IN THE CIRCUIT COURT OF THE CITY OF ST. LOUIS
STATE OF MISSOURI

DWIGHT L. QUINN, et al.,	)	
	)	Cause No. 22052-00821-01
Plaintiffs,	)	
	)	
v.	)	
	)	
BJC HEALTH SYSTEM d/b/a BJC HEALTHCARE, et al.,	)	
	)	
	)	
Defendants.	)	

BRIEF OF AMICUS CURIAE IN SUPPORT OF
OBJECTIONS TO PROPOSED SETTLEMENT FILED BY
MICAH BAGBY, VAIN SAEED, ASYA KHALID AND KHADIJA BARWARI

In support of their Motion for Leave to File a Brief as Amicus Curiae, Community Catalyst, St. Louis Area Jobs With Justice and the Missouri Association for Social Welfare set forth herein their reasons for supporting the objections of the above-named Class Members to the proposed Settlement Agreement as not fair, reasonable or adequate.

I. Introduction

As asserted in the class petition filed in this action, hospitals charge individuals who lack insurance rates that are many times the hospitals' costs and that are far higher than the levels paid by private and government third-party payers.[1] Although every hospital has a master price list (the "chargemaster"), insurers and government programs rarely, if ever, pay the amounts listed because they can negotiate discounts or cap payments. Similarly reduced rates are not routinely offered to

[1] *See* Gerard F. Anderson, From 'Soak the Rich' to 'Soak the Poor': Recent Trends in Hospital Pricing, 26 Health Affairs at 780 (2007); Uwe Reinhardt, The Pricing of U.S. Hospital Services: Chaos Behind A Veil Of Secrecy, 25 Health Affairs at 57 (2006).

uninsured patients, leading to harsh consequences, including bankruptcy and inability to access future care.[2]

A meaningful remedy for the unfairness in the hospital charge system must combine fair pricing with recognition of patients' ability to pay. Charity care is essential; however, it is not enough where many patients who receive "discounts" still pay well above the cost of providing care. As one Pennsylvania court concluded, chargemaster rates are *de facto* unreasonable because so few payers are charged or pay these amounts. Temple University Hospital v. Healthcare Management Alternatives, Inc., 832 A. 2d 501, 508-510 (Pa. Super. Ct. 2003), *appeal denied*, 577 Pa. 724, 847 A. 2d 1288 (2004) (declaring "untenable" hospital's contention that it could unilaterally set price for services that bore no relationship to amount typically paid for those services). Courts in Illinois and California have held that charging uninsured patients the chargemaster rates while other payers pay far less supports claims for unconscionability and unfair and deceptive practices. *See, e.g.*, Hill v. Sisters of St. Francis Health Services, Inc., 2006 WL 3783415 at *5, *6 (N.D. Ill.) (claims stated under Illinois Consumer Fraud Act and doctrine of unconscionability); In re Sutter Health Uninsured Pricing Cases, 2005 WL 1842582 at *2 (Cal. Super. Ct.) (claims stated for unfair advertising, unfair and illegal business practices and unjust enrichment); *see also* Servedio v. Our Lady of the Resurrection Medical Center, Cir. Ct. Cook Co. Ill., No. 04 L 3381, Memorandum Opinion and Order, March 9, 2005, at 7-9 and 11 (court found that "requiring emergency room patients to pay two and three times the de facto normal rate is 'oppressive' and unethical," and refused to dismiss claims for breach of contract and violation of

[2] *See, e.g.*, Michelle M. Doty, Jennifer N. Edwards and Alyssa L. Holmgren, Seeing Red: Americans Driven into Debt by Medical Bills (Commonwealth Fund, 2005); David U. Himmelstein, Elizabeth Warren, Deborah Thorne and Steffie Woolhandler, Illness And Injury As Contributors To Bankruptcy, Health Affairs Web Exclusive (February 2, 2005) http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.63v1.

the Illinois Consumer Fraud and Deceptive Business Practices Act) (copy available at http://www.povertylaw.org/poverty-law-library/case/55800/55819/55819a.pdf).[3]

In the case before the court, class counsel made similar allegations to those in the Illinois and California cases cited and survived defendants' motion to dismiss. *See* Second Amended Class Petition, at ¶¶ 93-124 (filed June 29, 2005); Order Denying Defendants' Motion to Dismiss Second Amended Class Petition (January 10, 2006). After this court certified the class, the parties entered into negotiations and arrived at the Settlement Agreement now before the Court. While the proposed Settlement contains some of the elements necessary to meaningful relief, it does not sufficiently protect the interests of the uninsured patients, past and future, that make up the class. Instead, the Settlement offers limited benefits and places the burden on uninsured class members to seek those benefits, while allowing BJC Health System (BJC) to continue charging the uninsured grossly inflated prices and aggressively collecting debts based on those unfair prices. On the whole, the proposed settlement affords little relief to the plaintiff class but largely protects the interests of BJC and class counsel.

A class action settlement agreement must be "fair, reasonable and adequate." State ex rel. Byrd v. Chadwick, 956 S.W.2d 369, 378 n. 6 (Mo. App., 1997). The reviewing court owes a particular duty to absent class members. *Id.* at 378 (elements of Missouri Rule 52.08 that are designed to protect absentees demand heightened attention in the settlement context). For the reasons set forth below, this court should determine that the Settlement is unfair, unreasonable and inadequate, and should urge the parties to make corrective amendments.

[3] All three cases cited resulted in class action settlement agreements. The terms of the Hill and Servedio agreements were confidential; however, the Sutter Health settlement is publicly available.

II. Argument: Reasons the Proposed Settlement Should Not Be Approved

A. The Self-Pay Discount maintains a large and unjustified disparity between uninsured patients and other payers.

Under the Self-Pay Discount Policy, any uninsured patient who receives hospital services at a BJC-affiliated hospital during the Class Period is eligible for a 25 percent discount off the hospital's chargemaster rates. Settlement at § III(A)(1). The proposed discount will not alleviate price discrimination for BJC patients given that, in Missouri, chargemaster rates on average are nearly three times costs.[4] This means that uninsured patients are charged *three times* what it costs the hospital to provide the service. Insurance companies are charged and pay far less. In 2005, private insurers on average paid BJC only 1.38 times cost.[5]

Under the terms of the Settlement, uninsured patients will continue to be charged rates far above the hospitals' costs and substantially higher than insurance companies. For a service that has a chargemaster price of $3,000 and thus costs the hospital $1,000, an uninsured patient will be billed $2,250. This "discount" results in a charge that is still more than double the cost of the service and far above the typical insurance rate of $1,380.

Settlements in several similar cases have tied rates for the uninsured to the rates paid by insurance companies. *See, e.g.,* In re Tenet Healthcare Cases II**,** 2005 WL 1949562, Cal. Sup. Ct., J.C.C.P. No. 4289, August 8, 2005 (approving Joint Motion for Final Approval of Class Action Settlement,), Settlement Agreement at 14, 16 (uninsured discount at rates comparable to hospital's current managed care rates), at http://op.bna.com/hl.nsf/id/psts-6agrfn; Quintana v. Health Management Associates, Inc., Circ. Ct. 11th Jud. Circ. Fla., Case No. 04-16944-CA-31, Settlement Agreement and Release (approved January 23, 2007) (uninsured to receive average discounted rate

[4] Information provided by Dr. Gerard F. Anderson of the Johns Hopkins Bloomberg School of Public Health. Missouri's cost-to-charge ratio in 2004 was 2.85. This calculation was derived by Dr. Anderson from Medicare cost data in preparing his 2007 article, From 'Soak the Rich' to 'Soak the Poor', *supra,* note 1.

[5] In 2005, Medicare and Medicaid paid BJC at or slightly below cost. *See* 2007 St. Louis Health Care Industry Overview, St. Louis Area Business Health Coalition, at 6, available at http://www.stlbhc.org/reports/report_8.pdf.

given to insurance companies and employer plans), at http://kttlaw.com/quintana. Notably, class counsel in the present case initially sought similar discounts for BJC patients.[6] The Settlement should be approved only if amended to require fair and reasonable prices for uninsured and underinsured patients of BJC hospitals – that is, prices that are in line with what third-party payers (insurers and government programs) pay.

B. The Settlement Class is too narrowly defined

1. The underinsured should be explicitly included in the Settlement

The Settlement Class does not expressly include patients who are underinsured, whose health insurance plan does not pay, in whole or in part, for medically necessary hospital services. Settlement § 1 at 9. The Settlement Agreement refers only to "Uninsured Patients," defined as patients whose hospital services are not covered by an indemnity payer or a Third-Party Payer. *Id.* Yet, increasingly health plans impose substantial cost-sharing (deductibles, coinsurance, co-payments), and set annual and lifetime benefit limits.[7] While the BJC Charity Care policy applies to such cost-sharing (Settlement, Attachment B, page 2), limitation of the Settlement Class to the "Uninsured" may exclude underinsured patients from the Self-Pay Discount. The court should not approve the Settlement unless it is amended to provide the same reduced prices to *all* patients affected by inadequate insurance.

2. Receipt of "Disclosed Charges" Should Not Preclude Eligibility for Settlement Benefits

The Settlement Class also excludes patients who were provided "Disclosed Charges" before receiving services. Settlement § 1, at 9. Disclosed Charges mean charges made known to the patient before services were rendered, in accordance with a hospital's regular procedures, identifiable by

[6] "[T]he real charge at a hospital and the baseline for comparison is a rate in line with what the government and insurance carriers pay. Amounts substantially above those 'baselines' are inflated, not simply lacking in discounts." Second Amended Class Petition, at ¶ 6.

[7] According to a recent study, this trend resulted in a 60 percent increase in the underinsured between 2003 and 2007. How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007. C. Schoen, S. R. Collins, J. L. Kriss, M. M. Doty. The Commonwealth Fund, June 2008. Health Affairs Web Exclusive, June 10, 2008.

specific billing codes, and that are offered as part of "pre-packaged plan" or "for which pre-payment is required." The Settlement offers no guidance or limits on what types of services may be included in these categories, allowing BJC to prospectively avoid offering discounts in many cases if it adopts expansive prepayment and pre-packaged plan policies. Settlements in similar cases have required hospitals to provide an estimate of charges when possible but have not used this greater transparency to punish class members. *See, e.g.*, R.M. Galicia, Inc. d/b/a Progressive Management Systems v. Franklin Settlement Agreement ("Scripps Health Settlement"), Cal. Sup. Ct., Case No. IC859468 (approved June 6, 2008) at http://uninsuredclassaction.com/pdfs/Scripps_settlement_Agreement_FINAL.pdf; Final Order and Judgment Approving Settlement, Quintana v. Health Management Associates, Inc., Cir. Ct. 11th Jud. Circ. Fla., Case No. 04-16944-CA-31 (Jan. 23, 2007), at ¶ 12b. Advance disclosure of fundamentally unfair charges does not make them fair and should not negate eligibility for a reduction from chargemaster prices.

C. The scope of services covered by the Settlement Agreement is unduly restricted

1. Hospital Services should not be defined by "typical" insurance criteria

To be included in the Settlement Class, a person must receive "Hospital Services" at a BJC hospital during the Class Period. Settlement § 1, at 9. Hospital Services are defined as all charges for hospital rooms, equipment, drugs, devices, and other goods and services "typically" provided to patients in a hospital. Settlement § 1, at 5-6. Excluded from the definition are services "typically" not covered by insurance, regardless of the medical necessity of such services. *Id.*

The tying of Self-Pay Discount eligibility to insurance criteria is problematic. The fact that certain services are not covered by insurance does not mean they are not medically necessary. Also, there is no guidance as to who will decide which services "typically" are not covered by insurance or what criteria will be applied. The fair approach is for *all* medically necessary services to be

included, without reference to "typical" insurance conduct or other qualifiers. The following is a proposed definition of medically necessary services for this purpose:

> Services that are reasonably expected to prevent, diagnose, prevent the worsening of, alleviate, correct or cure conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap or result in illness or infirmity. These include but are not limited to inpatient and outpatient services mandated under Title XIX and emergency care as defined in Section III(K) of the federal Social Security Act, as well as provision of prescription drugs.[8]

2. BJC staff physician services should be covered by the Settlement

The Settlement Agreement also excludes "physician services, treatments and procedures" from the definition of Hospital Services. Settlement § 1, at 5-6. To the extent that services, treatments and procedures are provided by physicians or clinicians that are members of the hospital's staff, i.e., BJC employees rather than independent contractors, any discount or reduction in price under the Settlement should expressly apply.

D. Retrospective Self-Pay and Charity Care discounts should be automatically applied.

Under the Settlement, a patient who wants a Self-Pay Discount refund must file a Claim Form by October 1, 2008. *See* Settlement § III(B)(4), at 17; Notice of Class Action and Proposed Settlement, Attachment C, at 3. The form must include the name of the hospital and the year the patient received services. Settlement § III(B)(4), at 17. The claimant must affirm "under penalties of perjury" that she or he: qualified as an Uninsured Patient in the year services were received; paid some or all of the hospital bill; and was not aware of the amount to be charged in advance. Settlement § III(B)(4), at 17. Similarly, if seeking retrospective Charity Care, a patient must apply via the Claim Form or otherwise in writing. Settlement § III(B)(2), at 16.

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[8] *See* [Model] Patient Financial Assistance Act, §3T, Community Catalyst, Inc. (May 2004), available at http://www.communitycatalyst.org/doc_store/publications/model_act_and_guide_may04.pdf; *see also* regulations for Massachusetts' Health Safety Net program, which defrays hospitals' cost of caring for the uninsured and underinsured.114.6 CMR 13.02.

1. BJC should have to be more proactive in establishing patient eligibility for the Settlement

The Settlement places too great a burden on Class Members to pursue refunds or adjustment of their bills when the hospitals are in the best position to ascertain in the first instance which patients are eligible. The Settlement should place the initial burden on BJC to identify eligible individuals and proactively issue a refund if a bill was paid in full or more was paid than is owed to the patient under the Self-Pay Discount policy. If the balance remaining exceeds the amount of any refund, then the BJC hospital should have the obligation to adjust the bill accordingly. Requiring that claim forms be signed under the penalties of perjury is intimidating and seems unnecessary given the hospitals' likely superior knowledge of eligible patients. The hospital should have to notify all patients eligible for a Self-Pay Discount of possible further adjustments based on Charity Care and invite affected patients for financial counseling and assistance.

2. The Claim Form filing deadline should be extended

The Claim Form filing deadline of October 1, 2008 is far too short – less than one month after the fairness hearing. Pursuant to the Settlement (see §§ IVD and E), individual and published notices should have been issued around June 17, 2008. BJC should have to demonstrate the success of such notification – based on the number of notices returned undeliverable, the number of claims filed, etc. The Class Period continues for four years; if evidence of successful notice thus far is weak, potential claimants should be given at least one year from the effective date of the Settlement to file requests for refunds or adjustments.

E. The Charity Care Policy is too limited in scope and uses unreasonable criteria

BJC's existing Charity Care policy is incorporated into the Settlement even though it contains at least two highly problematic elements for uninsured and underinsured patients.

1. The policy should cover more than emergent services

BJC provides charity care for "medically necessary" services, which are defined as "services that are necessary in continued treatment of the Patient's condition and *are emergent*." (Italics added.) Settlement, App. B, at 2. On its face, this definition limits eligibility for charity care to services of an emergency or urgent nature.[9] Eligibility for financial assistance should apply to *all* medically necessary health services. If in practice BJC hospitals offer charity care for this broader group of services, the practice should be memorialized in the official policy.

2. The policy imposes excessive liability relative to patient income

The Charity Care policy limits the *annual* out-of-pocket liability for uninsured patients to 30 percent of gross income. Settlement, Appendix B, at 2. In effect, these patients must be given an extended payment plan but there is no reduction or waiver of the balance under the Charity Care policy. Thirty percent of income is too much to expect families to be able to pay and remain solvent – particularly those that have suffered serious illness or injury. Patients with substantial hospital bills likely have separate bills from physicians, labs and other health providers.

Settlements in other cases have included more reasonable upper limits for annual patient liability. *See, e.g.*, Scripps Health Settlement § III(A)(7)(g) (10 percent of annual gross household income); Catholic Health Care West Cases, Order Granting Motion for Final Approval of Class Action Settlement § III(A)(7)(b), J.C.C.P. No. 4453, Cal. Sup. Ct., San Francisco (Jan. 12, 2007) (15 percent gross annual household income for patients under 500 percent of poverty level). For patients with income under 300 percent of poverty level, the cap should be no more than five percent of gross household income.[10]

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[9] *See* Merriam-Webster Dictionary, http://www.merriam-webster.com/dictionary/emergent, which defines "emergent" in relevant part as a) arising unexpectedly; b) calling for prompt action; urgent.

[10] *See* Mo. Rev. Stat. 208.640 (defining affordable health care coverage for the State Children's Health Insurance Program as limiting cost sharing to five percent of family income); 42 CFR 457.560. *See also* How Many Are Underinsured?, note 7, *supra*, at w299 (defining "uninsured" as those with out-of-pocket medical expenses equal to 10

BJC's policy should provide for "medical hardship" to protect those without insurance (or with inadequate insurance) that have catastrophic medical bills, regardless of their income level. Under the present policy, a family could be required to pay 30 percent of income for two, three or even 10 years if the hospital bill is large and the family's income is relatively small. A Medical Hardship policy would allow *forgiveness* of debt above a certain percentage of income, not merely extended payment subject to an annual cap.[11]

Finally, the Settlement should provide explicitly for extended payment terms that are not subject to interest charges, as agreements in similar cases have done. *See, e.g.,* Scripps Health Settlement § III(A)(4); Tenet Health Care Cases II, Settlement Agreement, § III(A)(4).

F. The Prompt Pay discount is negligible and provides too short a payment period

The Prompt Pay discount proposed is five percent if paid within 30 days of the initial bill. Settlement, § III(A)(3). This is a *de minimis* discount for patient conduct that greatly benefits the hospital. *Compare, e.g.,* Sutter Health Uninsured Pricing Cases, Final Order and Judgment § III(A)(4), Cal. Sup. Ct, Sacramento (Dec. 12, 2006) (10 percent prompt pay discount). Moreover, 30 days is not a sufficiently generous time frame. A settlement in one similar case allowed 60 days. *See* Scripps Health Settlement, § III(A)(3). Finally, as with the Self-Pay Discount and Charity Care, BJC should have to apply the Prompt Pay discount automatically to bills that qualify.

G. Provisions concerning ongoing notice of discount policies should be strengthened

1. Posters

Under the Settlement, BJC must post the Self-Pay Discount and Charity Care policies in admitting areas in a "conspicuous" place and manner. Settlement § III(A)(4)(a), at 14-15. "Admitting areas" should be defined as all parts of the hospital where a patient may arrive to

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percent or more of income, except 5 percent for those under 200 percent of poverty level; also, regardless of income, those who have deductibles equal to 5 percent or more of income).

[11] For examples of medical hardship policies, *see* Massachusetts Health Safety Net regulations at 114.6 CMR 13.05 and Community Catalyst Patient Financial Assistance Act, § IVC, supra, note 8.

receive care – the emergency room, inpatient wards and outpatient clinics. Posters should also be required in business offices and other areas within the hospital that are customarily used by patients.

The required statement on the posters should read -- "Uninsured Patients will be billed a reduced rate and they may qualify for free or further reduced cost medical care by paying promptly *and/or* by filling out an application for financial assistance" (amendment in italics) -- to make clear that patients may qualify for *all three* reductions – Self-Pay, Charity and Prompt Pay. Also, the posters should provide specifics on the amount of the uninsured and Prompt Pay discounts and the basis for receiving Charity Care, to encourage eligible patients to apply for appropriate relief.

2. Language access

According to the Settlement, posters and brochures must be in appropriate languages "as may be required under applicable law." Settlement § III(A)(4)(a), at 15. This is too narrowly tailored to provide for effective communication with the majority of eligible patients whose primary language is not English. A more patient-protective standard is to require that posters and brochures be produced in all languages primarily spoken by 10 percent of the residents in the hospital's service area.[12]

3. Bills

Per the Settlement, notice that "payment assistance is available" must be on billing statements. Settlement § III(A)(4)(a), at 15. Bills are critical vehicles for conveying information about discount and charity care policies. Therefore, a sufficient description of the criteria for payment assistance should also be included on billing statements. Bills should also provide enough information in commonly spoken foreign languages (see standard above) to direct non-English speakers to where they can get help applying for financial assistance.

[12] *See* Commonwealth of Massachusetts Health Safety Net regulations at 114.6 CMR 13.08(1)(e).

4. Websites

The Settlement requires notice that "payment assistance is available" to be posted on the affected hospitals' websites. Settlement § III(A)(4)(a), at 15. This information should have to be "conspicuously" displayed, with enough information to direct patients to where and how they can apply for financial help.[13] Enough of the websites' content should be translated into common languages (see standard above) so as to inform non-English speaking patients how to get help.

H. Training of hospital staff on financial assistance policies should be expanded and enhanced

The covered hospitals must train admitting and registration staff on the financial policies set forth in the Settlement. Settlement § III(A)(4)(a), at 15. The court should further require BJC hospitals to train relevant *medical* staff, in particular social services staff, as these employees are key contacts for patients that may qualify for the discounts. We recommend that the following provision be included:

> BJC hospitals shall provide regular in-service training to all hospital staff and personnel on Charity Care, Self-Pay Discount, Prompt Pay Discount and any other financial assistance policies and procedures.[14]

Furthermore, the Settlement should require direct (face-to-face) financial counseling of patients upon admission, registration and discharge, and, as appropriate, during the course of the treatment or hospital stay. Seeking financial assistance can be confusing and intimidating to patients and the BJC hospitals should have to take the lead in this area. The Settlement Agreement should therefore specify that BJC personnel will provide patients with reasonable assistance in completing applications for Charity Care. *Compare*, *e.g.*, Sutter Health Final Order and Judgment § III(A)(5)(a), at 9; Scripps Health Settlement § III(A)(5)(d), at 12.

[13] A review of BJC hospitals' websites in July revealed wide variation in the accessibility of this information, with charity care guidelines and information about the Settlement difficult to find in many cases.
[14] *See* Patient Financial Assistance Act, Community Catalyst (May 2004), at § IX(E).

I. The provisions relating to collection actions must be substantially strengthened.

1. Definition of collection agency

Throughout the Settlement, the term "collection agency" appears without definition. To adequately protect class members, this term must be defined broadly. Amici curiae suggest a definition derived from the definition of "debt collector" in the federal Fair Debt Collection Practices Act (FDCPA), 15 U.S.C. §§ 1692a(6), as follows:

> The term "collection agency" as used in the Settlement means any person or business (other than the BJC-affiliated hospital to which the debt is due), the principal purpose of which is the collection of debts, or who regularly collects or attempts to collect, directly or indirectly, debts owed or due or asserted to be owed or due to another. The term specifically includes attorneys retained by or on behalf of a BJC hospital to collect patient debt. The term also includes any BJC hospital which, in the process of collecting its own debts, uses any name other than its own which would indicate that a third person is collecting or attempting to collect such debts. Such term also includes any person or business the principal purpose of which is the enforcement of security interests.

Without such a definition, the scope of protection against unreasonable collection action is too limited, and unfair collections against uninsured and underinsured patients of BJC hospitals will likely continue.

2. BJC's residual right to sue and refer accounts to collection is too broad

Pursuant to the proposed Settlement, BJC may sue Class Members for amounts owed after any discounts are applied, if their accounts are still the active subject of billing or collection activity. Settlement § VII(B) at 30-31. This provision highlights the importance of requiring BJC to identify eligible accounts and automatically apply relevant discounts so that patients are not pursued for amounts that should be waived. Permitting collections under these circumstances also makes clear the need for an expanded time period (minimum one year from the effective date of the Settlement) to claim a Self-Pay Discount refund and retrospective eligibility for Charity Care.

Otherwise, it is not only possible but likely that BJC hospitals and their collection agents will be seeking payment from individuals who should benefit under the Settlement.

The Settlement Agreement should be far more protective of patients with regard to collections. We suggest at a minimum the following terms:[15]

a. BJC will not send patients' bills to collection agencies within 180 days from the date of initial billing unless the patient specifically refuses to pay any obligation or cannot be located.

b. BJC will not negatively report the medical debts of patients and will prohibit collection agencies from so doing at any time prior to 180 days after initial billing.

c. Neither BJC nor its collection agencies will file liens on a patient's primary residence or motor vehicle unless the patient has multiple residences or properties and significant personal assets and the hospital's board of trustees gives express approval in writing.

d. Neither BJC nor its collection agencies will garnish the wages of any patient.

e. BJC may not require pre-admission or pre-treatment deposits from patients that require emergency services or have income at or below 400 percent of federal poverty level.

f. Neither BJC nor its collection agencies shall bill patients enrolled in Medicaid, the State Children's Health Insurance Program (SCHIP) or other health insurance programs for low-income individuals and families, except for any required co-payments and deductibles.

g. A collection agency shall not file any lawsuit against an uninsured or underinsured patient with income at or below 400 percent of federal poverty level.

h. BJC shall not sell or otherwise transfer patients' debts to third parties under terms that would negate any of the protections to which they are entitled under the Settlement.

BJC should be required to put its credit and collection policy in writing and make the policy readily available to patients. The terms of the policy should also be included in contracts between BJC hospitals and collection agencies. Without these additional steps, the Settlement substantially fails to protect uninsured and underinsured patients from aggressive debt collection practices by BJC hospitals and their agents.

[15] The terms suggested are based on regulations in other states, *see* Massachusetts Health Safety Net regulations, 114.6 CMR 13.08, settlements in other hospital overcharge cases, *e.g.*, Scripps Health Settlement, §III(A)(7), and The Patient Financial Assistance Act, *supra*, note 14, §VI.

3. Provisions for patient accounts in collection are too weak

The Settlement provides that accounts that have been placed with collection agencies are eligible for the Self-Pay Discount and Charity Care and that BJC agrees to "instruct" collection agencies with respect to these policies. This requirement is too weak and will result in eligible patients missing out on reductions in their bills. BJC hospitals should have to ensure enforcement of the policies by making their proper application, and the credit and collection standards set forth above, part of the collection agents' contracts and by monitoring compliance with said contracts. Similar provisions have been included in settlements in other hospital overcharge cases. *See, e.g.*, Sutter Health Final Order and Judgment § III(A)(7), at 10-12; Scripps Health Settlement § III(A)(7).

The Settlement contains provisions specific to patients who are subject to collections judgments, i.e., who have had a judgment on a debt issued against them by a court. Settlement § III(B)(5), at 18. Such individuals must submit a Claim Form or other request in writing to get BJC and its agents to cease collection efforts on any discount-eligible amount. BJC agrees to take "reasonable" steps "to the extent practicable" to modify judgments to reflect applicable refunds and/or discounts only if the *class member so requests and submits a copy of the judgment*. These requirements are far too onerous for patients and place too light a burden on BJC and its collection agents. BJC should have to identify and contact post-judgment accounts or ensure that its collection agents and attorneys do so. Absent this obligation, patients are unlikely to know that they are eligible for reduction of their debt in order to submit a claim. ("Instruction" to collection agencies to accomplish individual notice of the settlement is insufficient. *See* Settlement § IV(E) at 22.) Fair and complete adjustment of post-judgment accounts is critical, as discount-eligible patients may be facing destruction of their credit, as well as attachment of their homes and motor vehicles and garnishment of wages.

J. The terms under which the Settlement may be modified are too deferential to BJC.

1. Self-Pay Discount Policy

In order to obtain modification of the Self-Pay Discount Policy, BJC must only show that its continued application would effect a *material negative change* in a hospital's pricing, charging or reimbursement structure. Circumstances that may effect such a change include: changes in the hospital charging structure; a decrease in the discounts the hospital is offering to managed care companies; a significant increase in uninsured patients following a reduction in health coverage by government programs or other means; a significant increase in the number of uninsured patients from outside of a hospital's traditional service area; changes in local market conditions; and changes in law, regulations or agency guidance. Other than legal developments that would require a change in BJC policy, the listed circumstances are not sufficient justification for modifying the Self-Pay Discount. BJC has had ample opportunity to consider the impact of the policy and should be knowledgeable about the conditions under which its hospitals are likely to operate during the Class Period. A change in the charge structure or managed care discounts would only be relevant if chargemaster rates came into line with costs and reasonable profits.

2. Modification of the Settlement Agreement as a Whole

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In addition to modification of the Self-Pay Discount, BJC may seek modification of the Settlement as a whole based on "good cause," to be determined by the court. Settlement § III(D), at 18-19. This provision provides no guidance as to what would constitute "good cause" other than to refer to BJC's need for flexibility to comply with the law and ensure "orderly provision of services to patients." These considerations are too vague and deferential to the defendant hospital system, and not sufficiently protective of class members' rights.

K. The Notification of Settlement Provisions are Flawed

BJC was required to notify class members via print media (the St. Louis Post-Dispatch, St Louis American and the Alton Illinois Telegraph), the hospitals' websites and individual notice to patients who paid more than $500, received no "Disclosed Charges" and had no prior bill adjustments of over 25 percent (other than Charity Care). Settlement §IV(D) and (E). First, there is no apparent justification for excluding patients who paid $500 or less – if the patients paid an inflated rate for services they should be entitled to a reduction or refund. Second, patients who received "Disclosed Charges" should nonetheless be eligible for a discount. (See discussion § B(2), *supra*) Moreover, permitting the hospitals to decide who did and did not receive "Disclosed Charges" in the first instance is likely to exclude people who are eligible. Finally, patients who received prior discounts of more than 25 percent may nonetheless be eligible if the previous adjustments were due to correction of billing errors or prompt payment. The best approach is to notify everyone who received services at a BJC hospital during the Class Period, permitting all potentially eligible patients to request adjustment or a refund as appropriate. The Court should therefore require BJC to reissue notice of the Settlement (as amended after hearing) to this more broadly defined class.

L. The Court Should Order a *Cy Pres* Distribution

The Settlement provides for no minimum payout to the class. Yet the overly restrictive notice and refund provisions may result in fewer class members than are eligible benefiting from the Settlement.[16] Amici recommend that the Settlement be amended to designate a minimum fund, with any residue not paid in response to individual claims to be used for health-related charitable purposes based on *cy pres* principles.

[16] In general, consumer class action settlements that require filing of claims result in low take-up rates. *See* 2 Newberg on Class Actions, Appendix 8-4 (3d ed. 1992) (claim rates in three-quarters of cases examined were under 20 percent).

The goal of *cy pres* distributions is to benefit absent class members and others affected by issues raised by the class action litigation. There is clear precedent for creating a cy pres fund in class action hospital overcharge litigation. *See* Tenet Healthcare Cases II, Settlement Agreement § III(B)(3).[17] In the Tenet case, a multi-million dollar fund was established to redress the overcharging of underinsured patients, and was made payable to a nonprofit organization recommended by the plaintiffs and approved by the Court.[18]

M. The Court should appoint an independent monitor to oversee implementation of the Settlement

The Settlement Agreement leaves control with the BJC hospital system to monitor its own compliance. The court should appoint an independent monitor to oversee implementation of the relief described in the Agreement. The monitor would report to Class Counsel and the court regularly during the Class Period, addressing BJC's implementation of the Settlement elements – prospective relief, retrospective relief, charity care policies, the self-pay and prompt pay discounts, credit and collections policies and the hospitals' ongoing notice obligations. The monitor would be empowered to gather information from covered hospitals to evaluate the success of the remedial measures, including but not limited to the number of patients who have applied for relief, the number who have qualified for relief and the estimated value of the relief afforded. The function of the monitor is separate from and in addition to that of the Claim Administrator, whose sole function is to review and rule on claims for retrospective relief under the Self-Pay and Charity Care provisions. Settlement §V(B).

[17] There are many other examples of cy pres funds in consumer health care cases generally, *e.g.*, In re Brand Name Prescription Drugs Antitrust Litigation, 1994 WL 663590 (N.D. Ill. 1994) (*cy pres* distribution paid for free prescription drugs for indigent persons).

[18] Amicus Community Catalyst was appointed to distribute the Tenet cy pres funds to state consumer advocacy organizations and manage the grants under its Hospital Accountability Project. The goal of this Project is to improve health access and reduce medical debt for low to moderate-income underinsured patients. For more information, see http://www.communitycatalyst.org/projects?id=0009.

N. The proposed attorneys' fee bears no relation to BJC's liability

Class counsel propose a fee award of three million dollars for their work on this case. Settlement § X(A), at 35-37. While counsel have no doubt put in many hours on this matter, the proposed award bears no relation to BJC's liability under the Settlement, given the lack of a minimum payout for class members. As noted above, because the notice and claims filing processes may fail to result in claims from a sufficient number of Class Members, class counsel should have to substantiate to the Court that the fee award is reasonable in relation to anticipated payments by BJC. As discussed above, the Court should require the creation of a cy pres fund and ensure that any fees awarded are in proportion to the principal of such fund.

III. Conclusion

For the reasons set forth herein, amici curiae Community Catalyst, Inc., St. Louis Area Jobs With Justice and the Missouri Association for Social Welfare recommend that the Court reconsider the provisions of the proposed Settlement, adopt the recommendations set forth in this memorandum, and order the parties to arrive at a more fair, adequate and reasonable settlement outcome for the class.

Respectfully submitted,

COMMUNITY CATALYST, INC.
ST. LOUIS AREA JOBS WITH JUSTICE
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By their Attorney,

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