Attachment B

November 25, 2013 Order

Denying Motion for Reconsideration

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PAUL B. WICKENSIMER
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STATE OF SOUTH CAROLINA)
) IN THE COURT OF COMMON PLEAS
COUNTY OF RICHLAND)

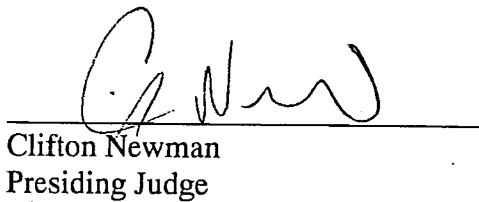
In re: South Carolina Hospital Pricing Litigation

ORDER DENYING MOTION FOR RECONSIDERATION

This matter came before the Court on Plaintiffs' Motion for Reconsideration of this Court's July 15, 2013 Order Denying Plaintiffs' Motion for Declaratory Judgment. Having carefully considered the arguments submitted and the applicable law, the Court finds the Motion for Reconsideration should be denied.

It is therefore ORDERED that the Plaintiffs' Motion for Reconsideration is DENIED.

AND IT IS SO ORDERED.



Clifton Newman
Presiding Judge

November 25, 2013
Columbia, South Carolina

original

Attachment A

July 15, 2013 Order

Denying Declaratory Judgment

STATE OF SOUTH CAROLINA

COUNTY OF GREENVILLE

IN THE COURT OF COMMON PLEAS
C.A. NO. 2004-CP-23-6065

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Jeyilud Bennett, on behalf of herself, and all others similarly situated,

Plaintiffs,

v.

Greenville Hospital System,

Defendant.

ORDER DENYING DECLARATORY JUDGMENT

2013 JUL 19 P 3:02

IN RE: SOUTH CAROLINA HOSPITAL PRICING LITIGATION

(ASSIGNED TO THE HONORABLE CLIFTON NEWMAN BY ORDER OF CHIEF JUSTICE JEAN HOEFER TOAL DATED APRIL 21, 2010)

STATE OF SOUTH CAROLINA
IN THE COURT OF COMMON PLEAS

2013 JUL 19 P 3:02

IN RE: HOSPITAL PRICING LITIGATION (Specifically Assigned to the Honorable Clifton Newman by Order of Chief Justice Jean Hoefer Toal)	**ORDER DENYING DECLARATORY JUDGMENT**

This matter came before the Court on April 29, 2013, for a non-jury hearing and trial on two bifurcated issues (hereinafter, the "Declaratory Judgment Issues"):

1. **Does the Court have the power/authority to declare the use of a Charge Master to be unreasonable based on the record before the Court?**

2. **Is the use of a Charge Master unreasonable based on the record before the Court?**

The bifurcation of and procedure for ruling on the Declaratory Judgment Issues is memorialized in the Court's June 29, 2012 Consent Order Governing Further Proceedings (hereinafter "2012 Consent Order"). After carefully considering the evidence presented, the legal arguments set forth in the Parties' memoranda, and the arguments made at the April 29, 2013 Hearing, the Court finds the answer to each of the Declaratory Judgment Issues is "NO."[1] As required by Rule 52(a), SCRCP, the Court enters the following findings of fact and conclusions of law thereon:

<u>BACKGROUND AND PROCEDURAL POSTURE</u>

[1] This Order applies to those cases listed in <u>**Exhibit A**</u> attached hereto (hereinafter referred to as the "Pending Cases"). In some of the cases, the patients' claims were presented as counterclaims. For ease of reference, the term "Plaintiffs" refers to the patients who have asserted claims against the hospitals, and the term "Defendant Hospitals" refers to the hospitals that have been sued, regardless of whether the claims were asserted in complaints or as counterclaims.

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Chief Justice Jean Hoefer Toal assigned the South Carolina Hospital Pricing Litigation (the "Litigation") to this Court for all pre-trial proceedings and trial pursuant to the Order dated April 21, 2010. The Plaintiffs filed these proposed class action lawsuits over eight years ago. This Court is the third Judge assigned to manage the Litigation. Chief Justice Toal previously assigned the Litigation to The Honorable Kenneth G. Goode and The Honorable Ralph King Anderson, Jr. The Order of Chief Justice Toal dated April 21, 2010 authorizes this Court to manage all aspects of the Litigation and to try each of the included cases. Under that Order, the Parties would likely try each case separately in the county where each Defendant Hospital has its principal place of business or is located.

Originally, there were three distinct groups of cases: the "statutory" cases brought by both insured and uninsured patients under the old "Discount Statute" (now repealed, S.C. Code Ann. § 38-71-120); the "common law" cases brought by uninsured patients; and the "hybrid" cases brought by uninsured patients, asserting "common law" claims based directly or indirectly on the old "Discount Statute." After some discovery, and an intervening appeal to and ruling by the South Carolina Supreme Court in In re Hosp. Pricing Litig., King v. AnMed Health, 377 S.C. 48, 659 S.E.2d 131 (2008), Plaintiffs dismissed with prejudice their "statutory" cases and most of the "hybrid" cases. Plaintiffs also amended the remaining complaints (including the original "common law" cases) to assert only "common law" claims by uninsured patients. Today, in the nine Pending Cases now before the Court, Plaintiffs have filed amended complaints asserting a single cause of action for declaratory relief. Plaintiffs ask this Court to declare that each Defendant Hospital's use of its respective uniform list of charges for every service and treatment

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the Hospital provides – commonly known as a "Charge Master"[2] – is an "illegal, unreasonable, and/or unconscionable" method of billing.

In June 2012, the Parties entered into a written agreement and submitted a joint proposal to the Court whereby the two Declaratory Judgment Issues set forth above would be bifurcated pursuant to Rule 42(b), SCRCP, for a non-jury trial and ruling. The Court reviewed the Parties' joint proposal, which the Parties presented to the Court in the form of a Consent Order, and held a status conference on June 29, 2012 to discuss the same. The Court then entered the 2012 Consent Order.[3]

Rule 42(b), SCRCP, provides that this Court, "in furtherance of convenience . . . or when separate trials will be conducive to expedition and economy, may order a separate trial of any . . . separate issue or . . . issues . . . ." Our Supreme Court has stated that bifurcated trials are appropriate in complex cases, particularly when bifurcation would help to clarify and simplify the issues. See Durham v. Vinson, 360 S.C. 639, 652, 602 S.E.2d 760, 766 (2004). The Court concludes that a separate trial on the two Declaratory Judgment Issues will be in "furtherance of convenience" and "will be conducive to expedition and economy" in the nine Pending Cases. Rule 42(b), SCRCP. The Declaratory Judgment Issues are common and dispositive issues in all nine Pending Cases that would have to be resolved against each Defendant Hospital in a separate

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[2] King, 377 S.C. at 53 n.2, 659 S.E.2d at 133 n.2 ("A Charge Master is a list of each medical procedure or service and its cost that a hospital provides.").

[3] As set forth and defined in the 2012 Consent Order at Paragraph 5, the non-jury trial on the Declaratory Judgment Issues is limited to the evidence contained in the Written Record in this Litigation to include depositions, affidavits, discovery responses, etc., contained in the existing discovery universe in the nine Pending Cases with no live witness testimony presented at the non-jury trial/hearing. The Defendant Hospitals have objected to certain materials designated by Plaintiffs for inclusion in the Written Record because those materials fall outside the existing discovery universe in this Litigation. The Court sustains those objections and holds the Parties to the terms to which they agreed in Paragraph 5 of the 2012 Consent Order. In any event, the Court has considered the excluded evidence, and it would not change the Court's rulings even if the excluded evidence were properly before the Court.

trial if these issues are not bifurcated and tried separately now. Bifurcation and a separate trial of the Declaratory Judgment Issues, with a ruling on the merits and an immediate appeal, will help to clarify and simplify other issues in the nine Pending Cases and in this Litigation, including the complex question of class certification. Additionally, the Declaratory Judgment Issues are so distinct that resolving them will not result in injustice or prejudice to any of the Parties. See Wright v. Hiester Constr. Co., 389 S.C. 504, 516, 698 S.E.2d 822, 828 (Ct. App. 2010).[4]

DECLARATORY JUDGMENT ISSUE NO. 1

I. FINDINGS OF FACT

Declaratory Judgment Issue No. 1 requires that the Court answer the following question:

Does the Court have the power/authority to declare the use of a Charge Master to be unreasonable based on the record before the Court?

Because Declaratory Judgment Issue No. 1 presents a question of law for the Court, Holden v. Cribb, 349 S.C. 132, 137, 561 S.E.2d 634, 637 (Ct. App. 2002), the Court is not required to make specific factual findings. However, the Court adopts herein the findings of fact under Declaratory Judgment Issue No. 2 to the extent factual findings might be required for any appellate review of the Court's ruling on this Issue. See infra pp. 30-49.

II. CONCLUSIONS OF LAW

Plaintiffs are not presenting their individual contracts and hospital bills to the Court and asking the Court to tell them what they owe any Defendant Hospital. Plaintiffs expressly

[4] All other proceedings in the Litigation are stayed pending the Court's ruling on the Declaratory Judgment Issues and any subsequent appeal. See 2012 Consent Order at ¶ 7. The Parties waived their rights to a jury trial on the Declaratory Judgment Issues and the Defendant Hospitals waived any venue rights to have the Declaratory Judgment Issues tried or heard in the County where each Hospital is located. Id. at ¶¶ 7-8.

disclaim in their Reply Memorandum that they are asking the Court to do this.[5] Plaintiffs are asking this Court to declare illegal and outlaw an entire way of doing business, which has been in effect for approximately 50 years. In their original memorandum, Plaintiffs asked this Court "to declare the Charge Master Billing Scheme to be an unreasonable [method] by which to charge for hospital services and goods" and "to order the Defendants re-bill the Plaintiffs by another [but unspecified] reasonable method."[6] However, Plaintiffs conceded in their Reply that a Hospital may have a pre-set price list, such as a Charge Master, that is applied as services are rendered to each patient.[7]

As shown by their Reply, Plaintiffs are complaining about alleged price discrimination to the uninsured. Plaintiffs assert that this Court should declare Charge Master Billing illegal and unlawful because uninsured patients are charged one price while Medicare and insurance companies are allegedly charged or pay a different, lower price.[8] Moreover, Plaintiffs' Reply makes clear that Plaintiffs want uninsured patients to receive the benefit of reimbursement rates or discounts these Hospitals have negotiated with insurance companies. Plaintiffs want the Court "to stop [Charge Master Billing], declare it unreasonable and mandate that Defendants only bill Plaintiffs in a reasonable manner that is truly comparable to their actual regular rates." Plaintiffs define actual regular rates as "those rates which produce 95% of Defendants' collections."[9] According to Plaintiffs, "[t]he reasonable charges for hospital services . . . can be found in the

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[5] See Plaintiffs' Reply to Defendant Hospitals' Joint Memorandum in Opposition to Plaintiffs' Motion for Declaratory Judgment (hereinafter "Pls' Reply") at 5 n.5 ("Plaintiffs do not invite this Court to choose any specific price.").

[6] Plaintiffs' Amended Motion and Memorandum in Support of Declaratory Judgment (hereinafter "Pls' Mem.") at 14, 18.

[7] See, e.g., Pls' Reply at 2.

[8] See Pls' Reply at 2 n.2, 3, 4, 5 n.4, and 10.

[9] Pls' Reply at 3-4.

rates that are negotiated as reasonable between the Defendant Hospitals and insurance companies."[10]

The Court finds that the answer to Declaratory Judgment Issue No. 1 is "NO." The Court does not have the power/authority to declare the use of a Charge Master to be unreasonable because:

(1) Such a finding would be business regulation and require policy decisions reserved solely to the General Assembly under the South Carolina Constitution.

(2) The General Assembly has already refused to make price discrimination in hospital billing illegal or to give uninsured patients the benefit of discounts mandated by the federal government under Medicare or negotiated between a hospital and insurance companies.

(3) Such a finding would violate the Supremacy Clause of the United States Constitution.

(4) To the extent Plaintiffs contend that the way Defendant Hospitals charge for hospital services violates Medicare regulations, there is no private right of action under settled South Carolina law for Medicare patients to sue for violation of Medicare provisions, let alone for uninsured patients who are not beneficiaries of the program to sue.

A. The Common Law

The basis for Plaintiffs' claim of unreasonableness or illegality of Charge Master billing is the contention that the Charge Master is applied in a disparate or unequal manner to uninsured patients because insurance companies and Medicare pay the Defendant Hospitals less than Charge Master prices. However, Plaintiffs cite no statute making this illegal. The South Carolina Supreme Court's decision in In re Hosp. Pricing Litig., King v. AnMed Health, 377 S.C. 48, 659 S.E.2d 131 (2008), makes clear that there is no South Carolina statute prohibiting alleged price discrimination by hospitals. Plaintiffs cite no case in which a court has declared Charge Master Billing to be illegal, unlawful, or unreasonable because hospitals allegedly charge

[10] Pls' Reply at 20; see also Pls' Am. Compl. ¶ 65.

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uninsured patients an amount and Medicare patients or insured patients a different, lower amount. Plaintiffs cite no case in which a court has held lower charges to Medicare or insurance companies to be evidence that Charge Master prices are unreasonable or that prices to the uninsured are unreasonable. Plaintiffs cite no case in which a court has declared Charge Master Billing to be illegal or unlawful for any reason.

First, there is no common law right in South Carolina to be charged a "reasonable" price. In this state, sellers of goods and services are allowed to set prices at any amount they wish. See, e.g., Gwynette v. Myers, 237 S.C. 17, 24, 115 S.E.2d 673, 676 (1960), overruled on other grounds by R.L. Jordan Co. v. Boardman Petroleum, Inc., 338 S.C. 475, 527 S.E.2d 763 (2000)(stating "one's ownership of property consists not only of his right to possess it, but also of his right to use it as he pleases, to sell it at his own price, and to give it away if he wishes to do so")(emphasis added); Rogers-Kent, Inc. v. Gen. Elec. Co., 231 S.C. 636, 645, 99 S.E.2d 665, 668 (1957)(holding the "right of an owner of property to fix the price at which he will sell is an inherent attribute of the property itself").

Second, there is nothing improper about a seller charging or requiring one group to pay one price for goods and services and charging or requiring another group to pay a different price for the same goods and services. See Bruce's Juices, Inc. v. American Can Co., 330 U.S. 743, 745-46 (1947)(stating "[q]uantity discounts are among the oldest, most widely employed and best known of discount practices. They are common in retail trade, wholesale trade, and manufacturer-jobber relations. They are common in regulated as well as unregulated price structures."); Adams v. G.J. Creel & Sons, Inc., 320 S.C. 274, 277-79, 465 S.E.2d 84, 85-86 (1995)(holding that charging lower prices for bulk gasoline purchase to a buyer who had entered

into an agreement with seller and higher prices to a buyer with no such agreement was not inherently unfair).[11]

Third, a business may generally operate as it sees fit, subject to a legitimate exercise of the police power of the State to protect the public welfare. See Peoples Program for Endangered Species v. Sexton, 323 S.C. 526, 529, 476 S.E.2d 477, 479 (1996); Gwynette, 237 S.C. at 29-30, 115 S.E.2d at 679. However, any restriction on the operation of a business or a seller's right to set prices, such as antitrust or usury, must be authorized by statutory enactment, i.e., legislative action, because only the General Assembly in South Carolina possesses the police power of the State. See Gasque, Inc. v. Nates, 191 S.C. 271, 297, 2 S.E.2d 36, 39 (1939). Because the General Assembly, not the court system, is the proper constitutional forum for the Plaintiffs to raise their concerns about the well-established business practice of Charge Master Billing, the separation of powers mandate in our State Constitution prohibits this Court from granting the relief Plaintiffs seek.

B. Separation of Powers

A fundamental underpinning of our system of government, found in both the United States and the South Carolina Constitutions, is this basic but core concept: there are three distinct branches of government, each with separate and distinct functions and roles in the operation of government. One branch does not and cannot perform any function of the other two branches of government. See S.C. Const. art. I, § 8; Hampton v. Haley, Op. No. 27244 (S.C. Sup. Ct. re-filed May 8, 2013)(Shearouse Adv. Sh. No. 20 at 98, 103-04); Condon v. Hodges, 349 S.C. 232, 244,

[11] See also Whitwell v. Cont'l Tobacco Co., 125 F. 454, 459, 461 (8th Cir. 1903); Energex Lighting Indus., Inc. v. North Am. Philips Lighting Corp., 765 F. Supp. 93, 109 (S.D.N.Y. 1991); Foremost Dairies, Inc. v. Thomason, 384 S.W.2d 651, 661 (Mo. 1964); Laughlin v. Evanston Hosp., 550 N.E.2d 986, 990 (Ill. 1990); Shah v. Chicago Title & Trust Co., 430 N.E.2d 342, 345 (Ill. App. Ct. 1981); Perrin v. Pioneer Nat'l Title Ins. Co., 404 N.E.2d 508, 514-15 (Ill. App. Ct. 1980).

562 S.E.2d 623, 630 (2002); McLeod v. McInnis, 278 S.C. 307, 312, 295 S.E.2d 633, 636 (1982).

It is fundamental to the separation of powers mandate that "legislative and judicial powers are entirely separate." State v. Bates, 198 S.C. 430, 436, 18 S.E.2d 346, 348 (1941). The courts in South Carolina "[have] no legislative powers; it is [the courts'] province to construe laws, not make them." Santee Cooper Resort, Inc. v. South Carolina Pub. Svc. Comm'n, 298 S.C. 179, 184, 379 S.E.2d 119, 122 (1989); see also Am. Petroleum Inst. v. South Carolina Dep't of Revenue, 382 S.C. 572, 579, 677 S.E.2d 16, 20 (2009). The judicial branch shall not act in a way that infringes either directly or indirectly on any legislative function. See Brown v. State, 198 S.C. 430, 436, 18 S.E.2d 346, 348-49 (1941).

C. Legislative Functions

Article III, § 1 of the South Carolina Constitution confers all legislative powers and functions solely on the South Carolina General Assembly. See Hampton, Shearouse Adv. Sh. 20 at 104; Calhoun Life Ins. Co. v. Gambrell, 245 S.C. 406, 411, 140 S.E.2d 774, 776 (1965). Plaintiffs have put forward a series of policy arguments about why Charge Master Billing applied improperly to the uninsured and why the uninsured should get the benefit of discounts mandated by the federal government for Medicare beneficiaries or negotiated between the Hospitals and insurance companies.

As discussed infra, the evidence demonstrates that there are countervailing policy reasons why the uninsured should not get the benefit of these discounts or payment arrangements. Resolving this policy conflict is a legislative function. As recently stated in Hampton, "[i]ncluded within the legislative power is the sole prerogative to make policy decisions; to exercise discretion as to what the law will be." Shearouse Adv. Sh. 20 at 104 (citations omitted).

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According to the Supreme Court, "while non-legislative bodies may make policy determinations when properly delegated such power by the legislature, absent such a delegation, policy making is an intrusion upon the legislative power." Id. Since there has been no valid, constitutional delegation to this Court of the power to regulate, or to make policy decisions regarding the regulation of hospital business or billing practices, the policymaking proposed by Plaintiff and the policy decisions Plaintiffs ask this Court to make are "an intrusion upon the legislative power." Id.

Beyond policymaking, the legislative powers conferred to the General Assembly also include "the police power" of the State, which is the power to make laws for the general benefit of the public or for the benefit of a specific group. Sammons v. City of Beaufort, 225 S.C. 490, 499, 83 S.E.2d 153, 157 (1954); Gasque, 191 S.C. at 277-78, 2 S.E.2d at 39. Plaintiffs are asking this Court to find unreasonable and prohibit Defendant Hospitals from using a pricing methodology and business practice that has been used since the 1960s and is common throughout the hospital industry. The power to regulate businesses, the ways in which they operate, and the prices they charge is a legislative function within the general police powers of the General Assembly. See Bd. of Bank Control v. Thomason, 236 S.C. 158, 165, 113 S.E.2d 544, 547 (1960); Day-Brite Lighting, Inc. v. Missouri, 342 U.S. 421, 425 (1952); Richards v. City of Columbia, 227 S.C. 538, 547, 88 S.E.2d 683 (1955).[12] This is particularly true in South Carolina

[12] See also, e.g., Gasque, 191 S.C. at 277-78, 2 S.E.2d at 39; Hamm v. S.C. Pub. Serv. Comm'n, 294 S.C. 320, 322 n.1, 364 S.E.2d 455, 456 n.1 (1988); Bruce's Juices, 330 U.S. at 745-46; Ferguson v. Skrupa, 372 U.S. 726, 730-31 (1963); Miles Labs. v. Seignious, 30 F. Supp. 549, 557 (D.S.C. 1939); Pue v. Hood, 22 S.E.2d 896, 898-99 (N.C. 1942)(cited with approval in Board of Bank Control, 236 S.C. at 165, 113 S.E.2d at 547); Reynolds v. Milk Comm'n of Va., 179 S.E. 507, 510 (Va. 1935); In re Blanchflower, 834 A.2d 1010, 1012 (N.H. 2003); Butler Oak Tavern v. Div. of Alcoholic Beverage Control, 120 A.2d 24, 30 (N.J. 1956); Scarborough v. Webb's Cut Rate Drug Co., 8 So. 2d 913, 915-18 (Fla. 1942).

because our State Constitution confers the authority to regulate businesses and hospitals to the General Assembly.[13]

Plaintiffs argue that this Court should declare Charge Master Billing unreasonable and illegal and the Hospitals can either come back to the Court with another billing method or go to the legislature and ask it to deal with Hospital billing given the Court's Order. As Hampton makes clear, such policy choices are "the sole prerogative" of the legislature and any attempt by this Court to make those types of policy choices would be "an intrusion upon the legislative power." Shearouse Adv. Sh. 20 at 104. It is for the legislature to say in the first instance whether an industry should be regulated and what that regulation should be. See State v. Gibbes, 171 S.C. 209, 218, 172 S.E. 130, 133-34 (1933); Douglass v. City Council of Greenville, 92 S.C. 374, 380, 75 S.E. 687, 688-89 (1912).

In the specific context of hospital pricing lawsuits by uninsured patients, numerous courts in other jurisdictions have held that the resolution of claims like those asserted by Plaintiffs is beyond the scope of judicial function and is reserved in the legislative branch.[14] While there is

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[13] In addition to the General Assembly's broad plenary powers to act in a legislative capacity, Article IX, § 2 of the South Carolina Constitution gives the General Assembly alone the power to regulate corporations and to "prescribe their powers, rights, duties and liabilities . . . ." Article XII, § 1 states that the "health, welfare, and safety of the lives . . . of the people of this State . . . are matters of public concern" and gives the General Assembly the authority to create and determine the "activities, powers, and duties" of "agencies" to act in these areas. More specifically, the General Assembly has the constitutional power to create and regulate hospitals in South Carolina. Law v. City of Spartanburg, 148 S.C. 229, 238, 146 S.E. 12, 15 (1928).

[14] See, e.g., DiCarlo v. St. Mary Hosp., 530 F.3d 255 (3d Cir. 2008), affirming, No. 05-1665, 2006 U.S. Dist. LEXIS 49000 at *14 (D.N.J. July 19, 2006); Kolari v. New York Presbyterian Hosp., 382 F. Supp. 2d 562, 565-66 (S.D.N.Y. 2005); 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); Banner Health v. Med. Savs. Ins. Co., 163 P.3d 1096, 1103 (Ariz. App. Div. 2007); Buckner v. Banner Health Sys., No. CV 2005-003052 at p. 4 (Super. Ct. Ariz. Nov. 22, 2005); Galvan v. Northwestern Mem'l Hosp., 888 N.E.2d 529, 539 (Ill. Ct. App. 2008); Elliot Hosp. v. Boerner, No. 04-C-739 at p. 13 (Super. Ct. N.D. N.H. July 15, 2005); Firelands Reg'l Med. Ctr. v. Jeavons, No. E-07-068, 2008 Ohio App. LEXIS 4234 at **10-11 (Ohio Ct. App. 2008).

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no published appellate opinion in South Carolina addressing this issue, the Honorable Paul E. Short, Jr., then Circuit Court Judge for the Sixteenth Judicial Circuit, held that a court determining the unreasonableness of hospital charges on a class wide basis, either retroactively or prospectively, would violate the separation of powers:

> Only the General Assembly has the power to regulate business and the prices such businesses charge. See S.C. Const., Art. IX, §2. Health care is one of the most heavily regulated businesses in this State. Thus, it is telling that the General Assembly decided to forego regulating hospital charges, and left that sector of the business of health care to the free market.

Atherton v. Tenet Healthcare Corp., Civil Action No. 03-CP-46-1688, Order granting Def's Mot. for Sum. J. at pp. 12-14 (2004), aff'd, Op. No. 2005-UP-362 (S.C. Ct. App. 2005). Even if the Court sympathizes with Plaintiffs' policy arguments, it would violate the separation of powers mandate in our State Constitution for this Court to turn that sympathy into the result requested by Plaintiffs. See Gallman v. Springs Mills, 201 S.C. 257, 260, 22 S.E.2d 715, 716 (1942)(noting that "it is not within [the court's] power to translate [the court's] sympathy and conviction into law. That is a strictly legislative function.").

D. The South Carolina Legislature Has Declined to Act

The Supreme Court's opinion in In re Hosp. Pricing Litig., King v. AnMed Health, 377 S.C. 48, 659 S.E.2d 131 (2008), makes clear that the General Assembly has repeatedly declined the opportunity to either prohibit alleged price discrimination in hospital billing or to give uninsured patients the benefit of the discounts hospitals negotiate with insurance companies. This Court cannot grant Plaintiffs, under the guise of applying the common law, the very relief that the Legislature has rejected. See Dantzler v. Callison, 230 S.C. 75, 97, 94 S.E.2d 177, 189 (1956)(holding that, where "the primary duty and responsibility for determining a question rests with the Legislature, this Court will not substitute its judgment for that of the legislative

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authority"); South Carolina Farm Bureau Mut. Ins. Co. v. Mumford, 299 S.C. 14, 19, 382 S.E.2d 11, 14 (Ct. App. 1989)(holding that "[o]nce the Legislature has made [a] choice, there is no room for the courts to impose a different judgment based upon their own notions of public policy").

First, in 1967 and 1968, when the General Assembly considered the statutory predecessor to former Section 38-71-120 of the South Carolina Code, it rejected a proposed statute which would have prohibited what Plaintiffs are complaining about here, alleged price discrimination by hospitals, and which would have given uninsured patients the same discounts offered or granted to any insurance company, the very relief sought by Plaintiffs.[15] See King, 377 S.C. at 55-58, 659 S.E.2d at 135-36 (stating the "Commissioner's proposed legislation . . . would have required any discount to be uniform to all patients," and finding that "the legislature rejected the Insurance Commissioner's proposed legislation which would have mandated broad, uniform discounts . . . .").

Second, by 1987, Charge Master Billing had been in place for at least 20 years, and the practice of hospitals accepting discounted payments from insurance companies was well known.[16] According to King, the General Assembly amended former Section 38-71-120 in 1987 to delete certain language and significantly narrow its scope. 377 S.C. at 58-59, 659 S.E.2d at 136. The legislature could have tried to outlaw the use of Charge Masters, could have outlawed giving discounts off Charge Master charges, or could have required that uninsured patients be given the same discounts or some percentage of the discounts negotiated with insurance companies. The legislature did not do this but, instead, amended former Section 38-71-120 to limit any restrictions on price discrimination or discounts to a single, very narrow way of doing business. Thus, Plaintiffs' arguments are inconsistent with the statutory history. See Byrd v.

[15] Letter from Ins. Comm. to S-3 Committee, dated November 22, 1967 (DsWR008721).

[16] See, e.g., Pls' Mem. at 3-4; Letter of Knowlton July 21, 1983 (DsWR008708-10).

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Irmo High Sch., 321 S.C. 426, 433, 468 S.E.2d 861, 865 (1996)("Where a statute expressly enumerates the requirements on which it is to operate, additional requirements are not to be implied."); Scholtec v. Estate of Reeves, 327 S.C. 551, 559, 490 S.E.2d 603, 607 (Ct. App. 1997)(holding that, if the legislature intended a certain result, "we believe that it would have expressly stated so . . . .").

Third, as mentioned in King, less than three months after Judge Goode ruled that former Section 38-71-120 of the South Carolina Code required all patients, including the uninsured, be given the same discounts, the General Assembly repealed the statute, indicating it did not agree with this interpretation of the law. 377 S.C. at 52, 659 S.E.2d at 133.

E. Supremacy Clause / Federal Preemption

The United States Department of Health and Human Services ("DHHS") oversees the Medicare program and issues relevant regulations through its operating division, the Centers for Medicare & Medicaid Services ("CMS"). CMS issues and implements regulations under the Act, publishes interpretative guidance through various administrative manuals and determines agency policy through various administrative rulings. See Shalala v. Guernsey Mem'l Hosp., 514 U.S. 87, 95-100 (1995); Albert Einstein Med. Ctr. v. Sebelius, 566 F.3d 368, 373 (3d Cir. 2009).

The CMS Provider Reimbursement Manual ("CMS Manual") expressly provides that "each [hospital] facility should have an established charge structure which is applied uniformly to each patient as services are furnished to the patient . . . ." CMS Manual §2203 (DsWR008139-40); see also CMS Manual §2202.4 (DsWR008138)(providing "[c]harges should be . . . uniformly applied to all patients whether inpatient or outpatient"). This requirement has

been in effect since the Medicare program started nearly fifty years ago in the 1960s.[17] As stated in Paragraph 5.d of the 2012 Consent Order, each Defendant Hospital "created, used and uses its Charge Master as its established charge structure which is applied as services are furnished to each patient and has done so since the 1960s." Hospitals must use the uniform structure of a Charge Master and charge everyone the same price under Medicare regulations.[18] Any contentions of Plaintiffs to the contrary are without foundation and inconsistent with federal mandates.

The Supremacy Clause of the United States Constitution prohibits this Court from declaring that something encompassed within a federal regulatory scheme is "unnecessary," "outdated," or "unreasonable." Howlett v. Rose, 496 U.S. 356, 371-74 (1990); Nat'l City Bank v. Turnbaugh, 463 F.3d 325, 330 n.3 (4th Cir. 2006). "Federal regulations have no less pre-emptive effect than federal statutes." Fid. Fed. Sav. & Loan Ass'n v. de la Cuesta, 458 U.S. 141, 153 (1982). Federal law preempts the relief that Plaintiffs seek. This Court lacks the authority to declare that Charge Master Billing, or the federal requirement of having a uniform charge structure, is illegal, unlawful or unreasonable, even if this Court thinks the federal regulation or requirement is unnecessary, Medicare has implicitly abandoned it or it is unreasonable or unnecessary given the current state of reimbursement. Such arguments are properly directed to DHHS or to Congress.

F. Plaintiffs' Arguments

Plaintiffs advance several arguments on Declaratory Judgment Issue No. 1, none of which establishes that this Court has the power/authority to declare the use of a Charge Master to be unreasonable.

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[17] Bradford Aff. ¶ 6.B.i. (DsWR000360); Duffy Aff. ¶ III.4. at 11 (DsWR000162).

[18] Bradford Aff. ¶ 6.D. (DsWR000361).

1. Medicare Regulations

At the April 29, 2013 Hearing, Plaintiffs attempted to distinguish the numerous cases cited above that hold that Plaintiffs' challenge to Charge Master Billing is a matter for legislative determination. Plaintiffs claim this Litigation is one of first impression because Plaintiffs are complaining that the way Defendant Hospitals use their Charge Masters violates the Medicare requirements of a uniform charge structure and that charges should be reasonably related to a hospital's costs. This argument fails for two reasons.

First, there is no private right of action under Medicare for Medicare beneficiaries, let alone uninsured patients. See, e.g., Wogan v. Kunze, 366 S.C. 583, 601, 623 S.E.2d 107, 117 (Ct. App. 2005); Brogdon v. Nat'l Healthcare Corp., 103 F. Supp. 2d 1322, 1342 (N.D. Ga. 2000). Section 2203 of the CMS Manual, on which Plaintiffs base this argument, clearly provides that the Medicare intermediary, an independent third party retained by Medicare, makes decisions on compliance with this section of the CMS Manual and is the entity that has authority to take steps to enforce compliance through the reduction of Medicare payments. See St. Luke's Hosp. v. Sebelius, 611 F.3d 900, 903 n.6 (D.C. Cir. 2010).[19] Nothing in the CMS Manual states, suggests, or implies that uninsured patients have the authority to bring a private lawsuit against a hospital in state court to enforce Medicare regulations or requirements. Second, as discussed at Pages 57 through 60 infra, the way in which the Defendant Hospitals are using their Charge Masters does not violate Section 2203 of the CMS Manual or any Medicare regulation.

2. Plaintiffs' Case Citations

At the April 29, 2013 Hearing, the Court asked the Plaintiffs what authority supported their argument that the Court has the power/authority to declare the use of a Charge Master to be

[19] The functions of fiscal intermediaries are now performed by Medicare administrative contractors. 42 U.S.C. § 1395kk-1.

illegal, unlawful or unreasonable. Plaintiffs cited three cases: Doe v. HCA Health Services of Tennessee, Inc., Colomar v. Mercy Hosp., Inc. and Quinn v. VJC Health Systems.[20] None of these cases addresses the question of whether a court has the power/authority to declare a hospital's use of a charge master to be unreasonable or to mandate that the hospital bill uninsured patients using a method other than Charge Master Billing.

3. Plaintiffs' Requested Relief

Plaintiffs contend they are not asking this Court to perform legislative functions because they are merely asking the Court to find the use of the Charge Master unreasonable and prohibit the Defendant Hospitals from using the Charge Master to bill uninsured patients. According to Plaintiffs, they are not asking the Court to set a specific price and, therefore, are not asking the Court to engage in ratemaking. This contention fails for several reasons.

First, this argument is factually incorrect. Plaintiffs want this Court to outlaw the use of Charge Master Billing and mandate that the uninsured be given the benefit of reimbursement rates or discounts "negotiated . . . between Defendant Hospitals and the insurance companies."[21]

Second, a court performs legislative functions by doing things other than ratemaking. See State v. Barnes, 119 S.C. 213, 217-18, 112 S.E. 62, 64 (1922)(determining licensing requirements for chiropractors is a legislative function, not a judicial one); Myrtle Beach Hosp.v. City of Myrtle Beach, 333 S.C. 590, 595, 510 S.E.2d 439, 441 (Ct. App. 1998), aff'd as modified by 341 S.C. 1, 532 S.E.2d 868 (2000)(holding whether city should be required to pay for the hospital services rendered to pre-trial detainees was "for the legislature to decide and not the court system"). As the Supreme Court's recent decision in Hampton makes clear, included within the legislative power conveyed to the General Assembly by our State Constitution "is the

[20] April 29, 2013 Hearing Tr. at 125-26.

[21] Pls' Reply at 3, 20; see also Pls' Third Am. Compl. ¶ 62.

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sole prerogative to make policy decisions; to exercise discretion as to what the law will be." Shearouse Adv. Sh. 20 at 104. "[P]olicymaking is an intrusion upon the legislative power." Id.

The complaints Plaintiffs make about "the Charge Master Billing Scheme" are not illegal at common law but are policy arguments, which would necessarily have this Court engage in business or price regulation.[22] Plaintiffs' request that this Court declare Charge Master Billing unlawful, illegal, and unreasonable and prevent Defendant Hospitals from using this longstanding business practice is business regulation, a function reserved solely to the General Assembly. See, e.g., Santee Cooper Resort, 298 S.C. at 184, 379 S.E.2d at 122; Board of Bank Control, 236 S.C. at 165-66, 113 S.E.2d at 547. Further, Plaintiffs' contention that Charge Master Billing is illegal or unlawful because it is applied unequally to uninsured patients is contrary to settled common law that different customers may lawfully be charged different prices for the same goods or services. "In the exercise of proper judicial self-restraint, the courts should leave it to the people, through their elected representatives in the General Assembly, to say whether or not [a longstanding common law principle] should be revised or discarded." Page v. Winter, 240 S.C. 516, 519, 126 S.E.2d 570, 572 (1962); Rogers v. Florence Printing Co., 233 S.C. 567, 574, 106 S.E.2d 258, 261-62 (1958).

Plaintiffs are asking that this Court require the uninsured be given the benefit of reimbursement rates or discounts mandated by the federal government under the federal

[22] For example, Plaintiffs' contention that Charge Master Billing is unreasonable because the charges are allegedly an excessive multiple of costs ("two to four times costs") raises policy issues for legislative decision such as whether costs should be the sole measure of reasonableness, what factors should be considered in costs, whether prices should be set at a ratio of costs or some other method, and how much of a markup over costs should be allowed. The judgment that prices more than two times costs are excessive is price capping, a legislative function itself. City of Farmington v. Amoco Gas Co., 568 F. Supp. 1265, 1273 (D.N.M. 1983); Payne v. Griffin, 51 F. Supp. 588, 594-95 (D. Ga. 1943)(holding that "[f]ixing fair and equitable prices is a legislative function"); Butler Oak Tavern, 120 A.2d at 30.

Medicare program or negotiated by the Defendant Hospitals with insurance companies. That would be price regulation, which is a legislative function. See A. & M. Brand Realty Corp. v. Woods, 93 F. Supp. 715, 717 (D.D.C. 1950)(stating "[i]t is well established as a matter of constitutional law that the fixing of rates or prices is a legislative function"). The question of whether uninsured patients should be charged no more than the rates paid by insurance companies raises numerous issues for legislative discretion such as whether this is a good idea, which insurance company or companies to use as the baseline, how this requirement will affect the health care and insurance markets, and what collateral consequences may follow.[23]

Further, although Plaintiffs suggest that the obligation to create an allegedly more "reasonable" billing scheme can be shifted to the Defendant Hospitals once the Court declares Charge Master Billing unreasonable, Plaintiffs acknowledge in their Memorandum at page 18 that whatever the Defendant Hospitals do would be "subject to judicial review." Simply put, the relief Plaintiffs seek would make this Court a permanent regulatory body over the prices charged by the Defendant Hospitals and the manner in which patients are charged and billed, a power this Court lacks. The Court declines that invitation.

A final issue of concern is the fact this Court does not have broad, across-the-board regulatory authority over all hospitals in the State, which would only exist in the legislature or a statewide agency. The effect of the relief sought by Plaintiffs would be to subject the billing

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[23] For example, Plaintiffs' expert testified before Congress in 2004 and in his deposition in this Litigation that giving uninsured patients the benefit of the same discounts negotiated with insurance companies could induce more individuals to become uninsured. Anderson Dep. at Ex. 22 (June 24, 2004 Congressional Testimony)(DsWR004685-93); see also Anderson Dep. at Ex. 17 (Anderson's Expert Report in Blackwell v. Medical Savings Ins. Co.)(DsWR004574); McCormick Supp. Aff. ¶ 6.b (discussing economic policy reasons why uninsured should not be given discounts given to insurance companies)(DsWR000398); 42 U.S.C. § 18091(2)(I)(Congressional finding as part of Affordable Care Act that requiring uninsured patients to purchase health insurance and, thus, including typically younger, more healthy uninsureds in insurance pool would reduce health insurance rates for all).

practices of a few hospitals in South Carolina to regulation and court control while all the other hospitals in the state would be unregulated and free to use Charge Master Billing. Strong economic policy reasons weigh against regulating one hospital's prices or business practices while its competitors' prices are unregulated.[24] This could further increase the Defendant Hospitals' burden of providing uncompensated care to the uninsured and make them less able to compete effectively. See S.C. Code Ann § 44-6-132(4)(containing legislative finding that "[h]ospitals which provide the bulk of unreimbursed services [to indigent persons] cannot compete economically with hospitals which provide relatively little care to indigent persons"). Additionally, substantial costs and interference with business operations would result from the Defendant Hospitals having to develop a completely new billing structure and re-bill a decade of transactions while their competitors continue to operate under the "Charge Master Billing Scheme," which could reduce availability of essential services.

Given these broad policy implications, the decision to prohibit Charge Master Billing is one for the legislature, not the courts. This proposition is particularly applicable here because, as discussed in footnote 13, supra, the South Carolina Constitution specifically confers on the General Assembly the authority to regulate corporations and hospitals. See Segars-Andrews v. Judicial Merit Selection Comm'n, 387 S.C. 109, 121, 122-23, 691 S.E.2d 453, 460-61 (2010).

4. The Uniform Declaratory Judgments Act

Plaintiffs assert that the Declaratory Judgments Act furnishes the Court with the power/authority to declare the use of a Charge Master to be unreasonable. Plaintiffs' contentions are without merit.

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[24] Bradford Aff. ¶ 2.F.iii (DsWR000355); McCormick Aff. ¶ 22.k (DsWR000293); McCormick Supp. Aff. ¶ 6.d (DsWR000398).

The "Declaratory Judgment[s] Act is not an independent grant of jurisdiction." Tourism Expenditure Review Comm. v. City of Myrtle Beach, Opinion No. 27249 (S.C. Sup. Ct. filed May 8, 2013)(Shearhouse Adv. Sh. 21 at 44, 48). The Declaratory Judgments Act "does not create substantive rights or duties" or provide "a new source of legal rights and obligations." Felts v. Richland County, 299 S.C. 214, 216, 383 S.E.2d 261, 262-63 (Ct. App. 1989), aff'd, 303 S.C. 354, 400 S.E.2d 781 (1991). It merely "creates a new remedy" for previously existing causes of action. Id. at 216, 383 S.E.2d at 263.

First, Plaintiffs are asking this Court to issue a declaration that is not authorized under any possible interpretation of the express language of the Declaratory Judgments Act, S.C. Code Ann. § 15-53-10 et seq. Plaintiffs are not asking this Court to take a contract and bill from a Defendant Hospital and tell a Plaintiff what that contract means or what a Plaintiff owes the particular Hospital. As Declaratory Judgment Issue No. 1 is stated in the 2012 Consent Order and framed in Plaintiffs' memoranda, Plaintiffs are asking this Court to issue a sweeping declaration that the Defendant Hospitals' business practice of creating and using a uniform list of prices for all services and goods, the Charge Master, is "illegal," "unlawful" and "unreasonable" in its entirety. In addition, Plaintiffs asks this Court to order the Hospitals to re-bill patients using some other unspecified method. Under the plain language of the Declaratory Judgments Act, there is no authority permitting this Court to declare an established business practice "unreasonable" and outlaw its use.

Second, as discussed above, the regulation of business practices and prices is a legislative function reserved solely to the General Assembly under the South Carolina Constitution. A statute cannot change this constitutional separation of powers because the legislature cannot delegate legislative functions, and particularly its police power, to another branch of government.

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See, e.g., Joytime Distribs. & Amusement Co. v. State, 338 S.C. 634, 643, 528 S.E.2d 647, 652 (1999); McLeod, 278 S.C. at 312 & 317, 295 S.E.2d at 637 & 639; Sammons, 225 S.C. at 499, 83 S.E.2d at 157. Moreover, even if police powers could be delegated, nothing in the Declaratory Judgments Act properly delegates to the courts the power to regulate the price structures or billing mechanisms of a business or a hospital. See McNickel's, Inc. v. South Carolina Dep't of Revenue, 331 S.C. 629, 634, 503 S.E.2d 723, 725 (1998); Terry v. Pratt, 258 S.C. 177, 184, 187 S.E.2d 884, 887-88 (1972).

5. Haselden v. Davis

Plaintiffs argue that Haselden v. Davis, 353 S.C. 481, 579 S.E.2d 293 (2003), authorizes this Court to determine whether Charge Master Billing is reasonable or unreasonable. Haselden contains no such holding—either express or implied. In Haselden, the issue the court addressed was whether a plaintiff in a personal injury case could present as evidence of damages the amount billed by her treating physician when the plaintiff was not liable to pay any amount in excess of the amount paid by Medicaid. 353 S.C. at 483, 579 S.E.2d at 294. The court held that the injured plaintiff was entitled to recover in tort the reasonable value of the hospital services provided and that the amount billed by the provider was one factor the court should consider in that analysis. The Haselden court did not, in any way, opine or suggest that trial courts in South Carolina are empowered to declare that an entire way of doing business is unnecessary or unreasonable, to control or regulate how a business charges for services, or to declare a business's entire price list unreasonable.

6. Alleged Open Price Term

The alleged existence of an open price term in the Defendant Hospitals' contracts does not furnish a legal basis for this Court to declare the decades old and accepted method of Charge

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Master Billing to be unreasonable or improper. None of the cases Plaintiffs cite stand for this proposition, either expressly or impliedly. There is nothing, in any of those cases, which suggests that an open price term furnishes a court with the authority to declare Charge Master Billing unreasonable. Nor is there anything that gives a court the authority to prohibit a hospital from using a pre-set price list, like a Charge Master, to charge and bill all patients.

Moreover, the contracts of these Defendant Hospitals do not contain an open price term. South Carolina law clearly provides that a price term is not open if there is a definite method for ascertaining price. See McPeters v. Yeargin Constr. Co., 290 S.C. 327, 331, 350 S.E.2d 208, 211 (Ct. App. 1986). Plaintiffs acknowledge that six of the eight admission forms at issue in the Pending Cases "obligate the Plaintiffs to pay for some variation of the term 'all charges'" and "[t]he remaining two contracts contain [an additional] phrase that obligates the Plaintiffs to pay according to the regular rates and terms" of the Hospital.[25]

Courts around the country addressing similar hospital pricing claims have overwhelmingly found that the patient's agreement to pay the hospital's "charges" is an unambiguous agreement to pay the hospital's Charge Master prices which precludes any inquiry into the reasonableness of the hospital's charges or the Charge Master prices. See, e.g., DiCarlo, 530 F.3d at 259; Holland v. Trinity Health Care Corp., 2010 Mich. App. LEXIS 490 (Mich. Ct. App. Mar. 16, 2010); Morrell v. Wellstar Health Sys., Inc., 633 S.E.2d 68, 72 (Ga. Ct. App. 2006); Burton v. William Beaumont Hosp., 373 F. Supp. 2d 707, 718 (E.D. Mich. 2005); Nygaard v. Sioux Valley Hosps. & Health Sys., 731 N.W.2d 184, 192 (S.D. 2007); Harrison v. Christus St. Patrick Hosp., 430 F. Supp. 2d 591, 595-96 (W.D. La. 2006).

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[25] Pls' Mem. at 24-25.

Plaintiffs cite Doe v. HCA Health Services of Tennessee, 46 S.W.3d 191 (Tenn. 2001) and Allen v. Clarian Health Partners, Inc., 955 N.E.2d 804 (Ind. Ct. App. 2011), for the proposition that reference to "charges" in the contract between the patient and hospital is not sufficient to indicate Charge Master prices will be charged. Doe is clearly in the minority. The more recent cases, holding that an agreement to pay "charges" is an unambiguous reference to the Charge Master prices, represent the current, majority view.[26]

The Indiana Supreme Court has overruled the Allen decision from the Indiana Court of Appeals. See Allen v. Clarian Health Partners, Inc., 980 N.E.2d 306 (Ind. Sup. Ct. 2012). The Indiana Supreme Court held that a patient's agreement "to pay their account" was a contract to pay the hospital's charge master prices and cited with approval cases holding that an agreement to pay "charges" is a contract to pay charge master prices. The Allen decision recognized but refused to follow Doe.

The more recent, persuasive cases hold that an agreement to pay "any charges" or "all charges" is an unambiguous reference to Charge Master prices. Because the majority rule is consistent with South Carolina law, the Court finds an agreement to pay "any charges" or "all charges" is an unambiguous agreement to pay Charge Master prices. Therefore, none of the contracts here has an open price term.

In addition to the patients agreeing to pay "any charges" or "all charges," the patient contracts with GHS and Mary Black provided that the patient will pay the Hospital's "regular

[26] Plaintiffs also include a quote from an unpublished Missouri trial court order issued at the class certification stage. Quinn v. BJC Health Sys., No. 22052-0821A, 2007 WL 7308622 (Circuit Court of Mo. March 2, 2007). This order relies exclusively on the flawed analysis of Doe, which has been rejected by the vast majority of courts around the country. The Quinn trial court opinion has never been cited by any other court in the country.

rates."[27] Courts nationwide have consistently held that a patient's agreement to pay charges according to the hospital's "regular rates" is also an unambiguous agreement or contract to pay the price in the hospital's Charge Master. See, e.g., Woodruff v. Fort Sanders Sevier Med. Ctr., 2008 Tenn. App. LEXIS 11 at **5-8 (Tenn. Ct. App. Jan. 16, 2008)(expressly distinguishing Doe where the patient contract references the hospital's "rates" or "regular rates"); Harrison, 430 F. Supp. 2d at 595; Cox v. Athens Reg'l Med. Ctr., Inc., 631 S.E.2d 792, 795-97 (Ga. Ct. App. 2006); Shelton v. Duke Univ. Health Sys., Inc., 633 S.E.2d 113, 116 (N.C. Ct. App. 2006).

However, even if the Defendant Hospitals' contracts lack a specific price term or method for determining a price, this Court is not then permitted to infer or impute a "reasonable" price or, more importantly, declare all Charge Master Billing illegal and outlaw its use. In South Carolina, an alleged contract that is missing an essential term, such as price, is unenforceable and the courts cannot supply essential terms omitted by the parties. See Ellis v. Taylor, 316 S.C. 245, 249, 449 S.E.2d 487, 489 (1994); Consignment Sales, LLC v. Tucker Oil Co., 391 S.C. 266, 271-72, 705 S.E.2d 73, 76 (Ct. App. 2010).

Plaintiffs cite Braswell v. Heart of Spartanburg Motel, 251 S.C. 14, 159 S.E.2d 848 (1968), and Adams, for the proposition that "[w]here the price term in a contract is left open, the party providing the services can only charge the reasonable value for the goods and services."[28] Nowhere in Braswell is this alleged proposition stated, nor is that the holding of the case. Braswell stands for the unremarkable proposition that, when one party has provided goods or services to the other with the expectation of payment, equity will allow the one providing the goods or services to sue to recover the reasonable value of the goods or services provided to the

[27] See Bichel Aff. ¶ 2 (DsWR000099-100), Waters Aff. ¶ 8 (DsWR000502-03); J. Bennett Dep. at 91-93 (DsWR002083-85); K. Paulson Dep. at 79-80 (DsWR006383-84); Coley Dep. at 57-61 (DsWR002977-81), Ex. 5 (DsWR003043-44); Meyer Aff. ¶ 2 (DsWR000113-14).

[28] Pls' Mem. at 14-15.

other under a theory of quantum meruit. 251 S.C. at 18-19, 159 S.E.2d at 850. In the case of an open price term, Braswell would merely allow the hospital to sue the uninsured patient to recover the reasonable value of the hospital services provided. See Boykin Contr., Inc. v. Kirby, Op. No. 5133 (S.C. Ct. App. Filed May 15, 2013)(Shearouse Adv. Sh. No. 22 at 61, 66-67)(explaining holding in Braswell).

Plaintiffs' citation to Adams is also misplaced because Adams does not say what Plaintiffs' claim and its holding is based on UCC Article 2, S.C. Code Ann. § 36-2-305. 320 S.C. at 278-79, 465 S.E.2d at 86. Article 2 of the UCC does not apply to the provision of services or goods by healthcare providers during the course of medical treatment. In re Breast Implant Prod. Liab. Litig., 331 S.C. 540, 552, 553, 503 S.E.2d 445, 451-52 (1998).

Therefore, even assuming arguendo that Plaintiffs' contracts with the Defendant Hospitals contain a missing, open or "undefined" price term, the necessary result would be that the Court must find the contracts void and unenforceable. See Edens v. Laurel Hill, Inc., 271 S.C. 360, 364, 247 S.E.2d 434, 436 (1978); Gantt v. Morgan, 199 S.C. 138, 140-42, 18 S.E.2d 672, 673-74 (1942); Stanley Smith & Sons v. Limestone Coll., 283 S.C. 430, 433, 322 S.E.2d 474, 477 (Ct. App. 1984). An open price term simply does not allow this Court to declare all Charge Master Billing unlawful or to hold that all prices in the Charge Master are "unreasonable."

7. Adhesion Contracts

Plaintiffs argue the admission forms signed by the patients are "adhesion contracts" which allow this Court to make an across-the-board determination as to Charge Master Billing or the reasonableness of the Defendant Hospitals' charges. Plaintiffs' argument is contrary to settled South Carolina contract law.

Adhesion contracts are standard form contracts offered on a take-it-or-leave-it basis with nonnegotiable terms. See Simpson v. MSA of Myrtle Beach, Inc., 373 S.C. 14, 26-27, 644 S.E.2d 663, 669 (2007). South Carolina law makes clear that adhesion contracts are not per se improper, illegal or unlawful. See Fanning v. Fritz's Pontiac-Cadillac-Buick, Inc., 322 S.C. 399, 403, 472 S.E.2d 242, 245 (1996). As our Court of Appeals has noted, "[t]he contract of adhesion is a part of the fabric of our society" and the standardization of contracts is "a rational and economically efficient response to the rapidity of market transactions and the high costs of negotiations." Lackey v. Green Tree Fin. Corp., 330 S.C. 388, 395-96, 498 S.E.2d 898, 902 (Ct. App. 1998).

Other than the fact that the contracts signed by the Plaintiffs in these cases are "form" contracts, there is no evidence that they are adhesion contracts. On the contrary, the record clearly reflects that the Defendant Hospitals provide estimates of the anticipated charges to patients and their physicians upon request.[29] Additionally, the record shows that the Hospitals allow patients to negotiate payment amounts and terms under all types of circumstances.[30]

However, even assuming the admission forms signed by Plaintiffs were adhesion contracts, this fact would not permit this Court to rule that Charge Master Billing is "unreasonable." First, entitlement to any relief requires proof that an adhesion contract is unconscionable. See Herron v. Century BMW, 387 S.C. 525, 532, 693 S.E.2d 394, 397 (2010). "Unconscionable" is not the same as "unreasonable." Under South Carolina law,

[29] See Eckert Aff. ¶ 5 (DsWR000584-85); Graudin Aff. ¶ 12 (DsWR000621-22); Johnson Aff. ¶ 13 (DsWR000432-33); Lee Aff. ¶¶ 29-31 (DsWR000131-32); Meyer Aff. ¶ 13 (DsWR000449-50); Parrish Aff. ¶ 18 (DsWR000329); Stewart Aff. ¶ 14 (DsWR000485-86); Waters Aff. ¶ 11 (DsWR000504-05); Weeks Aff. ¶ 12 (DsWR000414-15).

[30] See Eckert Aff. ¶¶ 7-11 (DsWR000585-86); Graudin Aff. ¶ 23 (DsWR000629-30); Johnson Aff. ¶ 26 (DsWR000437); Lee Aff. ¶ 9 (DsWR000474-75); Meyer Aff. ¶ 21 (DsWR000456-57); Parrish Aff. ¶¶ 13, 21, 26 (DsWR000327, 000329, 000331); Stewart Aff. ¶ 23 (DsWR000489); Waters Aff. ¶ 21 (DsWR000513-14); Weeks Aff. ¶¶ 32-33 (DsWR000423-24).

unconscionability requires a great showing, Lackey, 330 S.C. at 395, 498 S.E.2d at 901-02, and is defined as "the absence of meaningful choice on the part of one party due to one-sided contract provisions, together with terms that are so oppressive that no reasonable person would make them and no fair and honest person would accept them." Carolina Care Plan, Inc. v. United HealthCare Servs., Inc., 361 S.C. 544, 554, 606 S.E.2d 752, 757 (2004). Moreover, in Gladden v. Boykin, 402 S.C. 140, 145, 739 S.E.2d 882, 884-85 (2013), our Supreme Court recently held that, even where contract "terms appear grossly unreasonable" and there is "an extreme inequality of bargaining power," unconscionability exists only if there are other "factors such as lack of basic reading ability and the drafter's evident intent to obscure the [challenged] term." "A determination whether a contract is unconscionable depends upon all the facts and circumstances of a particular case." Holler v. Holler, 364 S.C. 256, 269, 612 S.E.2d 469, 476 (Ct. App. 2005).

The evidence fails to establish that use of Charge Master Billing or any specific charge to any patient treated by the Defendant Hospitals was so oppressive and unfair as to meet the high standard necessary to establish "unconscionability" under South Carolina law. The evidence shows that Charge Master Billing is an accepted method of charging patients for hospital services which has been used for decades, and that the prices in these Defendant Hospitals' Charge Masters are consistent with what other hospitals charge for similar services and with the Defendant Hospitals' costs.[31] Moreover, the evidence in the Written Record does not establish the elements required by the recent Gladden opinion. 402 S.C. 140, 739 S.E.2d 882.

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[31] See Graudin Aff. ¶ 8 (DsWR000620); Johnson Aff. ¶¶ 8-9 (DsWR000429-31); Lee Aff. ¶¶ 12-13 (DsWR000127-28); Meyer Aff. ¶ 9 (DsWR000447-48); Parrish Aff. ¶ 15 (DsWR000327-28); Stewart Aff. ¶¶ 9-10 (DsWR000483); Waters Aff. ¶ 7 (DsWR000501-02); Weeks Aff. ¶¶ 7-8 (DsWR000411-12).

Second, even if proof of unconscionability existed, a finding of unconscionability would require this Court to hold the contracts are void and unenforceable. See Holler, 364 S.C. at 264, 612 S.E.2d at 473. Unconscionability does not allow this Court to declare an entire pricing mechanism or way of doing business illegal and prohibit its use. As with Plaintiffs' open price term argument, their "adhesion contract" theory does not give this Court the authority to grant the relief requested of outlawing the Charge Master and requiring a new billing method for uninsured patients.

8. Defendant Hospitals' Counterclaims for Quantum Meruit/Unjust Enrichment

Plaintiffs argue that the quantum meruit counterclaims and setoffs asserted in Defendant Hospitals' answers constitute an admission that this Court can determine the reasonableness of the Hospitals' prices and apparently of Charge Master Billing as a whole. The Court disagrees.

First, the quantum meruit counterclaims have been raised because: (a) the Defendant Hospitals have conferred a non-gratuitous benefit on the Plaintiffs in the form of hospital services for which Plaintiffs have admittedly not paid; and (b) the counterclaims are compulsory and must be asserted now or lost. See Mullinax v. Bates, 317 S.C. 394, 396, 453 S.E.2d 894, 895 (1995); Plantation Fed. Bank v. Gray, 401 S.C. 507, 510, 737 S.E.2d 515, 517 (Ct. App. 2013).

Second, the Defendant Hospitals' answers expressly allege affirmative defenses asserting that the relief sought by Plaintiffs violates the separation of powers mandate, that it falls outside the constitutional authority of this Court, and that this Court does not have the authority to grant the relief requested.[32] The fact that Defendant Hospitals' answers contain other inconsistent defenses or counterclaims that are potentially contrary to their constitutional separation of

[32] See, e.g., Greenville Hospital System's ("GHS's") Answer to Plaintiff's Amended Complaint, ¶¶ 75, 79, and 130.

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powers arguments does not undermine the validity of those defenses and is not an admission of any kind under settled South Carolina law. The Defendant Hospitals are entitled under Rule 8, SCRCP, to plead defenses and counterclaims in the alternative so that one defense or counterclaim does not constitute a concession as to any other inconsistent denial, defense, or counterclaim. See Rule 8(e)(2), SCRCP; Hayne Fed. Credit Union v. Bailey, 327 S.C. 242, 252, 489 S.E.2d 472, 477 (1997); Cunningham v. Anderson County, Op. No. 5072 (S.C. Ct. App. filed January 16, 2013)(Shearouse Adv. Sh. No. 3 at 37, 51). It is long established that a defendant may plead inconsistent defenses and the allegations in one defense may not be used to undermine the validity of another alternate or inconsistent defense. See Gilreath v. Furman, 57 S.C. 289, 293, 35 S.E. 516, 517 (1900).

DECLARATORY JUDGMENT ISSUE NO. 2

Declaratory Judgment Issue No. 2 requires the Court to answer the following question:

Is the use of a Charge Master unreasonable based on the record before the Court?

Issue No. 2 is a question of fact on which Plaintiffs bear the burden of proof by the preponderance of the evidence. See Vermont Mut. Ins. Co. v. Singleton, 316 S.C. 5, 10, 446 S.E.2d 417, 421 (1994); Menne v. Keowee Key Prop. Owners' Ass'n, 368 S.C. 557, 564, 629 S.E.2d 690, 694 (Ct. App. 2006).

I. FINDINGS OF FACT

The Court makes the following findings of fact under Rule 52(b), SCRCP, based on the preponderance of the credible evidence in the Written Record:

A. The Parties

As an initial matter, the Court determines that the affidavits submitted by employees of each of the Defendant Hospitals and that the affidavits of Defendants' experts are credible. Plaintiffs have not presented any evidence to refute or undermine these affidavits as to the respective Defendant Hospitals.

The individual Plaintiffs were residents of South Carolina, at the time of filing the nine Pending Cases, who received care at one or more of the Defendant Hospitals between mid-2000 and the present. At the time of treatment, none of the Plaintiffs had any form of coverage with a health insurance company or health maintenance organization, nor were any of the Plaintiffs beneficiaries of a government program such as Medicare that paid or should have paid for some or all of the costs of his or her hospital treatment. In other words, the individual Plaintiffs were uninsured.

Each Defendant Hospital in the nine Pending Cases is a hospital licensed by the State of South Carolina to provide hospital services to patients in this State. Each of the Defendant Hospitals participates in the federal Medicare program.

Each Defendant Hospital competes in markets serviced by other hospitals that are not defendants in the nine Pending Cases and are not before this Court.

The Defendant Hospital that treated an individual Plaintiff sent the Plaintiff a bill at the Charge Master price for the actual goods and services received by the Plaintiff during treatment.

The Defendant Hospitals provided hospital care to the individual Plaintiffs bringing the nine Pending Cases, billed them for that care, and the individual Plaintiffs made payments on their bill, if at all, as reflected in the chart below:

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Hospital	Plaintiff	Charges	Payment	Written Record Source
AnMed Health	Stanfield, Susan	$627.00	$0.00	Bowen Aff. ¶ 3 (DsWR000119).
Greenville Hospital System	Bennett, Jeyilud Paulson, Kelli Jean	$10,804.50 $38,443.10	$0.00 $40.00	Waters Aff. ¶ 36, 39 (DsWR000521, 522).
Kershaw County Medical Center	Bisbee, Lynn	$2,940.94	$11.09	Weeks Aff. ¶ 27 (DsWR000420-21).
Mary Black Memorial Hospital	Coley, Brett	$14,480.00	$0.00	Meyer Aff. ¶¶ 4-5 (DsWR000114-15).
Palmetto Health Alliance	Bisbee, Lynn Garrett, Jarrod Gary, Ron Ross, John Michael	$20,952.00 $36,352.00 $16,692.34 $14,356.00	$14,000.00 $0.00 $303.00 $25.00	Eckert Aff. ¶ 3.a.-3.d. (DsWR000135-37).
Roper St. Francis Hospital	Monteith, Marsha	$6,128.25	$0.00	Graudin Aff. ¶ 5 (DsWR000144).
Sisters of Charity Providence Hospitals	Green, Kathy	$319.00	$0.00	Outlaw Aff. ¶ 6 (DsWR000110); Green Dep. at 69:6-23 (DsWR001263).
Tuomey Healthcare System	Arrants, Eddie Bean, Doris Dubose, Bashira	$3,348.00 $8,056.08 $6,392.00	$2,678.40 $510.00 $625.00	Johnson Aff. ¶¶ 28-31 (DsWR000438).

The individual Plaintiffs bringing the nine Pending Cases have not paid their full bill, i.e., full Charge Master prices. Eleven of the Plaintiffs have paid nothing on their hospital bills or only a nominal amount. For those who have paid some amount, the facts demonstrate that discounts off Charge Master prices are available to uninsured patients.[33]

[33] By way of example, with respect to Lynn Bisbee's treatment at Kershaw County Medical Center ("Kershaw"), Ms. Bisbee negotiated a payment plan so that her charges could be paid over time at $100 per month, interest free. Weeks Aff. ¶ 27 (DsWR000420-21). Ms. Bisbee made only one payment of $11.09 on December 19, 2007. Id. Ms. Bisbee's father paid the remaining balance; therefore, no balance is owed with regard to the treatment associated with the Pending Case. Id. It is worth noting that since 2005, Ms. Bisbee has visited Kershaw 39 times and has had insurance for some of the visits. Id. at ¶ 28. For the treatment she received during her 39 visits: (i) Ms. Bisbee has been charged $158,481.15; (ii) of these charges, Ms. Bisbee has paid $1,290.68; (iii) insurance has covered $31,693.71; (iv) Kershaw has written off $124,525.76; and (v) Ms. Bisbee has no outstanding balance. Id.

At the time of admission to a Defendant Hospital, each Plaintiff signed a contract agreeing to pay for "all charges" or "any charges" incurred at the Defendant Hospital that was treating the individual Plaintiff. The contracts signed by Plaintiffs Bennett, Paulson and Coley, who were treated at GHS or Mary Black, also stated that the Plaintiff would agree to pay "according to the regular rates and terms" or to pay the "then current regular rates" for treatment.

B. The Charge Master and How It is Used

Since the 1960s, each of the Defendant Hospitals has created and used a master list of the amount that it charges every patient for every service, supply, and pharmacy item used in treating its patients. This master list is commonly known as the "Charge Master." Simply put, a Charge Master is a list of all goods and services offered by a hospital and the price for each one.

Charge Masters have been used by hospitals across South Carolina and the United States as the standard way of billing patients since the 1960s. As recently stated by the Indiana

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With respect to Ms. Bisbee's treatment at Palmetto Health Alliance ("Palmetto"), Ms. Bisbee negotiated a payment plan in early 2004 whereby she paid $100.00 per month toward all outstanding balances at no interest. From 2004 through 2008, Ms. Bisbee paid approximately $14,000.00. In November 2008, Palmetto adjusted and wrote off the remainder of Ms. Bisbee's outstanding balance of over $7,000.00. Accordingly, Ms. Bisbee currently owes nothing on her charges. She received a discount of approximately 33% off Charge Master charges. Neither Medicare nor any insurer that contracts with Palmetto receives as favorable an interest arrangement or payment schedule as did Ms. Bisbee. Eckert Aff. ¶ 3.d. (DsWR000136-37).

With respect to John Michael Ross's treatment at Palmetto for which he has paid only $25.00, Mr. Ross testified that he owes money for the services provided to him. Ross Dep. at 19-20 (DsWR002462-63). He testified that he could not pay the full billed amount at one time, but admitted it would be financially feasible for him to make a down payment of $10,000 and enter into a payment plan for the remaining balance. Id. at 11, 28 (DsWR002454, 002471). Nevertheless, Ross rejected offers to discount his bill, including an offer to discount his bill by 40%. Id. at 25 (DsWR002468); Eckert Aff. ¶ 3.c. (DsWR000136). Mr. Ross maintains that he is willing to pay a "reasonable" amount, but caps his calculation of a "reasonable" amount at $2,811.60, which amounts to an 80% discount. See Ross Dep. at 20-21 (DsWR002463-64).

With respect to Eddie Arrants's treatment at Tuomey Healthcare System ("Tuomey"), Mr. Arrants entered into an agreement to pay his charges over time with monthly installments. Johnson Aff. ¶ 29 (DsWR000438). Once he paid 80% of his charges, Tuomey credited him with a 20% discount. Accordingly, Mr. Arrants no longer owes any money to Tuomey. Id.

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Supreme Court in Allen v. Clarian Health Partners, Inc., 980 N.E.2d 306, 310 (Ind. Sup. Ct. 2012):

> [A] hospital's chargemaster rates serve as the basis for its pricing. Each hospital sets its own chargemaster rates, thus each hospital's chargemaster is unique. It is from these chargemaster prices that insurance companies negotiate with hospitals for discounts for their policyholders. And other reimbursement schemes are based in part on hospital chargemaster rates. Even the 2010 Federal Patient Protection and Affordable Care Act recognized the centrality of chargemasters to hospital billing practices.

For each Defendant Hospital, only one Charge Master is in effect at any one time, and it is applied equally to all patients at that Hospital. Each Defendant Hospital uses its Charge Master to create a bill for each patient the Hospital treats, whether that patient is insured, uninsured, or covered by Medicare. The patient is charged and billed for the actual services received by the patient at the price in the Charge Master in effect when the patient is treated. Every bill reflects the full Charge Master prices in effect at the time the patient receives treatment, whether the patient is insured or uninsured.[34]

There is no separate price or charge structure for uninsured and insured patients.[35] For identical services received, every patient is charged and billed the same amount, the Charge Master price.[36] These Plaintiffs were charged the same amount for the services they received as

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[34] See Eckert Aff. ¶¶ 3-4 (DsWR000345-46); Graudin Aff. ¶¶ 3-6 (DsWR000618-19); Johnson Aff. ¶ 7 (DsWR000482); Lee Aff. ¶¶ 2-4 (DsWR000471-72); Meyer Aff. ¶¶ 3-7 (DsWR000445-47); Parrish Aff. ¶¶ 3-4, 9 (DsWR000324-25, 000326-27); Stewart Aff. ¶ 7 (DsWR000482); Waters Aff. ¶¶ 3-6 (DsWR000499-501); Weeks Aff. ¶ 6 (DsWR000411); see also Abernathy Aff. ¶ 7.E. (DsWR000057-58).

[35] See Eckert Aff. ¶ 4 (DsWR000346); Graudin Aff. ¶ 4 (DsWR000144); Lee Aff. ¶ 3 (DsWR000472); Johnson Aff. ¶ 7 (DsWR000429); Meyer Aff. ¶ 6 (DsWR000446); Parrish Aff. ¶¶ 4, 9 (DsWR000325, 000327); Stewart Aff. ¶ 7 (DsWR000482); Waters Aff. ¶ 4 (DsWR000499); Weeks Aff. ¶ 6 (DsWR000411).

[36] Bradford Aff. ¶ 6.B. (DsWR000360-61); Duffy Aff. III.4. at 11 (DsWR000162).

would have been charged by that Hospital to patients covered by insurance or Medicare who received the same services.[37]

Plaintiffs' own expert admits that all patients are charged the same price for the same service.[38] Plaintiffs' counsel conceded this point in the brief they filed in the King appeal, which involved some of the same Pending Cases currently before this Court:

> The Charge Master, which is usually kept in the billing office, is very extensive and lists every service and item available from a Hospital. Hospitals use the Charge Master list to determine the bill for its services to all patients. This bill is called a "UB-92." Thus, all patients are charged the Charge Master rate in the compilation of their UB-92 bills.[39]

There is no evidence of a specific insured patient and a specific uninsured patient who were charged or billed different prices for the same hospital services by any of the Defendant Hospitals.

Based on a sampling of five uninsured patients conducted by each Defendant Hospital pursuant to this Court's June 30, 2010 Order, Plaintiffs contended in their Reply Memorandum "the Record is full of examples, from each Hospital, that the same goods and services are charged in drastically different amounts to different patients." According to Plaintiffs, the 2010 five patient samples contained "Defendant Hospitals' estimates of what they would have charged Medicare and what they would have charged Blue Cross Blue Shield for the exact same service given to an uninsured patient." Pls' Reply at 12. Although Plaintiffs appeared to abandon this

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[37] See also, e.g., Eckert Aff. ¶ 15 (DsWR000589); Lee Aff. ¶ 3 (DsWR000472); Johnson Aff. ¶ 7 (DsWR000429); Stewart Aff. ¶ 7 (DsWR000482); Meyer Aff. ¶ 31 (DsWR000461); Waters Aff. ¶¶ 36, 40 (DsWR000521, 000523); Weeks Aff. ¶ 6 (DsWR000411).

[38] Anderson Dep. at 237 (DsWR003753).

[39] Respondents' Final Joint Br., Page 5 n.5 (DsWR008766).

contention at the April 29, 2013 Hearing,[40] the Court addresses the 2010 five patient sampling for the sake of clarity and certainty.

The five patient sample performed by each Defendant Hospital in the summer of 2010 does not, in any way, establish that a Defendant Hospital charges uninsured patients more for similar goods and services than it charges Medicare or Blue Cross Blue Shield. The estimates provided by the Hospitals were estimated Medicare and Blue Cross reimbursements only: i.e., what Medicare or Blue Cross would have paid on the uninsured patient's bill if the patient had been covered by Medicare or a Blue Cross policy.[41]

Each Defendant Hospital's Charge Master is a pre-existing price list of all goods and services that is not created or amended for any specific patient, uninsured or otherwise. When a patient is admitted at a Defendant Hospital, it is typically not possible to know the precise treatment, medication, and other goods and services the patient will need because the exact course of the patient's treatment depends on variables then unknown.[42] Treatment is often governed by decisions made by independent physicians and each individual patient.[43] Even two patients having the same general surgery or illness during the same time period may need different goods and services based on their course of treatment and responses thereto.[44] A price

[40] See April 29, 2013 Hearing Tr. at 33-35.

[41] See, e.g., DsWR007181; July 30, 2010 Consent Order.

[42] See Eckert Aff. ¶ 15 (DsWR000140); Eckert Aff. ¶ 4 (DsWR000584); Graudin Aff. ¶ 9 (DsWR000620); Meyer Aff. ¶ 10 (DsWR000448); Johnson ¶ 13 (DsWR000433); Parrish Aff. ¶ 16 (DsWR000328); Stewart Aff. ¶ 12 (DsWR000484); Weeks Aff. ¶ 10 (DsWR000413); Waters Aff. ¶ 8 (DsWR000502).

[43] Abernathy Aff. ¶¶ 9.E., 10 (DsWR000061-62, 000065); Meyer Aff. ¶ 10 (DsWR000448); Johnson ¶ 13 (DsWR000433); Lee Aff. ¶ 8 (DsWR000474); Parrish Aff. ¶ 17 (DsWR000328); Stewart Aff. ¶ 12 (DsWR000484); Weeks Aff. ¶ 10 (DsWR000413); Waters Aff. ¶ 10 (DsWR000503).

[44] Waters Aff. ¶ 10 (DsWR000503); Graudin Aff. ¶ 11 (DsWR000621); Meyer Aff. ¶ 12 (DsWR000448-449); Lee Aff. ¶ 8 (DsWR000474).

list that exists before services are rendered and that is applied based on the services actually received is a reasonable way to approach pricing given the uncertainty of treatment.[45]

C. The Federal Medicare Program

Medicare requires that each hospital participating in the federal Medicare program maintain a uniform price structure and submit periodic Medicare cost reports. See CMS Manual § 2202.4, 2203. (DsWR008138, 008139-40). There is no evidence in the Written Record before this Court that the federal Medicare program has withdrawn or eliminated its requirement that each hospital have a uniform charge structure that is applied uniformly to each patient as services are provided or that this requirement no longer applies to the Defendant Hospitals in the Pending Cases. The guidance materials referenced in Secretary Tommy Thompson's 2004 letter (cited in Plaintiffs' Amended Complaint) expressly reaffirm the requirement of a uniform charge structure that must be uniformly applied to all patients so that the Medicare Cost Report is accurate.[46] The CMS Manual quoted in Plaintiffs' memoranda expressly provides a hospital should have an established charge structure that is uniformly applied to each patient as services are rendered to the patient. The CMS Manual remains in effect at this time.

The evidence does not support Plaintiffs' claim that Medicare has "abandoned" the Medicare cost report system. Each year, hospitals participating in the Medicare program are required by CMS to file a "Medicare cost report." See 42 U.S.C. § 1395(g); 42 C.F.R. §§ 413.20(b), 413.24(f). The cost report shows the portion of a Hospital's costs to be allocated to Medicare patients. 42 C.F.R. § 413.9 (defining "costs" for purposes of the Medicare reimbursement program). Costs attributable to noncovered persons are not includable in the cost

[45] McCormick Aff. fn. 6 at 7 (DsWR000188); McCormick Aff. ¶ 17.b. and c. (DsWR000188).

[46] See "Questions on Charges for the Uninsured" attached to Letter from Tommy G. Thompson, Secretary of Health and Human Services to Richard J. Davidson, President, American Hospital Association (Feb. 19, 2004)(DsWR008711-18).

report. For example, bad debt attributable to Medicare beneficiaries is includable (e.g., deductibles and coinsurance obligations of Medicare beneficiaries that a hospital is unable to collect after bona fide collection efforts)[47] while the cost report excludes bad debt and charity allowances attributable to non-Medicare covered patients (e.g., self-pay patients who fail to pay all or any portion of their bills or commercially insured patients who fail to pay their deductibles and coinsurance). 42 C.F.R. § 413.89. Hospital charges are also reported on the cost report and are used by the Medicare program to calculate the Medicare cost to charge ratio. The Medicare cost to charge ratio is used by Medicare to determine additional reimbursement payable to a hospital for outlier claims.[48] Medicare also uses the data derived from the various cost reports it receives for a number of other purposes including determining the weight assigned to different DRG classifications used to determine DRG reimbursement.[49]

If the Defendant Hospitals failed to timely submit the cost reports in compliance with the Medicare regulations, they would not receive reimbursement for the care provided to Medicare beneficiaries they treat. This requirement remains in effect and has not been repealed or withdrawn. The Medicare Cost Report form itself states on its cover that "this report is required by law . . . ."[50]

D. Prices in the Charge Master

The Defendant Hospitals' Charge Masters are prepared and the prices therein revised with a reasoned approach based on a number of factors, including each Defendant Hospital's

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[47] "Bad debts growing out of the failure of a beneficiary to pay the deductible, or the coinsurance, will be reimbursed (after bona fide efforts at collection)." 42 C.F.R. § 413.5(6). Waiver or reduction of Medicare copayments cannot be treated a bad debt. 42 U.S.C. § 1395x(T).

[48] Duffy Dep. at 77-84 (DsWR006791-98).

[49] Id. at 45 (DsWR006759).

[50] Sample Cost Report Cover Sheet (DsWR008720).

various costs associated with treating patients. The factors that weigh in the determination of Charge Master prices are numerous and vary from hospital to hospital and from department to department within the individual hospitals, but they include what other hospitals charge for similar services and the Hospital's total costs.[51] An analysis that considers what other hospitals charge similarly situated patients is consistent with generally accepted principles of economic theory and practice and the concept of "reasonable value." A highly relevant measure of the reasonable value of a service is what would be charged for similar services in the relevant market.[52]

All of the Defendant Hospitals reviewed and revised their Charge Master prices multiple times during the purported class period in the nine Pending Cases. This process involves consideration of each individual price listed in the Charge Master. Some Hospitals also review data from CMS and other sources for purposes of comparing their pricing to Charge Master prices for the same or like services at other hospitals. Consideration is given to the Hospital's operating expenses and prices are set to give the Hospital a reasonable rate of return based on various factors such as the extensive amount of charity care provided to uninsured and other self-pay patients who qualify for charity care. Each Defendant Hospital's "costs" are considered in setting Charge Master prices; however, costs are but one of many factors the Hospitals weigh in these complex determinations.[53]

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[51] See Graudin Aff. ¶ 8 (DsWR000620); Johnson Aff. ¶¶ 8-9 (DsWR000429-31); Lee Aff. ¶¶ 13, 24 (DsWR000128, 000130); Meyer Aff. ¶¶ 8-9 (DsWR000447-48); Parrish Aff. ¶¶ 14-15 (DsWR000327-28); Stewart Aff. ¶¶ 8-10 (DsWR000482-83); Waters Aff. ¶ 7 (DsWR000501); Weeks Aff. ¶¶ 7-8 (DsWR000411-12).

[52] See McCormick Aff. ¶ 17.a. (DsWR000188); McCormick Aff. ¶ 17 (DsWR000187-90); Abernathy Aff. ¶ 9.H. (DsWR000064); McCormick Supp. Aff. ¶ 5 (DsWR000397).

[53] See Graudin Aff. ¶ 8 (DsWR000620); Johnson Aff. ¶¶ 8-9 (DsWR000429-31); Lee Aff. ¶¶ 12-24 (DsWR000127-30); Lee Aff. ¶¶ 5-6 (DsWR000472-73); Meyer Aff. ¶ 9 (DsWR000447-48); Parrish Aff. ¶¶ 14-15 (DsWR000327-28); Stewart Aff. ¶¶ 9-10 (DsWR000483); Waters Aff. ¶ 7

Plaintiffs assert that Defendant Hospitals' charges are "two (2) to four (4) times higher than costs." The Court finds this argument is unsupported by the evidence. In fact, Plaintiffs' expert, Gerard Anderson, testified that he could not opine on the Defendant Hospitals' costs until he viewed the Defendant Hospitals' Charge Masters and cost structure. It is undisputed that Anderson never reviewed these data and never rendered any opinion on the Defendant Hospitals' Charge Master charges or the Defendant Hospitals' costs.[54]

Section 2203 of the CMS Manual provides that each hospital should have "an established charge structure . . . which is reasonably and consistently related to the costs of providing the service." The Hospitals' operating margins (revenue over expenses) ranged between approximately -6.22%to 5%.[55] These low operating margins demonstrate that the Hospital's charges are not excessive relative to actual costs.[56]

E. Patient Access to the Charge Master

Plaintiffs complain that individual uninsured patients are not given access to the Charge Master in effect when they are treated. However, the Charge Master for each Defendant Hospital contains thousands of entries and is hundreds of pages long. It is based on a coding system that requires expertise to understand. Only a small number of items in the Charge Master appear on each patient's bill, depending the patient's diagnosis and course of treatment.[57] Giving

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(DsWR000501-2); Weeks Aff. ¶¶ 7-8 (DsWR000411-12); see also Abernathy Aff. ¶¶ 7.D., 7.H. (DsWR000057, 000059).

[54] Anderson Dep. at 99-104, 112, 122-25, 140 (DsWR003615-20, 003628, 003638-41, 003656).

[55] See Graudin Aff. ¶ 34 (DsWR000633); Johnson Aff. ¶ 38 (DsWR000441); Lee Aff. ¶ 9 (DsWR000126-27); Stewart Aff. ¶ 36 (DsWR000494); Waters Aff. ¶ 33 (DsWR000519-20); Weeks Aff. ¶ 36 (DsWR000424); see also Abernathy Aff. ¶ 8 (DsWR000011).

[56] Abernathy Aff. ¶ 8 (DsWR00011); McCormick Aff. ¶ 17.g. (DsWR000287).

[57] See Graudin Aff. ¶¶ 3, 10-11 (DsWR000618, 000620-21); Johnson Aff. ¶¶ 8, 10-11 (DsWR000429-30, 000431-32); Lee Aff. ¶¶ 2, 7-8 (DsWR000471-72, 000473-74); Meyer Aff. ¶¶ 3, 11-12 (DsWR000445-46, 000448-49); Parrish Aff. ¶¶ 3, 17 (DsWR000324-25, 000328);

uninsured patients access to the Charge Master at the time they are admitted would not assist them in determining what their treatment will cost since they could not decipher the Charge Master and their exact course of treatment is unknown.[58] Plaintiffs' own expert concedes that giving uninsured patients access to the Charge Master would not accomplish anything.[59] Where feasible and if the treating physician provides certain information, the Defendant Hospitals provide patients with estimates based on average costs of a particular treatment.[60]

F. Reimbursements from Medicare and Insurance Companies

The Defendant Hospitals accept payments from Medicare and insurance companies that are less than the Charge Master prices in satisfaction of Charge Master bills. Reimbursements paid to hospitals for Medicare patients are mandated by the Medicare program. The Medicare Diagnostic Related Group ("DRG") payment system and the actual payments are specifically tailored to the Medicare population, which does not include uninsured patients.[61] For approximately half of the Medicare patients, the reimbursement amount paid by Medicare to a hospital does not compensate the hospital for the cost of treating the Medicare patient.[62] The costs Medicare considers or allows are significantly less than the costs recognized under

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Stewart Aff. ¶¶ 8, 11-12 (DsWR000482-83, 000484-85); Waters Aff. ¶¶ 3, 8-9 (DsWR000499, 000502-3); Weeks Aff. ¶¶ 9-10 (DsWR000412-14).

[58] See Graudin Aff. ¶ 9 (DsWR000620); Johnson Aff. ¶ 12 (DsWR000432); Lee Aff. ¶¶ 28, 31 (DsWR000131, 000132); Meyer Aff. ¶ 10 (DsWR000448); Parrish Aff. ¶¶ 3, 16-17 (DsWR000324-25, 000328); Stewart Aff. ¶ 13 (DsWR000485); Waters Aff. ¶ 8 (DsWR000502-3); Weeks Aff. ¶ 11 (DsWR000414); see also Abernathy Aff. ¶ 10 (DsWR000065).

[59] Anderson Dep. at 118-19(DsWR003938-3939).

[60] See Graudin Aff. ¶ 12 (DsWR000621); Johnson Aff. ¶ 13 (DsWR000432); Lee Aff. ¶¶ 28-31 (DsWR000131-32); Meyer Aff. ¶ 13 (DsWR000449); Parrish Aff. ¶ 18 (DsWR000329); Stewart Aff. ¶ 14 (DsWR000485); Waters Aff. ¶ 11 (DsWR000504); Weeks Aff. ¶ 12 (DsWR000414).

[61] Duffy Aff. III.2. (DsWR000159); Bradford Aff. ¶ 6.B. (DsWR000360-61); McCormick Aff. ¶ 22.c. (DsWR000291). The DRG payment system is but one component of Medicare reimbursement. Medicare also reimburses hospitals for outlier claims.

[62] Bradford Aff. ¶ 7.D. (DsWR000362-63).

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generally accepted accounting principles and specifically exclude the expense of bad debt incurred by the uninsured, the very population at issue here.[63] Medicare reimbursement payments do not adjust for local competition issues.[64] There is no evidence Medicare reimbursement rates are a generally accepted way to measure either the reasonableness of a hospital's prices or a hospital's real costs. There is no evidence that Medicare reimbursement rates would compensate a hospital for the cost of treating a non-Medicare patient such as an uninsured patient. In fact, the evidence is to the contrary.[65]

The amounts paid by insurance companies for insured patients are based on negotiated contracts between the hospital and each individual insurance company and apply solely to the persons insured by that company. This is a standard way of doing business throughout the United States. As stated by the Nebraska Supreme Court in Midwest Neurosurgery, P.C. v. State Farm Ins. Co., 686 N.W.2d 572, 576 (Neb. 2004):

> Within the health insurance industry, it is common for insurers and medical providers to enter into agreements in which the provider agrees to accept as full payment an amount less than what is billed to the insured patient. In exchange for the provider's agreeing to offer its services at a discounted rate, the insurer agrees to create incentives for its insureds to use the provider, thus helping to ensure a higher volume of patients for the provider.

The way in which hospitals around the country use the Charge Master to bill all patients uniformly and then to accept reduced reimbursement amounts depending on individual contracts

[63] Anderson Dep. at 120-123(DsWR003940-03943); Bradford Aff. 7.E. (DsWR000363); Duffy Aff. 5 (DsWR000162-63); McCormick 22.e. (DsWR000291); see also Shalala v. Guernsey Mem'l Hosp., 514 U.S. 87 (1995)(Medicare cost accounting regulations, which mandate that only the actual cost of services rendered to beneficiaries during a given year be reimbursed, do not bind the Secretary to make Medicare reimbursements in accordance with generally accepted accounting principles.).

[64] Bradford Aff. ¶ 7.F. (DsWR000363).

[65] Bradford Aff. ¶ 8.A. (DsWR000364).

with individual insurance companies is a function of the Medicare requirement of having an established charge structure which is applied uniformly to each patient as services are rendered to the patient.[66]

The discounts negotiated with third party payors, such as insurance companies, are based on a variety of economic factors specific to each Defendant Hospital and are not a measure of the reasonable value of hospital services or the reasonableness of prices in a Hospital's Charge Master.[67] Reimbursement rates or payment amounts are set considering factors such as competition from other hospitals, patient volumes and an analysis of which patients will need the Hospital's specific services and technology, service mix, certainty of payment and promptness of payment. These considerations do not apply with uninsured patients.[68] Moreover, insured patients pay premiums, co-pays, co-insurance, and deductibles, which uninsured patients do not pay.[69]

G. Free Care and Discounts to the Uninsured

All of the Defendant Hospitals in this Litigation have charity care policies and programs that provide substantial discounts to uninsured patients who do not have the financial means to pay for the hospital services they have received. Uninsured patients making 200% or less of the federal poverty guidelines are given a complete write off their charges (they owe nothing on their bill) and patients making 200% to 400% of the federal poverty guidelines receive varying payment discounts depending on the Defendant Hospital.[70] During the proposed class periods in

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[66] Bradford Aff. ¶ 3.F.iv (DsWR000355).

[67] Abernathy Aff. ¶ 7 (DsWR000055-59).

[68] Abernathy Aff. ¶ 7.a.-7.h. (DsWR000055-59); Bradford Aff. ¶ 6.B.ii. (DsWR000360).

[69] McCormick Supp. Aff. ¶ 6.e. (DsWR000405-06).

[70] See Graudin Aff. ¶ 17 (DsWR000623-24); Johnson Aff. ¶ 20 (DsWR000435); Eckert Aff. ¶ 4 (DsWR000137); Meyer Aff. ¶ 17 (DsWR000451-452); Parrish Aff. ¶¶ 6, 19 (DsWR000325-26,

this Litigation, the Defendant Hospitals provided over a billion dollars in free or significantly discounted care to uninsured patients eligible for charity care.[71]

At each of the Defendant Hospitals, uninsured patients who are not eligible for charity care are still offered discounts off Charge Master prices equal to or greater than discounts negotiated with some insurance companies, if the uninsured patient will pay the discounted portion of his or her bill.[72] In addition to general uninsured discounts, the Defendant Hospitals allow uninsured patients who do not qualify for charity care to negotiate a variety of discounts and payment plans to assist patients in meeting their obligation to pay the Hospitals for the services received.[73] The affidavits submitted by the Defendant Hospitals include specific, concrete examples of the various discounts and alternative payment arrangements the Hospitals negotiate that are tailored to the uninsured patient's particular financial situation.

H. Payments by the Uninsured on Their Bills

Uninsured patients, as a group, pay little or nothing toward their charges for hospital care at any of the Defendant Hospitals or in the United States generally. At each of the Defendant Hospitals, uninsured patients not eligible for charity care paid, on average, a very small fraction of charges. Between 2001 and 2009, uninsured patients as a group paid, on average, between

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000329); Stewart Aff. ¶ 21 (DsWR000488); Waters Aff. ¶ 16 (DsWR000506); Weeks Aff. ¶ 20 (DsWR000418).

[71] Parrish Aff. ¶¶ 7, 8 (DsWR000326); Waters Aff. ¶ 18 (DsWR000509); Weeks Aff. ¶ 34 (DsWR000423); Meyer Aff. ¶ 20 (DsWR000455); Lee Aff. ¶ 4 (DsWR000123); Graudin Aff. ¶ 19 (DsWR000626-27); Stewart Aff. ¶ 34 (DsWR000493); Johnson Aff. ¶ 36 (DsWR000441).

[72] Waters Aff. ¶ 15 (DsWR000505); Weeks Aff. ¶¶ 24-25 (DsWR000419-20); Eckert Aff. Ex. A, B. ¶ 12 (DsWR000609-616); Eckert Aff. ¶ 6 (DsWR000346); Meyer Aff. ¶ 16 (DsWR000451); Stewart Aff. ¶¶ 22-23 (DsWR000489); Graudin Aff. ¶ 16 (DsWR000623); Johnson Aff. ¶¶ 25-27 (DsWR000437).

[73] See Graudin Aff. ¶ 23 (DsWR000629-30); Johnson Aff. ¶ 26 (DsWR000437); Eckert Aff. ¶¶ 12, 17 (DsWR000139, 000140); Eckert Aff. ¶ 11 (DsWR000587); Meyer Aff. ¶ 21 (DsWR000456-57); Parrish Aff. ¶¶ 13, 21, 26 (DsWR000327, 000329, 000331); Stewart Aff. ¶ 23 (DsWR000489); Waters Aff. ¶ 21 (DsWR000513-15); Weeks Aff. ¶¶ 32-33 (DsWR000423).

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2.9% and 11% of charges.[74] Plaintiffs' expert admitted that, nationwide, only one in ten uninsured patients pays anything to the hospital and those that do pay only approximately 10% of charges.[75]

Instead of "cost-shifting" from the insured to the uninsured, as alleged by Plaintiffs, it is the other way around. Uncompensated care for uninsured patients is borne by insurance companies and, ultimately, passed on to insured patients or their employers in the form of higher premiums.[76]

Plaintiffs' contention that Charge Master Billing is allowing the Defendant Hospitals to shift costs from insurance companies, who pay, to the uninsured, who do not pay their bills, is totally unsupported by the evidence.

I. <u>Medicare Disproportionate Share Hospital Program</u>

Without citation to any document, testimony, or other fact contained in the Record before this Court, Plaintiffs asserted that the Defendant Hospitals are motivated to raise their Charge Master prices "in order to compete with other hospitals in the state, all of whom are vying for a maximal share of the Federal Disproportionate Share allotment given to the state of South Carolina to distribute." The Court finds this matter is not an appropriate subject for the Court's inquiry based on the evidence and the terms of the 2012 Consent Order. Although the Plaintiffs' expert mentioned the Disproportionate Share Hospital Program ("DSH") in passing during his

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[74] Parrish Aff. ¶ 25 (DsWR000330-31); Waters Aff. ¶ 25 (DsWR000517); Weeks Aff. ¶ 35 (DsWR000423); Meyer Aff. ¶ 23 (DsWR000459); Lee Aff. ¶ 6 (DsWR000125); Stewart Aff. ¶ 35 (DsWR000493-94); Graudin Aff. ¶ 25 (DsWR00063); Johnson Aff. ¶ 37 (DsWR000441).

[75] Anderson Dep. at 274-75 (DsWR003437-38), 91-92 (DsWR003911-12).

[76] In 2005, Families USA released a report titled "Paying A Premium: The Added Cost of Care For the Uninsured" which found that the impact of uncompensated care for uninsured patients on premium costs for family health insurance provided by private employers in 2005 included an extra $922 in premiums; premiums for individual coverage cost an extra $341 due to uncompensated care for the uninsured. Abernathy Aff. ¶ 7 (DsWR000007-11).

deposition, he did not offer any testimony on how the DSH operates either generally or as to any of the Defendant Hospitals in this Litigation specifically.[77] The Plaintiffs' assertion that "for the Fiscal Year 2011, Defendant Hospitals collectively received well over one hundred million dollars ($117,425,589.00) from the federal government to reimburse them for uncompensated care administered" is unsupported by any fact in the Written Record before this Court.

However, even if Plaintiffs could point to some evidence regarding the DSH, the argument is nevertheless irrelevant because the federal DSH, 42 U.S.C. § 1395ww(d)(5), is unrelated to the prices charged by hospitals in their Charge Masters. "Whether a hospital qualifies for a Medicare DSH adjustment, and the amount of the adjustment it receives, depends on the hospital's 'disproportionate patient percentage,' 42 U.S.C. § 1395ww(d)(5)(F)(v), which is determined by the Secretary pursuant to a statutory formula." See, e.g., Covenant Health Sys. v. Sebelius, 820 F. Supp. 2d 4, 6 (D.D.C. 2011)(citing 42 U.S.C. § 1395ww(d)(5)(F)(v)-(vii); 42 C.F.R. § 412.106(b)). According to the statutory formula, the disproportionate patient percentage is the sum of two fractions, which have no relation or connection to the prices contained in the hospitals' Charge Masters. See 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I)-(II).

[77] Anderson Dep. at 89, 105 (DsWR003909, 003925).

J. What Is Not In Evidence

There is no Charge Master in the Written Record.[78]

There is no evidence that other hospitals in South Carolina or the United States bill patients, uninsured or otherwise, in a different manner than Charge Master Billing. There is no expert testimony or opinion that the Defendant Hospitals acted improperly or violated any industry standard in the way they used Charge Master Billing to charge or bill uninsured patients. There is no expert testimony or opinion that the Defendant Hospitals charge or bill uninsured patients differently than Medicare or insured patients. In fact, Plaintiffs' own expert testified that the Charge Master is applied equally to all patients.

There is no opinion from an expert witness that the prices in these Defendants' Charge Masters are inconsistent with what other Hospitals in the relevant market charge for similar services. Plaintiffs did not introduce any evidence to challenge the evidence introduced by the Defendant Hospitals that their Charge Master prices are consistent with what other hospitals charge for similar services. There is no opinion from an expert witness that the prices in these Defendants' Charge Masters are out of line with these Defendants' actual costs. Plaintiffs' own expert refused to render such an opinion.

There is no evidence that the payment amounts mandated by the federal Medicare program or negotiated by hospitals with insurance companies are an appropriate benchmark to use to measure the reasonableness of the Charge Master or prices in the Charge Master. There is

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[78] Plaintiffs ask this Court to declare use of a Charge Master to be unreasonable without even presenting a Charge Master for the Court to review from 7 of the 8 Defendants. Charge Masters for Mary Black from 2002 to 2005 were improperly included in Plaintiffs' Written Record because they were produced during discovery in another case that was dismissed three years ago and is not a Pending Case subject to this Court's 2012 Consent Order. Moreover, the Charge Masters from 2002 through early 2004 fall outside the proposed class period in the one Pending Case against Mary Black. The Court sustains the objection to the inclusion of these Charge Masters, as it is inconsistent with the terms of Paragraph 5 of the 2012 Consent Order.

no testimony in the Written Record that the payment amounts mandated by the federal Medicare program or negotiated by hospitals with insurance companies are a reliable or generally accepted way to measure the reasonableness of the Charge Master or the prices in the Charge Master.

Plaintiffs have not mounted a challenge to the price of any particular item or items in the Defendants' Charge Masters nor have Plaintiffs made a challenge to the price of any particular procedure such as childbirth, heart bypass, knee replacement surgery, etc. The Court was not presented with any specific evidence relating to charges for particular items or services.

There is no evidence that the prices in a Defendant Hospital's Charge Master generally or the Hospital's charges for a particular service or procedure are excessive compared to the prices of another hospital.

There is no evidence that the treatment Plaintiffs received from the Defendant Hospitals was negligently provided or defective in any respect. At the April 29 Hearing, Plaintiffs' counsel suggested that uninsured patients at the Defendant Hospitals receive substandard care or care that is of a lesser quality than what is received by insured patients. There is no evidence in the Written Record to support this contention. Each of the individual Plaintiffs was deposed and made no complaints about the quality of the care provided to them by the Defendant Hospitals.

There is no evidence that the treatment Plaintiffs received was inappropriate or excessive for their medical conditions or diagnoses.

There is no evidence that the Plaintiffs were charged or billed for goods and services that they did not actually receive or were charged an improper fee or assessment.

There is no evidence that any Plaintiff's bill was inaccurate as far as the hospital goods and services received by that Plaintiff.

There is no evidence that any Plaintiff was told the services the Plaintiff received would cost a certain amount and he or she was charged more than that amount.

There is no evidence that any Plaintiff was promised or told he or she would get the benefit of reimbursement rates or discounts negotiated with insurance companies or mandated by the federal government under Medicare.

There is no evidence that any Plaintiff was promised or told he or she would not be charged or billed using Charge Master Billing.

There is no evidence that any Plaintiff entered into a payment agreement with a Defendant Hospital that was not honored.

There is no evidence that any Plaintiff paid his bill and a Defendant Hospital continued to try to collect the bill.

II. CONCLUSIONS OF LAW

In light of the above findings of fact and after carefully considering the Written Record submitted by the Parties, the arguments in the Parties' memoranda and the Parties' argument at the April 29, 2013 Hearing, the Court finds that the answer to Issue No. 2 is "NO" because the preponderance of the evidence establishes that:

(1) The Charge Master was created, used, and continues to be used by the Defendant Hospitals to comply with federal Medicare requirements.

(2) Charge Master Billing is a reasonable way to bill patients given the potential uncertainty of treatment when a patient initially enters the hospital.

(3) The prices contained in the Defendant Hospitals' Charge Masters cannot be "unreasonable" because the uncontradicted affidavits and testimony of the Defendant Hospitals and their expert witnesses demonstrate that the Charge Master prices are set based on factors that are consistent with the law and generally accepted economic principles.

(4) The controlling law and the preponderance of the evidence in the Written Record do not support the claims of unreasonableness of Charge Master Billing asserted by Plaintiffs.

A. Plaintiffs Have Failed to Meet Their Burden of Proof

First, the record demonstrates that Charge Master Billing was created, used, and is still used by the Defendant Hospitals as their uniform charge structure to comply with the Medicare requirement that each hospital facility have a charge structure that is uniformly applied to each patient as services are rendered. Charge Master Billing is the accepted methodology that has been used in the hospital industry for decades to comply with this requirement. Plaintiffs have not proved otherwise.

Second, Charge Master Billing is a reasonable approach to billing patients given the uncertainty of which goods and services a patient will need during his/her individual treatment. The Charge Master is a pre-existing price list of all of a hospital's goods and services that is not created or amended for any specific patient, uninsured or otherwise. Given the uncertainties of medical treatment, the complications an individual patient might experience and what goods and services will be needed to treat each individual patient, taking a pre-set price list and applying it equally to all patients based on the goods and services actually used is practical, fair and reasonable. See, e.g., Shelton v. Duke Univ. Health Sys., Inc., 633 S.E.2d 113, 116 (N.C. Ct. App. 2006); Cox v. Athens Reg'l Med. Ctr., Inc., 631 S.E.2d 792, 797 (Ga. Ct. App. 2006); Harrison v. Christus St. Patrick Hosp., 430 F. Supp. 2d 591, 595-96 (W.D. La. 2006). As noted in DiCarlo, a contract that provides the patient will pay "all charges" combined with the Charge Master is "the only practical way in which the obligations of the patient can be set forth, given the fact that nobody yet knows just what condition the patient has, and what treatments will be

necessary to remedy what ails him or her." DiCarlo v. St. Mary Hosp., No. 05-1665, 2006 U.S. Dist. LEXIS 49000 at *11 (D.N.J. July 19, 2006), aff'd 530 F.3d 255 (3d Cir. 2008).

Third, the evidence in the record establishes that the prices in the Defendant Hospitals' Charge Masters are set with a reasoned approach and are based on relevant legal and economic considerations. The Defendant Hospitals' Charge Master prices are set based on, among other things: (1) what other hospitals in the relevant market charge for similar services; and (2) the costs of providing services. Courts examining the reasonable value of health care services in other contexts have held the reasonable value is determined by a variety of factors including "the amount billed to the plaintiff, and the relative market value of those services." Haselden v. Davis, 353 S.C. 481, 484, 579 S.E.2d 293, 295 (2003). The Haselden court articulated this method for determining reasonable prices by reference to other states with similar requirements, such as Pennsylvania, which holds the "reasonable value of medical services may be determined through expert testimony regarding the market value of the medical services provided based on the average charges in the region where the services were performed." Kashner v. Geisinger Clinic, 638 A.2d 980, 983, n.6 (Pa. Super. Ct. 1994) (citation omitted)(emphasis supplied)(cited with approval in Haselden).[79]

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[79] See also Colomar v. Mercy Hosp., Inc., 242 F.R.D. 671, 680 (S.D. Fla. 2007); Charlotte-Mecklenburg Hosp. Auth. v. Talford, 727 S.E.2d 866, 870-71 (N.C. 2012); Rogers v. Mid-Am. Door, Fire & Cas. Ins. of Conn., 996 P.2d 490, 492 (Okla. Civ. App. 1999); Gould v. Workers' Comp. Appeals Bd., 6 Cal. Rptr. 2d 228, 236 (Cal. Ct. App. 1992); Adler v. Hosp. Serv. Ass'n of New Orleans, 278 So. 2d 177, 180 (La. Ct. App. 1973); see also Heartland Health Sys., Inc. v. Chamberlin, 871 S.W.2d 8, 11 (Mo. Ct. App. 1993); Sherman Hosp. v. Wingren, 523 N.E.2d 220, 222 (Ill. App. Ct. 1988); Ellis Hosp. v. Little, 409 N.Y.S.2d 459, 461 (N.Y. App. Div. 1978); Jackson v. Brown, 268 So. 2d 837, 841 (Ala. Civ. App. 1972); Spencer v. West, 126 So. 2d 423, 428 (La. Ct. App. 1960); Best v. McAuslan, 60 A. 774, 775 (R.I. 1905); CBE Group, Inc. v. Bubeck, No. 07-0868, 2007 Iowa App. LEXIS 1303 at *4-5 (Iowa Ct. App. Dec. 12, 2007).

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The evidence establishes that each of the Defendant Hospitals consider and use what other hospitals charge for similar services and that Defendant Hospital's particular costs in setting Charge Master prices.[80] Plaintiffs have introduced no contrary evidence on these factors specific, in any way, to the Defendant Hospitals or their Charge Masters. Again, Plaintiffs do not challenge and have not offered evidence that the prices in a Defendant Hospital's Charge Master generally or a Defendant Hospital's charges for a particular service or procedure are excessive compared either to the prices of another hospital or that Defendant Hospital's costs.[81]

B. Plaintiffs' Arguments

1. Defendants' Charge Master Prices Versus Defendants' Costs

Without citation to any evidence in the Written Record related to these Defendant Hospitals, Plaintiffs claim that Charge Master prices are arbitrarily set and bear no relation to the Hospitals' cost of providing treatment.[82] As a threshold matter, Plaintiffs have not directed the

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[80] See Graudin Aff. ¶ 8 (DsWR000620); Johnson Aff. ¶¶ 8-9 (DsWR000429-31); Lee Aff. ¶¶ 13, 24 (DsWR000128, 000130); Meyer Aff. ¶¶ 8-9 (DsWR000447-48); Parrish Aff. ¶¶ 14-15 (DsWR000327-28); Stewart Aff. ¶¶ 8-10 (DsWR000482-83); Waters Aff. ¶ 7 (DsWR000501-02); Weeks Aff. ¶¶ 7-8 (DsWR000411-12).

[81] The record establishes that the Defendant Hospitals hire independent, third party services to evaluate the prices in their Charge Masters to ensure the prices are consistent with what other hospitals charge for similar services. See, e.g., Waters Aff. ¶ 7 (DsWR000501-02); GHS Interrogatory Answers (DsWR007008); Med Assets and Med Par Reports (DsWR008678-8704 and DsWR008141-8342); Lee Aff. ¶ 13 (DsWR000128). While acknowledging the involvement of these third party services in reviewing hospitals' prices and charges, Plaintiffs attempted to brush off their relevance with the generic claim that "when one pays for oneself to be reviewed, one generally comes out quite well." Pls' Mem. at 4. However, Plaintiffs did not introduce into the Written Record any actual evidence of bias or any actual evidence to challenge the conclusions of these independent services. Plaintiffs' generic "you get what you pay for" argument suggests this Court should reject the opinion of any expert retained by a party.

[82] The cost of providing a good or service is not the measure of its reasonable value. See Stringer Oil Co. v. Bobo, 320 S.C. 369, 373-74, 465 S.E.2d 366, 369 (Ct. App. 1995). Courts considering the precise question of charges to uninsured patients have held "[t]here is little doubt that what the market charges for similar services is one relevant measure of reasonableness" and that "the appropriate analysis of reasonableness is multifaceted and does not look only at internal

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Court to any evidence regarding the costs incurred by any Defendant Hospital in providing any good, service, or treatment to any Plaintiff in this Litigation, or any other uninsured patient treated by the Defendant Hospitals. Plaintiffs have offered no evidence that any specific Defendant Hospital's Charge Master prices are excessive compared to that Hospital's internal costs in providing the goods and services. Plaintiffs have not carried their burden of proof on this issue.

Plaintiffs' expert, Gerard Anderson, has never testified or opined that the prices in these Defendant Hospitals' specific Charge Masters are unreasonable or excessive in comparison to the Hospitals' costs. In fact, Anderson expressly testified that he could not render any such opinion because he had not seen any data from the individual Defendant Hospitals. Anderson admitted that he has never reviewed or even seen any Charge Master for any Defendant Hospital and that he has never viewed or even seen any cost or expense information for any Defendant Hospital. Anderson testified he could not render an opinion as to the Defendant Hospitals without seeing this information.[83]

The Defendant Hospitals, on the other hand, have put forward specific evidence affirmatively demonstrating that the prices in their specific Charge Master are set based on a comprehensive consideration of the relevant legal and economic factors. Costs are one of these factors. Prices are set to allow a reasonable rate of return over costs.[84]

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costs relative to price in isolation." Colomarv. Mercy Hosp. Inc, 461 F. Supp. 2d 1265, 1270, 1272 (S.D. Fla. 2006)(emphasis supplied).

[83] Anderson Dep. at 25-30 and 183-85 (DsWR003845-50, 0003346-48).

[84] See Graudin Aff. ¶ 8 (DsWR000620); Johnson Aff. ¶¶ 8-9 (DsWR000429-31); Lee Aff. ¶¶ 12-23 (DsWR000127-30); Lee Aff. ¶¶ 5-6 (DsWR000472-73); Meyer Aff. ¶¶ 8-9 (DsWR000447-48); Parrish Aff. ¶¶ 14-15 (DsWR000327-28); Stewart Aff. ¶ 9-10 (DsWR000483); Waters Aff. ¶ 7 (DsWR000501-02); Weeks Aff. ¶¶ 7-8 (DsWR000411-12).

In their initial original memorandum and at the April 29, 2013 Hearing, Plaintiffs presented excerpts from the depositions of the health care economist experts retained by Defendant Hospitals in which Plaintiffs' counsel asked a series of purely hypothetical questions, such as whether it is reasonable for the Defendant Hospitals to charge an alleged excessive amount relative to costs—i.e., "let's say [it costs] a dollar and you charge $10,000. Would that be per se unreasonable?"[85] These deposition exchanges prove nothing about the reasonableness of the Defendant Hospitals' Charge Master prices versus their specific costs for two reasons.

First, the witnesses repeatedly insisted they were unable to answer these hypothetical questions without further facts. Jackson v. Price, 288 S.C. 377, 381, 342 S.E.2d 628, 631 (Ct. App. 1986)(stating "all material facts necessary to form an opinion [must be] included in the [hypothetical] question posed"); State v. Anderson, 195 S.E.2d 561, 566 (N.C. 1973)(holding "[a] question asked and unanswered is not evidence of any fact. Likewise, a question in which counsel assumes or insinuates a fact not in evidence, and which receives a negative answer, is not evidence of any kind.").

Second, Plaintiffs have presented no evidence that the facts alleged in the hypotheticals actually exist in the Written Record. There is no evidence as to any Defendant Hospital's specific cost structure and certainly, for example, no evidence of a charge being $10,000 and the associated cost being $1 at any of these Defendant Hospitals. Absent such evidence, the questions were improper. See, e.g., Hartfield v. Getaway Lounge & Grill, Inc., 388 S.C. 407, 414, 697 S.E.2d 558, 561 (2010)(holding that "[a] party may ask a hypothetical question of an expert, but the hypothetical must be based on facts supported by the evidence").

[85] See Pls' Mem. at 19. Defendants expressly objected to the form of these questions during the experts' depositions. State v. Tyner, 273 S.C. 646, 654-55, 258 S.E.2d 559, 563-64 (1979)(holding trial court properly sustained objections to questions which assumed facts not in evidence).

2. Reimbursement amounts from Medicare and insurance companies

The primary "evidence" presented by Plaintiffs in support their claim that Charge Master Billing is unreasonable is the fact that the Defendant Hospitals accept payments from Medicare and insurance companies that are less than Charge Master prices. This "evidence" does not prove Charge Master Billing is unreasonable.

First, there is a complete lack of any foundational evidence that the reimbursement amounts paid by Medicare and insurance companies is a reliable, generally accepted or appropriate measure of the reasonableness of the charges in the Charge Master or charges to the uninsured. There is no testimony in the Written Record that the payment amounts mandated by the federal Medicare program or negotiated by hospitals with insurance companies are an appropriate benchmark to use to measure the reasonableness of the prices in the Charge Master or the Charge Master. The Hospitals' experts testified that such discounts are not an appropriate way to measure the reasonableness of the charges to the uninsured.[86]

Second, the cases hold that the fact uninsured patients are charged or pay more than insurance companies or Medicare pay is not probative of or relevant to the reasonableness of the Charge Master. See, e.g., Collection Prof'ls, Inc. v. Schlosser, 977 N.E.2d 315, 321 (Ill. App. Ct. 3d Dist. 2012); Howard v. Willis-Knighton Med. Ctr., 924 So. 2d 1245, 1263 (La. App. 2006); Kolari v. New York Presbyterian Hosp., 382 F. Supp. 2d 562, 579 (S.D.N.Y. 2005); Banner Health v. Med. Savs. Ins. Co., 163 P.3d 1096, 1101-02 (Ariz. App. Div. 2007). Plaintiffs do not cite a single case that has held that a hospital accepting reduced reimbursement or payment amounts from other third parties is evidence, in any way, that Charge Master Billing is unreasonable or unfair to the uninsured. In fact, it is well settled that payment or reimbursement

[86] See Abernathy Aff. ¶ 7 (DsWR000055-59); McCormick Aff. ¶ 22 (DsWR000289-94).

amounts received from insurance companies or Medicare are simply not evidence of the reasonableness or unreasonableness of a hospital's Charge Master prices.[87] As stated in Covington v. George, 359 S.C. 100, 104, 597 S.E.2d 142, 144 (2004), "payments made to a medical provider by an insurance company . . . and amounts accepted by medical providers . . . are not evidence of whether the medical bills are 'reasonable, i.e. not excessive in amount, considering the prevailing cost of such services" and "[s]uch negotiated amounts . . . do not reflect the 'prevailing cost' of those services to other patients." (Emphasis in original).[88] No court in the country has used payment amounts received from or discounts given to other payers as a basis for prohibiting or outlawing Charge Master Billing in its entirety, and Plaintiffs do not cite any such case.

Insurance company reimbursements to a hospital are the result of complex negotiations and include factors such as patient volume, service mix, certainty or promise of timely payment;

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[87] See, e.g., Eufaula Hosp. Corp. v. Lawrence, 32 So. 3d 30 (Ala. 2009); Colomar v. Mercy Hosp., Inc., No. 05-22409-CIV-Seitz/McAliley, 2007 U.S. Dist. LEXIS 52659 at *14, *16-17 (S.D. Fla. July 20, 2007); Naples Cmty. Hosp., Inc. v. Medical Savs. Ins. Co., No. 2:04-cv-280-FtM-33SPC, 2006 U.S. Dist. LEXIS 25894 at *6 (M.D. Fla. May 3, 2006); Firelands Reg'l Med. Ctr. v. Jeavons, No. E-07-068, 2008 Ohio App. LEXIS 4234 at **17-18 n.3 (Ohio Ct. App. 2008); Roberts v. Univ. of Ala. Hosp., 27 So. 3d 512, 518 (Ala. Civ. App. 2008); Leitinger v. DBart, Inc., 736 N.W.2d 1, 18 (Wis. 2007); Galvan v. Northwestern Mem'l Hosp., 888 N.E.2d 529, 538-39 (Ill. App. Ct. 2008); Niewinski v. Resurrection Health Care Corp., No. 04 CH 15187 at p. 2 (Cir. Ct. of Cook County, Ill. Aug. 14, 2006); Elliot Hosp. v. Boerner, No. 04-C-739 at p. 10 (Super. Ct. N.D. N.H. July 15, 2005); Huntington Hosp. v. Abrandt, 779 N.Y.S.2d 891, 892 (N.Y. App. Term 2004); Parnell v. Madonna Rehab. Hosp., 602 N.W.2d 461, 464 (Neb. 1999).

[88] Plaintiffs argue that the Haselden court considered the amount paid by Medicaid as one factor in determining the reasonable value of hospital services. However, in Haselden, evidence of the Medicaid payment came into evidence without objection. In its later Covington opinion, the Supreme Court stated that Haselden, "insofar as the actual [Medicaid] payment amount was before the court as evidence of reasonableness, is limited to its facts." Covington held that "the trial court properly excluded the evidence of the amount [the] medical provider accepted as payment" for the bills in question. 359 S.C. at 102-03, 597 S.E.2d 143-44. Here, the Defendant Hospitals specifically objected at the April 29, 2013 Hearing to the relevance, admissibility, and probative value of Medicare and insurance company reimbursements. See General Objection No. 1.

those factors do not apply to uninsured patients.[89] Insurance spreads the risk of loss across a population, which pays premiums based on the actuarial risk associated with that population. The uninsured should not get the benefit of discounts or more favorable payment terms negotiated with insurance companies because the uninsured do not participate in that risk spreading. For example, the typical insured patient may pay premiums for years without ever having any need for the benefits—uninsured patients do not contribute in this fashion.[90] Insured patients have already paid money into the system before they are treated and insurance companies pay while the uninsured do not. Galvan v. Northwestern Mem'l Hosp., 888 N.E.2d 529, 538-39 (Ill. App. Ct. 2008). Additionally, there are strong economic reasons for not requiring that uninsured patients be given the benefit of discounts mandated by the federal Medicare program or negotiated with insurance companies because to do so will encourage more persons to become uninsured.[91]

3. The Federal Medicare Program

Relying on Section 2202.4 of the CMS Manual, Plaintiffs argue that the Defendant Hospitals are violating federal Medicare requirements by charging uninsured patients Charge Master prices because "charges" under the Medicare program refer not to the amount billed, but the amount "realized by" a hospital from the Medicare program and insurance companies. Even assuming there were a private right of action for an uninsured patient to enforce a requirement in the Medicare program, nothing in the Medicare regulations or in the CMS Manual defines "charges" as the amount "paid to" or "realized by" the Hospital. There is no evidence to support

[89] Abernathy Aff. ¶7.F. (DsWR000058); Bradford Aff. ¶6.b.ii. (DsWR000360).

[90] Abernathy Aff. 7.B. (DsWR004574-98); McCormick Supp. Aff. ¶ 6.e. (DsWR00008).

[91] Anderson Congressional Testimony (Dep. Ex. 22)(DsWR004673-4681); Anderson Expert Report in Blackwell (Dep. Ex. 17)(DsWR004574-4598); McCormick Supp. Aff. ¶ 6.b. (DsWR000398)

a definition of "charges" as meaning the amount realized by the Hospital, nor is there any evidence of an industry standard or custom that "charges" means the amount realized by a Hospital from Medicare and insured patients.

Moreover, Plaintiffs' have taken an isolated provision from the CMS Manual out of context and distorted its meaning. Section 2202.4 states that "[c]harges should be . . . uniformly applied to all patients whether inpatient or outpatient" and "[a]ll patients' charges . . . should be recorded at the gross value; i.e., charges before the application of allowances and discounts deductions." (Emphasis added). Section 2202.4 itself establishes that "charges" are the rates "established by the provider" and "uniformly applied to all patients whether inpatient or outpatient" "before the application of allowances and discounts deductions." (Id.)(emphasis added). Nothing in Section 2202.4 even suggests that "charges" are what is paid to the Hospital by various third party payors or realized by a Hospital from third-party payors. Such an interpretation is incompatible with longstanding directives from the DHHS.[92]

Under settled principles of regulatory construction, Section 2204 of the CMS Manual must be construed in light of other, related Medicare regulatory provisions. See, e.g., Black & Decker Corp. v. Comm'r, 986 F.2d 60, 65 (4th Cir. 1993); Am. Fed'n of Gov't Employees, Local 2782 v. Fed. Labor Relations Auth., 803 F.2d 737, 740 (D.C. Cir. 1986); Anderson v. South Carolina Election Comm'n, 397 S.C. 551, 556, 725 S.E.2d 704, 707 (2012). The actual Medicare regulation, 42 C.F.R. § 413.53(b)(2)(ii), defines "charges" as the "regular rates for various services which are charged to both [Medicare] beneficiaries and other paying patients

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[92] See "Questions on Charges for the Uninsured" attached to Letter from Tommy G. Thompson, Secretary of Health and Human Services to Richard J. Davidson, President, American Hospital Association (Feb. 19, 2004)(DsWR008713-8718).

who receive services," not what is paid by or what the Hospital realizes from Medicare and insurance companies.

Similarly, Section 2203 of the CMS Manual provides that each hospital "should have an established charge structure which is uniformly applied to each patient as services are furnished to the patient . . . ." Plaintiffs have made no attempt to explain how a hospital can have an established charge structure applied uniformly as services are provided to each patient but which is based on the many varied reimbursement amounts from insurance companies that are paid long after services are provided and a bill is sent. The Written Record contains no evidence of how such a system would work, whether it is feasible, whether any hospital anywhere in the United States has such a system, or whether Medicare or the Medicare intermediary would accept it. Simply put, charges are the prices in the hospital's uniform charge structure (the Charge Master) and not the amount Medicare or an insurance company pays or the amount a hospital realizes from Medicare or insurance companies.[93]

Plaintiffs also cite to Section 2202 of the CMS Manual and complain that the Hospitals do not state what the precise formulaic relationship is between Charge Master prices and a Hospital's costs. Again, assuming there was a private right of action to enforce Medicare regulations in favor of an uninsured patient, there is no requirement in the Medicare regulations that there be a precise formula. There is no evidence in the Written Record from an expert

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[93] See Bradford Affidavit ¶ 6.B.i-ii. (DsWR000360); see also "Questions on Charges for the Uninsured" supra fn. 92 (DsWR008714)(explaining that the "[t]he Medicare Cost Report should reflect full uniform charges rather than the discounted amounts"; "[d]iscounting charges to uninsured or underinsured patients is no different than giving an allowance to Blue Cross or other commercial insurers for non-Medicare patients. The provider reimbursement manual directs the provider to report its full uniform charges before courtesy, charity, and third-party payer allowances." (emphasis added)).

witness or otherwise that there must be a precise formula. Plaintiffs cite no administrative decision or court decision that holds that a precise formula is required.

The CMS Manual merely provides that charges must be reasonably related to costs. The preponderance of the evidence shows that the Defendant Hospitals consider their costs in setting the Charge Master prices and that the Charge Master prices are reasonably related to the Hospital's costs. Plaintiffs' expert refused to give an opinion that these Defendant Hospitals' charges were out of line with their actual costs.

Moreover, the Medicare intermediary is tasked with evaluating the charging practice of hospitals participating in the program and assessing compliance with the CMS Manual. CMS Manual § 2203. "The provider, upon request, must furnish the intermediary copies of patient service charge schedules and changes thereto as they are put into effect. The intermediary will evaluate such charge schedules to determine the extent to which they may be used for determining program payment." 42 C.F.R. § 413.20(d)(3). "While the Medicare Program cannot dictate to a provider what its charges or charge structures may be, the program may determine whether or not the charges are allowable for use in apportioning costs under the program." CMS Manual § 2203. Thus, Medicare holds the ultimate sanction for excessive charges: withholding payment.

4. The Defendant Hospitals' Debt Collection Efforts

At the April 29, 2013 Hearing, Plaintiffs complained that uninsured patients are subject to various debt collection efforts by the Defendant Hospitals. First, this allegation is irrelevant to the two Declaratory Judgment Issues presented to the Court by the Parties' agreement. Additionally, many of the Defendant Hospitals, as a matter of common practice, do not engage in debt collection efforts against uninsured patients, such as filing lawsuits to recover outstanding

balances.[94] Moreover, Plaintiffs concede in their current Complaint that they owe the Hospitals for the reasonable value of the treatment they admit they received. (See, e.g., Pls' Am. Compl. ¶¶ 31-32). There is no evidence in the Written Record that Plaintiffs would pay and thus not be subject to debt collection efforts—even if they had been billed an amount equivalent to what Medicare or insurance companies would pay the Defendant Hospital for similar services. Many Plaintiffs testified in their depositions that they could not pay even if their bills were reduced by more than 50% to 80%.[95] To the extent a Defendant Hospital uses the South Carolina Setoff Debt Collection Act to recover a delinquent debt from an uninsured patient, that Act expressly provides a procedure, which complies with due process, whereby a patient can dispute liability for the debt, including the amount owed. See S.C. Code Ann. §§ 12-56-63 and 65.

5. The Patient Protection and Affordable Care Act

At various points in their filings on the two Declaratory Judgment Issues, Plaintiffs have suggested that the federal Affordable Care Act, which went into effect in December 2010, is somehow "evidence" that the Defendant Hospitals' use of Charge Master Billing going back to 2001 is unreasonable. The Court finds Plaintiffs' reliance on the Affordable Care Act unavailing and irrelevant to the issues herein.

First, contrary to Plaintiffs' contention, the Affordable Care Act does not eliminate the class of uninsured patients. The Affordable Care Act does not create universal health insurance coverage. Congress rejected several proposals that would have given uninsured patients the benefit of Medicare payment amounts or the reimbursement amounts negotiated between

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[94] See, e.g., Weeks Aff. ¶ 18 (DsWR000416-17); Stewart Aff. ¶ 20 (DsWR000488); Johnson Aff. ¶ 19 (DsWR000435).

[95] See, e.g., A. Bennett Dep. at 89-90 (DsWR002374-5); J. Bennett Dep. at 101 (DsWR002093); Coley Dep. at 82 (DsWR003002); K. Paulson Dep. at 119 (DsWR006423); M. Paulson Dep. 92-93 (DsWR006556-7).

hospitals and insurance companies.[96] Instead, Congress's solution to the uninsured problem was to require that uninsured patients purchase insurance or be taxed. Nat'l Fed'n of Indep. Bus. v. Sebelius, __ U.S. __, 132 S. Ct. 2566 (2012).

Second, Congress made no finding in the Affordable Care Act that Charge Master Billing is illegal, unreasonable or unconscionable. As recognized in the Indiana Supreme Court Opinion in Allen, the Affordable Care Act continues the Medicare requirement that each hospital have a list of standard hospital charges for all items and services provided by the hospital. See 42 U.S.C. § 300gg-18.

Third, the Affordable Care Act does not outlaw Charge Master charges to all uninsured patients. The provision of the Affordable Care Act cited by Plaintiffs, Section 9007, amended provisions of Section 501(c)(3) of the Internal Revenue Code to add a new requirement for a charitable hospital to maintain its charitable status. Section 501(r)(5) imposes a prohibition on gross charges (i.e., charge master charges) to a specific subset of uninsured patients—those who qualify for financial assistance under a hospital's written financial assistance policy.[97] This Court cannot expand the application of a federal statute beyond its express terms. See Artuz v. Bennett, 531 U.S. 4, 10 (2000); Badaracco v. Comm'r, 464 U.S. 386, 398 (1984); Ferguson v. Skrupa, 372 U.S. 726, 730 (1963).

In enacting the Affordable Care Act, Congress could have prohibited the use of Charge Master charges to all uninsured patients or could have given all uninsured patients the benefit of discounts negotiated with insurance companies or the Medicare reimbursement structure.

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[96] See, e.g., Plaintiffs' Written Record (Master000141, 000196).

[97] See Technical Explanation to Section 501(r), Joint Committee on Taxation at 82 (Pls' Memorandum, Ex. 8)(stating a "hospital facility may not use gross charges (i.e., 'charge master' rates) when billing individuals who qualify for financial assistance"). Plaintiffs' counsel conceded this point at the April 29, 2013 Hearing. See April 29, 2013 Hearing Tr. at 49.

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Congress did not do so. Congress limited the prohibition of Charge Master charges to only a subset of all uninsureds. This Court is not free to apply Section 501(r)(5) to situations it does not expressly cover. See Mohamad v. Palestinian Auth., ___ U.S. ___, 132 S. Ct. 1702, 1710-11 (2012)(refusing to expand the remedies contained in a statute, despite the suggestion by plaintiff that limiting the statute's application would make the statute "toothless," because it is not the province of the courts to do what Congress has declined to do).

Further, new Section 501(r) of the Internal Revenue Code does not give uninsured patients any rights whatsoever, does not purport to create any private rights for uninsureds to receive hospital prices at a certain discount and does not purport to create a private right of action to enforce the alleged restrictions on Charge Master charges contained in Section 501(r)(5). Courts across the country have repeatedly rejected use of a hospital's 501(c)(3) status as a basis to create a private cause of action to challenge charges or prices to the uninsured. See, e.g., Nygaard, 731 N.W.2d at 198 n.15; Nash v. Lee Mem'l Health Sys., No. 2004CV369FTM29DNF, 2005 U.S. Dist. LEXIS 27248 (M.D. Fla. Aug. 25, 2005); Amato v. UPMC, 371 F. Supp. 2d 752 (W.D. Pa. 2005); Kolari, 382 F. Supp. 2d 562; Quinn v. BJC Health Sys., 364 F. Supp. 2d 1046 (E.D. Mo. 2005); Shriner v. Promedica Health Sys., Inc., No. 3:04CV7435, 2005 WL 139128 (N.D. Ohio Jan. 21, 2005); Lorens v. Catholic Health Care Partners, 356 F. Supp. 2d 827 (N.D. Ohio 2005). Indeed, the clear language of 26 U.S.C. § 7401 precludes any attempt to enforce the Internal Revenue Code, which includes the provision in question in Section 501(r), without the authorization of the Secretary of the Treasury and the United States Attorney General, which authorization has not been secured by Plaintiffs in this Litigation.

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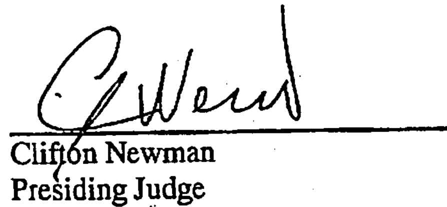
CONCLUSION

For all of the above reasons, the Court finds in favor of the Defendant Hospitals on the two Declaratory Judgment Issues and orders that judgment be entered in favor of each Defendant Hospital on all claims made by a Plaintiff against a Defendant Hospital in the nine Pending Cases. A certified copy of this order shall be filed with the clerk of court in each of the nine Pending Cases.

IT IS SO ORDERED.



Clifton Newman
Presiding Judge

July 15, 2013

Columbia, South Carolina

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EXHIBIT A

South Carolina Hospital Pricing Litigation
Pending Cases

Case Caption	Civil Action Number	County
Jeyilud Bennett, on behalf of herself, and all others similarly situated v. Greenville Hospital System	2004-CP-23-6065	Greenville
Lynn Bisbee, on behalf of herself and all others similarly situated v. Kershaw County Medical Center	2004-CP-28-630	Kershaw
Brett Coley, and all others similarly situated v. Mary Black Memorial Hospital	2007-CP-42-1744	Spartanburg
Bashirah Dubose, Eddie L. Arrants, Jr. and Doris M. Bean, on behalf of themselves and all those similarly situated v. Tuomey, Inc. d/b/a Tuomey Healthcare System	2004-CP-43-1113	Sumter
Jarrod Garrett, Ron J. Gary, John Michael Ross and Lynn Bisbee, on behalf of themselves and all others similarly situated v. Palmetto Health Alliance d/b/a Palmetto Health Richland, Palmetto Health Baptist and Palmetto Health Baptist Easley	2004-CP-40-4116	Richland
Kathy Green, and all others similarly situated v. Sisters of Charity Providence Hospitals	2004-CP-40-5576	Richland
Greenville Hospital System v. Kelli Jean Paulson and Michael A. Paulson	2004-CP-23-5676	Greenville
Marsha Monteith, on behalf of herself and all others similarly situated v. CareAlliance Health Services Corp. d/b/a Roper St. Francis Healthcare, Roper Hospital, and Bon Secours St. Francis Hospital, Roper St. Francis, Roper St. Francis Rehabilitation Hospital and Roper Berkeley Day Hospital	2004-CP-10-3836	Charleston
Susan Stanfield, on behalf of herself and all others similarly situated v. AnMed Health	2004-CP-04-3017	Anderson

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