VIRGINIA MEDICAL LAW REPORT

Challenge to 'balance billing' hits hospital

By: Peter Vieth May 27, 2016

For what may be the first time in Virginia, a judge has ordered a hospital to slash its "balance billing" charges by 75 percent to reflect the hospital's usual write-off for uninsured patients.

The decision is rare judicial rebuke to the common hospital practice of billing full rate for patients whose insurance plans do not have reimbursement agreements with the hospital.

The judge said a contract signed by a distraught emergency room patient was invalid and he chided the hospital for treating its list of charges as "double secret."

Surprise bill

The court dispute arose after Glenn Dennis – a Martinsville banker – received what is sometimes termed a "surprise medical bill."

He is not alone. A recent Kaiser Family Foundation survey found that among insured, non-elderly adults struggling with medical bills, charges from out-of-network providers were a factor about one-third of the time.

In seven out of 10 such cases, patients did not know the providers were not in their plan's network when they received care.

The 57-year-old Dennis had little choice about his treatment.

He was at work at a bank branch in Martinsville in 2014 when other staffers noticed he was not feeling well. A co-worker drove him to an urgent care facility, but the staff there called an ambulance to take him to a hospital.

Dennis was having chest pains that recalled an earlier heart attack, and nitroglycerin did not seem to relieve his pain, according to a summary by Henry County Circuit Judge David V. Williams. Dennis' wife said he was "crying … upset … [and] agitated," the judge wrote.

Dennis arrived at Memorial Hospital of Martinsville & Henry County "in acute emotional and physical distress," Williams said.

While lying in a hospital bed awaiting treatment, a hospital staffer had him sign a "Financial Responsibility Agreement." The agreement provided that the patient was obligated to promptly pay the hospital in accordance with charges listed in the hospital's "charge description master" or CDM.

Dennis was in the hospital two days and underwent surgery to place five stents in his arteries, his lawyers said.

At issue: $83k

The hospital said the bill came to $111,115.37. Dennis had health insurance, and he and his insurer paid the hospital $27,254.95.

But Dennis' insurance carrier did not have a contract with the hospital for reduced reimbursement rates. He did not have Medicare or Medicaid. The hospital sued Dennis for the remaining balance of $83,860.42.

Dennis asked a judge to declare he did not owe anything beyond what he already paid. The hospital responded with a counterclaim for the full amount, based on both contract principles and on an implied contract theory.

Williams tried the case without a jury on Feb. 25.

No mutual assent

In a March 31 letter opinion, Williams rejected the hospital's contract and ruled that the reasonable value of Dennis' medical care was just $27,778.84. Dennis would owe the hospital only $523.89 in addition to the previous payments.

The opinion is *Dennis v. PHC-Martinsville Inc.* (VLW 016-8-050).

The hospital failed to meet its burden of proving that the parties mutually had made a binding contract, the judge said.

In the first place, the Financial Responsibility Agreement was a "contract of adhesion," the judge decided.

"So far as Dennis knew, his life was on the line. His hope of receiving medical treatment lay in signing the papers he was presented," Williams said.

He quoted U.S. Supreme Court Chief Justice John Roberts: "'Your money or your life' is a coercive proposition, whether you have a single dollar in your pocket or $500."

Williams found the hospital's secrecy about its charges also suggested the contract was not a product of mutual agreement.

After Dennis was billed, the hospital refused to allow him to have a copy of the CDM or even look at a copy. In litigation, the hospital declined to provide a copy until the court ordered production, the judge said.

Although the hospital's contract referred to charges in the CDM, "the hospital treated the contents of the CDM as 'double secret,' or confidential or proprietary information," Williams said.

"No definition of the word 'mutual' encompasses a situation in which all of the information about a critical contractual element is held by one of the parties, who refuses to share it with the other party," Williams said.

25 percent solution

Even if there were no enforceable written contract, both sides agreed the hospital was entitled to compensation for the reasonable value of Dennis' treatment. Dennis contended the amount already paid was sufficient.

Williams pointed to testimony from officials that the hospital would accept 25 percent of its charges as full payment if an uninsured patient arranged for pre-payment. The judge settled on that amount for Dennis' obligation.

Martinsville lawyer James W. Haskins, who represented Dennis, said, as far as he knows, the decision is the first in the country where a "balance billing" challenge went to a full trial.

He said the evidence revealed the illusory nature of the nominal hospital charges.

"One tenth of one percent actually pay a charge master rate," Haskins said. The lawyer said his firm is pursuing similar cases with several other hospitals in Virginia, contending the hospitals' official rates are little more than bargaining chips.

"The charge masters are always secret. None of the hospitals will let patients look at the charge master," said Scott C. Wall, another Dennis attorney.

"Welcome to the world of hospital billing practices. It is mind boggling what goes on," Haskins added.

The Martinsville hospital, owned by Tennessee-based LifePoint Health, was represented by John S. Buford of Richmond. He did not respond to a request for comment on the trial and the hospital's billing practice.

A spokesperson for the Virginia Hospital and Healthcare Association declined to comment on hospital balance billing practices.