No. 06-3579

IN THE

United States Court of Appeals for the Third Circuit

JUSTIN DICARLO, on behalf of himself and all others similarly situated,

Plaintiff-Appellant,

v.

ST. MARY HOSPITAL, BON SECOURS NEW JERSEY HEALTH SYSTEM, INC., and BON SECOURS HEALTH SYSTEM, INC.,

Defendants-Appellees.

On Appeal from the
United States District Court
for the District of New Jersey

BRIEF FOR AMICI CURIAE AMERICAN HOSPITAL ASSOCIATION AND NEW JERSEY HOSPITAL ASSOCIATION IN SUPPORT OF DEFENDANTS-APPELLEES

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STATEMENT OF INTEREST OF AMICI CURIAE

The American Hospital Association (AHA) and the New Jersey Hospital Association (NJHA) submit this brief amici curiae in support of St. Mary Hospital, Bon Secours New Jersey Health System, Inc., and Bon Secours Health System, Inc. (collectively, "St. Mary").[1]

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[1] The brief is submitted with the consent of all parties. See Fed. R. App. P. 29(a).

Founded more than a century ago, the AHA is a national not-for-profit association that represents the interests of nearly 5,000 hospitals, health care systems, networks and other care providers, as well as 37,000 individual members. The AHA and its members are committed to finding innovative ways of improving the health of the communities they serve – and, specifically, to helping ensure that health care is available to, and affordable for, all Americans. The AHA educates its members on health care issues and advocates on their behalf in state and federal fora to ensure that its members' perspectives and needs are understood and taken into account in the formulation of health care policy.

The NJHA is a not-for-profit trade association comprised of hospitals and other health care organizations throughout New Jersey. The NJHA supports its more than 100 member hospitals and other organizations through research and health care policy development initiatives with an eye toward helping members plan for their emerging role in improving community health. Through its advocacy and educational activities, NJHA helps its members provide accessible, affordable, high-quality care to their communities.

The AHA and NJHA have a great interest in the outcome of this case, for plaintiff Justin DiCarlo's legal theory has the potential to impair the coherence of hospital regulation. AHA and NJHA member hospitals serve their patients without regard to ability to pay, offer financial aid to those in need, and arrange their

pricing in response to an intricate array of factors, not least of which are a substantial number of state and federal laws. The issue of how best to offer service to uninsured patients is just one small piece of the much broader structural problem confronting the American health care system – a problem that the United States Congress, the New Jersey legislature, and policymakers including the AHA and NJHA have been working to address for years. As the District Court recognized, plaintiff vastly oversimplifies matters by proceeding as if the structure of health care pricing is susceptible to resolution in a state-law contract case. In light of the potentially broad implications of plaintiff's theory, the AHA and NJHA offer their perspective to aid this Court in its review of the District Court's well-reasoned decision.

SUMMARY OF ARGUMENT

While policy issues of rare complexity lurk beneath the surface of this case, the Court need not reach them; DiCarlo's breach-of-contract claim founders on purely legal grounds. He posits the existence of an "open price term" in patient billing contracts and invites the court to supply a reasonable price term of its own choosing. But the price term in contracts like the one DiCarlo signed is not "open"; the contract references "all charges," and there is no dispute that St. Mary – like all hospitals – kept a pre-set list of all its charges (the "Charge Master"). In this circumstance there is no "open term" for the courts to supply. The District

Court's sound conclusion to that effect is in line with the great weight of national precedent.

The District Court also properly recognized the ineluctable problems that would have flowed from a contrary decision. Despite DiCarlo's best effort to cram his complaint into the confines of contract law, the fact remains that "[t]he United States has an incredibly complex and convoluted system for financing and delivering health care,"[2] and that hospital pricing decisions are pulled this way and that by a confusing array of market factors including government regulation, Medicare underpayments, increasingly powerful insurers and health plans, and rapidly growing health care costs. This is not a problem susceptible to piecemeal resolution; just as importantly, any attempt at such a piecemeal resolution likely would introduce new inconsistencies elsewhere down the line. This Court, like the District Court, should decline DiCarlo's invitation to "solve the problems of the American health care system." DiCarlo v. St. Mary Hosp., No. 05-1665, at 8 (D.N.J. July 19, 2006) (hereinafter "Dist. Ct. Op.").

[2] Alliance for Health Reform, Health Care Coverage in America: Understanding the Issues and Proposed Solutions 4 (Mar. 2007).

ARGUMENT

I. THE DISTRICT COURT CORRECTLY HELD THAT THE CONTRACT DID NOT CONTAIN AN OPEN PRICE TERM.

Amici of course are well versed in the policy matters underlying this case. But the Court need not delve into policy at all to resolve the breach-of-contract claim that lies at the heart of DiCarlo's suit. Instead, it may – and should – follow the District Court's sound approach and affirm on the simple ground that the contract between DiCarlo and St. Mary did not contain an open price term.

The contract DiCarlo signed when he came to St. Mary for treatment stated that he "guarantee[d] payment of all charges * * * for services rendered." See Dist. Ct. Op. at 3. The District Court held that the term "all charges" "unambiguously can only refer to St. Mary's uniform charges set forth in its Chargemaster." Id. at 7. This fact, the court explained, was fatal to DiCarlo's contract claim because where the price term is not open, a court has no authority to supply a price of its own choosing. Id.

The District Court's conclusion was the correct one. Hospitals, like most service providers, do not engage in ad hoc pricing. To the contrary, they maintain a detailed listing with set prices for each of the thousands of services and procedures that they offer. This document is known as the hospital's "Charge

Master."[3] All hospitals have Charge Masters. Indeed, their existence is contemplated by both federal and state law: Federal regulations require hospitals that care for Medicare patients to have records of "[p]atient service charge schedules," 42 C.F.R. § 413.20(d)(2)(vi), and New Jersey regulations set charity-care pricing by mandating certain percentage discounts from "the normal charge for health services," N.J. Admin. Code § 10:52-11.8(c).

Because St. Mary indisputably maintains a full list of charges, set in advance, there is nothing "open" about the price term in the contract that DiCarlo signed – the contractual reference to "all charges" can refer only to the Charge Master prices. This makes common sense. If a customer walks into a restaurant and signs a contract to pay "all charges" for her dinner, no one would doubt that the "charges" referred to are the prices listed on the restaurant's menu. For a hospital, the "menu" is the Charge Master, and the legal principle is the same.

Courts across the country have recognized that this is so: They have held again and again that contracts obligating patients to pay "all charges" or "regular rates" do not have an open price term. See Brief of Appellees at 18 n.6 (collecting cases). In Shelton v. Duke Univ. Health Sys., Inc., 633 S.E.2d 113 (N.C. Ct. App.

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[3] See Maldonado v. Ochsner Clinic Found., -- F.3d --, 2007 WL 2054906, at *4 (5th Cir. July 19, 2007) (describing the Charge Master as "an exhaustive and detailed price list for each of the thousands of services and items" provided by a hospital).

2006), for example, the court found "that plaintiff was agreeing by her signature to pay the 'regular' rates charged by defendant for the services it was to render," and that "the 'regular' rates existed on defendant's 'charge master.' " Id. at 116. Given these two facts, the court concluded, "the price term * * * 'was definite and certain or capable of being made so,' " and the court had no reason to engage in gap-filling. Id. (quoting Elliott v. Duke Univ., Inc., 311 S.E.2d 632, 636 (N.C. Ct. App. 1984)) (emphasis deleted).

Likewise, in Nygaard v. Sioux Valley Hosps. & Health Sys., 731 N.W.2d 184 (S.D. 2007), the South Dakota Supreme Court rejected the precise argument made by DiCarlo here. Plaintiffs in Nygaard had alleged – just as DiCarlo has – that they signed contracts obligating them to pay "unspecified and undiscounted charges for medical care," which charges turned out to be based on the defendant hospitals' Charge Master prices. Id. at 191. The court explained that because the Charge Master prices were indisputably set in advance, "the contract prices were fixed at a given amount prior to the execution of the contracts. And obviously, prices that are previously fixed at a given amount are determinable." Id. "For that reason," the court concluded, "the contracts were not silent or open concerning price," and the court had no authority to impute price terms. Id. at 191-192. The Nygaard court cited more than a half-dozen other courts that had reached the same conclusion, and summed up their holdings as follows:

> [T]he point of these cases is that if the contract price is fixed and determinable from sources outside the written agreement, the price term is not open in the sense that it allows a claim for some imputed, commercially reasonable price term. * * * That is precisely what occurred in this case. [Id. at 192].

Just so here. DiCarlo does not dispute that St. Mary had a pre-set list of prices, or that that pre-set list is the basis for the bill he received. To the contrary, the gravamen of DiCarlo's claim is that his bill was unreasonable because he was not offered a discount from the pre-set Charge Master price. See, e.g., Cmpl. at ¶¶ 3-4. It is undisputed, in short, that St. Mary (like all hospitals) had a list of applicable charges. It follows that the phrase "all charges" cannot be held to constitute an open price term.

The conclusion the District Court reached is therefore correct as a logical proposition. As the court recognized, the result also is compelled by the realities of hospital operation: A contractual phrase such as "all charges" or "regular rates" is "the only practical way in which the obligations of the patient to pay can be set forth, given the fact that nobody yet knows * * * what treatments will be necessary." Dist. Ct. Op. at 7-8. DiCarlo takes issue with this statement, arguing that "the most 'practical way' to set forth a patient's obligation to pay has absolutely nothing to do with whether or not 'all charges' constitutes an open price term." Opening Br. at 13. DiCarlo is wrong. Context is crucial to determining whether a price term is ambiguous or missing. See, e.g., Shelton, 633 S.E.2d at

116 ("When we consider the situation of the parties at the time, the subject matter, and the purpose sought, we find the price term was sufficiently definite.") (quotation marks omitted). And in this context – a hospital setting, a contract to pay "all charges," and a pre-existing document listing all of the hospital's charges – the District Court was correct to hold that there was no gap to be filled.[4]

Amici urge this Court to follow suit, not only because the District Court's outcome makes sense but because a contrary conclusion would wreak havoc both on the hospital industry and in the courts. The rule DiCarlo advocates would mean the price term arguably is "open" in millions of patient-hospital payment agreements nationwide. Hospitals will be forced to litigate their charges one by one, incurring colossal litigation costs, as patients seek to have judges rewrite the Charge Master line by line. And the courts, for their part, would be thrust into a

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[4] DiCarlo argues that the District Court's approach is the "minority [ ] view." Opening Br. at 12 n.5. This is just not so. The vast majority of courts across the nation have taken the exact same approach as the District Court. See Brief of Appellees at 18 n.6 (collecting cases); see also Nygaard, 731 N.W.2d at 192 & n.5 (collecting cases). The Nygaard court, in fact, noted just this April that "most courts * * * in similar hospital pricing litigation" have taken the route the District Court chose here. Id. at 192 (emphasis added). The few cases DiCarlo cites, by contrast, are largely off-point, as St. Mary explains in its responsive brief. See Brief of Appellees at 21-22. Amici would add to St. Mary's discussion only the fact that Payne v. Humana Hospital Orange Park, one of the two cases on which DiCarlo relies most heavily, is wholly inapposite because of its procedural posture. Because it was dealing with a motion to dismiss, the Payne court simply accepted as true the plaintiff's allegations that the hospital's prices were not "set and ascertainable"; it declined to even consider the hospital's contrary evidence. See 661 So.2d 1239, 1241 n.2 (Fla. 1st App. Dist. 1995).

gap-filling role in countless contract cases, clogging dockets nationwide. This outcome would do no one any good.

II. HOSPITAL PRICING IS NOT SUSCEPTIBLE TO A JUDICIAL "REASONABLENESS" DETERMINATION.

Besides being legally sound, the District Court's approach has a second benefit: it avoids the thorny policy problems that would accompany any judicial attempt to set prices for individual hospital services. As the District Court recognized, "[a] court could not possibly determine what a 'reasonable charge' for hospital services would be without wading into the entire structure of providing hospital care and the means of dealing with hospital solvency." Dist. Ct. Op. at 8. The District Court wisely declined to dip a toe in these waters: "These are subjects with which state and federal executives, legislatures, and regulatory agencies are wrestling and which are governed by numerous legislative acts and regulatory bodies. For a court to presume to address these issues would be rushing in where angels fear to tread." Id.

DiCarlo and his amicus take issue with this sound exercise of judicial restraint. They contend that courts should have no trouble determining what a given hospital service reasonably should be worth. See Dist. Ct. Op. at 9 (quoting plaintiff's sur-reply brief below); Brief of Amicus Curiae Legal Services of New Jersey (hereinafter "Legal Services Br.") at 15. Tellingly, however, DiCarlo immediately runs into difficulty when he tries to explain how, exactly, such an

inquiry would work. He says a court should examine "the hospital's costs, functions, and services," "the hospital's internal factors," and "the hospital's budgetary needs." Dist. Ct. Op. at 9 (quoting plaintiff's sur-reply) (emphasis added); see also Legal Services Br. at 15. This proposed "internal factors" test is a sign of the oversimplification inherent in DiCarlo's approach. The health care funding issue, including the problem of how to bill uninsured patients, is extraordinarily complex. It is informed by a wealth of state and federal regulations. It has been the topic of Congressional hearings. And it is the subject of current initiatives (several involving the AHA and/or NJHA) that seek ways to revamp the health care system. The problem of American health care financing is, in short, not susceptible to being shoehorned into a state-law contract claim. The District Court properly bore this in mind in defending its analytical path.

A. Hospital Pricing Must Take Into Account A Multitude of Institutional Payers, All Of Whom Demand Different Prices.

Perhaps the most important point about hospital pricing is that it "is not entirely of hospitals' own making"; to the contrary, hospitals "are part of a wider system of healthcare financing" and must "deal with anywhere from 20 to 100 different [institutional] payers," such as insurance companies, "in addition to Medicare and Medicaid."[5] This system is especially confusing because "[e]ach

[5] Healthcare Fin. Mgmt. Ass'n, Reconstructing Hospital Pricing Systems 2-3 (July 2007) (citation omitted).

payer's contracting requirements and basis for payments is different," leaving it "up to the hospital to adapt to each one."[6]

Private institutional payers like insurers and managed health plans cannot set prices by legal dictate, but neither do they simply agree to pay hospitals' list prices. They instead use their "market clout" to demand "lower fee schedules" and individually negotiated rates.[7] And because larger insurance companies are better positioned to demand bigger discounts, "[p]rivate insurance company payment rates vary widely."[8] This, in turn, makes it difficult for hospitals to predict year-to-year revenues from the privately insured individuals who typically make up 37 percent of a hospital's patient volume.[9]

The Medicare and Medicaid payment systems add to the problem. Medicare and Medicaid recipients make up more than half of a typical hospital's total patients, and the United States Congress and state governments unilaterally set

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6 Id. at 2.

7 Christopher P. Tompkins et al., The Precarious Pricing System for Hospital Services, 25 Health Affairs 45, 47 (2006) ("Precarious Pricing").

8 AHA, Hospital Charges Explained 3 (Dec. 2003) ("Charges Explained") (emphasis deleted); see also Maldonado, 2007 WL 2054906, at *2 ("The discount from the chargemaster rate paid by Ochsner's insured patients varies widely depending on the insurance provider and the particular procedure involved.").

9 Charges Explained 2.

payment rates for all of that care.[10] For years, however, both the federal government and the states have set rates too low to cover the cost of the care hospitals provide. In 2007, for example, the forecast "Medicare margin," or percentage by which Medicare payments fall short of hospital costs for that care, is 5.4 percent.[11] That shortfall – the largest deficit in recent history – translates to a massive loss for hospitals: In 2005, Medicare underpayments were not as severe on a percentage basis, and even then the loss to hospitals was more than $15 billion for that year alone.[12] As to Medicaid, the shortfall in payments varies from state to state, but it consistently gets worse during times of governmental belt-tightening. Most state governments operate under balanced budget requirements, and when tax revenues fall, Medicaid payment rates are often first on the chopping block.[13] In 2005, the national Medicaid underpayment was nearly $10 billion.[14] That means hospitals lost more than $25 billion in one year alone from their provision of medical services to Medicare and Medicaid recipients.

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10 Id.

11 Medicare Payment Advisory Comm'n ("MedPac"), Report to the Congress: Medicare Payment Policy 60 (Mar. 2007).

12 AHA, Underpayment by Medicare & Medicaid Fact Sheet 3 (Oct. 2006) ("Underpayment"). The shortfall has become far worse since 2000, when it was $1.4 billion. Id.

13 Charges Explained, supra n.7 at 5.

B. Hospitals Spend Billions on Charity Care, Assistance To The Uninsured, And Community Service Programs.

Medicare and Medicaid care are not the only underfunded (or unfunded) mandates of the modern American hospital – far from it. Hospitals provide care to every patient who walks through the door, without regard to ability to pay. They provide free care or substantial discounts to millions of lower-income patients. And they routinely treat uninsured patients from whom they never receive any payment. All in all, according to one estimate, America's hospitals provided $28.8 billion in uncompensated care in 2005.[15] And this figure does not count the millions more hospitals spend on free community assistance programs and lobbying for broader health care availability and insurance coverage. "[T]hese acts of charity," PricewaterhouseCoopers recently concluded, "are all that stand between a thorny policy dilemma and an access crisis for millions of Americans."[16]

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[14] Underpayment, supra n.11 at 3.

[15] See AHA, Uncompensated Hospital Care Cost Fact Sheet 1 (Oct. 2006) ("Uncompensated Hospital Care"), available at http://www.aha.org/aha/content/2006/pdf/uncompensatedcarefs2006.pdf. In New Jersey alone, the NJHA reports, "[o]n an annual basis [the state's] hospitals absorb more than $1 billion in uncompensated care and are underpaid by the state an additional $400 million for services provided to the charity care population that they are mandated to provide. See NJHA, Statement of Principles and Guidelines for Hospital Billing and Collection Practices (2004) ("NJHA Statement"), available at http://www.aha.org/aha/content/2004/pdf/newjerseyguidelines.pdf.

[16] PricewaterhouseCoopers, Health Research Inst., Acts of Charity: Charity Care Strategies for Hospitals in a Changing Landscape 1 (2005) ("PwC Report").

1. Perhaps the biggest contribution made by American hospitals on this front is their provision of free and reduced-price care for low-income patients. According to a recent study conducted by Ernst & Young on behalf of the AHA, hospitals "provid[ed] uncompensated care to, on average, 12% of their total patients during the past year," at a cost of approximately "$14 million per hospital."[17] Much of this care is provided to uninsured patients – including many whose incomes are well above the federal poverty line. Indeed, AHA has urged its members to "provide free care to those below 100 percent of the federal poverty level and financial assistance to those who are between 100-200 percent of that level," and has noted that "[t]he vast majority of hospitals already meet or exceed these guidelines."[18] In New Jersey, state law mandates free care for all patients with incomes below 200 percent of the federal poverty level and reduced-price care for patients with income between 200 and 300 percent of the federal poverty level. See N.J. Admin. Code § 10:52-11.8.

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[17] Ernst & Young LLP, Community Benefit Information from Non-Profit Hospitals: Lessons Learned from the 2006 IRS Compliance Check Questionnaire, A Report Prepared for the Am. Hosp. Ass'n i-ii (Nov. 27, 2006) ("Ernst & Young Report").

[18] Taking the Pulse of Charitable Care & Community Benefits at Nonprofit Hospitals 5, Hearing Before S. Comm. on Finance, 109th Cong. (Sept. 13, 2006) (statement of Kevin Lofton) ("2006 AHA Statement").

In addition to formal price reductions, hospitals offer billions more in uncompensated care by way of bad debt write-offs – that is, care provided to patients who are unable to pay their bills and do not, for whatever reason, apply for assistance.[19] A recent report confirms that "the great majority of [hospitals'] bad debt was attributable to patients with incomes below 200% of the federal poverty level."[20] This finding, the report concluded, warrants considering not-for-profit hospitals' bad debt in measuring the extent of their community benefits.

The critical safety net that hospitals provide is only becoming more important as the number of uninsured Americans soars. The Census Bureau recently reported that 46.6 million Americans are uninsured – an increase of 1.3 million people, including 400,000 children, from 2004 to 2005.[21] As the health insurance crisis deepens, amici and their member hospitals have stepped up their longstanding commitment to easier access to insurance for all Americans. In 2004, for example, hospitals sponsored or took part in hundreds of health and enrollment

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19 See Uncompensated Hospital Care, supra n.15 at 1.

20 See Congressional Budget Office, Nonprofit Hospitals & the Provision of Community Benefits 10 n.34 (Dec. 2006).

21 2006 AHA Statement 5; see also Carmen DeNavas-Walt et al., U.S. Census Bureau, Current Population Reports, Income, Poverty, & Health Insurance Coverage in the United States: 2005, at 20 (GPO Aug. 2006) ("In 2005, 46.6 million people were without health insurance coverage, up from 45.3 million people in 2004.")

fairs aimed at helping eligible residents sign up for coverage programs during Cover the Uninsured Week.[22] This spring, hospital leaders and their colleagues planned more than 2,000 events (including fairs, seminars, and campus activities) to enroll eligible children in the State Children's Health Insurance Program (SCHIP) and to press Congress for SCHIP reauthorization.[23] And the AHA has lobbied strenuously for SCHIP reauthorization, publishing advertisements and writing to key congressmen in an effort to secure the program's renewal. [24]

2. Hospitals' charitable commitments, however, stretch still further. Ernst & Young reports that "[o]ne hundred percent of the hospitals [surveyed in a recent study] indicated that they provided additional community programs."[25] The study found, for example, that 96 percent of surveyed hospitals provided free or reduced-price medical screening programs for diseases such as breast cancer and HIV; the

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[22] Hearing on Tax Exemption; Pricing Policies of Hospitals: H. Subcomm. on Oversight of the H. Comm. on Ways and Means, 108th Cong. (2004) (statement of David Bernd, Chairman, American Hosp. Ass'n Bd. Of Trustees) ("Bernd Statement"), available at http://waysandmeans.house.gov/hearings.asp?formmode=view&id=1691.

[23] See Risa Lavizzo-Mourey, M.D., Hospitals Play Vital Role in National Campaign to Cover Our Uninsured Kids (AHA News Apr. 30, 2007).

[24] See, e.g., Letter from AHA Executive Vice President Rick Pollack to Rep. Ron Klein (Mar. 30, 2007), available at http://www.aha.org/aha/letter/2007/070330-let-rp-klein.pdf.

[25] Ernst & Young Report, supra n.17 at ii.

majority provided free immunization programs; 89 percent had satellite clinics in impoverished areas and other programs to increase health care access for the uninsured; and 93 percent produced publications informing the community about critical health care issues such as heart disease and obesity.[26]

A few specifics illustrate the ways in which hospitals respond, out of their own pockets, to the unique healthcare problems facing their communities. In Annapolis, Maryland, the Anne Arundel Medical Center addressed the needs of the city's indigent and homeless by opening a free healthcare clinic – the Annapolis Outreach Center – in 1994. By 2005, the Center was receiving 300 patients a month.[27] At Parkland Hospital in Dallas, a program to provide prenatal care to low-income women reduced the rate of NICU admissions by 40 percent.[28] And St. Mary Hospital, the appellee in this case, sponsors (among other free benefits) a Community Health Fair that included free blood pressure screenings, diabetes tests, immunization information, and smoking cessation classes.[29]

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[26] Id. at 5.

[27] Caring For Communities, Hospitals in Action, Case Examples, available at http://www.caringforcommunities.org/caringforcommunities/hospitalsaction/caseexamples/access/2007/arundel.html (last visited July 26, 2007).

[28] See The Chartis Group, Prepared to Care: The 24/7 Role of America's Full-Service Hospitals 10 (2006) ("Prepared to Care").

[29] See City of Hoboken Web site, St. Mary Hospital Will Offer Free Health Screenings at its Community Health Fair on September 28th (Sept. 15, 2006)

3. The vital medical research and education functions performed by American hospitals are yet another facet of their uncompensated service. The Ernst & Young report revealed that approximately one third of the not-for-profit hospitals surveyed in the study conduct medical research, "with those hospitals spending an average of $19 million on the medical research programs."[30] Forty-two percent conducted medical trial studies. And another 64 percent conducted medical education and training programs costing an average of $7 million annually.[31] St. Mary is among this latter group.[32]

4. Hospitals, in short, "do more to assist the poor, sick, elderly, and infirm than any other entity in the health care sector,"[33] and they are proud to do so. But this recitation is not meant to be self-congratulatory. It is, instead, meant to highlight a critical juxtaposition in American health care policy: (1) hospitals provide an enormous and growing amount of essential charity care; (2) government is not prepared to provide that care; (3) but neither is government setting

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("Hoboken Site"), available at http://hobokennj.org/html/hservices/health_Free_screening.html.

30 Ernst & Young Report, supra n.17 at 4.

31 Id.

32 See Hoboken Site (noting that St. Mary "is a teaching hospital with several residency programs and academic affiliations with hospitals throughout the state").

33 2006 AHA Statement at 1.

reimbursement rates at a level that permits hospitals to do all they can for the community without serious fiscal overextension. "Rising charity care and bad debt costs have come at a time when increases [from] Medicare, Medicaid, and [insurers] are not keeping up with rising expenses."[34] As one hospital official said during a recent study: "The government wants to pay less, commercial insurers want to pay less – so who will ultimately pay for charity care? * * * [T]he dollars associated with that safety net are at risk."[35] This confluence of factors further confounds any effort to tinker with the margins of health care funding policy.

C. Hospital Costs Can Swing Substantially Due To Hard-To-Predict Changes In Costs And Regulatory Mandates.

There are still more complicating factors in the health care funding picture. For one, new technologies often add to the cost of a given hospital service, but "[t]he adjustment process under Medicare to pay more for a service is painfully slow," often taking "many years" to catch up with the cost of technology.[36] Hospitals must try to figure out where these deficits will occur and factor them into the bottom line. For another, shortages of nurses and other specialists have forced hospitals to offer higher salaries and other compensation – such as bonuses and

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34 PwC Report, supra n.16 at 6.

35 Id. (quoting Louisiana Hosp. Ass'n Vice President Paul Salles).

36 Precarious Pricing, 25 Health Affairs at 50-51.

tuition reimbursement – to attract the minimum necessary staff.[37] This has led to unavoidable growth in costs.[38] And most significant of all are the frequent changes in the amazingly dense federal health care regulatory scheme. Hospitals must "navigate thousands and thousands of pages of rules that govern the Medicare and Medicaid programs,"[39] figuring out not only the cost of each new regulatory mandate but also whether existing mandates will cost more as each year passes.[40]

D. Growing Uncompensated Care Costs And Shrinking Reimbursements Are Driving Some Hospitals Into The Red.

The long and short of it is, "[t]he payment system for hospitals is broken."[41] As the AHA testified before Congress in 2004, "Medicare and Medicaid * * * reimburse hospitals at less than the cost of providing those services," powerful insurers "negotiate big discounts," and "rapidly rising technology costs, aging

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37 PricewaterhouseCoopers, Cost of Caring: Key Drivers of Growth in Spending on Hospital Care 10 (Feb. 2003) ("Cost of Caring").

38 Indeed, even with increased hiring, hospitals face worsening staff shortages. A recent report predicted "a shortage of 1 million registered nurses and 84,000 specialist and generalist physicians" by 2020 and said "[s]taff shortages combined with physical capacity constraints make it increasingly difficult for hospitals to meet the rising demand for emergency care." Prepared to Care, supra n.27 at 16.

39 See Comments of AHA Board of Trustees Chairman David Bernd, 2003 National Health Policy Conference (Jan. 22, 2003), available at www.academyhealth.org/nhpc/2003/bernd.pdf.

40 See Charges Explained, supra n.8 at 4.

41 Id. at 7.

facilities in need of repair, and a shortage of workers all place increasing burdens on hospital resources that are already struggling to meet rising demand."[42] All of these factors, combined with the huge and growing cost of uncompensated care, have left one-third of hospitals losing money on operations[43] and "another third on the financial brink."[44] The problem also has forced hospitals to make ends meet in unsustainable ways – for example, by neglecting to invest as much as they should in updating facilities to accommodate growing numbers of elderly patients.[45]

Ultimately, if they are to shoulder additional burdens, hospitals may be forced to reassess the extent of the services they offer. Many hospitals have already stopped providing high-cost services like trauma units that cannot function absent a subsidy. Others may have no choice but to limit the important community benefit programs they have implemented to meet the unique needs of their communities. See supra at 14-20. "At the end of the day," as one commentator

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42 Bernd Statement, supra n.22.

43 AHA, Hospital Facts to Know at 1 (May 2007), available at http://www.aha.org/aha/content/2007/pdf/07-am-hospital-facts.pdf.

44 Bernd Statement, supra n.22. Indeed, St. Mary itself has fallen victim: Its parent company transferred it to the City of Hoboken in 2007 "[a]fter several years of catastrophic financial losses." Brief of Appellees at 7 n.2.

45 Cost of Caring, supra n.37 at 16 (noting that the average age of hospital plants increased in the 1990s, which suggests insufficient capital construction).

has noted, "even a nonprofit organization has to make enough money to cover its costs and set aside reserves for asset replacement and other capital projects."[46]

E. Legislatures And Policymakers Are Seeking Comprehensive Solutions For The Dilemmas of Health Care Policy.

Faced with unsustainable demands on hospitals on the one hand, and the need to achieve affordable care for all citizens (including the uninsured) on the other, legislators and policymakers have been active in seeking broad-based health care reform. In New Jersey, as St. Mary notes in its brief, the legislature chose to "expressly reject[ ]" a "rate-setting regime" and focus instead on ensuring that the state's neediest residents – those making less than 300 percent of the federal poverty level – were entitled to discounts or free care. Brief of Appellees at 13 (citing the New Jersey Charity Care Program, N.J. Stat. Ann. § 26:2-H-18.51 et seq.). New Jersey, in other words, has examined the health-care situation statewide and decided that regulation is called for only as to those uninsured patients whose incomes are below a set limit; for the rest of the hospital pricing field, the legislature made a conscious decision to deregulate. On the federal level, Congress since 2004 has held no fewer than three hospital pricing hearings[47] –

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[46] John D. Colombo, Hospital Property Tax Exemption in Illinois: Exploring the Policy Gaps, 37 Loy. U. Chi. L.J. 493, 513 (2006).

[47] See Hearing Before S. Comm. on Finance, 109th Cong. (Sept. 13, 2006); Hearing Before H. Comm. on Ways and Means, 109th Cong. (May 26, 2005);

hearings at which at least one congressman called for a focus on universal health insurance solutions instead of pricing discounts.[48] And all the while, the AHA, NJHA, and other organizations have been working to achieve comprehensive reform. The AHA, for example, has played a leading role in the Health Coverage Coalition for the Uninsured, a group of health care and business organizations that has developed a compromise plan to cut the number of uninsured Americans in half and has "committed to pressing lawmakers" to institute the plan.[49] The AHA and NJHA also have approved policies calling for their member hospitals to (1) offer free and reduced-price care to those in need; (2) publicly report the full value of the community benefits they provide; and (3) develop more transparent, easier-to-access pricing policies.[50] And the AHA on July 23 unveiled a five-point framework for health reform that it will use "to engage the public and elected officials in a debate about health reform as the 2008 elections near"; among the

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Hearing Before H. Subcomm. on Oversight and Investigations of the H. Comm. on Energy and Commerce, 108th Cong. (June 24, 2004).

[48] See Hearing Before H. Subcomm. on Oversight and Investigations of the H. Comm. on Energy and Commerce, 108th Cong. (June 24, 2004) (statement of Rep. John D. Dingell), available online at http://energycommerce.house.gov/press/108st122.shtml.

[49] See Health Coverage Coalition for the Uninsured Web site, available at www.coalitionoftheuninsured.org.

[50] See 2006 AHA Statement 4-6; NJHA Statement, supra n.14 at 3-4.

five goals are "efficient, affordable care" and "health coverage for all paid for by all."[51] In addition to all of this policymaking activity, there are of course numerous studies that have been performed, and are being performed, on ways to overhaul health care financing. A number of those studies are cited in this brief.[52]

F. All Of These Factors Demonstrate Why The Courts Are Ill-Positioned To Set Hospital Prices.

The preceding discussion illuminates just how radical – and unworkable – DiCarlo's theory of the case really is. DiCarlo would have courts set reasonable prices for discrete hospital services by examining " 'the hospital's costs, functions, and services,' " " 'the hospital's internal factors,' " and " 'the hospital's budgetary needs.' " Dist. Ct. Op. at 9 (quoting plaintiff's sur-reply). But as the District Court rightly recognized, these are no simple inquiries. They are complicated systemic issues that the courts are "ill-equipped to examine." Id. at 9. Indeed, the court correctly grasped that by examining them at all, the judiciary would be nudging needlessly into a macro-level regulatory sphere that long has been occupied by legislators and policymakers with the time, training, and tools necessary to consider the issues at a depth a court simply cannot. See id. As the District Court

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[51] See AHA Website, A Framework to Improve America's Health and Health Care, available at http://www.aha.org/aha/content/2007/pdf/07-am-framework.pdf.

[52] See, e.g., Precarious Pricing, supra n.7; Reconstructing Hospital Pricing Systems, supra n.5.

noted during motions argument, what DiCarlo seeks is to have the courts "replac[e] what various state and federal agencies * * * have been trying to do * * * for many years." [53] The court properly declined to take such a drastic step.

Other federal courts have agreed. Last month, a Florida district court dismissed a lawsuit just like DiCarlo's on the rationale that the complaint was not cognizable in court. See Urquhart v. Manatee Mem'l Hosp., No. 06-1418, 2007 WL 2010761 (M.D. Fla. July 6, 2007). The Urquhart plaintiff, like DiCarlo, was an uninsured patient who received treatment, refused to pay, and sued on a breach-of-contract theory, pointing to the Charge Master discounts demanded by large insurers and the government. Id. at *1-*2. The court rejected her claim:

> Plaintiff argues that UHS charges unreasonable rates to uninsured patients. [But] [p]laintiff still fails to indicate steps the Court may take to redress her injury. If the Court were to issue an injunction against UHS to prevent it from charging "unreasonable" prices, the court would also have to determine what prices were "reasonable" for not only her procedure, but every other hospital procedure. This goes against * * * Article III considerations of justiciability and separation of powers. * * * Medical regulation issues have typically been resolved by the legislative process. [Id. at *4].

The Urquhart court based its holding on notions of standing and separation of powers. But the same considerations undergird the District Court's conclusion in this case that it had avoided a "political morass" by grounding its holding in fundamental notions of contract. Furthermore, the identical considerations also

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[53] Transcript of Mot. Hrg. 10, DiCarlo, No. 05-1665 (Feb. 14, 2006) (No. 22).

would operate to defeat DiCarlo's theory even if a court were to reject the District Court's ground for decision and attempt to set a price for hospital services. This is so because the very complexity of the issues belies any attempt to seize upon some external measure besides the Charge Master that could be used to determine a "reasonable" price. What external measure would a court choose? It would be inappropriate to look to the discounted rates demanded by Medicare, Medicaid, and large insurers: Not only are those rates so low as to cause hospitals financial distress, but they also "vary widely" from provider to provider.[54]

For all of these reasons, the District Court was right to stop where it did. The problems of the American health care system are sufficiently complex and inter-related that "the political branches of both the federal and state governments and the efforts of the private sector" have not yet been able to resolve them. Dist. Ct. Op. at 8. The hospital Charge Master "sits at the vortex" of the dilemma, forced to try to accommodate "government regulation, rapidly growing health care costs, [and] growing segments of the population lacking sufficient or any insurance."[55] The only logical way to alter the health care funding system is to do

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[54] Charges Explained, supra n.7 at 3; see also Maldonado, 2007 WL 2054906, at *3 ("[T]here is not one charge for insured patients and one charge for uninsured patients, but an array of charges tailored to each patient's treatment. In addition, the percentage of the chargemaster rate paid by an individual insurance company may vary from procedure to procedure.").

[55] Precarious Pricing, 25 Health Affairs at 54.

so globally. If courts began creating their own Charge Masters piecemeal, plaintiff by plaintiff and charge by charge, there would be no end in sight.

CONCLUSION

For all of the foregoing reasons, the District Court's judgment should be affirmed.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE WITH RULE 32(a)

Pursuant to Fed. R. App. P. 32(a)(7)(C), I hereby certify that this brief was produced in Times New Roman 14 point typeface using Microsoft Word 2003 and contains 6,543 words.

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I hereby certify that I am a member in good standing of the Bar of the United States Court of Appeals for the Third Circuit.

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