

Nova Law Review

Volume 33, Issue 1

2008

Article 9

Article I. The Role of the Florida Courts in Protecting the Uninsured from Being Overcharged for Emergency Medical Services

David Stahl*

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ARTICLE I. THE ROLE OF THE FLORIDA COURTS IN PROTECTING THE UNINSURED FROM BEING OVERCHARGED FOR EMERGENCY MEDICAL SERVICES

DAVID STAHL*

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I. INTRODUCTION

In 2003, a series of *Wall Street Journal* articles brought to the American public's attention a problem that had been brewing for decades.¹ The prob-

* The author is a J.D. Candidate, May 2010, Nova Southeastern University, Shepard Broad Law Center. David Stahl has a B.A in Biochemistry from Harvard University and an M.B.A from Florida Atlantic University. The author wishes to thank his family for their support, understanding, and encouragement, in particular his wife Tattiana, his son and fellow "second grader," Benjamin, and his parents Diane and Peter Stahl. The author would also like

lem was that hospitals were charging uninsured patients rates that were much higher than rates that the hospitals accepted as full payment from the government and private insurers.² The price differences cited in many articles were astonishing. One article described a woman being charged \$14,000 for a hospital stay, when the same hospital would regularly accept \$2500 from private insurance.³ Similar stories were being disclosed across the country including here in Florida where typical examples included an emergency room bill of \$12,000 when the hospital accepted less than \$3000 as full payment from private insurers.⁴ Similarly, in another Florida case, a woman was charged \$48,000 for inpatient care when a private insurance company would only be billed \$7000.⁵

In response to the public reaction to these stories and success in class action suits against the tobacco industry, many class action suits were filed on behalf of the uninsured to try to stop the seemingly outrageous prices the uninsured were charged for necessary medical services.⁶ Under pressure from the public outcry, threat of legislation, and the cost of defending class action suits, many hospitals claimed to have changed their policies.⁷ Nevertheless, the number of uninsured in America continues to grow and was reported as over forty-six million in 2006.⁸ The problem is especially prevalent in Florida, which ranks third worst in terms of the total number of uninsured—close to three million—and in terms of the percentage of uninsured.⁹ Furthermore, Florida has one of the highest charge-to-cost ratios in the United States, which means that, on average, Florida hospitals' standard charges

to recognize Professor Stephanie Feldman Aleong for her valuable suggestions and guidance. Finally, the author thanks his colleagues on *Nova Law Review* for their hard work and dedication in the editing of this article.

1. See Beverly Cohen, *The Controversy over Hospital Charges to the Uninsured—No Villians, No Heroes*, 51 VILL. L. REV. 95, 98–99 (2006).

2. *Id.* at 100–01.

3. George A. Nation III, *Obscene Contracts: The Doctrine of Unconscionability and Hospital Billing of the Uninsured*, 94 KY. L.J. 101, 101 (2005).

4. Bob LaMendola, *Uninsured Patients Sue Kendall Hospital for Bills; Group Wants Same Discount as Insured*, SUN SENT., May 12, 2005, at 5B.

5. Frank Gluck, *Woman Sues over Hospital Bill; She Says Lakewood Ranch Center Charged Her \$40,000 More Because She is Uninsured*, SARASOTA HERALD TRIB., Aug. 9, 2006, at BM1.

6. See Cohen, *supra* note 1, at 111–14.

7. See Gerald F. Anderson, *From 'Soak the Rich' to 'Soak the Poor': Recent Trends in Hospital Pricing*, 26 HEALTH AFF. 780, 786–87 (2007).

8. Fla. S. Comm. on Health Reg., SB 1756 (2007) Staff Analysis 1 (Mar. 17, 2007), available at <http://www.flsenate.gov/data/session/2007/Senate/bills/analysis/pdf/2007s1756.hr.pdf> [hereinafter SB 1756 Staff Analysis].

9. *Id.*

represent a much higher markup over costs than hospitals in other states.¹⁰ Although hospitals claim to have changed their policies, hospitals are still free to charge whatever they want and some continue to fight lawsuits regarding overcharges to the uninsured.¹¹

Although there has been some success in terms of settlements to class action lawsuits, results from cases where the parties did not settle are now starting to find their way to the appellate courts for determination of what each state's laws permit. This article will evaluate the way courts can and should be utilized to help the uninsured obtain reasonable charges for medical services.

Part II of this article will discuss the most likely causes of action that an uninsured party may have against a medical service provider that has charged the uninsured unreasonable rates. Part III evaluates issues that such uninsured parties may have with trying to achieve class certification. Part IV is a case analysis of a federal court case where an uninsured party tried to pursue a class action against a hospital for overcharging her and other similarly situated uninsured patients. Part V evaluates the Florida legislative response to the issue of determining reasonable rates for medical services for the uninsured and others that utilize the hospitals services without a pre-negotiated contract rate. Finally, part VI evaluates the best course of action for an uninsured person that believes he or she has been overcharged by an emergency medical service provider.

II. POSSIBLE CAUSES OF ACTION

Although commentators have suggested numerous causes of action that uninsured patients who have been overcharged by emergency medical service providers could pursue, the two most viable causes of action under Florida law appear to be breach of the reasonable price term implied into open priced contracts and violation of Florida consumer protection law.¹² This section will evaluate what an uninsured person would need to prevail on either of these claims.

A. *Breach of Open Priced Contract*

Under Florida common law, if a contract does not contain any fixed price or rate, the contract is considered an open priced contract and the law

10. See generally Anderson, *supra* note 7, at 783.

11. See *id.* at 786–87.

12. See generally Colomar v. Mercy Hosp., Inc. (*Colomar II*), 461 F. Supp. 2d 1265 (S.D. Fla. 2006).

implies a reasonable price to make the contract valid.¹³ In *Payne v. Humana Hospital Orange Park*,¹⁴ the First District Court of Appeal held that under this rule of law, where the agreement with the medical service provider indicates a patient is to pay the “standard and current rates,” a patient is only bound to pay reasonable charges.¹⁵ Even if the patient could have accessed the service provider’s list of charges—commonly referred to as a charge master—prior to agreeing to the terms of the contract, he or she would not have been able to truly consent to all of the charges as these charge masters are generally hundreds of pages long and codified.¹⁶ Thus, unlike situations where the payor can know the market price based on prior dealings or market conditions, patients have no real means of determining what charges to expect prior to accepting the hospital’s terms.¹⁷ The inherent nature of emergency room services, where at the time the patient is asked to sign a contract, neither the hospital staff nor physicians can know which services will be needed, ensures that Florida courts are likely to continue to consider admission contracts for emergency room services as open priced contracts under Florida law.¹⁸

Many courts around the country, however, have held that prices of hospital admission agreements are definite—therefore, the courts do not need to imply a fair and reasonable price—where the agreements refer to the hospitals’ “regular charges,” and where the hospitals’ price lists are obtainable through outside sources.¹⁹ The courts seem to be deferential to the hospitals since the alternative would be for the hospitals to give every emergency room patient a contract that was hundreds of pages long listing the prices of all services even though the patient would never be able to read and under-

13. See *Payne v. Humana Hosp. Orange Park*, 661 So. 2d 1239, 1241 (Fla. 1st Dist. Ct. App. 1995) (per curiam).

14. *Id.* at 1239.

15. *Id.* at 1241 (citing *Mercy Hosp., Inc. v. Carr*, 297 So. 2d 598, 599 (Fla. 3d Dist. Ct. App. 1974)).

16. *Id.* at 1242 n.3.

17. See *id.* at 1242.

18. See Mark A. Hall & Carl E. Schneider, *Patients as Consumers: Courts, Contracts, and the New Medical Marketplace*, 106 MICH. L. REV. 643, 647 (2008).

19. See, e.g., *Nygaard v. Sioux Valley Hosps. & Health Sys.*, 731 N.W.2d 184, 191–92 (S.D. 2007) (holding that the patients’ own allegations that the price terms were present showed “the charges [were] ascertainable through reference to outside sources” and there was “no need to judicially impute a fair and reasonable price term”); *Cox v. Athens Reg’l Med. Ctr., Inc.*, 631 S.E.2d 792, 796 (Ga. Ct. App. 2006) (holding that the contracts authorized the hospital to charge patients the rate it normally charged uninsured patients); *Shelton v. Duke Univ. Health Sys.*, 633 S.E.2d 113, 116 (N.C. Ct. App. 2006) (holding that “rates of services contained in the ‘charge master’ were necessarily implied in the contract signed by plaintiff”).

stand the entire contents prior to agreeing to treatment.²⁰ Thus, as one court concluded, it would be “entirely reasonable and predictable that patients would agree to pay the hospital’s regular rates for whatever services might be necessary.”²¹ This logic is especially prevalent in states such as Arizona, where state law requires the hospital to submit their pricing lists to the state for approval and publication.²²

The question remains whether Florida courts will allow hospitals to distinguish the language of their form admission contracts from those in *Payne*.²³ For example, in *Doe v. HCA Health Services of Tennessee, Inc.*,²⁴ the Supreme Court of Tennessee held that a hospital’s form contract had an indefinite price term because the contract did not have a specific reference to any extrinsic document from which the patient could have ascertained the meaning of the word “charges.”²⁵ The language of the opinion suggests that if the contract did indicate a reference to a means of obtaining the standard charges, then the contract price would be definite and the contract would be valid.²⁶ In fact, in a recent appeals court decision in Tennessee, the court made such a distinction indicating that the contract in that case was sufficient and the price term definite where the contract used the terms “facility’s rates and terms” instead of “charges.”²⁷ The court held that the language of the contract showed that the hospital had established rates which the patient

20. See *DiCarlo v. St. Mary’s Hosp.*, No. 05-1665, 2006 WL 2038498, at *4 (D.N.J. July 19, 2006).

21. *Shelton*, 663 S.E.2d at 116.

22. *Banner Health v. Med. Sav. Ins. Co.*, 163 P.3d 1096, 1101 (Ariz. Ct. App. 2007). Arizona law requires hospitals to file their customary rates and charges with the Arizona Department of Health for approval. *Id.* After the Department of Health approves the rates, the department then publishes the rates. *Id.* at 1100. After this, a hospital cannot change its rates without approval from the department. *Id.* In this case, the signed admission agreements stated that the patients would “pay the hospital’s usual and customary charges, which are those rates filed annually with the Arizona Department of Health Services.” *Id.* at 1098. Based on the Arizona statutes and the reference to the published list in the admission agreement, the court held that the contracts did not contain any open price terms and that the court would not imply a reasonable price term into the contracts. *Banner Health*, 163 P.3d at 1101.

23. See generally *Hall & Schneider*, *supra* note 18.

24. 46 S.W.3d 191 (Tenn. 2001).

25. *Id.* at 197. Where the contract contained text that the patient was “financially responsible to the hospital for charges not covered by this authorization.” *Id.*

26. See *id.* The court held that that the contract without a definite price term was invalid. *Id.* The court applied a quantum meruit equitable action to come to the same result as in Florida—the hospital was entitled to a reasonable price for its services. *HCA Health Servs.*, 46 S.W.3d at 197–98.

27. *Woodruff v. Fort Sanders Sevier Med. Ctr.*, No. E2007-00727-COA-R3-CV, 2008 Tenn. App. LEXIS 11, at *7–8 (Tenn. Ct. App. Jan. 16, 2008).

could evaluate for reasonableness.²⁸ The recent passing of the Health Care Consumer's Right to Information Act will require hospitals to make certain financial information as well as the costs for some services publicly available.²⁹ Thus, Florida courts may be influenced by Arizona precedent and no longer consider the price of hospital admission contracts to be fixed if the admission contracts refer to this publicly available information.³⁰

1. Declaratory Relief

Although the claim that a hospital admission contract implies a reasonable price term can serve as a defense to a collection suit by a hospital or collection agency, the uninsured patient has the right under Florida law to preemptively seek declaratory judgment to determine his or her obligation under the contract rather than defaulting and waiting for the medical provider to sue.³¹ Section 86.031, *Florida Statutes*, states that a plaintiff can seek declaratory judgment on a contract "before or after there has been a breach of it."³² Ironically, the plaintiff that has already paid the hospital's full charges may not have a cause of action for damages if the court finds that the plaintiff paid the bill in full because of a mistake of law—that is, the plaintiff did not know that the contract was an open priced contract and that the plaintiff was only required to pay a reasonable fee.³³ The patient might be able to recover the overpayment if he or she can show the hospital indicated it would not provide the necessary services before payment was received.³⁴ This is unlikely to be the case, however, because hospitals usually send their bills after treatment—again because of the difficulty of knowing what treatment will be needed in advance.³⁵

28. *Id.* at *8.

29. See Health Care Consumer's Right to Information Act, ch. 2008-47, § 1, 2008 Fla. Laws 739, 739-40.

30. See *Banner Health v. Med. Sav. Ins. Co.*, 163 P.3d 1096, 1101 (Ariz. Ct. App. 2007).

31. See FLA. STAT. § 86.021 (2008).

32. FLA. STAT. § 86.031 (2008).

33. Compare *Payne v. Humana Hosp. Orange Park*, 661 So. 2d 1239, 1240-41 (Fla. 1st Dist. Ct. App. 1995) (per curiam) (holding that plaintiff does have a cause of action to recover overpayment on an open priced hospital contract), with *Hall v. Humana Hosp. Daytona Beach*, 686 So. 2d 653, 657 (Fla. 5th Dist. Ct. App. 1996) (holding that a mistake of law regarding the enforceability of an open priced contract for medical services did not warrant "equitable relief once payment" had been made).

34. See *Hall*, 686 So. 2d at 657 & n.6.

35. See generally *id.*

2. Determining a Reasonable Price for Emergency Medical Services

Once the uninsured plaintiff has convinced the court that the hospital admission contract contained an indefinite price term, the plaintiff must also allege facts that could lead a reasonable juror to infer that the charged price is unreasonable.³⁶ The common theme in Florida case law is that determining the reasonableness of a particular hospital charge is a matter for the trier of fact to determine.³⁷ The Second District Court of Appeal has offered some guidance for making this determination by indicating “that evidence of . . . contractual discounts, standing alone, is insufficient to prove that . . . charges [are] unreasonable.”³⁸ From this, courts have inferred that reasonableness of charges is based on a multitude of factors of which evidence of contractual discounts is one.³⁹ Florida courts have also been reluctant to hold that a reasonable charge could always be determined based on a multiplier of the Medicare reimbursement rate.⁴⁰

In *Colomar v. Mercy Hospital, Inc. (Colomar II)*,⁴¹ a federal district court judge interpreting Florida law in a class action case evaluated Florida

36. See *State Farm Mut. Auto. Ins. Co. v. Sestile*, 821 So. 2d 1244, 1246 (Fla. 2d Dist. Ct. App. 2002).

37. *Id.* (holding that where legislation left the term “reasonable” medical expenses undefined, “[t]he fact-finder must construe the word ‘reasonable’”).

38. *Hillsborough County Hosp. Auth. v. Fernandez*, 664 So. 2d 1071, 1072 (Fla. 2d Dist. Ct. App. 1995) (holding that the hospital was entitled to the full amount of its charges in a statutory lien against an uninsured’s recovery in a personal injury case where the only evidence offered that the hospital’s full charges were unreasonable was that it offered discounts to managed care providers).

39. See *Colomar II*, 461 F. Supp. 2d 1265, 1269 (S.D. Fla. 2006).

40. See *Merkle v. Health Options, Inc.*, 940 So. 2d 1190, 1196 (Fla. 4th Dist. Ct. App. 2006) (indicating that a Health Maintenance Organizations (HMOs) could not base its statutory duty to reimburse non-contracted emergency service providers based on simply a percentage above Medicare reimbursement rates). Section 641.513(5), *Florida Statutes*, dictates how an HMO must reimburse non-participating emergency service providers who provide services for the HMO members. FLA. STAT. § 641.513(5) (2008). The statute requires the HMO to reimburse the provider “the lesser of: (a) The provider’s charges; (b) [t]he usual and customary provider charges for similar services in the community where the services were provided; or (c) [t]he charge mutually agreed to by the health maintenance organization and the provider within 60 days of the submittal of the claim.” *Id.* At issue in this case was how the court should determine the HMO’s liability to the non-participating providers. *Merkle*, 940 So. 2d at 1196. A court decision establishing a means of calculating “[t]he usual and customary provider charges for similar services in the community where the services were provided” could offer guidance on how to determine reasonable charges for uninsured patients. FLA. STAT. § 641.513(5)(b); see Leah Snyder Batchis, Comment, *Can Lawsuits Help the Uninsured Access Affordable Hospital Care? Potential Theories for Uninsured Patient Plaintiffs*, 78 TEMP. L. REV. 493, 525 (2005).

41. 461 F. Supp. 2d 1265 (S.D. Fla. 2006).

case law as well as case law from other states to establish a multiple factor approach for determining whether or not hospital charges were reasonable.⁴² These factors included an analysis of what other hospitals in the surrounding market charged for similar services (market analysis), a comparison of the rate that a hospital actually charges and what it accepts as full payment for those services from other patients (differential pricing), and an analysis of the hospital's actual costs for providing the service (actual costs).⁴³ The factors had to be analyzed together as no single factor was sufficient to establish that the charges were or were not reasonable.⁴⁴

a. *Market Analysis*

The first factor, market analysis, simply compares the prices that the hospital actually charged to the uninsured patient with what other hospitals in the same market would have charged for those services.⁴⁵ At the pleading stage, the court may be willing to infer that this factor weighs in favor of the hospital's charges being unreasonable if the hospital's charges are in the top twenty-five percent of hospitals nationwide.⁴⁶ Nevertheless, the court will probably require that during discovery, the patient produce evidence that the charges for the specific services provided were higher than those of hospitals in the same market.⁴⁷ Considering that hospitals rarely collect their full standard rates, the prices actually charged by hospitals are probably not truly market driven.⁴⁸ As a result, other area hospitals might also have standard charges that could be deemed unreasonable with respect to the cost of providing the services and with respect to what is actually paid in the community for those services.⁴⁹ Thus, comparing the standard rates might give a false sense of reasonableness.⁵⁰ This is the reason, however, that a market analysis is only one of several factors in determining reasonableness.⁵¹

42. *Id.* at 1269.

43. *Id.*

44. *Id.*

45. *Id.*

46. *Colomar II*, 461 F. Supp. 2d at 1270.

47. *See, e.g., Colomar v. Mercy Hosp., Inc. (Colomar IV)*, No. 05-22409, 2007 WL 2083562, at *5 (S.D. Fla. July 20, 2007).

48. *See Hall & Schneider, supra* note 18, at 687 (citing testimony that health economist Gerard Anderson gave to Congress).

49. *See id.*

50. *Colomar II*, 461 F. Supp. 2d at 1272.

51. *Id.* For example, data based on standard charges reported by California hospitals being forced to make their charge masters public illustrates standard charges do vary greatly among hospitals. *See Lucette Lagnado, Medical Markup: California Hospitals Open Books, Showing Huge Price Differences; State Law Requires Disclosing Charges for Goods, Servic-*

b. *Differential Pricing*

The next factor, price differentials, takes into account discounts that the hospitals will give to other patients that are covered by private insurance or government programs.⁵² Florida courts have held that differential pricing by itself is not sufficient to establish that prices are unreasonable.⁵³ This implies, however, that differential pricing, although not dispositive, is an important factor in determining whether or not prices for medical services are reasonable.⁵⁴ Evidence of differential pricing can be used to support the case that the hospital's costs, as well as the fair market value of the services are well below the hospital's standard charges.⁵⁵ A hospital is unlikely to contract with private insurers to accept payments that are below its actual cost of providing those services.⁵⁶ Although not binding, some courts from other jurisdictions have held that the reasonable value should be determined based on what the service provider normally accepts as full payment for the service and not what the provider charges.⁵⁷ This is especially true with respect to hospital billing where, according to one expert witness, some hospitals receive their "full published charges in only one to three percent of [their] cases."⁵⁸ Evidence of differential pricing, therefore, can strongly support a patient's case that the billed charges are unreasonable.⁵⁹

es; Big Bills for Uninsured; Why a Leech Retail for \$81, WALL ST. J., Dec. 27, 2004, at A1 (showing that in one case a simple blood test which costs \$97 at one hospital costs \$1733 at another). Thus, even if overall the standard rates are in line with others in the community, there is a chance that at least some of the charges will be out of proportion. *See id.*

52. *Colomar II*, 461 F. Supp. 2d at 1271–72 (citing *Payne v. Humana Hosp.*, 661 So. 2d 1239, 1242 (Fla. 1st Dist. Ct. App. 1995) (per curiam)).

53. *Hillsborough County Hosp. Auth. v. Fernandez*, 664 So. 2d 1071, 1072 (Fla. 2d Dist. Ct. App. 1995).

54. *See id.* (holding that the fact that evidence of "contractual discounts, standing alone, is insufficient to prove that" the hospital's charges were unreasonable, implies that combining the evidence of these discounts with other evidence could be sufficient).

55. *Colomar II*, 461 F. Supp. 2d at 1271–72.

56. *See id.* at 1272.

57. *Temple Univ. Hosp., Inc. v. Healthcare Mgmt. Alternatives, Inc.*, 832 A.2d 501, 510 (Pa. Super. Ct. 2003). "Reasonable value is what someone normally receives for a given service in the ordinary course of its business from the community that it serves." *Id.* (citing *Eagle v. Snyder*, 604 A.2d 253, 254 (Pa. Super. Ct. 1992)).

58. *Id.* at 508. The same expert witness also testified that the same hospital receives "eighty percent or less" of its published charges in ninety-four percent of its cases. *Id.*

59. *See id.*

c. *Costs*

The other major factor that the trier of fact will need to evaluate to determine if a hospital's charges for particular services are reasonable is the actual cost to the hospital for providing those services.⁶⁰ This factor is designed to take into consideration a hospital's internal costs for providing particular services—evidence of higher costs when compared to other hospitals could explain why that hospital's standard charges are higher.⁶¹ Thus, the higher than market price rates might be reasonable when considering these internal costs.⁶² As with the other factors, actual cost alone is not dispositive; therefore, a showing of a high markup from the hospital's actual costs will not by itself prove that the standard rates are unreasonable.⁶³ Thus, a hospital with lower costs, but similar prices to area hospitals, will not be penalized for its efficiency.⁶⁴ Nevertheless, this factor might not be highly probative because there is little correlation between hospitals' standard prices and their internal costs.⁶⁵

A hospital's internal costs will be the most difficult factor for the patient to prove since almost all of the facts regarding costs are within the hospital's control.⁶⁶ A court might be willing to look at overall hospital statistics—i.e., the hospital's overall ratio of its charges to costs—for the purpose of stating a claim.⁶⁷ After discovery, however, the patient will have to prove that the charges for the particular services in question greatly exceeded the hospital's costs for those services.⁶⁸ An additional problem with analyzing costs is that a hospital might be able to show that the cost of treating an uninsured patient is not the same as treating one that is either insured or covered by a government program where the hospital has more assurance that a portion of the bill

60. *Colomar II*, 461 F. Supp. 2d at 1272.

61. *Id.*

62. *Id.*

63. *See id.*

64. *Id.*

65. *See Anderson, supra* note 7, at 782–83.

66. *See Colomar II*, 461 F. Supp. 2d at 1272.

67. *See id.*

68. *See, e.g., Colomar IV*, No. 05-22409, 2007 WL 2083562, at *5 (S.D. Fla. July 20, 2007) (explaining that where the court, in determining whether or not there was sufficient evidence for a reasonable juror to infer that the hospital's charges were unreasonable, indicated that it expected the plaintiff/patient to have provided evidence of the hospital's actual cost for providing the specific services to that patient and that such an inference could not be made based solely on the hospital's overall ratio of its charges to costs for a general category of care).

will be paid.⁶⁹ Furthermore, the hospital could argue that the contracts with some private insurance companies generate volume and that this additional revenue would have to be reduced from the costs of providing service to patients covered by such contracts.⁷⁰

Even if the patient is able to produce sufficient evidence from which a reasonable jury could infer that the billed charges are unreasonable, the trier of fact will still have to make a determination of what a reasonable charge should be.⁷¹ Some courts and commentators have suggested that a reasonable rate should be based on the hospital's own collection data and should be the average amount that the hospital has actually received and accepted from government payers, contracted private insurers, and non-contracted private insurers.⁷² Because the rates paid by government agencies are fixed by statute and are not the result of any bargaining with the hospital, some have suggested that the reasonable price an uninsured should be required to pay should be based only on what the hospital collects from private insurers.⁷³ Rather than setting the reasonable rate as the average of what a provider has accepted from private insurers, the reasonable rate could be set at either the maximum or seventy-fifth percentile.⁷⁴ This would put the hospital in better position than with most private insurers.⁷⁵ In Florida, the court might also look to what the provider of emergency service has accepted as usual and customary charges from HMOs with which the hospital has no contract for services provided to those HMOs' members.⁷⁶ This situation is analogous to

69. *Galvan v. Nw. Mem. Hosp.*, 888 N.E.2d 529, 538–39 (Ill. App. Ct. 2008) (holding that it was not an unfair trade practice to charge uninsured patients twice what insured patients were charged because the patients were not similarly situated.)

Underlying the plaintiff's claim that charging uninsured patients a higher price amounts to oppressive pricing is a suggestion that the insured and uninsured patients are similarly situated. They are not. The plaintiff ignores the obvious difference between an insured patient and one uninsured. An insured patient by definition has medical insurance In return for the insurance premiums, his insurance company contracts with a hospital for medical services at a reduced rate. The contract benefits the hospital because payment is guaranteed. There is no such guarantee from uninsured patients.

Id.

70. *See id.* at 539.

71. *See, e.g., Colomar IV*, 2007 WL 2083562, at *6.

72. *See Nation, supra* note 3, at 135–36 (suggesting that “[a]n uninsured patient should [only] be required to pay the average amount [that] the hospital actually [collected] and accept[ed]” from governmental agencies and private insurers).

73. *Id.* at 104.

74. *See Maldonado v. Ochsner Clinic Found.*, (*Maldonado II*) 493 F.3d 521, 526 n. 10 (5th Cir. 2007).

75. *See id.*

76. *See generally* Batchis, *supra* note 40, at 525.

the uninsured patient since there is no benefit provided by the HMO of referrals as is the case with contracted private insurers.⁷⁷

B. *Violation of the Florida Unfair and Deceptive Practice Act*

An uninsured patient that has been charged an unreasonable amount for emergency room services might also have a statutory cause of action based on the Florida Deceptive and Unfair Trade Practice Act (FDUTPA).⁷⁸ One of the primary purposes of this act is “[t]o protect the consuming public and legitimate business enterprises from those who engage in unfair methods of competition, or unconscionable, deceptive, or unfair acts or practices in the conduct of any trade or commerce.”⁷⁹ The act specifically prohibits “[u]nfair methods of competition, unconscionable acts or practices, and unfair or deceptive acts or practices in the conduct of any trade or commerce.”⁸⁰ The act also provides for individual remedies that include a declaratory judgment that a particular act or practice violates FDUTPA and injunctive relief to stop such violations or prevent them in the future.⁸¹ While the Florida Legislature never defined “deceptive” or “unfair,” the Supreme Court of Florida in *PNR, Inc. v. Beacon Property Management, Inc.*⁸² has affirmed the definition of an unfair practice or act as “one that ‘offends established public policy’ and one that is ‘immoral, unethical, oppressive, unscrupulous or substantially injurious to consumers.’”⁸³ The Court has approved the definition of a deceptive act to be one where there is a “‘representation, omission, or practice that is

77. *See id.*

78. *See* FLA. STAT. §§ 501.201–.213 (2008).

79. *Id.* § 501.202(2).

80. *Id.* § 501.204(1).

81. *Id.* § 501.211(1).

82. 842 So. 2d 773 (Fla. 2003).

83. *Id.* at 777 (quoting *Samuels v. King Motor Co.*, 782 So. 2d 489, 499 (Fla. 4th Dist. Ct. App. 2001)). Section 501.203(3)(b), *Florida Statutes*, states that in determining violations of the Act, courts should use “[t]he standards of unfairness and deception set forth and interpreted by the Federal Trade Commission [(FTC)] or the federal courts.” FLA. STAT. § 501.203(3)(b). Thus, although this definition of unfair and deceptive acts is currently used by many Florida courts, the definition could be challenged because it differs from the FTC’s definition of unfair acts or practices. *See* David J. Federbush, *The Unexplored Territory of Unfairness in Florida’s Deceptive and Unfair Trade Practices Act*, 73 FLA. B.J. 26, 30 (May 1999). The current FTC definition of an unfair act or practice is an act or practice which “causes or is likely to cause substantial injury to consumers which is not reasonably avoidable by consumers themselves and not outweighed by countervailing benefits to consumers or to competition.” 15 U.S.C. § 45(n) (2008). Public policy considerations can now serve as evidence of an unfair practice but cannot be the primary basis for considering an act or practice to be unfair. *Id.*

likely to mislead the consumer acting reasonably in the circumstances, to the consumer's detriment.'"⁸⁴

Although there are no appellate decisions affirming that emergency service providers may be violating FDUTPA by charging unreasonable amounts, there is sufficient case law to suggest that such billing practices, if proven, would violate the act.⁸⁵ First, in *PNR*, the Supreme Court of Florida held that even a single breach of contract can result in a claim under FDUTPA if the action which led to the breach of contract would also be deemed "an unfair or deceptive act" or practice under prevailing case law.⁸⁶ Furthermore, although some states exclude members of the medical profession from their deceptive and unfair trade practices acts,⁸⁷ Florida law does not have any such exclusion.⁸⁸ Finally, there are no state or federal laws that might grant an exemption from FDUTPA to hospitals and authorize them to charge unreasonable rates to uninsured patients.⁸⁹

One main reason that pursuing a FDUTPA claim is so important for the uninsured patient is that the statute permits the court to award attorney's fees to the prevailing party.⁹⁰ The recovery of attorney's fees can be especially important in claims of unreasonable charges for emergency services for two reasons. First, the uninsured party is unlikely to have the financial resources to hire a lawyer regardless of whether the party is the plaintiff seeking decla-

84. *PNR, Inc.*, 842 So. 2d at 777 (quoting Millennium Commc'ns & Fulfillment, Inc. v. Office of the Att'y Gen., 761 So. 2d 1256, 1263 (Fla. 3d Dist. Ct. App. 2000)).

85. See generally, *Colomar v. Mercy Hosp., Inc. (Colomar I)*, No. 05-22409, 2006 U.S. Dist. LEXIS 95834, at *21-22 (S.D. Fla. Mar. 2, 2006).

86. *PNR, Inc.*, 842 So. 2d at 777 & n.2.

87. See, e.g., *Shelton v. Duke Univ. Health Sys.*, 633 S.E.2d 113, 117 (N.C. Ct. App. 2006) (citing *Gaunt v. Pittaway*, 534 S.E.2d 660, 664 (N.C. Ct. App. 2000)) (stating that North Carolina's unfair and deceptive trade practices statute specifically excluded "acts committed by medical professionals"); *DiCarlo v. St. Mary's Hosp.*, No. 05-1665, 2006 WL 2038498, at *8 (D.N.J. July 19, 2006) (stating that medical "professionals are not covered by the Consumer Fraud Act").

88. See Michael Flynn, *Consumer Protection Law: Physician Deceptive and Unfair Business Practices*, 71 FLA. B.J. 49, 50 (July 1997).

89. See *Colomar I*, 2006 U.S. Dist. LEXIS 95834 at *17. Section 501.212(1), *Florida Statutes*, states that "[a]n act or practice required or specifically permitted by federal or state law" is exempt from FDUTPA. FLA. STAT. § 501.212(1) (2008). Nevertheless, the court in *Colomar I* did not find that statutes which permitted the defendants to offer discounts to private insurers, nor statutes that required them to produce an itemized bill on request specifically authorized the defendants to charge unreasonable rates to uninsured patients. *Colomar I*, 2006 U.S. Dist. LEXIS 95834 at *17.

90. See FLA. STAT. § 501.2105(1) (2008) ("In any civil litigation resulting from an act or practice involving a violation of this part, . . . the prevailing party, after judgment in the trial court and exhaustion of all appeals, if any, may receive his or her reasonable attorney's fees and costs from the nonprevailing party.").

ratory judgment or a defendant in a collection suit.⁹¹ Second, without the recovery of attorney's fees, many claims against emergency service providers would be "negative-value suits" where the cost of attorney's fees exceeds the total expected recovery from the claim.⁹²

Those pursuing causes of action, under FDUTPA, however, have to be careful because the explicit language of the statute allows the court to award attorney's fees to the prevailing party.⁹³ The statute's award of attorney's fees was even riskier prior to a 1994 amendment when the "award of reasonable attorney's fees to the prevailing party" was mandatory and not left to the discretion of the court.⁹⁴ A recent decision by the Fourth District Court of Appeal rejected the notion that the trial court judge could only award attorney's fees to the prevailing defendant in a FDUTPA claim if the plaintiff's claim was "frivolous, unreasonable, or without foundation."⁹⁵ The court indicated that the statute clearly left the award of attorney's fees to the discretion of the trial judge.⁹⁶ The trial judge's decision to award attorney's fees to the prevailing defendant might have been influenced by the fact that both parties were charity organizations.⁹⁷ Unfortunately, another recent decision to award attorney's fees, which was also upheld by the same district court, suggests that trial judges are likely to award attorney's fees in contract dis-

91. See *Colomar v. Mercy Hosp., Inc. (Colomar III)*, 242 F.R.D. 671, 682 (S.D. Fla. 2007) (indicating that class action is not superior because plaintiffs could recover attorney's fees under FDUTPA). An uninsured patient is most likely going to be from a household "with less than \$25,000" where at least one person does work full time. 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, 193 (2007).

92. See J. Maria Glover, Note, *Beyond Unconscionability: Class Action Waivers and Mandatory Arbitration Agreements*, 59 VAND. L. REV. 1735, 1737 (2006) (addressing how class action waiver agreements can be unconscionable because they essentially remove one's right to recovery in cases where the cost of pursuing a claim will exceed the expected recovery for that claim).

93. FLA. STAT. § 501.2105(1).

94. See David J. Federbush, *Entitlement to Attorneys' Fees Under FDUTPA*, 78 FLA. B.J. 26, 26 (Jan. 2004) [hereinafter Federbush, *Attorneys' Fees*].

95. *Humane Soc'y of Broward County, Inc. v. Fla. Humane Soc'y*, 951 So. 2d 966, 968 (Fla. 4th Dist. Ct. App. 2007). Prior to this ruling, Mr. Federbush had theorized that the trial courts would likely only award attorney's fees to the prevailing defendant if the plaintiff's claims were frivolous because the courts would follow the Supreme Court of Florida's precedent for other public policy cases such as discrimination cases. Federbush, *Attorneys' Fees*, *supra* note 94, at 29. The plaintiff in *Humane Society* tried to apply Mr. Federbush's exact arguments as to why attorney's fees should not be granted, but the court disagreed. *Humane Soc'y*, 951 So. 2d at 968.

96. *Id.*

97. See *id.* (acknowledging in a motion for fees and costs that "both groups are doing good work and ultimately donations are going to be used to pay attorney's fees, whichever way it goes").

putes where the court believes the party adding the FDUTPA claim has only increased the risk for both parties by adding the extra claim.⁹⁸ In theory, this means that if the uninsured patient were to lose, not only would he or she be liable for the full hospital bill and his or her attorney's fees, but he or she could also be liable for the hospital's legal fees as well.⁹⁹

III. ISSUES WITH CLASS CERTIFICATION

A key for uninsured patients to succeed in using litigation as a means of redressing their overcharges by emergency service providers is class certification.¹⁰⁰ Class certification is important because the uninsured face two major obstacles in pursuing litigation.¹⁰¹ First, uninsured people are likely to lack the financial resources to contest the hospital's charges in court.¹⁰² Second, even if the uninsured people do have the financial resources, the cost of litigation might far exceed any gain they hope to achieve—either a reduction in their debt obligation to the hospital or a return of overcharges they have already paid.¹⁰³ If, however, the uninsured can certify themselves as a class against a particular provider, then they have a much better chance of success as the cost of the legal fees will be distributed amongst the class and the risk for the provider will be greatly increased.¹⁰⁴ In fact, in many cases, once courts granted class certification, hospitals sought prompt settlement.¹⁰⁵ Although there was some initial success with class certification,¹⁰⁶ the current trend in both Florida and federal courts seems to be that class certification for the uninsured, with respect to the rates they have been charged for emergency services, is not appropriate.¹⁰⁷

If the uninsured do certify a class, either the uninsured themselves or the defending service providers could remove the case to a federal court un-

98. See *Mandel v. Decorator's Mart, Inc.*, 965 So. 2d 311, 313 n.1 (Fla. 4th Dist. Ct. App. 2007) (noting that it was “not uncommon for litigants to inject claims of . . . deceptive . . . practices into a contractual dispute” and that the tactic was rarely successful).

99. See *id.*

100. See *Anderson*, *supra* note 7, at 787 (indicating that hospitals were usually quick to settle once class certification was granted).

101. See *McGrath*, *supra* note 91, at 193.

102. See *id.* (explaining that an uninsured person is more likely to have an income of less than \$25,000, with at least one family member working full time).

103. See *Glover*, *supra* note 92, at 1737 (discussing how class action waivers can prevent potential plaintiffs from ever bringing suits).

104. See *generally id.*

105. *Anderson*, *supra* note 7, at 787.

106. *Cohen*, *supra* note 1, 143–45.

107. See, e.g., *Maldonado II*, 493 F.3d 521, 526 (5th Cir. 2007).

der the Class Action Fairness Act of 2005.¹⁰⁸ According to this Act, the federal courts will have original subject matter jurisdiction if the amount in controversy exceeds five million dollars, the class action has over one hundred members, and there is minimal diversity.¹⁰⁹ Minimal diversity is established when “any member of a class of plaintiffs is a citizen of a State different from any defendant.”¹¹⁰ Although the federal court must decline jurisdiction if two-thirds of the class and the primary defendants are both citizens of Florida, many class actions, especially against for-profit hospitals, will satisfy these requirements.¹¹¹

A. *Numerosity, Commonality, Typicality, and Adequacy Factors*

Whether the case is tried in federal or state court will have little bearing on whether the class can be certified because the *Florida* and *Federal Rules of Civil Procedure* requirements for class certification are almost identical.¹¹² Under the *Federal Rules of Civil Procedure*:

One or more members of a class may sue or be sued as representative parties on behalf of all members only if: 1) the class is so numerous that joinder of all members is impracticable [(numerosity)]; 2) there are questions of law or fact common to the class [(commonality)]; 3) the claims or defenses of the representative parties are typical of the claims or defenses of the class [(typicality)]; and 4) the representative parties will fairly and adequately protect the interests of the class [(adequacy)].¹¹³

These requirements are generally referred to as the “numerosity, commonality, typicality, and adequacy factors.”¹¹⁴

To satisfy the numerosity requirement, the party seeking to certify the class must be able to prove with reasonable certainty that the class size will be so large that joinder of individual members would be impracticable.¹¹⁵ While it might be easy for an uninsured person trying to certify a class to

108. See 28 U.S.C. § 1332(d) (2006).

109. *Id.* § 1332(d)(2).

110. *Id.* § 1332(d)(2)(A).

111. See *id.* § 1332(d)(4)(A)(i)(I).

112. Compare FED. R. CIV. P. 23, with FLA. R. CIV. P. 1.220.

113. FED. R. CIV. P. 23(a).

114. *Colomar III*, 242 F.R.D. 671, 674 n.3 (S.D. Fla. 2007). Satisfying the adequacy factor for purposes of establishing a class action is not a problem that is unique to patients contesting the reasonableness of charges for emergency medical services and is beyond the scope of this article. See *id.* at 677–80.

115. FED. R. CIV. P. 23(a)(1).

determine how many uninsured patients received treatment from the same hospital, this information alone is not sufficient.¹¹⁶ The patient will probably also have to show that a certain percentage of those patients, like themselves, are still obligated to pay an unreasonable sum or have already paid an unreasonable amount.¹¹⁷ Since many of the uninsured that were treated at hospitals may have already been offered discounts or had their bills subsequently paid by a government program such as Medicaid, the absolute number of uninsured patients that were treated would be insufficient.¹¹⁸ This problem can be overcome; however, it might require significant expenditure just to reasonably identify the class prior to filing suit.¹¹⁹

To satisfy the requirement of commonality, the party seeking class certification only needs to show that there is at least one “common question of law or fact” as long as that single common question “affects all class members” the same way.¹²⁰ The courts in the Eleventh Circuit and in Florida do not require much to prove commonality.¹²¹ Nevertheless, uninsured people trying to show that the hospital charged them an unreasonable amount may have a difficult time showing commonality, unless they can establish that the hospital intentionally raised prices for uninsured patients.¹²² Without evidence of a common pricing scheme, and considering that some hospitals’ charge master lists comprise of tens of thousands of items, the only common question would be whether or not the hospital was obligated to charge a reasonable amount.¹²³ The defendant hospital could concede that the pricing term is open and at the same time argue that the prices on its charge master list are reasonable.¹²⁴ Thus, proving commonality could be difficult if the hospital wants to avoid class status.¹²⁵

Even if the uninsured parties could establish commonality, typicality is even more difficult to prove.¹²⁶ In order to satisfy the typicality requirement, the representative plaintiff must be able to prove the claims of other class members in proving his or her own claim.¹²⁷ Thus, typicality is usually es-

116. See *Colomar III*, 242 F.R.D. at 675–76.

117. See *id.*

118. *Id.* at 676.

119. See generally *id.*

120. *Id.*

121. See *Colomar III*, 242 F.R.D. at 676 (“The threshold for commonality is not high.”) (quoting *Cheney v. Cyberguard Corp.*, 213 F.R.D. 484, 490 (S.D. Fla. 2003)).

122. See *id.* at 680.

123. See *id.*

124. See *id.* at 680.

125. *Id.* at 676–77.

126. See *Colomar III*, 242 F.R.D. at 677.

127. *Id.*

tablished when the elements required to prove the representative's claims are the same elements required to prove the claims of the entire class.¹²⁸ Courts across the country seem unwilling to find that, in general, all of a hospital's charges are unreasonable or even to define a reasonable charge as a percentage of some government established rate—such as Medicare reimbursement rates.¹²⁹ Thus, courts will require that the uninsured prove that each charge itself is unreasonable.¹³⁰ Regardless of how this is measured, a representative member that proves his or her charges were unreasonable, would only establish that other patients charged the same amount for the same services during the same time period were also charged unreasonable amounts.¹³¹ A party seeking to certify a class could try to convince the court that a reasonable rate should be calculated based on the range of fees the hospital actually accepts for those charges.¹³² If the court agrees to this definition of reasonableness, the plaintiff might be able to establish typicality as the same source of hospital records could be used to prove the claims of other class members.¹³³

B. *Predominance and Superiority*

Even if the court were to accept that the representative member could establish typicality, in order to certify a class for monetary damages, the representative would still have to show that “the questions of law or fact common to class members predominate over any questions affecting only individual members” (predominance).¹³⁴ To establish predominance, the issues that are common to proving the claims of the class as a whole must predominate over issues that only need to be proven for individual claims.¹³⁵ If after all of the issues which are common to the entire class have been adjudicated, class members must still introduce a great deal of proof specific to individual claims, then the claim does not satisfy the predominance requirement.¹³⁶ Whereas in Florida, courts cannot establish unreasonableness based solely on price differentials and discounts offered to insured patients, the courts are

128. *Id.*

129. *See, e.g., Maldonado II*, 493 F.3d 521, 526 (5th Cir. 2007).

130. *See id.* at 525–26.

131. *Colomar III*, 242 F.R.D. at 677.

132. *See Maldonado II*, 493 F.3d at 526 n.10 (rejecting the proposal that a reasonable rate could be established as a weighted average of amounts the hospitals receive from insurers and government programs saying that “[u]nder this approach, contrary to common sense, approximately half of the insurers would have negotiated an ‘unreasonable’ rate”).

133. *See id.*

134. *See* FED. R. CIV. P. 23(b)(3).

135. *Colomar III*, 242 F.R.D. at 680.

136. *Id.*

unlikely to find that predominance is satisfied.¹³⁷ Each member of the class will have to prove that his or her individual charges are unreasonable.¹³⁸

In addition to proving predominance, the party seeking class certification for money damages must also show “that a class action is superior to other available methods” for the fair and efficient adjudication of the controversy.¹³⁹ The main factor that works against class action being a superior method to resolve the claims of hospital overcharging uninsured patients is the difficulty the court might encounter trying to manage all of the claims.¹⁴⁰ Since each class member will have been billed for different services and at different times, each additional member will add to the amount of evidence the court needs to manage.¹⁴¹ Those uninsured people who seek to certify the class are likely to claim that without class certification they lack the financial resources to seek a remedy for their injury.¹⁴² However, federal courts have determined that where there is a statutory basis for recovering attorney’s fees, class action is not superior to other methods of adjudication.¹⁴³ Thus, if plaintiffs include the FDUTPA claim in their complaint, they may actually hurt their chances of class certification based on superiority alone.¹⁴⁴

C. *Injunctive Relief*

If the plaintiffs seeking to certify the class seek injunctive relief, then in addition to the first four requirements, they must show that the medical service provider has acted on “grounds that apply generally to the class, so that final injunctive relief or corresponding declaratory relief is appropriate respecting the class as a whole.”¹⁴⁵ This type of injunctive class relief is generally applicable when a defendant has charged all of its customers an undifferentiated fee.¹⁴⁶ Thus, plaintiffs seeking to certify a class for injunctive relief would need to show that the service providers had some generally applicable system such as “systematically raising prices for uninsured patients by a set percentage.”¹⁴⁷ Furthermore, based on the Florida definition of reasonable

137. See *Maldonado II*, 493 F.3d at 525–26.

138. See *id.*

139. FED. R. CIV. P. 23(b)(3).

140. *Colomar III*, 242 F.R.D. at 682.

141. See *id.*

142. See *id.*

143. *Id.*

144. See *id.* at 680.

145. FED. R. CIV. P. 23(b)(2).

146. See *Colomar III*, 242 F.R.D. at 683.

147. *Id.* (quoting *Maldonado v. Ochsner (Maldonado I)*, 237 F.R.D. 145, 151 (E.D. La. 2006)).

charges, a court could not impose injunctive or class-wide relief across the whole class because an order requiring a service provider to stop “overcharging” uninsured patients would lack the specificity required for injunctive relief.¹⁴⁸ In fact, many courts see the request for injunctive relief in these types of cases as a violation of the separation of powers by asking the court to legislate.¹⁴⁹

D. *Florida’s Specific Class Certification Issues*

Plaintiffs filing their claims in Florida state courts rather than federal courts must comply with the same class certification requirements.¹⁵⁰ Moreover, the Florida courts require evidentiary support before granting class certification if the nonmoving party objects to the certification.¹⁵¹ Thus, the court cannot simply rely on the pleadings when one party objects to certification and must actually have an evidentiary hearing to determine if certification is appropriate.¹⁵² Florida law allows for an interlocutory appeal of class certification.¹⁵³ The court may find that the “trial court abused its discretion” if the class determination was made without the evidentiary hearing.¹⁵⁴ This provides an obstacle to class certification in state courts because the plaintiffs

148. *Id.*

149. *See* Howard v. Willis-Knighton Med. Ctr., 924 So. 2d 1245, 1259 (La. Ct. App. 2006) (concluding that plaintiffs’ request for the court to “establish what constitutes reasonable prices” for medical services was “a novel and untested theory” . . . [and] not appropriate for class certification”); Kolari v. N.Y.-Presbyterian Hosp., 382 F. Supp. 2d 562, 565–66 (S.D.N.Y. 2005) (“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 by the legislative branch.”).

If the Court were to issue an injunction against [the hospital] to prevent it from charging “unreasonable” prices, the court would also have to determine what prices were “reasonable” for not only [plaintiff’s] procedure, but every other hospital procedure. This goes against constitutional Article III considerations of justiciability and separation of powers. . . . Medical regulation issues have typically been resolved by the legislative process. . . . It is not within the scope of judicial powers to decide medical billing procedures and pricing, and the Court may not issue an advisory opinion in this regard.

Urquhart v. Manatee Mem’l Hosp., No. 8:06-cv-1418-T-17-EAJ, 2007 U.S. Dist. LEXIS 48867, at *11–12 (M.D. Fla. July 6, 2007).

150. *See* FLA. R. CIV. P. 1.220(a).

151. Fla. Health Scis. Ctr., Inc. v. Elsenheimer, 952 So. 2d 575, 581 (Fla. 2d Dist. Ct. App. 2007).

152. *Id.*

153. *See, e.g., id.* at 582 (where Second District Court of Appeal reverses a trial court’s grant of class certification even though there had been no final adjudication in the case).

154. *Id.*

seeking class certification will need to show that a sufficient number of the class was overcharged for medical services.¹⁵⁵

IV. CASE STUDY: *COLOMAR V. MERCY HOSPITAL, INC.*

Barbara Colomar, who at the time did not have medical insurance and did not qualify for any governmental assistance, went to Mercy Hospital in Miami, Florida, because she was having trouble breathing after exposure to pesticides in her house.¹⁵⁶ Prior to receiving any treatment at the hospital, Colomar signed an “Authorization and Guarantee” form in which she agreed to “pay any and all unpaid bills . . . which are not covered by insurance or otherwise paid.”¹⁵⁷ The authorization form did not indicate what treatment she would receive or how much she would be charged.¹⁵⁸ Colomar’s treatment at the hospital for her respiratory problems lasted approximately twenty-six hours.¹⁵⁹ Colomar later received a bill from the hospital for \$12,863.¹⁶⁰ She paid \$1750 of this bill and the hospital sent the remaining balance to collections.¹⁶¹

After Mercy Hospital allegedly threatened to damage Colomar’s credit if she did not pay the bill in full, Colomar filed suit on behalf of herself and other uninsured patients who had received treatment at Mercy Hospital.¹⁶² Colomar did not allege any problems with the care that she received at Mercy, but rather alleged that Mercy Hospital had breached its contract with her by charging her an unreasonable amount and that Mercy had violated FDUTPA with its unfair billing practices.¹⁶³ The case was removed to feder-

155. *See id.* Florida has allowed class certification for physicians that are contesting the reimbursement they have received from HMOs with which they had no contract for emergency services they provided to the HMOs’ members. *See Merkle v. Health Options, Inc.*, 940 So. 2d 1190, 1200 (Fla. 4th Dist. Ct. App. 2006). Those claims are based on a Florida statute that requires the HMOs to reimburse them at the reasonable and customary rate. *Id.* at 1196. The court will face the same challenges in determining the usual and customary rates in those cases as it will when determining reasonable rates for the uninsured and managing the physicians as a single class. *See id.*

156. *Colomar I*, No. 05-22409, 2006 U.S. Dist. LEXIS 95834, at *5 (S.D. Fla. Mar. 2, 2006).

157. *Id.* at *6.

158. *Colomar III*, 242 F.R.D. 671, 674 (S.D. Fla. 2007).

159. *Colomar I*, No. 05-22409, 2006 U.S. Dist. LEXIS 95834, at *5.

160. *Id.*

161. *Id.* at *5.

162. *Id.* at *2–3, 5; *Colomar III*, 242 F.R.D. at 673.

163. *Colomar I*, 2006 U.S. Dist. LEXIS 95834, at *6. In her first amended complaint, Colomar had also alleged that the hospital had been unjustly enriched and had violated its duty of good faith and fair dealing. *Id.* at n.3. The court dismissed these two charges along with a claim alleging that Mercy violated FUDPTA via deceptive practices that would lead the ordi-

al court under the Class Action Fairness Act of 2005, which gave the federal court original jurisdiction over certain class action cases with at least minimal diversity.¹⁶⁴

A. *The Good: Cause of Action Exists*

In denying Mercy's motion to dismiss Colomar's second amended complaint, the court acknowledged that a cause of action does exist in Florida for uninsured patients that claim to have been charged unreasonable amounts by hospitals.¹⁶⁵ In her second amended complaint, Colomar alleged that although she was charged \$12,863, the hospital's internal costs for the services she received were only \$2,098.¹⁶⁶ She also alleged that Mercy, on average, charges uninsured patients four times the Medicare reimbursement rates.¹⁶⁷ Furthermore, she alleged that hospitals owned by Mercy's parent corporation ranked "among the top 13% of all hospitals nationwide in charges" and "in the top 10% of hospitals nationwide in terms of cost-to-charge ratio"—charging uninsured patients, on average, four times the actual costs.¹⁶⁸

The court agreed that because the contracts with uninsured patients had open pricing terms, Mercy was obligated to charge Colomar and other uninsured patients that signed similar agreements reasonable amounts.¹⁶⁹ The court held that under Florida law, the court had to analyze several nonexclusive factors to determine if the charges were reasonable.¹⁷⁰ First, the court examined the overall market for hospital services to determine if Mercy's charges were within the range of what other hospitals in the community would charge for similar services.¹⁷¹ Because the court was only analyzing the sufficiency of the complaint, the court was willing to infer from the alleged facts that Mercy's charges were more than what most hospitals charged for the same services.¹⁷² The court noted that if Mercy's charges were not in the top twenty-fifth percentile, then the court would most likely have inferred

nary uninsured patient to believe he or she would be charged at a discounted rate. *Id.* at *16, *22.

164. *Id.* at *4.

165. *See Colomar II*, 461 F. Supp. 2d 1265, 1274 (S.D. Fla. 2006).

166. *Id.* at 1268.

167. *Id.*

168. *Id.*

169. *Id.*

170. *Colomar II*, 461 F. Supp. 2d. at 1269.

171. *Id.*

172. *Id.* at 1270.

that the charges were similar to other similarly situated hospitals.¹⁷³ Even if this were the case, however, the court could still hold that the charges were unreasonable based on other factors.¹⁷⁴

The second factor the court looked at was the price the hospital charged other patients for the same services.¹⁷⁵ The fact that the hospital will accept much lower payments from other patients implies that the actual value of the services may be less than what the hospital charges.¹⁷⁶ In this case, Colomar had alleged that the hospital offered significant discounts to insured patients and those covered by government benefits.¹⁷⁷ The court held that proving this differential pricing along with other factors could support the allegation that the charges were unreasonable.¹⁷⁸

Finally, the court analyzed the hospital's actual costs to determine if the price was reasonable.¹⁷⁹ Colomar alleged in her complaint that the hospital had charged her more than six times the cost of treating her.¹⁸⁰ Accepting the allegations as true for the purpose of the motion to dismiss, the court held that it could not conclude as a matter of law that the charges were reasonable.¹⁸¹ The court then held that the complaint alleged sufficient facts to support a claim that Mercy's charges for the services it provided to Colomar were unreasonable.¹⁸² The court also held that the same facts were sufficient to support a claim that the hospital's billing methods constituted an unfair practice in violation of FUDPTA.¹⁸³ Furthermore, even though Colomar may not have suffered any monetary damages since she had not yet paid an unreasonable amount, the court held she was entitled to declaratory judgment to determine the amount she lawfully owed.¹⁸⁴

173. *Id.*

174. *Id.* at 1271.

175. *Colomar II*, 461 F. Supp. 2d. at 1271.

176. *Id.* at 1272.

177. *Id.*

178. *Id.*

179. *Id.*

180. *Colomar II*, 461 F. Supp. 2d. at 1273.

181. *Id.*

182. *Id.* at 1274.

183. *Id.*

184. *Id.* at 1273 (determining she had not yet suffered monetary damages because she had not yet paid what she alleged in her complaint the services actually cost the hospital to provide).

B. *The Bad: Case Not Suitable for Class Certification*

After her initial success, however, Colomar suffered a major setback when the court denied her motion for class certification.¹⁸⁵ The court first held that Colomar failed to prove that the class size was “so numerous that joinder of all members [was] impracticable.”¹⁸⁶ Although Colomar was able to identify “over 24,000 uninsured patients” that Mercy treated during the class period, Colomar was unable to show which of those patients had either paid the full bill or at least were never offered discounts or write-offs.¹⁸⁷ The court was unwilling to infer that a minimal number of these uninsured patients had either paid or were still liable for an unreasonable portion of their bills without further evidence from Colomar.¹⁸⁸ The court implied that Colomar would establish the requirement of numerosity if she could specifically identify forty such members.¹⁸⁹

Nevertheless, even if Colomar could prove that the class size was sufficient, the court would most likely still have denied class status because of the fact specific nature of proving that Mercy’s charges were unreasonable.¹⁹⁰ That is, each bill from each class member would have to be evaluated separately and compared with market conditions, internal costs, and other contractual prices to determine if each charge were unreasonable.¹⁹¹ Proving that Mercy’s charges to Colomar were unreasonable would not prove that charges to any other class member were unreasonable.¹⁹² Colomar requested that the court analyze Mercy’s average charges to all class members to determine the reasonableness of the charges.¹⁹³ The court refused this proposal indicating that averages would not prove that a particular charge was unreasonable.¹⁹⁴ Thus, the court held that Colomar’s claim failed to satisfy the requirements of commonality and typicality.¹⁹⁵ Although Colomar might have been able to show some question of law in common under commonality, it was unlikely that she could show that proving her claim would neces-

185. *Colomar v. Mercy Hosp., Inc. (Colomar III)*, 242 F.R.D. 671, 673 (S.D. Fla. 2007).

186. *Id.* at 675 (quoting Fed. R. Civ. P. 23(a)(1)).

187. *Id.*

188. *Id.* at 676.

189. *See id.* at 675–76.

190. *Colomar III*, 242 F.R.D. at 677 n.7 (indicating that although plaintiff might be able to plead sufficient facts to satisfy numerosity and commonality, this effort would prove futile because of inherent problems with proving the other factors).

191. *See id.* at 677.

192. *Id.*

193. *Id.* at 678.

194. *Id.*

195. *Colomar III*, 242 F.R.D. at 677–78.

sarily prove any other class member's claim.¹⁹⁶ The court also held that the difficulty in obtaining reasonableness of each particular charge to every patient prevented the case from meeting the requirements of class certification for money damages under Federal Rule of Civil Procedure 23(b)(3) or injunctive relief under Federal Rule of Civil Procedure 23(b)(2).¹⁹⁷ The main problem was that Colomar did not allege any facts showing that the hospital was raising its prices by a set percentage to uninsured patients.¹⁹⁸ The complaint was that the undiscounted prices the hospital charged were unreasonable.¹⁹⁹ Because each charge would have to be evaluated separately, the case would become extremely difficult to manage as a class, and therefore class action was not "superior to other available methods" for the fair and efficient adjudication of the controversy.²⁰⁰ Colomar had argued that without class action status, plaintiffs would be deterred from bringing suit due to a lack of financial resources to hire a lawyer.²⁰¹ The court's response was that the statutory claim under FDUTPA allowed recovery of legal fees so that class status was not superior in this case.²⁰²

C. *The Ugly: Insufficient Evidence to Prove Price Was Unreasonable*

Although failing to have her class certified was a major setback, Colomar's next setback was even greater when the court granted summary judgment to Mercy Hospital because Colomar had failed to produce enough evidence upon which a reasonable juror could conclude that Mercy's charges were unreasonable.²⁰³ The court emphasized that its holding did not indicate that the hospital's charges were reasonable, but that Colomar had not produced sufficient evidence to carry her burden.²⁰⁴

196. *Id.* at 677.

197. *Id.* at 681–83.

198. *Id.* at 683.

199. *Id.*

200. *Colomar III*, 242 F.R.D. at 681–82.

201. *Id.* at 682.

202. *Id.* (citing FLA. STAT. § 501.2105 (2008)).

203. *Colomar IV*, No. 05-22409, 2007 WL 2083562, at *7 (S.D. Fla. July 20, 2007).

204. *Id.* Colomar's failure to produce sufficient evidence might have been particular to her case rather than indicative of challenges that face other uninsured patients that believe they were charged unreasonable amounts. *Id.* For example, the undisputed facts showed that she was only charged 155% of the Medicare reimbursement rate rather than the 436% that she alleged Mercy on average charges uninsured patients. *Id.* at *5 & n.4. Colomar's own expert witness had testified that charges in the range of 150% of Medicare would be reasonable. *Id.* at *5. Furthermore, she did not introduce any evidence to show what Mercy's actual cost to treat her was even though she originally alleged that Mercy's cost was just over two thousand

V. LEGISLATIVE RESPONSE

A common theme among the courts across the country seems to be that resolving medical billing issues is a legislative function.²⁰⁵ While the courts are equipped to analyze individual cases to determine if prices are reasonable for a particular service on a particular date, the courts are not empowered to make more far reaching resolutions.²⁰⁶ This section will focus on the actions that the Florida Legislature has taken to address issues with the open-ended nature of medical service pricing in the absence of contractual agreements.

There are five major situations where patients are treated in the absence of contractual agreements that prevent hospitals from charging their standard rates.²⁰⁷ The five classes are the uninsured, those covered by insurance but going to a provider that has not contracted with the insurance company, patients seeking treatment after automobile accidents that are covered by car insurance Personal Injury Protection requirements, and patients seeking treatment for work related injuries that are covered by workers' compensation plans.²⁰⁸ Section 440.13, *Florida Statutes*, provides for a maximum fee schedule for cases where patients are being treated for ailments or injuries covered by workers compensation insurance.²⁰⁹ Just recently, the Florida Legislature imposed maximum reimbursement rates for most services that are covered by Personal Injury Protection policies for those that seek medical treatment related to an automobile accident.²¹⁰ For most non-emergency services, this maximum rate is set to 200% of the Medicare reimbursement rate.²¹¹ In the case of emergency services, the maximum reimbursement rate for hospitals is set to be "75 percent of the hospital's usual and customary charges," and for physicians' services provided in a hospital, the maximum reimbursement is set to be "the usual and customary charges in the community."²¹² According to the legislative history, this maximum reimbursement rate was added because determining "the amount of reasonable charges is

dollars. *Colomar IV*, 2007 WL 2083562 at *6. Finally, she relied on nationwide market data rather than comparing Mercy's prices to other local hospitals. *Id.* at *5.

205. See *Urquhart v. Manatee Mem'l Hosp.*, No. 8:06-cv-1418-T-17-EAJ, 2007 U.S. Dist. LEXIS 48867, at *11-12 (M.D. Fla. July 6, 2007); *Kolari v. N.Y.-Presbyterian Hosp.*, 382 F. Supp. 2d 562, 565-66 (S.D.N.Y. 2005); *Howard v. Willis-Knighton Med. Ctr.*, 924 So. 2d 1245, 1259 (La. 2d Ct. App. 2006).

206. See *Maldonado II*, 493 F.3d 521, 526 (5th Cir. 2007).

207. See *Anderson*, *supra* note 7, at 781.

208. *Id.*

209. FLA. STAT. § 440.13(12) (2008).

210. FLA. STAT. § 627.736(5)(a)2 (2008).

211. *Id.*

212. *Id.*

often litigated in Florida courts between providers and insurers which further increases costs.”²¹³ Only time will tell if these provisions will reduce the amount of litigation between the providers and insurers given the reference to usual and customary charges in the statute.²¹⁴

The Florida Legislature has also tried to address the issue of protecting the uninsured from being overcharged in several ways. In 2007, a bill was introduced that would have required hospitals to charge any uninsured patients with a “household income of less than \$125,000,” a fee no higher than the highest contracted fee the hospital has agreed to accept for the same service from private insurers.²¹⁵ The bill was never passed, perhaps because of concerns from lobbyists for health insurance companies that such a bill could discourage providers from negotiating with health insurance companies—since lowering rates with the insurance companies would also lower the maximum they could charge to some uninsured.²¹⁶

Although this bill to set a maximum that health care providers could charge to some uninsured patients failed, the Senate has passed two new laws in 2008 which may help in some situations. The Health Care Consumer’s Right to Information Act, among other provisions, requires health care providers to automatically provide estimates to uninsured patients for any scheduled non-emergency medical services and requires the providers to automatically inform the patients of any “discount or charity policies” that might be available from that provider.²¹⁷ The act also requires hospitals to disclose their standard charges for some of the most common services as well as other pertinent financial information that is to be made publicly available by the Agency for Health Care Administration.²¹⁸ While this act may help the uninsured shop for reasonable rates and pre-negotiate prices with the service providers for non-emergency services, the bill will probably do little to help in dealing with overcharging for emergency services. Actually, the bill could hurt the patient’s chances of proving the charges are unreasonable if they were readily available before the emergency situation arose.

Even though the Florida Legislature may believe that price transparency will help the uninsured make more informed decisions, the primary focus of

213. Fla. H.R. Comm. on Ins., HB 13C (2007) Staff Analysis 8 (Oct. 4, 2007), available at http://www.flsenate.gov/data/session/2007C/House/bills/analysis/pdf/h0013Cc_JEC.pdf.

214. See FLA. STAT. § 641.513(5)(b) (2008).

215. Fla. S. Comm. on Health Reg., SB 1756 (2007) Staff Analysis 1 (Mar. 17, 2007), available at http://www.flsenate.gov/data/session/2007/Senate/bills/analysis/pdf/2007s1756_hr.pdf.

216. *Id.* at 3.

217. Health Care Consumer’s Right to Information Act, ch. 2008–47, § 3, 2008 Fla. Laws 739, 740.

218. See *id.* at 739, 742–43.

the legislature for resolving this crisis is to reduce the number of uninsured Floridians.²¹⁹ A new law which passed in May, 2008, creates the Cover Florida Health Care Access Program.²²⁰ The program creates a special type of health insurance that does not have to meet the same level of minimum coverage as other health insurance programs.²²¹ The hope is that private insurance companies will be able to offer affordable health insurance plans, with premiums of only around \$150 a month, with this minimal coverage.²²² The plan has been criticized because the law allows for the insurance companies to cover so little as to make the plans undesirable.²²³ Nevertheless, as long as this minimal coverage at least guarantees contractual discounts similar to those which other insurance plans provide, the program could help to alleviate the issue of determining reasonable charges as there would be fewer forced to pay without pre-negotiated rates.

VI. CONCLUSION

Because Florida law requires that determination of a reasonable charge be based on multiple factors which require individual analysis of each charge, class certification will probably remain elusive for uninsured patients that seek declaratory or injunctive relief.²²⁴ Nevertheless, all is not lost. Case law shows that Florida courts will most likely consider the hospital admission contracts, especially in emergency care situations, to be open priced contracts and will therefore infer a reasonable price term.²²⁵ Although the cost of litigation may prevent potential plaintiffs from seeking declaratory relief to have the courts clarify how much is actually owed, the patients can use this as a defense if they are sued by the hospitals or physicians that provided the emergency services for the charged prices. Courts may even place a higher burden on hospitals to prove their costs are reasonable when they are the plaintiffs in the action. Furthermore, the uninsured debtor might even be able to use unconscionability as a defense in such actions. Finally, the uninsured patient can file a counterclaim for a violation of the FDUTPA. Since many of the hospital contracts require the patient to pay legal fees as-

219. See Act effective May 21, 2008, ch. 2008-032, § 3, 2008 Fla. Laws 677, 680 (codified at FLA. STAT. § 408.9091 (2008)).

220. *Id.*

221. *See id.*

222. See Bob LaMendola, *Uninsured? Don't Hold Your Breath for Coverage*, SUN SENT., May 10, 2008, at A1.

223. *See id.*

224. See *Colomar II*, 461 F. Supp. 2d 1265, 1269 (S.D. Fla. 2006).

225. See *Payne v. Humana Hosp. Orange Park*, 661 So. 2d 1239, 1241 (Fla. 1st Dist. Ct. App. 1995).

sociated with debt collection, the patients have little to lose should they not prevail on their claim of the FDUTPA violation. On the other hand, if the court finds that the charged prices are unreasonable, the court is unlikely to award legal fees to the hospital even if the court does not believe the hospital's actions are an unfair or unconscionable act as defined by the statute. The fact that the hospital is actually trying to enforce the full debt via the courts, however, may make the trier of fact more inclined to find that the billing practices are unfair.

Thus, the best strategy for uninsured patients that believe they have been charged unreasonable amounts and cannot reach a reasonable settlement with the hospital, is to pay a reasonable amount—perhaps paying what Medicare would reimburse since this information is readily available—and forcing the hospital to bring legal action to collect the rest. The patients will have the right to dispute any reports to collection agencies and the hospital or collection agencies cannot attach any liens or other means of payment without court orders. Alternatively, the uninsured patient might contact the office of the state attorney—the enforcing authority under FDUTPA—and persuade the office to bring a claim on the patient's behalf.²²⁶ Under FDUTPA, the enforcing authority can seek to impose a \$10,000 civil penalty for every violation in addition to the remedies available to individuals.²²⁷ Proving that one has tried to make a reasonable settlement agreement which the hospital has refused might be persuasive in convincing the state attorney to pursue the claim.

Thus, although the courts are probably not the appropriate means in Florida of changing the practice by preventing medical service providers from overcharging uninsured patients, the courts may offer some protection to individuals who have already been overcharged.

226. See FLA. STAT. § 501.207(1)(c) (2008).

227. FLA. STAT. § 501.2075 (2008).