EXTREME PRICING OF HOSPITAL CARE FOR THE UNINSURED: NEW JERSEY'S RESPONSE AND THE LIKELY RESULTS

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I. INTRODUCTION

The stories are neither new nor surprising to the American public at large. These are stories of the excessive billing practices by American hospitals of the nation's uninsured—typically the segment of our population least able to pay for medical care. These billing practices and subsequent collection actions can be directly linked to increasing rates of personal bankruptcies caused by medical debt.[1] They are also the source of the uninsured's reluctance to seek care due to the fear of facing bills so overwhelming that they cause financial ruin.[2] Health insurers, whether for-profit or non-profit, pay substantially less than the rates charged to the un- and under-insured.[3] In my own recent Explanation of Benefits[4] (EOB), my provider charged my insurance company $70 for a visit. Of that amount, my insurance company was only responsible for $38.26, or fifty-five percent of the total bill for the service, a price negotiated between the insurance company and my provider. It is a broken system when an insurance company, an entity with far greater resources than a mere individual, habitually receives discounts for medical services, for which an individual with limited means does not.

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[1] *See generally* Hugh F. "Trey" Daly III, et al., *Into the Red to Stay in the Pink: The Hidden Cost of Being Uninsured*, 12 HEALTH MATRIX 39 (2002).

[2] George A. Nation, *Obscene Contracts: The Doctrine of Unconscionability and Hospital Billing of the Uninsured*, 94 KY. L.J. 101,102 (2006). Example of a patient who "checked himself out of the hospital the next morning against medical advice, because he lacked health insurance and was concerned about the expense." *Id.* Melissa B. Jacoby, *Health Law Symposium: The Debtor-Patient Revisited*, 51 ST. LOUIS L.J. 307, 308-310 (2007). "[R]esearchers have found that nearly 17% of poor families pass the threshold of spending more than 40% of family income on health care . . . ."

[3] Under-insured is a term used to identify individuals who have health insurance but are still exposed to high "out-of-pocket costs relative to income." Cathy Schoen, Sara R. Collins, Jennifer L. Kriss & Michelle M. Doty, *How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007*, 27 HEALTH AFFAIRS w298, w299 (2008).

[4] An Explanation of Benefits (EOB) "is a document you receive after you see a physician or other health care professional, at the time your claim is processed. The EOB provides claims and patient payment information for you and your covered family members on a single statement." *The ABCs of an EOB*, Horizon Blue Cross Blue Shield of New Jersey.
http://www.horizon-bcbsnj.com/nationalaccounts/pdf/fep_explanation_of_benefits.pdf.

To add insult to injury, the nation's unemployment rate has reached ten percent—doubling in just two years.[5] Higher unemployment rates lead to a larger uninsured population as fewer people have access to employment based health insurance.[6] While the Consolidated Omnibus Reconciliation Act of 1985 (COBRA) was designed to allow the recently unemployed population to carry their employer-sponsored health insurance for a period of time, this coverage is often unaffordable.[7] Although the children of the unemployed population may qualify for public coverage, this coverage typically does not extend to cover their parents.[8]

The practice of giving discounts to health insurers while expecting the uninsured to pay providers' full charges has been long-standing,[9] but has finally come under intense scrutiny as a result of a series of Wall Street Journal articles that ran in early 2003.[10] Even more ironic is that these billing practices contradict the original purpose of charitable hospitals—to provide medical services to the poor and those otherwise unable to obtain health care without such assistance.[11]

Government and industry have responded to these seemingly unfair billing practices in a variety of ways. In New Jersey, for example, hospitals must notify patients of the availability of various financial assistance programs to help pay for medical care when a financial hardship exists.[12] One of these programs is state-sponsored charity care[13] assistance, which is available for those who have

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[5] United States Department of Labor, Bureau of Labor Statistics, Labor Force Statistics from the Current Population Survey, http://data.bls.gov/PDQ/servlet/SurveyOutputServlet?data_tool=latest_numbers&series_id=LNS14000000 (last visited Jan. 17, 2010).

[6] Karen Schwartz, *Health Coverage in a Period of Rising Unemployment,* Kaiser Family Foundation, Dec. 2008, at 1, http://www.kff.org/uninsured/upload/7842.pdf (last visited Jan. 18, 2010).

[7] *Id.*

[8] *Id.*

[9] Gerard F. Anderson, *From 'Soak The Rich' To 'Soak The Poor:' Recent Trends In Hospital Pricing*, 26 HEALTH AFFAIRS 780 (2007).

[10] Beverly Cohen, *The Controversy Over Hospital Charges to the Uninsured—No Villians, No Heroes*, 51 VILL. L. REV. 95, 95-96 (2006); *see also* Lucette Lagnado, *Twenty Years and Still Paying*, WALL ST. J., Mar. 13, 2003, at B1.

[11] WILLIAM H. WILLIAMS, AMERICA'S FIRST HOSPITAL: THE PENNSYLVANIA HOSPITAL, 1751-1841 3 (1976).

[12] New Jersey Hospital Association, *Statement of Principles and Guidelines for Hospital Billing and Collection Practices*, http://www.aha.org/aha/content/2004/pdf/newjerseyguidelines.pdf [hereinafter *Statement of Principles*].

[13] Charity care is essentially equivalent to a sliding fee scale that reduces the amount of the hospital bill charged to a patient by at least 20 percent and by as much as 100 percent depending on the patient's income. Patients who are at or below 200 percent of the federal poverty level are completely

insufficient health coverage, are ineligible for private or public coverage and meet certain income and asset criteria.[14]

In a more aggressive approach, some states have expressly capped the amount at which hospitals (both non-profit and for profit hospitals) can charge the uninsured[15] at rates closer to the amount negotiated by most insurance companies.[16] As of August 2008, New Jersey became one of the most recent states to enact legislation enforcing a cap on the amount hospitals can charge certain uninsured patients.[17] Specifically, any hospital licensed by the New Jersey Department of Health and Senior Services[18] cannot charge a patient who is within 500 percent of the federal poverty level,[19] more than 115 percent above the Medicare[20] reimbursement rate for a particular service.[21]

Section II of this Note will briefly discuss the history of American hospitals and the origins of their billing practices. Section III will discuss how early forms of health insurance and legislative action contributed to the increased cost of hospital care. Section IV will examine the transformation of hospitals from charities to businesses and the consequences of this transformation on the uninsured. Section V

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covered by charity care. The percentage of the bill paid by the patient increases gradually by 20 percent as income increases and charity care eligibility diminishes when a patient's income is greater than 300 percent of the federal poverty level. State of New Jersey Department of Health and Senior Services, *New Jersey Hospital Care Payment Assistance Program Fact Sheet*, http://www.state.nj.us/health/cc/documents/ ccfactsh.pdf.

[14] Hal Moeller, *New Jersey and Charity Care, Imperfect Together*, N.J. LAW., Feb. 2007, at 53.

[15] The uninsured generally must have income under some threshold amount determined by the state. *See generally* FamiliesUSA, *A Pound of Flesh: Hospital Billing, Debt Collection, and Patients' Rights*, http://www.familiesusa.org/assets/pdfs/medical-debt.PDF.

[16] *Id.*

[17] N.J. STAT. ANN. § 26:2H-12.52 (2009).

[18] There are seventy-three acute care hospitals licensed in the State of New Jersey. State of New Jersey Department of Health and Senior Services, http://www.state.nj.us/cgi-bin/dhss/healthfacilities/hospitalsearch.pl (last visited Jan. 17, 2010). Nearly all New Jersey hospitals are non-profit. State of New Jersey Department of Health and Senior Services, NJ Commission on Rationalizing Health Care Resources, *Final Report 2008*, at 137, http://www.nj.gov/health/rhc/finalreport/index.shtml (last visited Jan. 17, 2010) [hereinafter *Commission Report*].

[19] The 2010 federal poverty level for a single person is $10,830. This number increases by $3,740 for each additional family member. United States Department of Health & Human Services, Centers for Medicare & Medicaid Services, http://www.cms.hhs.gov/ MedicaidEligibility/Downloads/POV10Combo.pdf.

[20] Medicare is known to reimburse at a rate between twenty-five and thirty-five percent of hospital charges in New Jersey. Lindy Washburn, *Law Curbs Fees to Uninsured*, NorthJersey.com, Aug. 9, 2008, www.northjersey.com.

[21] N.J. STAT. ANN. § 26:2H-12.52 (2009).

discusses how the Nation responded to the consequences imposed on the uninsured. Section VI examines New Jersey's response to the challenges facing its uninsured population and also analyzes New Jersey's new legislation capping hospital charges to the uninsured. Finally, Section VII discusses the next steps New Jersey should take in solving its uninsured crisis. Legislation capping hospital charges at 115 percent above the Medicare reimbursement rate will stem the financial burden that inflated hospital charges place on the uninsured. It could come, however, at the cost of increasing the flow of patients who use hospitals for care.

II. HISTORY OF THE AMERICAN HOSPITAL

This section will discuss the evolution of American hospitals from their humble origins on the outskirts of society to becoming the center of advanced medical science. The tax implications regarding hospitals' evolution are also examined.

A. General History—From the First American Hospital to Modern Health Care

The first American hospitals were established in the mid-eighteenth and early nineteenth centuries as charities for the diseased poor and the mentally ill.[22] The helplessness of the diseased poor led to the creation of the first American hospital—the Pennsylvania Hospital.[23] The hospital was 100 percent charitable—developed with donations from Pennsylvania's elite along with matching funds from the Pennsylvania Assembly[24]—and had a staff of volunteer physicians.[25] Those who could afford to do so sought the preferred method of care—treatment in comfort of their own homes.[26] Physicians routinely made home visits to monitor patients and even performed invasive surgical procedures in a patient's kitchen.[27] Very few physicians practiced

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[22] MORRIS J. VOGEL, THE INVENTION OF THE MODERN HOSPITAL 1 (1980).

[23] Williams, *supra* note 11, at 2. "Faced with increasing numbers of the poor who were suffering from physical maladies and increasing numbers of Pennsylvanians of all classes suffering from mental illness, certain Philadelphians and other Pennsylvanians sought a partial solution to the problem by founding a hospital." *Id.*

[24] *Id.* at 4.

[25] *Id.* at 7

[26] Vogel, *supra* note 22, at 1. "Good treatment was home treatment; sickness was endured, for the most part, in its traditional setting in the home and among family." *Id.*

[27] *Id.* "Physicians kept track of their seriously ill patients with frequent home visits, and surgeons

medicine in a hospital because the hospital was not yet "central to the practice of medicine."[28] In fact, care at a hospital was looked at with disdain as the hospital was considered "a primitive institution treating [a] . . . socially marginal constituency . . . ."[29] Beyond this, hospitals were traditionally viewed as the place people went to die.[30] Surgical mortality rates were actually higher in a hospital than they were if the surgery was performed at home. Thus, the hospital was considered a "house of death."[31]

As a result of technological advances and increasing concern for hygiene and sanitation, hospitals underwent somewhat of a facelift in the late nineteenth and early twentieth centuries.[32] Self-paying patients began to populate hospitals at increasing rates.[33] By 1903, self-paying patients accounted for more than seventy percent of the operating income for hospitals in over a dozen states and U.S. territories.[34] With the rise of surgery, hospitals became attractive to the more affluent members of society, as hospitals were expensive and catered to the whims of paying patients.[35] By 1920, the number of hospitals across the country had grown dramatically—totaling over six thousand.[36] These hospitals had "emerged as the center of advanced medical practice."[37] Even though they were originally viewed as "institution[s] whose use stigmatized patients, the hospital had become an emblem of the community."[38] In staunch contrast to their humble beginnings, hospitals

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might perform even the most difficult operations on kitchen tables or ironing boards stretched between tables . . ." *Id.*

[28] *Id.*

[29] *Id.* "Its patients were overwhelmingly the poor and those without roots in the community; dependence, as much as disease, distinguished them from the public at large." *Id.*

[30] PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 151 (1982).

[31] *Id.*

[32] ROSEMARY STEVENS, IN SICKNESS AND IN WEALTH AMERICAN HOSPITALS IN THE TWENTIETH CENTURY 30 (1989) "[T]he rise of surgery created a new market of services to relatively well-off individuals who were not otherwise disabled or socially dependent." *Id.* Starr, *supra* note 30, at 154. "Primarily because of increased concern for cleanliness and ventilation, hospitals began to emerge from obloquy and disrepute even before any major technological advances had been made."

[33] Stevens, *supra* note 32, at 30.

[34] *Id.*

[35] *Id.* "Hospitals were complex, expensive, and particularly attractive to paying patients . . . . [T]he rise of surgery created a new market of services to relatively well-off individuals who were not otherwise disabled or socially dependent." *Id.*

[36] Vogel, *supra* note 22, at 1.

[37] *Id.*

[38] *Id.*

had become models for sanitary and coordinated health care.[39]

As hospital-based medicine evolved into the preferred method of medical care, hospitals became "peculiar hybrids economically."[40] They were still charities because private donations accounted for the vast majority of money that the hospitals used as capital for buildings and other investments.[41] Beyond these capital expenditures, hospitals carried on their affairs much more like businesses.[42] Having a greater number of paying patients would increase the income of the hospital and provide it with the resources it needed to expand and furnish paying patients with more advanced medical facilities.[43] With the goal of increasing its income, hospitals expanded to meet the demand it created with patients who could afford to pay for its services.[44]

B. American Hospital Tax History

Around this same time, the 1913 federal income tax law took affect.[45] This tax law was particularly relevant to hospitals because it exempted them from any income tax liability if the hospitals could prove they were non-profit charities.[46] Given the charitable origin of hospitals, legislators had no problem classifying them as charitable institutions.[47] Case law from this era indicates that opposition to this classification grew as it became difficult to reconcile the tax exemption for institutions whose evolution made them less and less charitable.[48] The Internal Revenue Service responded with criteria to determine non-profit hospitals' charitable status.[49]

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[39] Stevens, *supra* note 32, at 18. Hospitals were described as "[m]odels of cleanliness, efficiency, and expertise. Where only twenty or thirty years before there had been noise, dirt, and disarray, there was now control and organization." *Id.*

[40] *Id.* at 33.

[41] *Id.*

[42] *Id.*; Starr, *supra* note 30, at 147.

[43] Stevens, *supra* note 32, at 33.

[44] *Id.* "Hospitals had a clear incentive to build the demand for hospital service; that is, to behave as successful, competitive enterprises in which the goal was expansion of units sold, including surgical operations and filled private beds." *Id.*

[45] Cecilia M. Jardon McGregor, *The Community Benefit Standard for Non-Profit Hospitals: Which Community, and for Whose Benefit?*, 23 J. CONTEMP. HEALTH L. & POL'Y 302, 307 (2007).

[46] *Id.*

[47] Helena G. Rubenstein, *Nonprofit Hospitals and the Federal Tax Exemption*, 7 HEALTH MATRIX 381, 393 (1997).

[48] *Id.* at 394.

[49] *Id.* at 395.

Section 501(c)(3) of the Internal Revenue Code (the "Code"), originally enacted in 1954, establishes what qualifies as a charity.[50] Among other things, if an entity is run exclusively for charitable purposes, then it is exempt from income taxes because of the public benefit it provides to the community,[51] so long as it passes certain organizational and operational requirements.[52] The organizational requirements are met when the organization's purpose(s) are limited to its exempt purposes.[53] In other words, "a charitable organization may not have something noncharitable as its purpose."[54] Operational requirements are met when a substantial part of the organization's activities are aligned with its exempt purpose.[55] Treasury regulations loosened the Code's requirement that the organization must operate exclusively for charitable purposes but requires instead, that it operate primarily for these purposes.[56] Some indicate that this standard may be too relaxed, arguing that it does not require health care organizations to provide free or even discounted health care.[57] Rather, the health care organizations' provision of services like health education and health care screenings are enough to satisfy the community benefit standard.[58] Most hospitals, in fact, qualify as charitable entities and likely because of the loose qualifications required to establish a charitable entity.[59]

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[50] I.R.C. § 501(c)(3) (1954).

[51] McGregor, *supra* note 45, at 312.

[52] Terri L. Brooks, *Billions Saved in Taxes While Millions Underserved—What has Happened to Charitable Hospitals,* 8 HOUS. BUS. & TAX L.J. 391, 395-96 (2008). The organizational requirement means that "[t]he entity's legal form must generally be that of a 'corporation [ ], . . . community chest, fund, or foundation.'" *Id.* at 396. The operational requirements "are more substantive in nature because they look more to the actual or proposed operations of the organization, apart from the organizing documents. In general, an organization must behave as a charitable organization in order to meet the operating requirements of I.R.C. § 501(c)(3)." *Id.* at 396-97.

[53] Joint Committee on Taxation, *Historical Development and Present Law of the Federal Tax Exemption for Charities and Other Tax-Exempt Organizations* 48 (April 19, 2005), *available at* http://www.jct.gov/x-29-05.pdf.

[54] *Id.*

[55] *Id.* at 49.

[56] *Id.*

[57] McGregor, *supra* note 45, at 317.

[58] *Id.*

[59] James McGrath, *Overcharging the Uninsured in Hospitals: Shifting a Greater Share of Uncompensated Medical Care Costs to the Federal Government*, 26 QUINNIPIAC L. REV. 173, 175 (2007).

III. RISE OF INSURANCE AND ITS IMPACT ON HOSPITAL COSTS

The innovation of health insurance was significant in increasing patients' ability to pay for hospital services. This, in turn, led to a significant increase in hospital revenue streams. One of the first forms of health insurance came in the form of workmen's compensation.[60] Established under President Theodore Roosevelt, the program "impos[ed] upon industry the cost of injury and other damage to workers," and by 1919 was adopted in thirty-seven states.[61] Later, in the 1930's and early 1940's, group hospitalization plans[62]—Blue Cross, for example— took off.[63] The plans "offered subscribers the opportunity to receive specified hospital services, without cost at the time of need, for a small, ongoing monthly payment."[64] Originally, the tax-exempt Blue Cross premiums were based upon community ratings whereby everyone paid the same amount despite differences in health history.[65] Most subscribers to the plan were large employers who offered the plan to their employees, thereby providing coverage to the more affluent members of society.[66]

Increased insurance coverage resulted in a surge of hospital

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[60] Stevens, *supra* note 32, at 85.

[61] *Id.*

[62] Lee R. Russ, *Part IV. Risks and Activities Covered by Insurance Policy*, 10A COUCH ON INS. § 144:7.

> Hospital expense insurance arose in the United States during the 1930s when the depression wreaked havoc on both private insurers and the ability of private citizens to pay their own medical bills. In order to lessen the impact of health emergencies, groups of hospitals and hospital associations created various "prepayment" schemes. The administration of these plans and the coverage afforded by them varied greatly until the American Hospital Association developed national standards. Thereafter, any hospital association which wished to use the Blue Cross name and symbol had to be organized as a not-for-profit, had to have uncompensated directors, and had to offer a set of minimum benefits to its subscribers.
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> *Id.*

[63] Stevens, *supra* note 32, at 182. "By 1937 more than 600,000 Americans were enrolled in twenty-six independent plans." *Id.*

[64] *Id.* at 183.

[65] Michael K. Beard, *The Impact of Changes in Health Care Provider Reimbursement Systems on the Recovery of Damages for Medical Expenses in Personal Injury Suits*, 21 AM. J. TRIAL ADVOC. 453, 461 (1998). Blue Cross later abandoned the community rating system so they could be competitive with commercial insurers and gauged premiums based on an individual's health risk assessment. The change caused people to question whether Blue Cross should maintain its non-profit status and ultimately lead to the repeal of its tax-exemption under the Tax Reform Act of 1986. Philip P. Bisesi, *Conversion of Nonprofit Health Care Entities to For-Profit Status*, 26 CAP. U. L. REV. 805, 824 (1997).

[66] Stevens, *supra* note 32, at 172, 184-185.

construction between 1936 and 1939, but construction plummeted in the years that followed.[67] By the mid-1940's, "[h]undreds of hospitals were regarded as obsolete, either because they were too small and ill-equipped or because of a reported lag in capital investment" and were in need of a major overhaul.[68] The answer to the state of disrepair came in the form of the Hill-Burton Act[69]—named after former Senators Lister Hill and Harold Burton.[70] The Act provided financial aid to survey, rebuild and modernize hospitals.[71] In addition to the provision of rebuilding and modernization funds, the Act was intended to provide medical care to patients who could not afford it.[72] In furtherance of this goal, the Act required funded hospitals to adopt non-discriminatory policies that would ensure the provision of care without regard to race.[73] Champions of racially integrated health care systems argued that segregated health care resulted in inferior medical care for the country's black population.[74] The goals of the Act, though noble in theory, were limited in their true application. The Act provided a caveat that allowed hospitals to continue segregation if the facilities were considered equal.[75] Hospitals receiving Hill-Burton funding largely ignored their obligation to provide uncompensated care until the late 1970's, when litigation prompted enforcement of the Act's charitable provision.[76] Early efforts to control cost of care to those least able to afford it, however, were generally ineffective.

Despite non-compliance with the Act's charitable provision, new community hospitals were built[77] vigorously with the passage of the Hill-Burton Act and extant hospitals experienced significant expansion.[78] As hospitals across the country underwent this extensive

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[67] *Id.* at 214.

[68] *Id.*

[69] 42 U.S.C. § 291a (1944).

[70] *Id.*; Stevens, *supra* note 32, at 216.

[71] *Id.*

[72] Peter D. Jacobson, *Legislating and Litigating Health Care Rights Around the World*, 33 J.L. MED. & ETHICS 725, 732 (2005).

[73] Lisa C. Ikemoto, *In the Shadow of Race: Women of Color in Health Disparities Policy*, 39 U.C. DAVIS L. REV. 1023, 1029 (2006).

[74] Vanessa Northington Gamble, *U.S. Policy on Health Inequities: The Interplay of Politics and Research*, 31 J. HEALTH POL. POL'Y & L. 93, 102 (2006).

[75] Ikemoto, *supra* note 73, at 1029.

[76] Jacobson, *supra* note 7, at 732.

[77] SANDY LUTZ & E. PRESTON GEE, THE FOR-PROFIT HEALTHCARE REVOLUTION 12 (1995).

[78] Stevens, *supra* note 32, at 226.

makeover, the price of hospital care began to rise.[79] In fact, "[h]ospital expenses per patient day more than doubled between the mid-1940s and the mid-1950s, and almost doubled again in the next ten years."[80]

With the growing cost of hospital care, the idea of universal insurance coverage became a theme of almost every president after President Roosevelt, [81] except President Reagan, who favored limited government.[82] In 1948, President Harry Truman proposed national health insurance, but was defeated by an opposition campaign spearheaded by the American Medical Association ("AMA"), which was unremitting in subsequent decades.[83]

As hopes for national health insurance dimmed, the focus narrowed to segments of the population who were most empathetic in a political maelstrom—the uninsured elderly and the poor.[84] As most opportunities for health coverage came through Blue Cross group insurance—which was typically offered through employment —those who were too old to work, disabled and not capable of working, or unemployed,[85] were excluded from coverage.

In 1965, Medicare and Medicaid emerged to create a safety net for these groups.[86] The programs guaranteed hospitals payment based on the reasonable costs of services.[87] Hospital spending dramatically increased, [88] as did the costs of hospital-based care.[89] For the first time, Medicaid and Medicare reimbursed hospitals for services that they once

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[79] *Id.* at 262.

[80] *Id.*

[81] Jacqueline Fox, *Medicare Should, but Cannot, Consider Cost: Legal Impediments to a Sound Policy*, 53 BUFF. L. REV. 577, 585 (2005).

[82] TOM DASCHLE, CRITICAL: WHAT WE CAN DO ABOUT THE HEALTH-CARE CRISIS 67 (2008).

[83] Raj Aujla, *The Impending Health Care Crisis in Texas: The Status of Health Care for Impoverished Texans*, 10 SCHOLAR 397, 427 (2008).

[84] Stevens, *supra* note 32, at 268; TERRY BOYCHUK, THE MAKING AND MEANING OF HOSPITAL POLICY IN THE UNITED STATES AND CANADA 24 (1999).

[85] Blue Cross subscribers were middle-class and the poor were neglected. MICHAEL MORAN, GOVERNING THE HEALTH CARE STATE 45 (1999).

[86] Stevens, *supra* note 32, at 281.

[87] *Id.*

[88] *Id.* at 284.

[89] *Id.* at 287. Two-thirds of the increase in hospital costs

> represented massive expansions in hospital payroll and nonpayroll expenses—including 'profits.' The average cost per patient day more than doubled, in real terms, between 1966 and 1976, that is, even after allowing for inflation. The total assets of short-term hospitals rose from $16.4 billion in 1965 to $47.3 billion ten years later, with all three sectors gaining in strength.

Id.

provided as a charity.[90] The promise of payment incentivized hospitals to perform almost unlimited services for patients.[91] The adoption of new and more costly technology enhanced patient care, but also increased hospital charges.[92] Hospitals were in the midst of undergoing a complete transformation in purpose and became increasingly receptive to the income potential they could never have imagined at their inception.

IV. HOSPITALS AS A BUSINESS AND THE CONSEQUENCES TO THE UNINSURED

This section begins with a discussion on the operation of hospitals as businesses with a primary goal to make money on their transactions. It goes on to discuss how insurance companies, as payers of these transactions on behalf of insured patients, had an interest in controlling costs and chose to negotiate with hospitals the cost of hospital services. Finally, this section will discuss the precarious hospital pricing system that resulted where the uninsured, who lacked the negotiating power of insurance companies, were forced to pay inflated rates for hospital care.

A. Payment System Between Hospitals and Insurance Companies

It is against the backdrop of heightened income potential that hospitals diverged from their initial charitable purpose to satisfy the medical needs of the poor and began to focus instead on profit generation, not unlike any other typical business. Even religious hospitals coined the phrase "no margin, no mission."[93]

Hospitals began setting prices for their services to cover actual costs plus a predetermined level of profit.[94] Until the 1980s, consumers and insurers, both private and government, paid whatever price hospitals charged. It was not long, however, before insurance companies began to negotiate with hospitals over how much they would

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[90] TIMOTHY STOLTZFUS JOST, HEALTH CARE AT RISK 72 (2007).

[91] Stevens, *supra* note 32, at 284.

[92] *Id.* at 287. Examples of technological advances include the use of C-sections for childbirth as compared to vaginal deliveries and the introduction of chemotherapy and radiation for the treatment of cancer. *Id.*

[93] Susan Berke Fogel, *Morning Panel: Recent Trends and Policy Developments at State & National Levels Featuring Marjorie Shultz, Lauren Sorrentino, and Susan Berke Fogel*, 17 BERKELEY WOMEN'S L.J. 216, 217 (2002).

[94] Cohen, *supra* note 10, at 108.

pay for particular services.[95] Eventually, insurance companies adopted a system "whereby they paid hospitals one set price for all services rendered to an inpatient with a particular diagnosis."[96]

A payment system between hospitals and insurance companies emerged where hospitals agreed to discounts for health insurance carriers, which nonetheless did not preclude them from earning healthy margins.[97] During this time, the uninsured were being charged undiscounted billing rates—with little to no constraint.[98] The impetus to regulate was lacking because government funded insurance programs, Medicare and Medicaid, were not burdened by the full cost of a hospital service, as they continued to enjoy a negotiated reimbursement rate.[99]

Those without health insurance were systemically excluded from the savings negotiated by insurance companies and were left with bills that grew unchecked by either free-market or government forces.[100] Charges soon bore little relation to the traditional formula of cost plus a "predetermined level of profit."[101] Uninsured patients regularly faced charges substantially greater than the actual cost of the service.[102] Such markups gave hospitals an excessive level of profit— in direct opposition to their charitable origins and not-for-profit status[103] that most currently enjoy. In fact, hospital charge-to-cost ratios[104] have more than doubled between 1984 and 2004,[105] as "hospital charges increased much faster than costs during this time period . . . ."[106] Insurance companies experienced a certain level of immunity from the rise in hospital charges because of their negotiated discounts.[107] The most tragic casualty of these billing practices, however, was the uninsured population.

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[95] *Id.* at 108-09.

[96] *Id.* at 109.

[97] McGrath, *supra* note 59, at 182-83.

[98] Cohen, *supra* note 10, at 107, 110-111.

[99] *Id.* at 109.

[100] *Id.* at 110.

[101] *Id.* at 108.

[102] For example, a hospital charged a patient "$532.50 for three bottles of dye to image his arteries, while the manufacturer sells the product to hospitals for twenty-eight to fifty dollars a bottle, a markup of at least 355%." *Id.* at 102.

[103] Nation, *supra* note 2, 118-19.

[104] Charge-to-cost ratio measures the relationship between hospital charges for services—what the uninsured pay—and the actual cost of care for the patient. Anderson, *supra* note 9, at 781.

[105] *Id.* at 782.

[106] *Id.* at 783.

[107] Nation, *supra* note 2, at 118–19.

B. The Result—Inflated Prices for the Nation's Uninsured Population

What ultimately resulted is the situation currently facing the country—where hospitals are charging the uninsured up to two and a half times more than they charge third party payers.[108] The extent of the gap between the rates charged to the uninsured and the rates charged to insurance companies varies widely, but the rates charged to the uninsured have been documented at up to eight times that charged to insurance companies.[109] For example, a twenty-five year old woman was hospitalized for two days after receiving an appendectomy at New York Methodist Hospital in Brooklyn, New York.[110] She was charged $19,000 ($14,000 for her hospital stay and $5,000 in physician fees) for care while an insurance company would have been charged approximately $2,500 if billed for the same procedure.[111]

Another story comes from Virginia, where a forty-three year old furniture salesman was brought to a local emergency room in Herndon, Virginia after suffering from chest pain.[112] He received a cardiac cauterization and a stent while at the hospital and proceeded to check himself out of the hospital the next morning, against medical advice, out of fear of the bill he was likely to face as an uninsured patient.[113] This patient deliberately compromised his medical care and potentially jeopardized his life to avert the financial devastation that was likely to result from his hospital stay.

Uninsured patients normally leave unpaid insurmountable medical bills, thereby subjecting themselves to hospitals' aggressive collection practices.[114] The results of these collection practices include bankruptcy, wage garnishment, seizure of bank accounts and property liens—even when relatively small amounts were at stake.[115] In 2003, the Wall Street Journal brought this crisis to the forefront of American consciousness through a series of articles depicting the plights of some of these

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[108] Anderson, *supra* note 9, at 780.

[109] Nation, *supra* note 2, at 101.

[110] *Id.*

[111] *Id.*

[112] *Id.* at 101-02.

[113] *Id.* at 102.

[114] STEVE TRIPOLI & CHI CHI WU, NAT'L CONSUMER LAW CTR., UNHEALTHY PURSUITS: HOW THE SICK AND VULNERABLE ARE HARMED BY ABUSIVE MEDICAL DEBT COLLECTION TACTICS 1 (2005), http://www.consumerlaw.org/news/content/medicaldebt.pdf.

[115] Cohen, *supra* note 10, at 105.

individuals.[116]

Hospitals responded, in part, by saying that they could not reduce hospital charges because it would put them in a precarious position with insurance providers.[117] They argued, in essence, that inflated charges were necessary in order for them to continue receiving adequate payment from insurance providers—Medicare and Medicaid in particular.[118] As noted earlier, insurance carriers did not pay the full list price for medical services provided to its subscribers, but instead received a negotiated discount.[119] Hospitals feared that if the full list price was reduced to accommodate the uninsured, the reimbursements it received from insurance carriers would be proportionately decreased, reflecting a discount off of the price already reduced to help the uninsured.[120]

Another concern pertains to a potential violation of Section 1128(b)(6)(A) of the Social Security Act[121]—a law enforced by the Office of Inspector General (OIG) that sanctions providers who charge Medicare or Medicaid substantially more than its usual charges.[122] Hospitals believed that if the reduced rates charged to the uninsured could be construed as a hospital's usual charges and these rates were substantially less than the amount billed to Medicare or Medicaid, they risked a Section 1128(b)(6)(A) violation.[123] These fears, however, were soon deemed unfounded.

V. NATIONAL RESPONSE

This section discusses the national response to the situation facing America's uninsured beginning with the Office of the Inspector General ("OIG" or "Office"). The Office attempted to quell any concern made by hospitals that charging reduced prices to the uninsured was an act

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[116] *Id.* at 95; *see also* Lagnado, *supra* note 10.

[117] Nation, *supra* note 2, at 120.

[118] *Id.*

[119] *See generally id.*

[120] *Id.* at 120.

[121] 42 U.S.C. § 1320a-7(b)(6)(A) (2003).

[122] Office of Inspector General, Department of Health & Human Services, *Hospital Discounts Offered to Patients who Cannot Afford to Pay Their Hospital Bills*, pp. 1-2, http://www.oig.hhs.gov/fraud/docs/alertsandbulletins/2004/FA021904hospitaldiscounts.pdf. "This law permits—but does not require—the OIG to exclude from participation in the Federal health care programs any provider or supplier that submits bills or requests for payment to Medicare or Medicaid for amounts that are substantially more than the provider's or supplier's usual charges." *Id.*

[123] Nation, *supra* note 2, at 120.

prohibited by certain legislative acts the Office enforces. Next, the section discusses litigation that occurred on behalf of the uninsured in a fight for more equity in pricing and the American Hospital Association's response to the litigation. Finally, this section examines whether price transparency can aid in achieving equitable pricing.

A. The Office of the Inspector General Response to Hospitals: It's Okay to Charge the Uninsured Reduced Prices

In 2004, the OIG responded to the allegations that it precluded hospitals from offering the uninsured reduced prices for hospital care, by declaring that the Office in no way "prohibits or restricts" a hospital's ability to provide discounts to uninsured patients who do not have the means with which to pay for their medical care.[124] In a statement released in February 2004[125] and in a Hearing of the House Committee on Energy and Commerce held in June 2004,[126] the OIG refuted two common arguments advanced by opponents, that the office prohibited hospitals from providing discounts to the uninsured. The first argument was that the practice of providing a discount in hospital charges to the uninsured violated the Federal Anti-Kickback Statute.[127] While the OIG's Federal Anti-Kickback Statute is designed to prohibit wrongfully gained referrals, it does little to punish hospitals for providing discounts to uninsured patients.[128] An example of a violation of the Federal Anti-Kickback Statute is an uninsured physician who seeks medical care for himself and receives discounted services at a hospital in exchange for referrals to the hospital.[129] Although this example proves that offering discounts to the uninsured can potentially violate the Federal Anti-Kickback Statute,[130] its facts are far from the norm and the vast majority of indigent patients who are in need of

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[124] *See supra* note 122, at 1.

[125] *Id.*

[126] *A Review of Hospital Billing and Collection Practices: Hearing Before the H. Com. On Energy and Commerce Subcomm. on Oversight and Investigations*, 108th Cong. 1-4 (2004) (statement of Lewis Morris, Chief Counsel to the Inspector General), http://www.oig.hhs.gov/testimony/docs/2004/40624oig.pdf [hereinafter *Hearings*].

[127] *Id.* at 9. "The Federal anti-kickback statute prohibits a hospital from giving or receiving anything of value in exchange for referrals of business payable by a Federal health care program, such as Medicare or Medicaid." *Id.*; *see also* 41 U.S.C. § 51 (1986).

[128] Hearings, *supra* note 126, at 2.

[129] *Id.* at 3.

[130] 42 U.S.C. § 1320a-7b(b) (West 1986).

hospital care do not pose any such risk.[131]

As mentioned earlier, hospitals' second argument is that reduced prices for the uninsured could violate Section 1128(b)(6)(A) of the Social Security Act.[132] The OIG quelled this argument by announcing that reduced charges for the uninsured need not be considered in a hospital's determination of its usual charges.[133] The OIG responded that it never "excluded or even contemplated excluding" providers on the basis of their decision to give discounts to the uninsured.[134]

B. Litigation on behalf of the Uninsured—Fighting for equity in pricing

Congress and the OIG were not the only ones outraged by hospitals' billing practices. In June 2004, attorney Richard Scruggs[135] brought suit on behalf of uninsured Americans in federal courts across the country.[136] The federal "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."[137] Overall, these cases were largely unsuccessful, with most claims being dismissed "on procedural and technical grounds involving legal standing and venue."[138] Litigation at the state level, however, appears promising, with several states allowing the plaintiffs to proceed with their causes of action.[139] These suits generally alleged that "hospitals ha[d] acted unlawfully, unfairly, or even fraudulently in their business with uninsured patients . . . " by charging the uninsured disproportionately

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[131] *Hearings*, *supra* note 126, at 3.

[132] *Id.*; *see also* Cohen, *supra* note 10, at 108.

[133] *See supra* note 122.

[134] Hearings, *supra* note 126, at 3.

[135] Richard Scruggs is a Mississippi attorney who led the anti-tobacco litigation of the 1990s. *See generally* Frontline Online, Inside the Tobacco Deal, *Interview with Richard Scruggs*,http://www.pbs.org/wgbh/pages/frontline/shows/settlement/interviews/Scruggs .html (last visited Jan. 17, 2010) [hereinafter *Scruggs*].

[136] David L. Nie, *Nonprofit Hospital Billing of Uninsured Patients: Consumer-Based Class Actions Move to State Courts*, 4 IND. HEALTH L. REV. 173, 175-76 (2007).

[137] *Id.* at 176.

[138] Press Release, Clifford Law Offices, Statement from Dick Scruggs Nonprofit Hospital Litigation Status (Oct. 11, 2005) http://www.cliffordlaw.com/not-for-profit-hospital-class-action-litigation/press-releases/statement-from-dick-scruggs-nonprofit-hospital-litigation-status (last visited Jan. 17, 2009).

[139] Nie, *supra* note 136, at 176.

higher rates than was charged to insurance companies.[140] In a settlement agreement reached in the *Sutter Health* cases, one of the largest class-action suits in the country encompassing twenty-six California hospitals,[141] class members were entitled to receive refunds or discounts ranging from twenty-five and forty-five percent of the original charge.[142]

C. American Hospital Association Responds with Billing and Collection Practice Guidelines for the Uninsured

In response to the increased attention given to the problem of the uninsured and hospital charges—resulting from the Wall Street Journal articles on the subject, the Scruggs litigation, settlement agreements, or a combination of all three—the American Hospital Association ("AHA")[143] and state hospital associations across the country established various billing and collection practice guidelines.[144] The AHA's guidelines seek to ensure that hospitals effectively advertise hospital-based charity care and any other financial assistance programs for which patients may qualify in a culturally appropriate manner and in languages spoken by the patient population.[145] State hospital associations, including the New Jersey Hospital Association (NJHA), followed suit with similar guidelines.[146] The NJHA even went further than the AHA regulations by adding a layer of transparency. The Association established a hospital price comparison website that allows consumers to compare prices for medical services at each of the state's hospitals.[147] Some believe that price transparency would force hospitals to be more uniform in their prices between self-pay patients and insurance companies, increasing equity between the two groups as a result.[148]

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[140] *Id.* at 178.

[141] *See supra* note 138.

[142] Sutter Health Uninsured Pricing Cases J.C.C.P. No. 4388, *Notice of Settlement Agreement* 5, http://www.uninsuredsettlement.com/pdfs/NoticeE.pdf.

[143] American Hospital Association, *Hospital Billing and Collection Practices*, http://www.aha.org/aha/content/2004/pdf/guidelinesfinalweb.pdf [hereinafter *Hospital Billing*].

[144] *See generally* American Hospital Association, *State Association Resources*, http://www.aha.org/aha/issues/BCC/stateresources.html (last visited Jan. 17. 2010).

[145] *See generally supra* note 143.

[146] *See generally* Statement of Principles, *supra* note 12.

[147] New Jersey Hospital Association, *New Jersey Hospital Price Compare*, http://www.njhospitalpricecompare.com/ (last visited Jan. 17, 2010).

[148] Margaret K. Kyle and David B. Ridley, *Would Greater Transparency and Uniformity of Health Care Prices Benefit Poor Patients?*, 26 HEALTH AFFAIRS 1384, 1384-85 (2007).

D. Price Transparency: Can it help the uninsured achieve more equitable pricing?

Price transparency[149] captured the attention of former President Bush and his former Secretary of Health and Human Services ("HHS"), Michael Levitt.[150] Bush issued an executive order on August 22, 2006, that encouraged health programs administered or sponsored by the federal government in order to improve transparency.[151] Levitt wrote an op-ed column urging the same.[152] President Obama has also promised full transparency by requiring "hospitals and providers to collect and publicly report measures of health care costs and quality."[153] However, at this time, federal legislation that would require hospitals and surgical centers to disclose their prices for care has not advanced since being introduced on May 8, 2008.[154]

Proponents argue that price transparency benefits consumers because it exposes pricier hospitals and allows consumers to patronize more affordable options.[155] More significantly, according to some proponents, price transparency gives consumers the ability to shop around for the best care at the best price and will, in turn, encourage providers to improve the quality of care and to price it competitively.[156] As it stands now, most patients have no idea how much they will be charged when they step inside a hospital for care.[157] If the patient has adequate insurance coverage, the patient can rest assured that he or she will be billed no more than the mandatory insurance co-pay and/or co-

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[149] Price transparency in health care involves one of two situations. First is one where "a buyer who is unaware of the price for treatment before receiving it and unaware of the price paid by others for the same treatment." *Id.* at 1384. The second "involves a buyer who knows the price offered to him or her by a seller but is unaware of the price offered to others by the same seller for the same treatment." *Id.*

[150] Anderson, *supra* note 9, at 786.

[151] National Conference of State Legislatures, *State Legislation Relating to Transparency and Disclosure of Health and Hospital Charges*, http://www.ncsl.org/ programs/health/transparency.htm (last visited Jan. 17, 2010).

[152] *Id.*

[153] Organizing for America, *Barack Obama and Joe Biden's Plan to Lower Health Care Costs and Ensure Affordable, Accessible Health Coverage for All*, http://www.barackobama.com/pdf/issues/HealthCareFullPlan.pdf.

[154] GovTrack.us, *H.R. 6015: Hospital and ASC Price Disclosure and Litigation Protection Act of 2008*, http://www.govtrack.us/congress/bill.xpd?bill=h110-6015 (last visited Mar. 6, 2009).

[155] Kyle & Ridley, *supra* note 148, at 1388.

[156] Paul B. Ginsburg, *Shopping for Price in Medical Care*, HEALTH AFFAIRS 26 w208, w209 (2007).

[157] Nation, *supra* note 2, at 116-17.

insurance.

Opponents of price transparency in hospital care note that even with a price list for all medical services a hospital offers, the list uses complicated medical and technical language, which is not readily understood by the average person.[158] Beyond this, emergency patients are not always in a position to comparison shop before heading to the hospital because of the urgent nature of the care they seek. Even if the circumstances allow the comparison of hospital prices beforehand, there is a good chance that patients will still be unable to determine how much a visit would cost. First, the patient may not know what services are needed to treat his condition. Someone going to a hospital for chest pain may have no idea what is causing the chest pain and a price list would serve no purpose. Further, it is rare for a hospital to bundle all the costs associated with a patient's medical care into one.[159] Instead, the bill typically has multiple lines covering a variety of services and products that the hospital used to treat the condition.[160] The Centers for Medicare & Medicaid Services (CMS) have, however, recently begun to revisit the concept of price bundling.[161] CMS hopes to establish global payments to compensate providers for all care received for a single medical incident.[162]

It is suggested that in order for medical price shopping to be effective, certain conditions must be met. These conditions require that: "(1) the services are not complex; (2) the need for the service is not urgent; (3) a diagnosis has already been made; [and] (4) bundled prices are the norm for the service . . . ."[163] While price transparency is arguably a mechanism that could help the cause of the uninsured, it clearly has its limitations.

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[158] Anderson, *supra* note 9, at 786.

[159] Ginsburg, *supra* note 156, at w211.

[160] Anderson, *supra* note 9, at 786.

[161] Centers for Medicare & Medicaid Services, *Solicitation for Applications Acute Care Episode Demonstration*, http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/ACE Solicitation.pdf.

[162] *Id.* at 2.

> Because Medicare's current payment systems reward quantity of services provided, rather than quality of care, CMS is pursuing new methods (through public reporting programs, demonstration projects, and other efforts) of paying providers that will encourage improvements in both the efficiency and quality of care provided to Medicare beneficiaries. The ACE [Acute Care Episode] demonstration is specifically designed to align financial incentives across providers and provide flexibility to hospitals and physicians by bundling all related inpatient services into an 'episode of care.'"

Id.

[163] Ginsburg, *supra* note 156, at w210.

VI. NEW JERSEY'S FRUSTRATED HEALTH CARE SYSTEM

A. New Jersey Health Care in Crisis

New Jersey hospital charges are particularly high,[164] ranking first in the country in 2004 for its charge-to-cost ratio—4.56—as compared to the lowest found in Maryland—1.42.[165] New Jersey also topped the country in its ratio of gross to net revenues—3.94.[166] These figures likely reflect the crisis of the New Jersey hospital financial infrastructure and undoubtedly have a disparate impact on self-pay patients, as they are not insulated from inflated hospital charges.[167] While many states have focused on price transparency, New Jersey has attempted to tackle the problem on two levels.

The NJHA established guidelines to protect patients from aggressive medical debt collection practices.[168] More recently, the state has enacted legislation that prohibits hospitals from billing uninsured poor people more than 115 percent above the Medicare reimbursement rate.[169] This legislation benefits New Jersey residents whose income is below 500 percent of the federal poverty level.[170] Under the 2010 Department of Health and Human Services Poverty Guidelines (left in tact from 2009), the income eligibility requirement translates to $54,150 for a single person; $72,850 for a married couple without dependent children; and $110,250 for a family of four.[171] Of the variety of ways to

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[164] Anderson, *supra* note 9, at 782-83.

[165] *Id.* at 783.

[166] *Id.* This means that for every $100 New Jersey hospitals collected, on average, they initially charged $394.

[167] *See generally Commission Report*, *supra* note 18. The New Jersey Commission on Rationalizing Health Care Resources was assembled by Governor Corzine to

> explore (1) why so many hospitals in [New Jersey] are struggling financially, (2) which among hospitals approaching the State for financial assistance warrant that assistance and (3) what steps might be taken to rationalize the functioning of New Jersey's hospital system and other components of the health care delivery system that interact with the hospital system.

Id. at i. "The Commission found that many [hospitals] are in poor financial condition when measured against national benchmarks and common financial indicators used by creditors." *Id.* at 3. "Once again as a result of price discrimination, hospitals function as a 'financial hydraulic system' under which they continually attempt to shift costs from one payer to another… Underpayment by public payers, particularly Medicaid, leads to intense efforts to shift costs onto private payers—including the uninsured." *Id.* at 5.

[168] *See Hospital Billing*, *supra* note 143.

[169] N.J. STAT. ANN. § 26:2H-12.52 (2009).

[170] *Id.*

[171] U.S. Department of Health and Human Services, Center for Medicare & Medicaid Services, *FY*

respond to the excessive prices of health care charged to the uninsured, this legislation most closely resembles one where government sets the rates at which hospitals can charge for care.

B. Potential Ways to Respond in General

Historically, three routes have been recommended to reduce hospital costs to the uninsured:[172] to provide health insurance to the forty-six million uninsured Americans,[173] to give a single rate to all payers where insurance companies and self-pay patients are charged the same fees for the same service[174] or to allow the government to establish hospital service rates.[175] Another sensible option would be to offer the uninsured the best rate negotiated with an insurer. Government rate setting proved to be effective on the state level in Maryland.[176] There, "[a]ll payers [ ] (including self-pay patients) pay nearly identical rates to hospitals" because the Health Services Cost Review Commission sets all hospital charge rates.[177] This system[178] has allowed Maryland to achieve the country's lowest charge-to-cost and gross-to-net-revenue ratios as of 2004.[179] With this system, the cost of uncompensated care is built into rates so that they are distributed equally between all payers.[180] Prior to implementation, the cost of an admission to a Maryland hospital was twenty-five percent above the national average.[181] By 2001, exactly twenty-five years later, this cost had fallen to 2.26 percent below the national average.[182] Further, from 1977 through 2000, Maryland

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2009/2010 Federal Poverty Guidelines, http://www.cms.hhs.gov/Medicaid Eligibility/Downloads/POV10Combo.pdf [hereinafter *Poverty Guidelines*]. Figures have been calculated using the guidelines.

[172] Anderson, *supra* note 9, at 785.

[173] *Id.*

[174] *Id.* "Countries such as Germany and Japan hold annual negotiations to set hospital rates. Insurer and hospital representatives sit on opposite sides of the table, with the government acting as the referee. However, current antitrust laws prohibit this from occurring in the United States."

[175] *Id.*

[176] Carl Jean-Baptiste, *Baby Boomers Retire—Impact on the Law*, 42 MD. B.J. 32, 36-7 (2009).

[177] Anderson, *supra* note 9, at 785.

[178] The system was established in 1971 but not fully implemented until 1977. Thomas R. Oliver, *Holding Back the Tide: Policies to Preserve and Reconstruct Health Insurance Coverage in Maryland*, 29 J. HEALTH POL. POL'Y & L. 203, 208 (2004) .

[179] Anderson, *supra* note 9, at 785.

[180] *Id.*

[181] Oliver, *supra* note 178, at 208.

[182] Press Release, Maryland Department of Health and Mental Hygiene, Disclosure of Hospital Financial and Statistical Data (Apr. 10, 2002), http://www.dhmh.state.md.us/publ-

experienced the lowest cumulative growth in cost per adjusted admission of any state in the nation.[183]

Maryland is the only state in the country that sets hospital rates to which all payers must comply.[184] Interestingly enough, in the early 1980's New Jersey's hospital billing system was similar to Maryland's current system. In 1978 the state passed legislation called Chapter 83, which extended the rate-setting system that had previously only applied to Medicaid and Blue Cross[185] to all payers.[186] Chapter 83 led to the creation of the diagnosis-related group ("DRG") payment system, whereby hospitals billed by DRG.[187] Included in every bill was a markup that allowed hospitals to recoup the money they lost for providing uncompensated care.[188] Hospitals in poor communities had higher markups because they provided more uncompensated care, which encouraged self-pay patients to avoid these hospitals and put an even greater financial strain on hospitals serving poor communities due to the decreased number of patients.[189] In 1987, the state responded by instituting an Uncompensated Care Trust Fund ("UCTF"), which put all

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rel/html/pr041002a.htm (last visited Jan. 17, 2010).

[183] *Id.*; *see also* Oliver, *supra* note 178, at 208. Despite these successes, it should be noted that Maryland's system has come under scrutiny in recent years by some of Maryland's health policy officials.

> Because of a vast expansion in managed care enrollment and competition among both health insurers and hospitals, the program has been under attack for several years from some quarters of the state health policy community. In addition, it has received scrutiny because hospital inflation in Maryland has actually exceeded national rates for more than a decade.

Id.

[184] Karen Pollitz, et al., *New Directions in Health Insurance Design: Implications for Public Policy and Practice*, 31 J.L. MED. & ETHICS 60, 61 (2003). New Jersey had a similar hospital rate-setting system that was established in 1978 and became completely effective by 1982, where hospitals billed by Diagnosis-related Group (DRG). Under this system, all payers paid the same price for a DRG and this price included a markup to compensate hospitals for the costs of uncompensated care; *see also* Kevin G. Volpp & Bruce Siegel, *Long-Term Experience With All-Payer State Rate Setting, State Model: New Jersey*, 12 HEALTH AFFAIRS 59, 60, *available at* http://content.healthaffairs.org/cgi/reprint/12/2/59.pdf.

[185] Medicaid and Blue Cross were already rate-controlled as a result of the New Jersey Health Care and Facilities Planning Act of 1971. "The act, which established both mandatory certificate-of-need (CON) health planning and hospital rate controls for Medicaid and Blue Cross, was passed in response to public anxiety over medical inflation and garnered the support of hospitals, which hoped to restrain the entry of new competitors from out of state." Volpp & Siegel, *supra* note 184, at 59.

[186] *Id.*

[187] *Id.* at 60; *see also* Joel C. Cantor, *Health Care Unreform The New Jersey Approach*, 270 J. AM. MED. ASS'N 2968, 2968 (1993).

[188] Volpp & Siegel, *supra* note 184, at 60.

[189] *Id.*

hospitals on the same playing field by making the uncompensated care markup uniform at all hospitals throughout the state.[190] This system was ultimately overstressed given some changes in the health care landscape and fell apart under the pressure.[191]

One of the facilitators of this dismantling was a change in Medicare. Medicare began to pay according to a prospective payment system ("PPS"), which capped the amount that Medicare would reimburse for a particular diagnosis to a particular level without any regard to provisions for uncompensated care.[192] The increasing number of uninsured patients further taxed the UTCF.[193] In 1992, the DRG rate-setting system and Chapter 83 came to an end with the passage of the Health Care Reform Act ("HCRA").[194]

Despite the policy failure in New Jersey, other states have since passed legislation or other agreements with hospital systems that cap the amount that hospitals can charge the uninsured who fall within specified income limits. Tennessee, California, Illinois, Minnesota, New York, and Alabama[195] have passed, or are in the process of passing, legislation to cap the amount that hospitals may charge the uninsured falling within specified income limits.[196] Data has yet to be produced that examines the efficacy of legislation of this type.

C. New Jersey Response—Detailed

Through both industrial and legislative action, New Jersey laid the groundwork to dramatically decrease its charge-to-cost ratio and the burden this ratio places on the uninsured. The two systemic mechanisms include: (1) guidelines for compassionate billing and

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[190] *Id.*

[191] *Id.* at 61.

[192] *Id.* at 60.

[193] Volpp & Siegel, *supra* note 184, at 61.

[194] N.J. STAT. ANN. § 26:2H-18.70 (2003). Volpp & Siegal, *supra* note 184, at 63. Urban hospitals opposed HCRA as they feared they would never fully recoup for the uncompensated care they provided, while suburban hospitals lauded its passage. The strife led many urban hospitals to break away from the New Jersey Hospital Association because of its support of HCRA. These hospitals formed the Hospital Alliance of New Jersey.

[195] Jimmy DeButts, *Senator Proposes Cap on Uninsured Patient Bills*, BIRMINGHAM BUS. J., Apr. 6, 2007, http://birmingham.bizjournals.com/birmingham/stories /2007/04/09/story3.html (last visited Jan. 17, 2010).

[196] *See generally* FamiliesUSA, *supra* note 15.

collection practices promoted by the NJHA[197] and (2) the aforementioned legislation recently signed into law by Governor Corzine prohibiting hospitals from charging the uninsured more than 115 percent above the Medicare reimbursement rate.[198]

1. New Jersey Hospital Association Recommendations

According to the NJHA, its 2004 guidelines for compassionate billing and collection practices for the uninsured were in response to the state's growing uninsured population and the increasing reports of the economic challenges facing the uninsured as a result of hospital bills.[199] Most hospitals in the state voluntarily agreed to abide by the principles and guidelines the NJHA set forth.[200] These guidelines mirror those outlined by the AHA that same year in their Statement of Principles and Guidelines for Hospital Billing and Collection Practices.[201] They encourage hospitals to effectively communicate financial aid programs that are available so that patients will not be discouraged from seeking hospital care due to fear of the bill they may receive.[202] Further, the guidelines recommend that hospital debt collection practices "reflect the mission and values of the hospital,"[203] implying that aggressive collection practices which resulted in the financial devastation of its patients are not consistent with the mission of tax-exempt entities.

One of the more important elements of a hospital financial assistance policy, which is noted in the NJHA guidelines, encourages hospitals to "attest that access to financial assistance or counseling will be provided to the lowest income individuals—those individuals that lack health insurance and don't qualify for Medicaid, Family Care, Charity Care[204] or other low income programs—with collections

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[197] *See generally* Statement of Principles, *supra* note 12.

[198] N.J. STAT. ANN. § 26:2H-12.52 (2009).

[199] Press Release, New Jersey Hospital Association, Hospital Association Task Force Develops Compassionate Bill Collection Guidelines (Apr. 22, 2004), *available at* http://www.njha.com/press/PressRelease.aspx?id=4741.

[200] Washburn, *supra* note 20.

[201] *See generally Hospital Billing*, *supra* note 143.

[202] Statement of Principles, *supra* note 12.

[203] *Id.*

[204] Medicaid is the state run health insurance program for low-income children, families with children under eighteen people who are aged, blind or permanently disabled, and pregnant women. State of New Jersey Department of Human Services, New Jersey Medicaid,http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ (last visited Jan. 17. 2010). New Jersey Family Care is an insurance program for working families who do not qualify for Medicaid

practices that recognize the limited financial capacity of those individuals."[205] The NJHA goes on to say that "[h]ospitals may consider providing financial assistance [to those who lack health insurance and do not qualify for any low income programs] and may establish collections policies and practices based on those patients' ability to pay."[206] The recommendations fall short of requiring hospitals to offer financial assistance to these individuals and provide little oversight on how to determine a patient's ability to pay. There is no indication of how many, if any, of these patients have received financial assistance. In 2003, 1.2 million, or fifteen percent, of New Jersey's population lacked health insurance.[207] The NJHA estimates that less than ten percent of patients are actually billed the full inflated price for hospital care and add that it is rare that they collect this amount even when billed.[208] Consequently, one could infer from this data that a significant proportion of the uninsured are billed sticker price.

In New Jersey, Charity Care[209] pays the extent of the bill for patients who are 200 percent or below the federal poverty line, or make $21,660[210] or less per year as an individual.[211] Unlike Medicaid, Charity Care does not preclude participation by illegal immigrants.[212] The percentage of the bill paid by the patient increases gradually until the benefit diminishes entirely for individuals who are at 300 percent or

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and fall within certain income levels. Children are the priority, but if family income is low enough, parents will be covered as well. NJ Family Care, http://www.njfamilycare.org/pages/who_njkc.html (last visited Jan. 17, 2010). Charity Care offers financial assistance for the payment of hospital bills for New Jersey residents who have no health coverage, do not qualify for government programs like Medicaid and are income eligible. State of New Jersey Department of Health and Senior Services, New Jersey Hospital Care Payment Assistance Program Fact Sheet, http://www.state.nj.us /health/cc/documents/ccfactsh.pdf (last visited Jan. 17, 2010).

[205] Statement of Principles, *supra* note 12.

[206] *Id.*

[207] *Id.* at 2.

[208] Washburn, *supra* note 20.

[209] N.J. STAT. ANN. § 26:2H-18.59i (2004).

[210] This number is adjusted every year based on the new federal poverty level guidelines. State of New Jersey Department of Health and Senior Services, New Jersey Hospital Care Payment Assistance Program Fact Sheet, http://www.state.nj.us/health /cc/documents/ccfactsh.pdf; *see also Poverty Guidelines, supra* note 171.

[211] *Id.* Other requirements for charity care are that the patient is a New Jersey resident who has no other health coverage or has health coverage that does not pay the extent of the bill, is ineligible for private or public health insurance coverage and does not have assets that exceed $7,500 if an individual and $15,000 if part of a family.

[212] N.J. STAT. ANN. § 26:2H-18.60 (1993).

above the federal poverty level, or make $32,490 or more per year.[213] The true benefit of the Charity Care program is compromised by the fact that the patient's original bill, before any deductions, is based on inflated, or sticker price, charges.[214] To prevent charges from becoming a major financial burden, however, out-of-pocket expenses are not to exceed thirty percent of the patient's annual income.[215]

Under the current system, if a patient is billed twenty percent of the inflated sticker price charge, the amount that he is obligated to pay could easily exceed thirty percent of the patient's annual income, thereby placing a financial burden on the patient. For example, if a patient makes $21,000, he is responsible for twenty percent of his hospital charges with Charity Care paying the remainder. If this patient's bill is $50,000, he will be responsible for paying $10,000—almost half of his total income. There does not appear to be any safety nets for these individuals and it is reasonable to believe that patients regularly find themselves in comparable situations. Equally alarming is the fact that hospitals count the dollars that they put towards grossly inflated prices for uninsured patients, when only a fraction of the amount spent actually reflects the cost of the care.[216] In response to this perverse reality, United States Senator Grassley (Iowa), is attempting to address the issue by requiring hospitals to report at cost the amount of charity care that they provide.[217]

2. Introduction of Legislation Capping Charges to the Uninsured

Charity Care may provide income/asset-eligible New Jersey residents with some protection against inflated hospital charges. Residents who are ineligible because of income,[218] and do not have work-based health insurance or qualify for government sponsored

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[213] *See supra* note 210.

[214] Moeller, *supra* note 14, at 54.

[215] *See supra* note 210.

[216] McGrath, *supra* note 59, at 175.

[217] Senator Grassley Report, *Executive Summary Hospital Compliance Interim Report*, http://www.senate.gov/~finance/press/Gpress/2007/prg071907e.pdf . Senator Grassley's report examined the extent to which hospitals provided a benefit to the community, based on a 487 hospital sample, to determine whether their tax-exempt status is warranted under 501(c)(3). The examination found that "there was no uniform definition of what constitutes 'uncompensated care' among the respondents." *Id.*

[218] Those at 300 percent or above the federal poverty level - or those who earn $32,490 per year or more. N.J. STAT. ANN. § 26:2H-18.60 (1993).

health coverage like Medicaid or Medicare[219] likely comprise a substantial portion of the population that received hospital bills at sticker price. In response, the New Jersey Commission on Rationalizing Health Care Resources ("Commission") recommended further action to protect this patient population.[220] Former Governor Corzine established the Commission by executive order[221] on October 12, 2006, in response to the financial distress of the New Jersey hospital system.[222] The order notes that ten hospitals had closed since 1999, two filed for bankruptcy in 2006 and in 2004, forty-five percent were operating at a loss.[223] One of the major findings of the Commission, given in its final report released 2008, was that uninsured patients were still unfairly facing the highest prices for hospital care[224]—despite the NJHA's compassionate billing guidelines adopted by most hospitals in the state. This is an indication that such voluntary guidelines are insufficient to relieve the burden facing the state's uninsured population.

To fill the gap, the Commission recommended that New Jersey require hospitals to charge New Jersey residents on a sliding fee scale, with the maximum amount charged limited to the amount Medicare would pay for the same services.[225] Governor Corzine followed the advice of the Commission by signing into law Assembly Bill No. 2609, which caps the rate at which hospitals can charge the uninsured at 115

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[219] Patients who qualify for Medicaid are primarily children whose families are within 185 percent of the federal poverty line. Parents of these children qualified in certain cases where the families' income was substantially low or one or both parents were incapacitated. Income eligible pregnant women, the blind, disabled and aged also qualify for Medicaid. U.S. Department of Health and Human Services, Health Resources and Services Administration, New Jersey Medicaid & S-Chip Eligibility, http://www.hrsa.gov /reimbursement/states/New-Jersey-Eligibility.htm (last visited Jan. 17, 2010). Patients who qualify for Medicare are U.S. citizens over the age of 65 or those under age 65 and disabled, HHS.gov, Medicare Eligibility Tool, http://www.medicare.gov/MedicareEligibility/Home.asp?dest=NAV|Home|GeneralEnrollment#TabTop (last visited Jan. 17, 2009).

[220] *See Commission Report*, *supra* note 18, at i. The New Jersey Commission on Rationalizing Health Care Resources was assembled by Governor Corzine to "explore (1) why so many hospitals in [New Jersey] are struggling financially, (2) which among hospitals approaching the State for financial assistance warrant that assistance and (3) what steps might be taken to rationalize the functioning of New Jersey's hospital system and other components of the health care delivery system that interact with the hospital system." *Id.*

[221] The governor has the highest executive power of the state and has the authority to issue orders in matters that have been granted executive discretion. *See* N.J. CONST. art. V. §. I, II, III.

[222] Exec. Order No. 39, 38 N.J.R. 4529(a) (2006).

[223] *Id.*

[224] *See* Commission Report, *supra* note 18, at 11.

[225] *Id.* at 12.

percent above the Medicare reimbursement rate.[226] The new legislation extends protection to patients who make up to 500 percent of the federal poverty level.[227] This protects those who are ineligible for Charity Care, because their income is greater than 300 percent of the federal poverty level,[228] but still unable to afford non-discounted hospital care.

3. Implications of New Legislation

While the legislation is not equivalent to insurance, it goes a long way in promoting equity in the pricing of hospital care. Prices of care fluctuate widely—"[d]epending on a hospital's pricing method, the charge for the same commodity or service, such as a blood test, can vary by as much as seventeen-fold from one institution to another."[229] By capping a patient's bill at 115 percent above Medicare's reimbursement rate, the legislation offers patients a degree of price transparency for the cost of their medical services. The benefit of price transparency is that patients will know the price for their medical care in advance, barring any kind of emergency situation. Armed with such knowledge, patients are theoretically capable of shopping around for better prices, thereby creating a system that "promot[es] price competition. . . reduc[es] prices and improv[es] access for the poor."[230] On the other hand, this may backfire by encouraging hospitals to charge equally high prices, greatly reducing the purported benefit of price transparency. In a market with few competitors, price transparency may have a similar effect because it may "make it easier for oligopolies to set a collusive price and easier to maintain that price, because they cannot secretly deviate from it."[231] Ultimately, these hospitals will lack any incentive to reduce prices for market competition purposes.

Given the number of hospital closures and potential closures in New Jersey, twenty-five since 1992 along with five currently in bankruptcy,[232] the idea of hospital oligopolies is not too far-fetched. The

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[226] N.J. STAT. ANN. § 26:2H-12.52 (2009).

[227] *Id.*

[228] State of New Jersey Department of Health and Senior Services, New Jersey Hospital Care Payment Assistance Program Fact Sheet, http://www.state.nj.us/health/cc/documents/ ccfactsh.pdf.

[229] E. Haavi Morreim, *High-Deductible Health Plans: New Twists on Old Challenges from Tort and Contract*, 59 VAND. L. REV. 1207, 1255 (2006).

[230] Kyle & Ridley, *supra* note 148, at 1385.

[231] *Id.* at 1388.

[232] New Jersey Hospital Association, *2008 Update: The Crisis Deepens 'What Will Happen to My Hospital?'*, http://www.njha.com/Advocacy/Pdf/NJHospitalCrisis0808.pdf.

shrinking number of hospitals represents a significant reduction in competitors and could lay the groundwork for the creation of future oligopolies. It should be noted that the legislation[233] does not mention a cap on what physicians directly charged uninsured patients who qualify for price protection from hospitals. It is reasonable to assume that to the extent the physician's charges are bundled together and charged as a whole by the hospital, the physician's bill will also be capped. If, however, the physician bills separately, these charges may be inflated.

The price cap legislation is also likely to increase access to care by the uninsured. If patients who were once reluctant to access care due to fear of the high sticker price of that care could rest assured that they would be billed reasonably, then they may be inclined to proactively seek out care. To that end, the legislation will likely increase utilization of hospitals and hospital emergency rooms, in particular. While some argue that the uninsured over-utilize emergency rooms because they lack a regular source of care,[234] studies actually indicate that this group is equally likely to use an emergency room as their privately insured counterparts.[235] As the evidence presented thus far indicates, many members of the uninsured population avoid hospital care because of its inflated pricing.[236] If hospital care for the uninsured becomes more affordable, this trend may change and hospital care may become more appealing.

In the 1980's and early 1990's this was, in fact, the trend in New Jersey when the Uncompensated Care Trust Fund shielded the uninsured from outrageous hospital bills.[237] Studies indicate that in 1990, hospital care was the preferred method of care for the uninsured.[238] The uninsured used hospitals thirty percent more than the insured during this time[239] - in staunch contrast to their counterparts on the national level who used hospitals forty-seven percent less than the insured.[240] Because the emergency room has historically been viewed as

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[233] N.J. STAT. ANN. § 26:2H-12.52 (2009).

[234] E. Weber et al., *Does Lack of a Usual Source of Care or Health Insurance Increase the Likelihood of an Emergency Department Visit? Results of a National Population-based Study*, 45 ANNALS EMERGENCY MED. 4, 4 (2005).

[235] *Id.* at 7.

[236] *See generally* Nation, *supra* note 2, at 101-02.

[237] Volpp & Siegel, *supra* note 184, at 60.

[238] *Id.*

[239] *Id.*

[240] *Id.*

the "gateway" to healthcare, access to care through a hospital will likely begin there.[241] This could potentially have beneficial effects on the uninsured population because it will grant them access to care that would have otherwise been cost-prohibitive. The resulting financial impact on hospitals, however, could be devastating as resource strained hospitals will be burdened with an increased number of uninsured patients.[242]

VII. PROPOSED NEXT STEPS FOR NEW JERSEY

This legislation imposing a cap on charges to the uninsured is a great first step in the state's attempt to ease the burden placed on the uninsured. However, further steps must swiftly follow its implementation in order to curtail further hospital losses. The legislation is, in effect, a mechanism to provide relief to uninsured patients by shielding them from hospital bills that could easily lead to bankruptcy. Standing alone, of course, this legislation does not sufficiently address the problems of New Jersey's hospital system; it could, in fact, be detrimental to it. The unintended consequence of the bill is that it could cause hospitals to operate at even greater losses than they are currently experiencing by increasing the number of patients whose care will not be fully compensated.

New Jersey's Commission on Rationalizing Health Care Resources indicates that many New Jersey hospitals are struggling financially as compared to hospitals nationally.[243] Twelve New Jersey hospitals, located in urban centers, were found by the Commission to be in serious financial distress.[244] The Commission goes on to say that many are on the road to acute financial distress, due to their location in the northeast and large Medicaid, Medicare or Charity Care patient loads.[245]

The NJHA paints an even grimmer picture of the financial state of New Jersey's hospitals—one where they are on the verge of collapse as

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[241] Barry R. Furrow, *Forcing Rescue: The Landscape of Health Care Provider Obligations to Treat Patients*, 3 HEALTH MATRIX 31, 70 (1993).

[242] Bretta R. Clark, *The Immigrant Heath Care Narrative and What It Tells Us About the U.S. Health Care System*, 17 ANNALS HEALTH L. 229, 249 (2008).

[243] *See* Commission Report, *supra* note 18, at 65.

[244] *Id.* at 79. "All 12 of these hospitals have had negative operating margins for two or more consecutive years, have less than 20 days of cash on hand and long-term debt to capitalization ratios greater than 50 percent." *Id.*

[245] *Id.* at 65.

a result of considerable underfunding.[246] It claims that Medicaid and Medicare, both comprising almost half of total hospital revenues, underpay for medical care.[247] It states that "Medicaid pays hospitals just $0.69 for every dollar of care they provide, and Medicare pays hospitals about $0.89 on the dollar."[248] Essentially, the NJHA asserts that its hospitals operate at a loss when they care for Medicaid and Medicare patients. The Reinhardt Commission Report, however, states that these figures may not be entirely accurate, with only Medicaid and Charity Care reimbursing below cost.[249] Further, the report notes that Medicaid reimbursements may even be above cost for some hospitals when other factors are considered.[250] Still, the report recognizes "historically low" Medicaid reimbursement rates in New Jersey and recommends that the state increase them to at least seventy-five percent of the Medicare reimbursement rate.[251]

Expanding on Charity Care, the NJHA states that it is grossly underfunded in the state with reimbursement consistently falling short of its costs.[252] As a result, hospitals have absorbed a loss of $6.8 billion since 1993 due to Charity Care underfunding alone.[253] Further, this loss is due to significantly increase as a result of a $111 million, or 15.5 percent, cut in funding for Charity Care, as reflected in the 2009 state budget.[254] Hospitals argue that they will bear the brunt of the cuts, pushing them closer to insolvency.[255] Once patients discover the more favorable pricing available to the uninsured, the increased patronage of

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[246] New Jersey Hospital Association, *supra* note 232.

[247] *Id.*

[248] *Id.*

[249] State of NJ Dep't of Health & Senior Serv., *supra* note 18, at 63.

[250] *Id.* at 102.

> When inpatient and outpatient [reimbursement] rates are combined, Medicaid covers approximately 75-80% of costs . . . [T]hirty-eight New Jersey hospitals receive supplemental payments totaling $263 million for Graduate Medical Education ($60M) and for providing certain services to low-income populations through the Hospital Relief Subsidy Fund (HRSF - $203M) . . . . When these supplemental payments are added to the nominal payments, some New Jersey hospitals are actually receiving payments and subsidies that approximate the full cost of care."

Id.

[251] *Id.* at 151.

[252] New Jersey Hospital Association, *supra* note 232.

[253] *Id.*

[254] Press Release, New Jersey Hospital Association, State Budget means an Uncertain Future for Hospitals (Jun. 30, 2008), *available at* http://www.njha.com/Press/ PressRelease.aspx?id=6340.

[255] *Id.*

New Jersey hospitals by uninsured patients will add to the hospitals' financial distress. While the uninsured patients who do not qualify for Charity Care will be charged 115 percent above the Medicare reimbursement rate—which could be as low as $1.02 for every dollar of cost to the hospital[256]— it is not reasonable to presume that hospitals will collect the full amount charged to this population. The final reimbursement rate of these patients could potentially be less than the rates guaranteed through Medicare and Medicaid. Assuming that the numbers the NJHA portrays are accurate, this legislation could result in continued and escalating financial losses for New Jersey hospitals.

One way to prevent additional losses to hospitals is to divert patients from hospital emergency rooms and into a traditional primary care setting. This legislation does not apply to care provided by physicians practicing outside of hospitals. If it did apply, it is reasonable to believe that some patients would be willing to seek care in physicians' private offices. Physicians in private practice have similar billing practices as hospitals in that they offer negotiated prices to health insurers that are substantially below the sticker price—only charging the uninsured the full sticker price rate.[257]

It is logical then, to impose on doctors operating in a private setting, a similar restriction on charges to the uninsured population, as is imposed on hospitals. Access to primary care doctors is particularly relevant because it "serves as the patient's first point of entry into the health care system and as the continuing focal point for all needed health care services."[258] Increased and regular access to primary care

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[256] This amount is based on the NJHA's figure that Medicare reimburses New Jersey hospitals at 89 cents on every dollar. Above this rate, the amount the legislation has requires hospitals to charge uninsured patients, is $1.02. New Jersey Hospital Association, *supra* note 232.

[257] Mark A. Hall & Carl E. Schneider, *Learning from the Legal History of Billing for Medical Fees*, 23 J. GEN. INTERNAL MED. 1257, 1257 (2008). "Primary care physicians typically charge uninsured patients one third to one half more than they receive from insurers for basic office or hospital visits, and markups are substantially higher (2 to 2.5 times) for high-tech tests and specialists' invasive procedures."

[258] American Academy of Family Physicians, *Primary Care*, http://www.aafp.org/online/en/home/policy/policies/p/primarycare.html (last visited Jan. 17, 2010).

> Primary care includes health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of health care settings (e.g., office, inpatient, critical care, long-term care, home care, day care, etc.). Primary care is performed and managed by a personal physician often collaborating with other health professionals, and utilizing consultation or referral as appropriate.

Id.

promotes optimal health through routine monitoring of a patient's health status and the opportunity to intervene and counter the onset of disease.[259] Affordable access to such care would clearly be ideal for the uninsured and could effectively relieve any strain the uninsured may place on hospital emergency rooms, "but imposing such a duty formally (by law or by ethical code) on doctors would be harder both in principle and in practice than to impose such a duty on hospitals."[260] In the absence of a statutory requirement, physicians should be encouraged for ethical reasons "to give patients in economic trouble at least the benefit of the lowest rate they accept from an established payer."[261]

An even better alternative to increasing access to primary care for the uninsured is to provide them all with insurance coverage through a universal health care plan. Most physicians and legislators would probably agree that the ultimate remedy for solving the problem of the uninsured is to provide universal health insurance. Not only would universal health care provide hospital coverage, but it would also give the uninsured access to highly coveted primary care. Such a plan was proposed by New Jersey Senator Joseph Vitale, with implementation set to occur in two phases.[262] Phase one of the plan "expands the NJ FamilyCare[263] Program, allowing New Jersey to reinstitute[264] enrolling parents up to 200% of poverty" and mandates children eighteen years of age and under to carry health coverage.[265] More notably, this phase establishes market reforms that include moving slightly away from community rating in New Jersey's Individual Health Coverage Program, by allowing age to be a rating factor, thereby reducing the financial burden on coverage for young, healthy enrollees.[266] The real

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[259] *Id.*

[260] Hall, *supra* note 257, at 1257.

[261] *Id.*

[262] *See generally* Joseph F. Vitale & David L. Knowlton, *Health Care Coverage for All A blueprint for New Jersey*, http://www.njsendems.com/docs/New%20Jersey%20Health% 20Care%20Reform%20Act%20-%20White%20Paper,%203-17-08.pdf.

[263] New Jersey FamilyCare, http://www.njfamilycare.org/pages/whatitis.html (last visited Oct. 31, 2008). "NJ FamilyCare is a federal and state funded health insurance program created to help New Jersey's uninsured children and certain low-income parents and guardians to have affordable health coverage. It is not a welfare program. NJ FamilyCare is for families who do not have available or affordable employer insurance, and cannot afford to pay the high cost of private health insurance." *Id.*

[264] Eligibility criteria at the time only allowed parental coverage in families with an income up to 133 percent of the federal poverty level. Vitale & Knowlton, *supra* note 262.

[265] *Id.*

[266] *Id.*

nuts and bolts of the reform come in Phase Two. This phase includes a state-managed health insurance product, an individual mandate for all New Jersey residents to have health insurance and a collaborative care system for those that remain uninsured.[267] The state-managed health insurance product, Garden State All-Care, would be available to all New Jersey residents and subsidies would be provided to ensure it is affordable.[268] The plan is costly, but Senator Vitale contemplates that the program would actually save the state money in the long-run by converting individuals who use hospital Charity Care funds to people who can now see primary care doctors for routine care.[269] If the numbers presented by Senator Vitale are accurate, universal health coverage for the state of New Jersey could be an extremely powerful and cost effective vehicle for providing necessary care to the state's uninsured population and providing financial relief for its hospitals. Phase one of Senator Vitale's Health care reform measure passed the Senate by a unanimous vote on June 23, 2008.[270] It passed both houses the same day and was translated into Public Law (P.L.2008, c.38) on July 8, 2008.[271] Phase two was scheduled to be introduced in the fall of that year, but has yet to be unveiled.[272]

Sen. Vitale does not mention Federally Qualified Health Centers ("FQHCs")[273] and why they may be insignificant to his universal health

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> Young, healthy individuals have quickly been priced out of the individual market. An analysis performed by the Rutgers Center for State Health Policy found that moving from pure to modified community rating could reduce premiums for persons under the age of forty, increase their enrollment from under seven percent to fifty-one percent (46,000 new enrollees). Modified community rating may cause the premiums for the oldest citizens enrolled in the IHC to increase fifteen percent, however this is consistent with recent increases experienced by this market and so should not result in many older enrollees becoming uninsured.

Id.

[267] *Id.*

[268] *Id.*

[269] *Id.* "The average cost of charity care per client is $3,413 each year. New Jersey can provide full health coverage to an adult in NJ FamilyCare at just $2,500." *Id.* at 20.

[270] New Jersey Legislature, http://www.njleg.state.nj.us/, (*see* Senate Bill S1557); *see also* N.J. STAT. ANN. § 26:15-1 (2008).

[271] *Id.*

[272] NJ For Health Care, New Jersey Health Care Reform, http://www.njforhealthcare.org/njreform.html (last visited Jan. 17, 2010).

[273] U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, Federally Qualified Health Center Fact Sheet, http://www.cms.hhs.gov/MLN Products/downloads/fqhcfactsheet.pdf.

> The Federally Qualified Health Center (FQHC) benefit under Medicare was added effective October 1, 1991. . . . FQHCs are 'safety net' providers such as community health

care plan. While FQHCs are likely effective at providing care to the populations they are geared toward—public housing residents, the homeless and migrants[274]—they probably do not appeal to the individuals who Vitale's bill or the bill capping hospital charges seek to protect. That legislation typically appeals to working-class individuals who make too much money to apply for any kind of financial assistance, but too little to be insulated from financial hardship from medical care bills. FQHCs employ the same sliding fee scale[275] that New Jersey Charity Care uses, which leaves many New Jersey residents income-ineligible for reduced medical costs through either program. Lastly, these health centers are only meant for primary care and would provide no protection from hospitals' inflated prices. Therefore, they are insufficient to achieve access to reasonably priced care for all New Jersey residents.

It should be noted that New Jersey's approach to universal health care bears resemblance to a similar reform effort in Massachusetts.[276] In particular, they both have state subsidized insurance and individual mandates for health coverage.[277] Massachusetts passed its landmark legislation in 2006, and has since achieved a 97.3 percent coverage rate as of the spring of 2009.[278] Proponents of the Massachusetts reform measure have lauded the state's highest in the country health coverage rate and note increasing support for the program.[279] Critics argue that the reform effort is financially unsustainable because of uncontrolled costs—with major insurance companies set to increase premiums by seven to twelve percent in 2010.[280] This increase in premium costs may

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centers, public housing centers, outpatient health programs funded by the Indian Health Service, and programs serving migrants and the homeless. The main purpose of the FQHC Program is to enhance the provision of primary care services in underserved urban and rural communities.

Id.; *see also* 42 U.S.C. § 254b (2008).

[274] 42 U.S.C. § 254b (2008).

[275] *Id.*

[276] *See generally* Tom Glynn, *Massachusetts Can Be a Model for National Healthcare Reform*, 39 SOC. POL'Y 20 (2009).

[277] Vitale & Knowlton, *supra* note 262. Joel S. Weissman & JudyAnn Bigby, *Massachusetts Health Care Reform—Near-Universal Coverage at What Cost?*, 361 N. ENGL. J. MED. 2012, 2012 (2009).

[278] Weissman & Bigby, *supra* note 277, at 2012.

[279] Glynn, *supra* note 276, at 20.

[280] Grace-Mare Turner, *Health Care (A Special Report)—Costs Keep Rising*, WALL ST. J., Oct. 27, 2009, at R8.

be attributed to Massachusetts' health reform plan, itself.[281] It is argued that government-run health insurers pay providers at lower rates than do private insurance companies, forcing providers to make up for this shortfall by charging more to private plans.[282] It has been estimated that "the average U.S. family in a private plan pays an additional $1,788 a year to compensate for lower payments by public plans, representing a hidden tax on private insurance."[283] In addition, critics point out that costly emergency room visits are still the treatment method of choice by many patients now enrolled in the state-subsidized insurance plan, even with access to more affordable and comprehensive primary care.[284] Even proponents recognize how the increasing cost of health care in the state could negate the positive effects of the reform efforts as more and more people become exempt from the individual mandate due to affordability, or lack thereof.[285]

VIII. CONCLUSION: MORE WORK AHEAD

In conclusion, the recent legislation[286] in New Jersey that caps the amount hospitals can charge its uninsured residents who are at or below 500 percent of the federal poverty level will effectively protect these individuals from facing grossly inflated bills. It is also likely to curb soaring medical debt, but not without consequences. Patients protected by this legislation, many of whom avoided hospitals due to fear of receiving an unaffordable bill,[287] may be more inclined to seek care at a hospital once they are aware that they will no longer be subject to inflated hospital prices. This increase in utilization of hospitals will most likely burden the emergency room and tax an already financially strained system.[288] The state will have to follow this legislation with a plan to divert this patient population from hospital emergency rooms and into a primary care setting, as not to further strain the already struggling financial infrastructure of New Jersey hospitals.

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[281] *Id.*

[282] *Id.*

[283] *Id.*

[284] *Id.* "Among people with subsidized insurance, the percentage who sought non-urgent care from emergency rooms was 14% higher than it was among Massachusetts residents overall, according to state data reported in 2008 by the Boston Globe." *Id.*

[285] Weissman & Bigby, *supra* note 277, at 2014.

[286] N.J. STAT. ANN. § 26:2H-12.52 (2009).

[287] Nation, *supra* note 2, at 101-02.

[288] Exec. Order No. 39, 38 N.J.R. 4529(a) (2006).

A study examining the number of self-pay patients who seek care at physician's private offices would prove helpful in determining whether it makes sense to extend the price cap to physician's private offices. The state may also consider expanding the reach of FQHCs by placing them in more communities and increasing the income limits so more residents can qualify for a sliding fee scale. As studies have recently indicated, however, expansion of FQHCs may not be the answer because of the quality of care disparities that exist at these centers between the insured and uninsured patients.[289]

In consideration of these shortcomings, it makes sense to devise a plan to provide universal health care to all citizens of the state. As the Massachusetts effort has shown, however, developing a sustainable universal health care program can prove to be a daunting task. The success of Senator Vitale's plan for universal health care[290] for the state of New Jersey rests on several assumptions. Like Massachusetts, it assumes that individuals who have health coverage will actually use a primary care doctor for routine care as opposed to an emergency room. New Jersey should be prepared for the possibility that the newly insured will continue to seek health care in the way that they are most familiar—in an emergency room setting. To this end, education and outreach measures can be used to help the newly insured understand the benefits of their new insurance, as well as the method in which to use the insurance for optimum health.

The plan's success also assumes that the increased participation in government-funded health insurance will not strain New Jersey's private insurance market and lead to increased rates for its members. Preparation for this possibility and other financial pitfalls are essential in creating a sustainable plan for universal health care. Continued pursuit of such a plan is, undoubtedly, the ideal way to go.

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[289] James X. Zhang, et al., *Insurance Status and Quality of Diabetes Care in Community Health Centers*, 99 AM. J. PUB. HEALTH 742, 742 (2009).

[290] *See generally* Vitale & Knowlton, *supra* note 262.