining whether hospital property is entitled to exemption from real estate taxes."<sup>108</sup> Although plaintiffs in California were not directly challenging the hospital's tax-exempt status, they did allege that the hospital had misrepresented itself and engaged in unlawful, unfair, and deceptive practices under the guise of a community-based nonprofit organization receiving significant tax benefits. Thus, the two causes of action which would likely have become the central issues of this litigation implicated California's Consumers Legal Remedies Act ("CLRA"), as well as alleged violations of California's Unfair Competition Law ("UCL"). Similar consumer protection statutes in other states could lead other plaintiffs to posit similar arguments. Therefore, despite the settlement, a review of these claims remains relevant to this area of litigation since it is on consumer protection statutes that the plaintiffs have premised their challenge of nonprofit hospital business practices.

### A. California's Consumers Legal Remedies Act

In 1970, the California legislature enacted the CLRA, which effectively permitted consumer class action suits for unfair methods of competition and unfair or deceptive acts undertaken by an organization that results in the sale of a good or service to a consumer.<sup>109</sup> Section 1780 of the Act provides that "[a]ny consumer who suffers any damage as a result of the use or employment

---

<sup>105</sup> Rachel Osterman, *Sutter Health Takes Gloves Off in Lawsuit*, SACRAMENTO BEE, Aug. 19, 2005, at D1.

<sup>106</sup> *Id.*

<sup>107</sup> Crowley II, *supra* note 83, at 3 (quoting *Kolari v. N.Y.-Presbyterian Hosp.*, 382 F. Supp. 2d 562, 579 (S.D.N.Y. 2005)).

<sup>108</sup> McClendon, *supra* note 53, at 48 & n.16 (citing several cases supporting the "lessening the burdens of government" proposition).

<sup>109</sup> Diane E. Dodge, *The California Consumers Legal Remedies Act*, 10 CAL. W. L. REV. 161, 161 (1973).

by any person of a . . . practice declared to be unlawful by Section 1770 may bring an action . . .”<sup>110</sup> Section 1781 of the Act provides the class action as a vehicle for recovery.<sup>111</sup> Specifically, the CLRA indicates three areas that afford the consumer protection: “a definite method of recovery for unfair competition, a statutory provision permitting collection of damages, and the consumer class action.”<sup>112</sup> Nevertheless, the intent of the CLRA was to balance the interests of the consumer and the merchant while not solely empowering the consumer to punish the merchant.<sup>113</sup> Section 1770 of the CLRA details the twenty-four unfair methods of competition and unfair or deceptive acts or practices that are considered unlawful for a merchandiser to undertake. In the Sutter Health class action, the uninsured patients claimed that the defendant violated four sections of the CLRA by engaging in “deceptive practices, unlawful methods of competition, and/or unfair acts to the detriment of Plaintiffs and the Class.”<sup>114</sup> These causes of action alleged that Sutter Health incorrectly represented and advertised the goods and services it provided to the uninsured, that it advertised the goods with the intent not to sell them as advertised, that the subject of a transaction had been supplied in accordance with a previous representation when it had not, and that its full charges were unconscionable.<sup>115</sup>

---

<sup>110</sup> CAL. CIV. CODE § 1770(a) (West 1998).

<sup>111</sup> *Id.* § 1781(a) (permitting the class action “if the unlawful method, act, or practice has caused damage to other consumers similarly situated. . .”).

<sup>112</sup> Dodge, *supra* note 109, at 162.

<sup>113</sup> *Id.* at 161.

<sup>114</sup> Complaint, *supra* note 1, at 20; The CLRA prohibits twenty-four different business practices, but the four sections of the CLRA to which the plaintiffs refer are in California Civil Code section 1770(a). CAL. CIV. CODE §§ 1770(a)(5), (9), (16), (19) (West 1998).

California Civil Code section 1770(a)(5) provides in relevant part: “Representing that goods or services have sponsorship, approval, characteristics, ingredients, uses, benefits, or quantities which they do not have or that a person has a sponsorship, approval, status, affiliation, or connection which he or she does not have.” *Id.* § 1770(a)(5).

California Civil Code section 1770(a)(9) provides in relevant part: “Advertising goods or services with intent not to sell them as advertised.” *Id.* § 1770(a)(9). See *Consumer Advocates v. Echostar Satellite Corp.*, 113 Cal. App. 4th 1351, 1362 (Cal. Ct. App. 2003) (“[R]eject[ing] defendants’ view that a plaintiff must produce a consumer survey or similar extrinsic evidence to prevail on a claim that the public is likely to be misled by a representation. . . . Federal cases holding otherwise do not accurately reflect California law.”).

California Civil Code section 1770(a)(16) provides in relevant part, “[r]epresenting that the subject of a transaction has been supplied in accordance with a previous representation when it has not.” *Id.* § 1770(a)(16).

California Civil Code section 1770(a)(19) provides in relevant part, “[i]nserting an unconscionable provision in the contract.” *Id.* § 1770(a)(19). See *Armendariz v. Found. Health Psychcare Servs.*, 6 P.3d 669, 689-90 (Cal. 2000) (finding that unconscionability has a procedural and substantive element).

<sup>115</sup> Complaint, *supra* note 1. See also *Nat’l Council Against Health Fraud, Inc. v. King Bio Pharm., Inc.*, 107 Cal. App. 4th 1336, 1348 (Cal. Ct. App. 2003) (“The falsity of the advertising claims may be established by testing, scientific literature, or anecdotal evidence.”).

In *Vasquez v. Superior Court San Joaquin County*,<sup>116</sup> the California Supreme Court acknowledged the importance of the class action as a method for consumer protection.<sup>117</sup> The *Vasquez* court held that consumers seeking a rescission of installment contracts could maintain a class action for fraudulent misrepresentation against a seller of freezers and frozen food and its finance company assignees.<sup>118</sup> The court noted two requirements for the maintenance of a class action: (1) the ascertainable existence of a class and (2) a well-defined community of interest in the issues to be litigated.<sup>119</sup> With the decision in *Vasquez*, the class action became the recognized vehicle in California for remedying unlawful or unfair conduct that results from the sale of services to a consumer in an effort to protect consumers from unscrupulous sellers.

Coincidentally, the California legislature adopted the CLRA while *Vasquez* was still pending in the California Supreme Court. The court acknowledged that the provisions of the CLRA were not exclusive, but rather the remedies it provides were in addition to remedies and procedures in other laws.<sup>120</sup> For example, if a plaintiff brought a claim under the CLRA alleging bad faith, then the CLRA provides that a court may award reasonable attorney's fees to the prevailing defendant.<sup>121</sup> The CLRA also states that its protections may not be waived by the consumer.<sup>122</sup> Similarly situated uninsured patients could rely on similar, liberally interpreted statutes if they exist in their respective states in their own challenges of hospital pricing.

### B. California's Unfair Competition Law

The UCL prohibits "any unlawful, unfair or fraudulent business act or practice and unfair, deceptive, untrue or misleading advertising."<sup>123</sup> The California plaintiffs in the hospital pricing cases alleged that Sutter Health "unfairly and unlawfully charge[d] uninsured patients unfair, unreasonable, and/or discriminatory rates that are significantly higher than those charged to its insured patients."<sup>124</sup> Fortunately for the plaintiffs in the California Sutter Health case,

---

<sup>116</sup> *Vasquez v. Super. Ct. San Joaquin County*, 484 P.2d 964 (Cal. 1971).

<sup>117</sup> James R. McCall, et al., *Greater Representation for California Consumers – Fluid Recovery, Consumer Trust Funds, and Representative Actions*, 46 HASTINGS L.J. 797, 800 (1995).

<sup>118</sup> *Vasquez*, 484 P.2d at 966.

<sup>119</sup> *Id.* at 970 (citing *Daar v. Yellow Cab Co.*, 433 P.2d 732, 730-35 (Cal. 1967) (noting principles that can help guide courts in determining whether the class action is an appropriate vehicle for claims of misrepresentation)).

<sup>120</sup> *Id.* at 975; see also CAL. CIV. CODE § 1752 (West 1998) (stating that the remedies provided for are not exclusive).

<sup>121</sup> CAL. CIV. CODE § 1780(d) (West 1998).

<sup>122</sup> *Id.* § 1751; see also *Broughton v. Cigna Healthplans*, 988 P.2d 67, 74 (Cal. 1999).

<sup>123</sup> CAL. BUS. & PROF. CODE § 17200 (West 1997); *Wang v. Massey Chevrolet*, 97 Cal. App. 4th 856, 869 (Cal. Ct. App. 2002).

<sup>124</sup> Complaint, *supra* note 1, at 17.



“the extraordinary breadth of the UCL is matched by the liberality of its enforcement provisions.”<sup>125</sup> Notably, California voters in 2004 adopted new legislation requiring that UCL plaintiffs must meet certain standing requirements and that actions involving aggregated claims must proceed under California’s class-action standards.<sup>126</sup> No longer could a business be the target of claims on behalf of consumers who were likely to be deceived by the business practice or act; rather, plaintiffs now must prove actual injury. Private litigants may not sue for damages; however, they may pursue injunctive relief in addition to restitution and disgorgement of money wrongfully obtained by the defendants’ use of unfair business practices.<sup>127</sup>

Different liability standards and defenses exist for the three types of conduct under the UCL.<sup>128</sup> Although an unlawful business act can be any act that violates the law of any section of the California Civil Code, an unfair business practice includes those acts that may technically be lawful in the sense that they do not violate any other statute.<sup>129</sup> An action for unfair business practices exists when a business practice “offends an established public policy or when the practice is immoral, unethical, oppressive, unscrupulous, or substantially injurious to consumers.”<sup>130</sup> California courts have generally held that a UCL claim premised on fraudulent conduct does not require proof of intent, scienter, actual

---

<sup>125</sup> Michael S. Greve, *Consumer Law, Class Actions, and the Common Law*, 7 CHAP. L. REV. 155, 165 (2004).

<sup>126</sup> JULIA B. STRICKLAND & LISA M. SIMONETTI, STROOCK & STROOCK & LAVAN, LLP, 2007 OVERVIEW OF CALIFORNIA’S UNFAIR COMPETITION LAW AND CONSUMERS LEGAL REMEDIES ACT 1 (2007) (“On November 2, 2004, California’s voters approved Proposition 64 [which] put an end to ‘private attorney general’ UCL cases prosecuted by unaffected plaintiffs, purportedly on ‘behalf of the general public.’”) (citing *Benson v. Kwikset Corp.*, 126 Cal. App. 4th 887, 934 (Cal. Ct. App. 2005) (Sills, P.J., concurring and dissenting) (commenting on the passage of Proposition 64, “this case represents what will hopefully be the last of a breed of lawsuits against businesses where lawyers make big bucks, and clients nothing, for finding some tiny arguable technicality and bringing an unfair competition suit.”)

<sup>127</sup> *Id.* at 166 (citing *Bank of the West v. Super. Ct. of Contra Costa County*, 833 P.2d 545, 557 (Cal. 1992); CAL. BUS. & PROF. CODE § 17203 (West 1997 & Supp. 2007)); *see also* *Dean Witter Reynolds, Inc. v. Super. Ct. of Alameda County*, 259 Cal. Rptr. 789, 799 (Cal. Ct. App. 1989) (denying compensatory damages and instead adopting an equitable remedy of restitution).

<sup>128</sup> *See* STRICKLAND & SIMONETTI, *supra* note 126, at 10-26 (discussing thoroughly relevant California case law).

<sup>129</sup> Greve, *supra* note 125, at 165 & n.64.

<sup>130</sup> *People v. Casa Blanca Convalescent Homes, Inc.*, 206 Cal. Rptr. 164, 177 (Cal. Ct. App. 1984); *accord* *Cel-Tech Communications, Inc. v. L.A. Cellular Telephone Co.*, 973 P.2d 527, 544 (Cal. 1999) (adopting the following test for unfairness: “When a plaintiff who claims to have suffered injury from a direct competitor’s ‘unfair’ act or practice invokes section 17200, the word ‘unfair’ in that section means conduct that threatens an incipient violation of an anti-trust law, or violates the policy or spirit of one of those laws because its effects are comparable to or the same as a violation of the law, or otherwise significantly threatens or harms competition.”).

reliance or damages.<sup>131</sup> Instead, the Supreme Court of California has held that “it is necessary only to show that members of the public are *likely* to be deceived” in order to bring a claim for injunctive relief under the UCL.<sup>132</sup> However, the new legislation in California, adopted while the Sutter Health case was still pending, effectively eliminated the *likely to deceive* standard thereby affording businesses greater protection than they had previously received under the UCL.<sup>133</sup> Although bolstered by the heightened standing requirements, a California hospital’s strongest defense may be that it was somehow justified in its business practices or that the laws on which the conduct was alleged to be unlawful are no longer applicable or that the alleged fraudulent practice will not likely mislead.<sup>134</sup> The UCL provides for restitution, injunctive relief, and civil penalties, but no damages are recoverable.<sup>135</sup> However, the CLRA explicitly provides for actual damages, restitution of property, punitive damages, and any other relief which the court deems proper.<sup>136</sup>

Under the formerly broad application of the UCL, a defendant hospital risked liability by merely representing itself to the community as being a charitable organization providing, what the average consumer misinterpreted to be, free or discounted health care for those who qualify. Ultimately, statements made to the public regarding the charitable purposes on which a hospital is founded are made to promote sales and services from those consumers who rely on such representations. If plaintiffs can show that the hospital subsequently billed at rates far in excess of its costs, engaged in discriminatory billing or aggressive debt collection, or failed to negotiate available discounts for those who

---

<sup>131</sup> See *Comm. on Children’s Television, Inc. v. Gen. Foods Corp.*, 673 P.2d 660, 668 (Cal. 1983); *but see* STRICKLAND & SIMONETTI, *supra* note 126, at 16 (“Proposition 64 . . . may substantially change the law in this regard, such that individualized proof of actual reliance will be required in order to establish standing on a claim of fraudulent conduct.”).

<sup>132</sup> *Kasky v. Nike, Inc.*, 45 P.3d 243, 250 (Cal. 2002) (quoting *Comm. on Children’s Television, Inc.*, 67 P.2d at 668) (emphasis added); *see also* *Day v. AT&T Corp.*, 74 Cal. Rptr. 2d 55, 60 (Cal. Ct. App. 1998) (“A perfectly true statement couched in such a manner that it is likely to mislead or deceive the consumer, such as by failure to disclose other relevant information, is actionable under these sections.”).

<sup>133</sup> ReedSmith.com, Special Topics, California’s Business & Professions Code § 17200 (Unfair Competition) and § 17500 (False Advertising), *available at* [http://www.reedsmith.com/special\\_topic.cfm?cit\\_id=7](http://www.reedsmith.com/special_topic.cfm?cit_id=7) (last visited Apr. 10, 2007) (“Before Prop. 64 was enacted, few plaintiffs asserted CLRA claims because the UCL provided so much flexibility and so many advantages. Since Prop. 64 helped level the UCL playing field, it appears there has been an increase in the number of CLRA claims asserted, although whether the CLRA will become as frequently misused as the UCL remains to be seen.”).

<sup>134</sup> STRICKLAND & SIMONETTI, *supra* note 126, at 10-26.

<sup>135</sup> *Korea Supply Co. v. Lockheed Martin Corp.*, 63 P.3d 937, 948-49 (Cal. 2003); *but see* STRICKLAND & SIMONETTI, *supra* note 126, at 30 (citing both *Madrid v. Perot Systems Corp.*, 30 Cal. Rptr. 3d 210, 219-20 (Cal. Ct. App. 2005) and *Feitelberg v. Credit Suisse First Boston, LLC*, 36 Cal. Rptr. 3d 592, 605 (Cal. Ct. App. 2005) (finding that nonrestitutionary disgorgement is impermissible under the UCL)).

<sup>136</sup> CAL. CIV. CODE § 1780(a)(1)-(5) (West 1998).

qualify then these actions could be considered by a sympathetic jury to be injuries inconsistent with the supposed charitable nature the hospital espouses and for which it receives tax-exemption.<sup>137</sup>

In support of such allegations, plaintiffs could highlight the contradiction between the hospital's billing practices and its stated mission. For example, plaintiffs may point to a hospital's messages appearing in advertising material as inconsistent with the practices the hospital implements.<sup>138</sup> Plaintiffs might argue that a public representation appearing either on the hospital's Web site or other advertising material contradicts the business practices an uninsured patient might encounter if he was billed for services at inflated or non-discounted rates. Unfortunately for the hospital, the likelihood of deception is high perhaps as a result, at least in part, of a confusing set of standards for tax-exemption. In its defense, a nonprofit hospital may assert that its practices and policies are consistent with its statutory requirements such that it is generally providing a community benefit. But plaintiffs might provide testimony from community members, former patients, current hospital employees, or the hospital executives that demonstrates a history of business practices that had the actual, if not intended, effect of deceiving patients. Essentially, plaintiffs would be arguing they were victims of a "bait and switch operation," where health care consumers entered a deal for the provision of medical services based on misleading information so that, as the plaintiffs alleged in the Sutter Health case, the hospital could make "enormous profits on the banks of the members of the community."<sup>139</sup> Such allegations are unsympathetic to the great work that hospitals do for their patients and for the community despite the strains of a problematic health care system. Plaintiffs may have a difficult task in asserting that a hospital, that skillfully provided them with medical care, created a pricing structure to capitalize on the vulnerability of uninsured patients. Nevertheless, critics argue, and sympathetic juries could agree, that nonprofit hospitals should be doing more to disclose their discount policies and adopting practices that are consistent with the charitable representations that they make to the public and justify their tax benefits.

California's UCL grants courts considerable discretion to prohibit new

---

<sup>137</sup> Batchis, *supra* note 51, at 534.

<sup>138</sup> See, e.g., SutterHealth.com, Mission, Vision and Values, <http://www.sutterhealth.org> (last visited Mar. 12, 2007). Complaint, *supra* note 1, at 18. Plaintiffs' attorneys pointed to a series of Sutter Health print advertisements that the hospital ran to educate the public about the current health care financing system and what the hospital was doing to make it better. *Id.* These advertisements included several representations about the hospital's charity care practices and discount policies for the uninsured. *Id.* The plaintiffs cited numerous instances where Sutter Health hospitals were not implementing charity care services consistent with the representations made in the advertisements. *Id.*

<sup>139</sup> Batchis, *supra* note 51, at 534; Complaint, *supra* note 1, at 17; see also *People v. Custom Craft Carpets*, 206 Cal. Rptr. 12 (Cal. Ct. App. 1984) (finding that the carpet dealer was operating a bait and switch operation by advertising one kind of carpet but then selling another).

schemes to defraud or deceive. For example, in *People v. Dollar Rent-A-Car*,<sup>140</sup> defendants, operators of car rental companies, were accused of misrepresenting collision damage waivers as insurance and then subsequently charging excessive amounts for repair of cars the customers damaged in accidents. The Court of Appeal found testimony from car rental employees, customers, and executives to be substantial evidence that the defendants were engaging in unfair competition and making false and misleading statements all in violation of the UCL.<sup>141</sup> Under similar interpretations of consumer protection laws in states other than California, plaintiffs might attempt to show that a defendant hospital's failure to notify patients of available discount policies for which the patients might qualify further supports allegations of unfair business practices, particularly if the hospital employees and executives had knowledge of these practices.

The plaintiffs in the California suit alleged that Sutter Health "provides minimal 'traditional charity care' which Sutter [Health] describes as 'health care services provided to persons who meet certain criteria and cannot afford to pay.'" <sup>142</sup> A court hearing similar claims may consider what exactly constitutes a reasonable rate. Although arguably this is a question more appropriate for the legislature, similarly situated plaintiffs may highlight the disparity between rates charged to the uninsured and the rates accepted from government subsidized programs in order to establish a scheme of unreasonable pricing. Further, plaintiffs could point to a hospital's cost-to-charge ratios as a way of assessing hospital pricing for services. For example, the Sacramento affiliate of Sutter Health reportedly made \$502,006,278 in profits over a three year period.<sup>143</sup> During that time, costs increased by \$121,103,228, but Sutter Health has increased charges by \$536,745,175.<sup>144</sup> By this account, some estimate Sutter Health's cost-to-charge ratio to be 0.21 percent, which implies that Sutter Health charged \$10,000 for services that actually cost them about \$2,100 to provide.<sup>145</sup> Any truth to this theory of an alleged mark-up could prove troubling for a defendant hospital if asked to justify its pricing in light of the tax benefits it is receiving.

The California Court of Appeal found that presenting consumers with a bill that does not reflect the cost incurred by the service provider can constitute an unfair business practice. In *Dollar Rent-A-Car*, a body shop repaired the defendant rental car company's damaged rental cars at a discounted "wholesale" price for the repairs due to the high volume of business the defendant car

---

<sup>140</sup> *People v. Dollar Rent-A-Car Sys., Inc.*, 259 Cal. Rptr. 191 (Cal. Ct. App. 1989).

<sup>141</sup> *Id.* at 197.

<sup>142</sup> Complaint, *supra* note 1, at 19.

<sup>143</sup> WhereTheMoneyGoes.com, Sutter Medical Center, <http://www.wherethemoneygoes.com> (last visited Mar. 12, 2007).

<sup>144</sup> *Id.*

<sup>145</sup> *Id.*

rental company was giving the body shop.<sup>146</sup> Subsequently, the rental car company prepared new repair invoices to be passed to the customers who caused the damage to the car, but these invoices reflected a higher “retail cost” rather than the actual repair costs the car rental company incurred for the repairs.<sup>147</sup> The car rental company never informed the customers of this practice, nor did the company supply customers with an itemized list of the inflated charges which led customers to believe they were paying the actual repair charges.<sup>148</sup> The California Court of Appeal found this failure to disclose inflated rates to be “misleading and constitut[ed] an unfair business practice.”<sup>149</sup> Notably, *Dollar Rent-a-Car* was about cars whereas the nonprofit hospital litigation involves human lives amidst a medical crisis. The nonprofit hospital litigation would likely garner significant attention from a sympathetic public. If the rates charged to the uninsured plaintiffs were in some way established as unreasonable, not merely because they were charged to the uninsured, but because they reflect the list price charged with little correlation to the actual cost incurred by the hospital to render the service, then this could add further support to allegations of unfair business practices.

Despite California’s generous consumer protection laws, plaintiffs’ attorneys should proceed with discretion when pursuing uninsured patients’ claims. In California, plaintiffs should consider first whether they have the following elements to their UCL claim before moving forward:

- (1) A business practice that is demonstrably a violation of section 17200; (2) A business practice that can be narrowly and discretely defined so that an injunction can appropriately be crafted; (3) A means of calculating the illegal profit gained by the defendant in engaging in the practice; and (4) Either identifiable victims to whom the restitutionary refunds can be made or who can be included if the action is converted into a class action.<sup>150</sup>

California courts have consistently construed the UCL broadly requiring honesty, legality, and fair dealing in business practices affecting consumers, and California case law reveals that the statute has often been invoked to enjoin business conduct that falls short of those standards.<sup>151</sup> Time will tell what impact the new standing requirements will have on California consumer protection claims. Although it may be difficult for a court to determine what a

---

<sup>146</sup> *Dollar Rent-A-Car Sys., Inc.*, 259 Cal. Rptr. at 194.

<sup>147</sup> *Id.* at 195.

<sup>148</sup> *Id.*

<sup>149</sup> *Id.* at 197.

<sup>150</sup> Sharon J. Arkin, *The Effective Use of California’s Unfair Competition Law to Redress Managed Care Abuses*, 22 WHITTIER L. REV. 467, 503 (2000).

<sup>151</sup> *Id.*

reasonable rate would be for certain medical services, the more dramatic the injuries to the plaintiffs and the more outrageous the charged amounts, the more likely the courts may find a hospital in violation of similar unfair competition laws.<sup>152</sup>

## V. THE SUTTER HEALTH SETTLEMENT

On August 3, 2006, Sutter Health agreed to a settlement valued at more than \$275 million which allows for thousands of refunds of between twenty-five and forty-five percent on patients' prior hospital bills.<sup>153</sup> Sutter Health officials say that the settlement will not change its charity care policies or procedures noting that the hospital chain had already made changes to its charity care practices.<sup>154</sup> Specifically, Sutter Health reports that,

In March 2006, Sutter Health adopted a new policy for all of its affiliated hospitals that provides for those facilities to offer automatic discounts to uninsured patients that are comparable to the negotiated discounts that the hospitals provide to private insurance companies. Under the terms of the settlement, Sutter's hospitals will continue to abide by this new policy for at least three more years. Sutter Health plans to maintain the policy indefinitely.<sup>155</sup>

Although the settlement may appear to be a victory for the uninsured, patient advocacy groups have opposed similar settlements in other jurisdictions, describing them as a temporary fix rather than a long-term solution.<sup>156</sup>

Mr. K.B. Forbes of advocacy group Consejo de Latinos Unidos explained that if a hospital adopts a new policy for discounting health care to the unin-

---

<sup>152</sup> Batchis, *supra* note 51, at 537.

<sup>153</sup> Rebecca Vesely, *Sutter Settles Class-action Lawsuit Worth \$275 Million*, THE OAKLAND TRIB., Aug. 4, 2006, at 4.

<sup>154</sup> Victoria Colliver, *Settlement Reached in Sutter Lawsuit*, S.F. CHRON., Aug. 4, 2006, at C1.

<sup>155</sup> Press Release, SutterHealth.org, Sutter Health Settles Lawsuit Over Prices Charged to Uninsured; Reaffirms its Charity Care and Discount Policies (Aug. 3, 2006), available at [http://www.sutterhealth.org/about/news/news06\\_settlement.html](http://www.sutterhealth.org/about/news/news06_settlement.html). The Sutter Health policy dictates that uninsured patients with annual incomes below 200 percent of the Federal Poverty Income Guidelines may qualify to receive free care. *Id.* Additionally, uninsured patients with annual incomes between 200 and 400 percent of the FPIG are billed at rates well below those charged to private insurance companies and no uninsured patients, regardless of their financial status, apparently will receive a bill under this policy for full-billed charges at a Sutter Health hospital. *Id.*

<sup>156</sup> Press Release, HispanicBusiness.com, Providence Health's Settlement of "Blatant and Unfair Discrimination" to be Opposed by Advocates for Uninsured (Nov. 4, 2005) (on file with author).

sured either in response to a settlement or on its own initiative, then “[t]he problem with tying discounts to a percentage off the full-billed prices is that it creates an incentive to raise the full-billed prices over time.”<sup>157</sup> Instead, these groups would prefer a system where the hospitals adopt discounted pricing policies that are tied, as Sutter Health has done, to the best managed care rate or federally reimbursed rates and then offer these discounted rates to all uninsured patients regardless of race, ethnicity, or income.<sup>158</sup> Without such reform, settlements that result in agreements to forgive patient debt or to develop new discount policies tend to primarily benefit the defendant hospital and the plaintiffs’ lawyers who cash in on the windfall.<sup>159</sup> Moreover, temporary fixes impose no lasting obligations or system for monitoring their application.

Alternatively, legislative action may be the best way to create lasting change. Legislative review of the tax-exempt sector at the state and federal levels could result in further findings that the current statutory scheme creates an environment where tax-exempt hospitals are incurring disproportionate burdens in exchange for their tax benefits. New legislation could subject nonprofit hospitals to stricter standards for qualifications of tax-exemption in order to maximize accountability and create an environment where the provision of free or discounted health care to qualifying patients is ensured. Moreover, new legislation in the hospital tax-exempt sector could lessen the level of confusion and potential for misrepresentation and deception in the provision of health care.

## VI. CONCLUSION

The problem surrounding the provision of medical care to the uninsured exists, at least in part, because of a federal shift in tax-exemption standards from the “charity care standard” to the broader “community benefit” standard. As the public questions the justification of federal tax-exemption for nonprofit hospitals that allegedly bill low-income uninsured persons excessive rates, the public outcry is uncomplicated by states that have adopted differing requirements for state tax-exemption. Although critics agree that the problem of the uninsured is bigger than the nonprofit hospitals’ billing practices, they also suggest that the hospitals could do much more to help.<sup>160</sup> Nonprofit hospitals, as some already have, may take the initiative and begin to recognize uninsured persons as consumers who deserve better clarity and assistance in understanding the financial obligations that could accompany medical treatment. But the voluntary adoption of charity care policies not obtained through a court settlement or mandated by legislation cannot be enforced or monitored by courts or

---

<sup>157</sup> *Id.*

<sup>158</sup> *Id.*

<sup>159</sup> *Id.*

<sup>160</sup> Cohn, *supra* note 13.

legislators.<sup>161</sup> Undoubtedly, the issues surrounding uninsured persons permeates the nation's attention on many levels, but until there is greater clarity in the laws that provide for the exemption, there will likely be continued confusion for the patients. The nonprofit hospital pricing litigation has hospitals concerned to the point that many have taken proactive steps to initiate change in their charity care practices. Thus, as long as the litigation continues in state courts around the country, perhaps it will continue to exert pressure on hospitals to examine and evaluate their charity care policies and procedures. Regardless of the vested interests of the different groups behind the litigation, those plaintiffs who, although likely grateful for the care they received, are suffering under the financial burden of enormous hospital bills may at least find relief in settlement agreements even if the settlements fail to effect lasting change in the tax-exempt health care sector.

California consumer protection laws, or similar laws in other states, may be broad enough to provide these patients with a favorable judgment or at least to carry these cases into state courts around the country. If this litigation continues to draw the attention of state and federal legislators, then it may instigate additional inquiries into the nonprofit health care sector to determine if and what kind of reform may be needed. State legislative action may be the best avenue for effecting change because the states would be in the best position to assess whether the adoption of stricter standards for tax-exemption mandating requisite levels of charity care – as in discounted or free – to those who qualify is the best solution for handling the uninsured. In the meantime, these class action suits and settlements will likely prove effective in persuading hospitals to avoid future litigation by adopting charity care policies that are consistent with their charitable missions. The less their messages create confusion for patients, the better.

---

<sup>161</sup> Batchis, *supra* note 51, at 541.