

Non-Profit Hospitals Survive Well First Year of Litigation

What started as a little more than a trickle about a year ago with suits filed by uninsured plaintiffs against non-profit hospitals has matured into a steady flow of actions nationwide. While the suits allege multiple causes of action, the core of the actions is based on theories of liability resulting from the hospitals' status as a non-profit entity under the Internal Revenue Code. 26 U.S.C § 501(c)(3) (2003).

Non-profit hospitals typically bill uninsured patients full freight. Other payors such as Medicare, Medicaid, insurance companies and managed care organizations pay reduced rates. The consistent theme in these cases is that non-profit hospitals have abused the public trust bestowed upon them by § 501(c)(3) status, and have breached an implied contract arising from § 501(c)(3), by overcharging and then dunning uninsured patients.

After a plethora of cases emerged in the summer and fall of 2004, the plaintiffs' request for multi-district litigation status was denied in October 2004. In re *Not-For-Profit Hosps./Uninsured Patients Litig.*, 341 F. Supp.2d 1354 (J.P.M.L. 2004). The Judicial Panel on Multidistrict Litigation heard the request of plaintiffs in twenty-eight actions pending in twenty-one federal judicial districts. The Panel found "centralization would neither serve the convenience of the parties and witnesses nor further the just and efficient conduct of this litigation." *Id.* at 1356. The Panel further provided that the plaintiffs had "failed to persuade us that these actions share sufficient common questions of fact to warrant transfer." *Id.*

Since the denial of multidistrict litigation status, federal district courts have issued dismissal after dismissal, in some cases chastising plaintiffs for bringing the action: "Plaintiffs here have lost their way; they need to consult a map or a compass or a Constitution because Plaintiffs have come to the judicial branch for relief that may only be granted in the legislative branch." *Kolari v. N.Y. Presbyterian Hosp.*, No. 04 Civ.5506LAP, 2005 WL 710452 (S.D.N.Y. Mar. 29, 2005). The *Kolari* court further commented on the plaintiffs' cases generally:

"This action is one of dozens of similar bootless actions filed in twenty-three district courts across the United States on behalf of uninsured and indigent patients, wherein Plaintiffs argue, without basis in law, that private non-profit hospitals are required to provide free or reduced-rate services to uninsured persons." *Id.*

Anatomy of a Lawsuit Against a Non-Profit

Plaintiffs filing cases in federal district courts across the country have asserted nine or more distinct causes of action, which fall generally within four categories. Plaintiffs also seek class action status in all cases.

The first category consists of plaintiffs' breach of contract claims as purported third party beneficiaries to the express or implied contract between the hospitals, as charitable entities, and the United States government pursuant to § 501(c)(3). As support for their argument, plaintiffs analogize to the Hill-Burton Act, which created a program awarding funds to hospitals that treat indigent patients. 42 U.S.C. § 291 (2005). Plaintiffs argue that because courts have recognized the Hill-Burton Act to be an enforceable contract between hospitals and the U.S. government, so should courts recognize § 501(c)(3) as creating a contract, from which plaintiffs benefit as third party beneficiaries. Further, plaintiffs allege that they have an implied right of action under § 501(c)(3), and that the hospitals have breached a charitable trust created by the hospitals' acceptance of federal tax exemptions.

The second category of claims consists of plaintiffs' allegations that the hospitals violated the Emergency Medical Treatment and Active Labor Act ("EMTALA"). EMTALA requires a hospital participating in the Medicare program to provide a medical screening examination to any individual who comes to an emergency room for an emergency medical condition to determine whether the emergency medical condition exists. 42 U.S.C. § 1395dd (2003). If an emergency medical condition exists, the hospital must provide sufficient medical treatment to stabilize the condition. Plaintiffs allege that the hospitals violated EMTALA by requiring patients to complete financial responsibility forms prior to receiving treatment.

The third category of claims consists of allegations related to hospitals' violations of the Fair Debt Collection Practices Act ("FDCPA"). 8 U.S.C. §§ 801-818 (1996). Plaintiffs allege that the hospitals are "debt collectors" as defined by the FDCPA, and as such, have engaged in aggressive, humiliating, and abusive collection practices in violation of the FDCPA.

The fourth category of claims are various state law claims, that are based again on the premise that the hospitals charge discriminatory rates to uninsured patients than they charge to patients who are either covered by Medicare or are beneficiaries of private insurance. Because many of the state law claims refer to state specific statutes, only a cursory discussion of these claims is provided.

The Courts' Response

The Federal District Courts have been less than charitable with claims asserted by the plaintiffs. Courts have specifically addressed each category of claims, showing diminishing patience for the uninsured patients. Judge Loretta A. Preska in the *Kolari* case indicated that the "orchestrated assault on scores of nonprofit hospitals, necessitating the expenditure of those hospitals' scarce resources to beat back meritless legal claims, is undoubtedly part of the litigation explosion that has been so well documented in the media." *Kolari*, No. 04 Civ.5506LAP, 2005 WL 710452.

Contractual Claims Related to § 501(c)(3) Status

Courts have held that as a threshold matter, uninsured patients cannot make any showing that § 501(c)(3) creates a contract. These courts have relied upon the reasoning that unless there is a clear indication that the legislature intends to bind itself contractually, the presumption is that a law is not intended to create private contractual rights. Rather, a law merely declares a policy to be pursued until the legislature decides otherwise. *Valencia v. Miss. Baptist Med. Ctr., Inc.*, 363 F. Supp.2d 867, 874 (S.D. Miss. 2005). Policies, unlike contracts, are “inherently subject to revision and repeal, and to construe laws as contracts when the obligation is not clearly and unequivocally expressed would be to limit drastically the essential powers of a legislative body.” *Id.* (citing *Nat’l R.R. Passenger Corp. v. Atchison Topeka & Santa Fe Ry. Co.*, 470 U.S. 451, 465-66 (1985)). The courts have found that 26 U.S.C. § 501(c)(3) contains no language which suggests that Congress intended to create a contract between the government and an organization receiving tax-exempt status. *See, e.g., Valencia*, 363 F. Supp.2d at 874.

Plaintiffs analogize to the Hill-Burton Act in an attempt to overcome the hurdle that § 501(c)(3) contains no contract-creating language. However, courts have drawn distinctions between the Hill-Burton Act and § 501(c)(3). *See, e.g., Lorens v. Catholic Health Care Partners*, 356 F. Supp.2d 827, 832 (N.D. Ohio 2005). First, the Hill-Burton Act provided direct funds to hospitals; section 501(c)(3) provides tax exemptions. *Id.* Second, the Hill-Burton Act required applicants to sign a “Memorandum of Agreement” containing express contractual language; 501(c)(3) status is granted by the IRS with no similar contractual agreement. *Id.* Third, the Hill-Burton Act provided funds for organizations performing specific, pre-negotiated purposes, and provided for a private cause of action to enforce the Act; section 501(c)(3) only permits the IRS or the exempt organization to challenge the determination of § 501(c)(3) eligibility. *Id.* Thus, Hill-Burton created a contract by virtue of conditional governmental grants; § 501(c)(3) does not create such a contract. *Id.*

The courts have thus far concluded that because § 501(c)(3) does not create a contract between the exempt organization and the government, there is no underlying contract on which plaintiffs may base an action for third party breach of contract. *See, e.g., Valencia*, 363 F. Supp.2d at 875; *Lorens*, 363 F. Supp.2d at 833.

Courts have also held that even if § 501(c)(3) created a contract between the government and the exempt hospital, the plaintiffs would still need to demonstrate that there is either an express or implied private right of action under § 501(c)(3). In *Lorens*, the court indicated that the inquiry of whether a statute creates a cause of action could be reduced to one question: did Congress intend to create a private cause of action? *Lorens*, 363 F. Supp.2d at 833. “As has been recognized by numerous courts, neither the language of § 501(c)(3) nor the language of any other provision of § 501 provides plaintiffs with an express cause of action.” *Valencia*, 363 F. Supp.2d

at 875 (internal citations omitted). The assertion that the plaintiffs “have an implied right of action under § 501(c)(3) is extraordinary given the fact that the Supreme Court [of the United States] has counseled against construing a statute as creating a contractual relationship.” *Burton v. William Beaumont Hosp.*, 347 F. Supp.2d 486, 493 (E.D. Mich. 2004).

The hospitals have pointed to other provisions of the Internal Revenue Code that create private causes of action and have argued, successfully, that the absence of such language in § 501(c)(3) is conclusive evidence that Congress had no intent to create a private cause of action under § 501(c)(3).

Additionally, courts have also found that even if there were a contract, and a private cause of action under § 501(c)(3), plaintiffs would lack standing because they cannot prove that they are direct beneficiaries under § 501(c)(3). *See, e.g., Kolari*, No. 04 Civ.5506LAP, 2005 WL 710452. At best, courts have found, plaintiffs are incidental beneficiaries under § 501(c)(3), and being an incidental beneficiary is not a sufficient basis to bring suit. *Valencia*, 363 F. Supp.2d at 876.

Plaintiffs also argue that because the hospitals accept federal tax exemptions under § 501(c)(3), the hospitals entered into a charitable trust to provide “mutually affordable health care to its uninsured patients.” *Valencia*, 363 F. Supp.2d at 877. Plaintiffs allege that the hospitals breached the trust by charging uninsured plaintiffs significantly more for services than it charged insured patients. Further, plaintiffs have asserted that the hospitals have been unjustly enriched. These claims, however, are predicated on plaintiffs’ allegations of a private right of action to enforce an alleged contract under § 501(c)(3), which the courts have uniformly found does not exist.

EMTALA Claims

Many of the named plaintiffs received care from the hospitals’ emergency rooms. Generally, the hospitals required the plaintiffs to complete certain forms prior to treatment, which included, among other things, a contract requiring the plaintiffs to pay for services they were about to receive. Plaintiffs alleged that the hospitals’ requirement that these contracts be signed before screening violates EMTALA. However, plaintiffs did not allege suffering any personal, physical harm as a result of being presented with contracts prior to treatment, only economic harm.

While EMTALA allows patients to recover damages if they suffer “personal harm,” 42 U.S.C. § 1395dd(d)(2)(A), the courts have universally held that “personal harm” does not include economic damages as alleged by plaintiffs. *Valencia*, 363 F. Supp.2d at 880.

FDCPA Claims

FDCPA defines a “debt collector” as a person engaged in a business the principal purpose of which is the collection of debts, or who regularly collects or attempts to collect, directly or indirectly, debts owed or due or asserted to be owed or due another. 15 U.S.C. § 1692(a)(6). The term includes any creditor who, in the process of collecting its own debts, uses any name other than its own which would indicate a third person is attempting to collect the debt. *Id.* Specifically excluded from the definition, however, are persons who act as a debt collector for another person when both are related by common ownership or affiliated by common corporate control. *Id.*

The *Kolari* court held that “a plain reading of the statute makes clear that, as a matter of law, the [hospital defendants] are not debt collectors under the FDCPA. *Kolari*, No. 04 Civ.5506LAP, 2005 WL 710452. Additionally, the court noted that a creditor that is not itself a debt collector cannot be vicariously liable for the actions of a debt collector it has engaged to collect its debts. Simply, the court found that no facts had been plead to indicate the defendant hospital had violated the FDCPA. *Id.*

State Law Claims

The plaintiffs also asserted various state law claims, principally stemming from a theory of implied contract. It is notable that in *Kolari*, Judge Preska disposed of all of the state law claims on the merits. *Kolari*, No. 04 Civ.5506LAP, 2005 WL 710452. Prior to *Kolari*, federal district courts had dismissed with prejudice the federal claims, but had declined to assert supplemental jurisdiction over the state law claims, and dismissed them without prejudice.

What’s Ahead?

It appears that the plaintiffs are undeterred, having recently indicated that they will pursue in state courts what has been unfruitful in federal courts. There is, however, fallout from the lawsuits. One of the cases involving North Mississippi Health Services, Inc. settled in the spring prior to litigation, but later, the settlement was rescinded. Interestingly, in the proposed settlement, the hospital promised to implement certain indigency policies, which included the hospital providing free care to uninsured patients whose incomes were at or below 200% of the federal poverty level, a sliding scale of charges for uninsured patients whose incomes were between 200% and 400% of the national poverty level, and a revision of collection practices.

Even though the settlement was not consummated, non-profit hospitals are freshening policies for collecting from indigents to ensure that objective criteria are used for reducing or eliminating charges. Further, hospitals are or should be reviewing collection practices to ensure compliance with FDCPA and applicable state law. With plaintiffs beginning to bring actions in state courts, hospitals want to ensure that indigency policies are adopted and followed, collection efforts are compliant, and EMTALA procedures are in place and being followed.

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