PREYING ON PAIN: A LEGAL AND BIOETHICAL ANALYSIS OF HOW HOSPITALS PROFIT FROM PLACING HOSPITAL LIENS ON MEDICAID PATIENTS' ACCIDENT RECOVERIES

BY

REMY O. SERVIS

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Approved By:

Nancy M. P. King, J.D, Advisor

Mark Hall, J.D., Chair

Jonathan Cardi, J.D.

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ABSTRACT

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PREYING ON PAIN: A LEGAL AND BIOETHICAL ANALYSIS OF HOW HOSPITALS PROFIT FROM PLACING HOSPITAL LIENS ON MEDICARE AND MEDICAID PATIENTS' ACCIDENT RECOVERIES

Thesis under the direction of Nancy M. P. King, JD, Co-Director of the Center for Bioethics Health and Society and the Graduate Program of Bioethics at Wake Forest University.

Hospital lien laws were codified into state statutes in the early to mid-twentieth century, during a time when large-scale, uniform health insurance coverage was not yet commonplace in the United States, and hospitals needed protection from the financial risk of providing costly emergency care to uninsured or insolvent patients. These statutory liens give a hospital a nonpossessory lien interest in a judgment or monies accruing to a patient who has recovered a settlement from a third-party tortfeasor after an accident. A hospital has the legal right to reject a lesser payment under a Medicaid patient's coverage scheme in favor of pursuing a larger payout from the settlement proceeds. This thesis proposes that these laws have unacceptable legal and ethical implications for patients with public insurance coverage. They directly harm the patient by eschewing the entire purpose of their coverage, which is meant to provide equitable access to care. I examine states that are at the forefront of progressive caselaw to curb hospitals' rights to place these liens, and suggest ways in which states with more hospital-friendly laws can follow in their footsteps. I also analyze the inequity of these hospital lien laws from a bioethical perspective, with

particular focus on the importance of reprioritizing distributive and compensatory justice in this context.

INTRODUCTION

Generally, research has shown that providing ample access to Medicaid coverage improves the financial stability of patients who can take advantage of Medicaid enrollment. For example, after Louisiana expanded Medicaid in 2016, one study found that those who gained coverage experienced reduction in their medical debt load and improved fiscal health for their family.[1] Other studies have found that, on a national level, the increase in the share of low-income people with access to health insurance through Medicaid correlated with reducing Chapter 7 (low-income) bankruptcy rates.[2] Undeniably, providing access to Medicaid for low-income patients possesses the potential to greatly improve the financial health (or at least reduce financial hardships) of the patients who are covered.

However, a nefarious risk unique to public health insurance holders lurks just under the surface. Picture this: a Medicaid patient presents to his local emergency room following a car accident in which a third-party tortfeasor is to blame. He receives care for his moderate injuries, but is left with long-term pain that is aggravated by movement and exercise. He quickly depletes his financial resources because of the time he has to take off work and the additional costs he incurs to hire help with his childcare duties and lost ability to cook meals. This patient has been working with a lawyer to secure a settlement from the third party who caused the accident. It's a settlement he desperately needs to help cover lost wages and other emotional and physical burdens of the accident.

Unfortunately, in the course of processing the settlement, the patient learns that the hospital where he received his care is placing a hospital lien on his settlement for the value of the emergency care he received calculated at the hospital's marked-up, undiscounted

rates, and not at the cheaper, contracted-for amount usually charged to Medicaid. The patient will receive little to no money from the third-party settlement after the hospital recoups its windfall. The patient is shocked to learn that this procedure is expressly allowed by his state's hospital lien law. In many cases, even if a hospital must, by statute, bill a private health insurer prior to seeking settlement funds, there is no express requirement that hospitals bill Medicaid first, as Medicaid considers itself to be a secondary payer to all other eligible payers, including a liable third party's insurance coverage.[3]

For years, hospitals have been taking advantage of this process to reap financial benefit at the expense of the equitable reimbursement of their patients for their pain and suffering following a car accident caused by a third party. Internet and print media are replete with documented stories of low-income patients being unfairly punished by these permissive state hospital lien laws, in cases where they expected their emergency treatment to be covered by their Medicaid, only to learn that their treating hospital circumvented their insurance entirely in favor of pilfering monies from their accident settlement. In some cases, hospitals claim they can recover up to 300 percent of the amount they would have otherwise agreed to accept from the patient's insurance.[4] A high-profile account of this unethical practice appeared in the New York Times in February of 2021. In an article titled "How Rich Hospitals Profit From Patients in Car Crashes", reporters Sarah Kliff and Jessica Silver Greenberg highlighted the personal narratives of numerous accident victims whose hospital bypassed their Medicaid coverage only to later pursue full charges from the victims' accident settlements.[5] In particular, the authors named hospital systems in Washington, Oklahoma, Tennessee, Georgia and Virginia as particularly egregious

offenders, though they acknowledged that this is a widespread practice likely happening at many hospital systems in every state.[6]

My thesis proposes that this practice has numerous unacceptable legal and ethical implications for Medicaid patients. Firstly, it directly harms the patient by placing an over-reaching claim on settlement monies that are meant to compensate the patient for their pain and suffering. Secondly, the practice seems to eschew the entire purpose of Medicaid, which attempts to provide equitable access to care – its mission is subverted if hospitals can actively profit by avoiding properly charging the program at predetermined prices. Through a legal lens, I present an overview of the current national landscape of these permissive hospital lien laws, and address a few key pieces of litigation – some that have expanded hospitals' powers to place these liens, and some that have curtailed them – in the last twenty years. For the purposes of a case study, I highlight the hospital lien law of Tennessee, a state known to be permissive in favor of hospitals' rights. I argue that hospitals' ability to place these liens against low-income Medicaid patients is too broad and unchecked in the modern era, especially now that the high rate of national insurance coverage removes one of the original, historical motivations for the lien statutes in question.

Beyond arguing against the legal tenability of the statutes, I address the practice from a bioethical perspective, given that the underlying motivation for caring about this issue is the breakdown of equity and health justice that occurs when a low-income patient is unfairly taken advantage of. The ethics of hospital lien laws, as of yet, have received fairly little attention within the bioethics literature. To elucidate the fundamental ethical concerns behind this practice, I employ two main concepts of justice: distributive justice

and compensatory justice. Firstly, I invoke the writings of Rawls and Daniels to explain why public health insurance is a benefit our society is obligated to provide to those facing the highest obstacles within various realms of social determinants of health. After synthesizing this hypothesis with the irrefutable connection between medical debt, public insurance coverage, and wellbeing, I propose an ethics-informed policy change intended to curtail the disproportionate effect of predatory hospital liens on low-income patients and patients of color. This builds on my direct proposals to change hospital lien statutes as discussed in the first chapter. Secondly, I provide support for this ethical endeavor from the perspective of compensatory justice, which seeks to provide resources to a victim of injustice in order to minimize the impact of harm done by that injustice. Allowing hospitals to continue to misappropriate funds meant to compensate accident victims for their incurred harm undermines those patients' abilities to recover after the accident, and prevents them from continuing their metaphysical pursuit of "not being hurt."

CHAPTER ONE: A LEGAL ANALYSIS OF PREDATORY HOSPITAL LIENS

I. A General Introduction to Statutory Hospital Lien Laws

Simply put, a lien is an interest in property that serves the purpose of securing a debt, meaning that the creditor has a legal right to take into possession (whether actual or constructive) some sort of property or collateral in satisfaction of a debt that the creditor is owed.[7] At a high level, liens can come into existence in various ways—by agreement between the debtor and the creditor, or by certain provisions in the law, which either demand judicial action for creation (a "judicial lien") or do not require judicial action and arises solely by force of statute ("statutory lien").[8] State hospital lien laws are statutory, meaning that by force of statute, they create a nonpossessory lien interest in a judgment or settlement accruing to a patient.[9] It is important to note that in the case of hospital liens, a state's hospital lien act gives the hospital an independent right to assert a lien, but that right is *not* against the patients themselves. It is only attached to the right to a potential settlement (or a portion of it) a patient may receive from a third-party tortfeasor. Every hospital lien act has language in it that limits the hospital's right to recover to the amount of the "reasonable and necessary" charges of the hospital for the services provided for the care, and most place limitations on what percentage of the patient's third-party settlement can be recovered.[10]

II. A Brief History of State Hospital Lien Laws

The first state hospital lien laws arose in the 1930s[11], during a time in the US when large-scale, uniform health insurance was not yet commonplace and hospitals needed to be protected from the financial risk of providing emergency medical treatment to uninsured or insolvent patients without any guarantee of recompense.[12] Part and parcel to this protection, the statutes also served to encourage hospitals to enthusiastically provide

emergency care for such patients, without delaying or refusing treatment due to their ability to pay (or lack thereof).[13] As the Arkansas Supreme Court explained in 1939, the state hospital lien statute was enacted "for the very humane purpose of encouraging physicians, hospitals and nurses to extend their services and facilities to indigent persons who suffer personal injuries through the negligence of another, by providing the best security available to assure compensation for services and facilities."[14] Courts also recognized that by establishing an orderly method for enabling hospitals to place these liens, these statutes also promoted a policy of conserving judicial resources of money and time, and minimizing potential litigation that would otherwise arise as physicians sought repayment for treatment costs.[15] Six states led the charge in enacting this new legislation during the Depression Era, thirty-four more followed by the year 1980, and in the present day, forty-two states have hospital lien laws on the books.[16] Each state's respective hospital lien act provides various procedural and substantive criteria limiting and regulating the application of the liens. For example, some states require a hospital lien to be filed in certain courts, whereas other states simply require service on the interested parties by certified mail.[17] There are further variations in elements like the allowed timing of filing, the types of providers that can assert these liens depending on population size, and the percentage of recovery that the provider can recover through the lien.[18]

III. How Hospitals Take Advantage of Medicaid as a Secondary Payer

Notably, Medicaid does not allow "balance billing" by healthcare providers.[19] Balance billing refers to a strategy by which a hospital, after receiving payment from a patient's insurance at the agreed-upon price for treatment, attempts to recoup the difference between this price and the hospital's more exorbitant chargemaster[20] prices by either

directly billing the patient or by asserting a lien on a patient's right to payment. Chargemaster rates are analyzed by a measure called "charge to cost ratio", which measures the markup rate of the hospital's prescribed rates as compared to Medicare and Medicaid allowable costs.[21] One study has shown that the national average charge to cost ratio is 3.4, while the most predatory hospitals in the country have their chargemasters set at up to ten times the public insurance negotiated rates.[22] This term of art, "charge to cost ratio", is also instructive because of the way it highlights that chargemaster rates are *charges* only, and do not represent the true *cost* of the medical services provided to patients. They are essentially a fictional creation—comparable to the undiscounted "rack room" rates at hotels—because so few patients ever truly pay for care at those rates.

Federal Medicaid statutes establish that once a provider accepts Medicaid funds, it cannot pursue additional payment from the patient or any fiduciaries of the patient to increase revenue.[23] It is a concession that a basic principle of the Medicaid program is that it is meant to be a payer of last resort;[24] in other words, Medicaid takes the role of a "secondary payer" when a primary payer is available and responsible for coverage, like a third-party liability insurer.[25] But it was also the intention of Congress when it passed the ban on balance billing that no amount should be charged to a Medicaid beneficiary for healthcare services exceeding the Medicaid reimbursement, because this would impede the beneficiary's access to medical care and would work against the fundamental purpose of Medicaid: to provide cost-effective "medical care for the needy."[26] Thus, we have clearly documented caselaw that shows, where a hospital has already been paid by a beneficiary's Medicaid coverage, the hospital cannot subsequently place a lien on the beneficiary's settlement award, as that recovery is meant to go to the injured party, not the provider.[27]

Unfortunately, in recent decades hospitals across the country have gotten savvy and have successfully taken advantage of Medicaid's "secondary payer" status to work around the prohibition on balance billing. State courts have been allowing hospitals to *choose* to assert liens against Medicaid beneficiaries in cases of third party liability that result in a significant settlement, instead of billing Medicaid first.[28] The Health Care Financing Administration (HCFA) published a 1995 memorandum that addressed this issue, elucidating that a medical provider "may, but is not required to" bill Medicare or Medicaid if a patient's liability insurance claim is not yet fully resolved.[29] This gave hospitals the discretion to choose to reject a lesser payment under a patient's Medicare or Medicaid coverage, in order to seek a larger payout from settlement proceeds.[30] So while this tactic does not look like balancing billing explicitly, as the hospital is not directly billing the beneficiary for the difference between the chargemaster price and the Medicaid price, it essentially still recovers the difference by taking away recovery monies from the beneficiary. The medical lien statute authorizes the hospital to collect more than the reduced, contracted payment rate negotiated for by Medicaid, simply by presenting the higher bill as a medical lien instead of as a claim filed against insurance. As the court noted in *Rabun v. St. Francis Med. Ctr.*, such a workaround substantively negates the protections offered by prohibitions against balance billing, as the hospital would still be able to collect an exorbitant amount of revenue that such prohibitions intend to prevent.[31]

State courts have done backflips to ratify and enable hospitals' constructions of state law as a workaround to hospital lien limitations. For example, in the 2012 case of *Gister v. Am. Family Mutual Ins. Co*, the Supreme Court of Wisconsin denied that a hospital's liens on a Medicaid beneficiary's third-party liability settlement constituted

“direct charges” on a Medicaid-eligible patient. For context, Wisconsin statute § 49.49(3m)(a) prohibits hospitals from "knowingly impos[ing] direct charges upon a [patient] in lieu of obtaining payment" from insurance.[32] Since the hospital liens on the Medicaid patient’s settlement were deemed not to be “direct charges” as the term of art is defined, the liens were consistent with both state and federal law and were not prohibited.[33] Thus, patients are inequitably losing not only their settlement monies, but also the intended benefit of their Medicaid coverage, too.[34]

Some state statutes even explicitly provide greater leeway for hospitals to take advantage of this workaround. In Alabama, for example, Ala. Code Ann. § 35-11-370 creates a hospital lien, which grants a hospital an automatic lien on a patient’s settlement arising from injuries, so long as the patient was treated at that hospital within 1 week of being injured.[35] The code was amended in 2019, to require hospitals to submit a claim to the patient’s health care payer *first* (before filing the lien), and if that payer has an agreement with the hospital under which services are paid for at a reduced rate, the hospital must honor that agreement.[36] However, importantly, this stipulation is limited to non-government insurance. If the hospital is uncertain whether the patient is covered by a health care payer at all, or if it knows the patient is “covered by a governmental payer including Medicare or Medicaid”, the hospital may still perfect its lien within 20 days after discharge, without first seeking payment from the insurer.[37] This upholds the established practice discussed earlier of hospitals being able to choose to perfect their hospital liens instead of billing Medicare or Medicaid.[38]

This is the practice that, rightfully, comes under fire when patients report these experiences to academics, watchdogs, and media outlets. In the Kliff and Silver-Greenberg

New York Times article, the authors told the story of Monica Smith, who was treated at Parkview Regional Medical Center in Fort Wayne, Indiana in 2016 following a car accident.[39] Smith states she showed her Medicaid insurance card at the emergency room, but the hospital never billed Medicaid, instead electing to place a lien on her accident settlement at an amount five times higher than the hospital could have recovered by billing Medicaid.[40] Indiana hospital lien law[41] states that, of course, a hospital cannot place a lien on a patient's recovery if the hospital accepts Medicare or Medicaid payout for that patient's care. Like Alabama's law, Indiana law states the hospital must first bill "health insurance"; but because the state's courts have historically interpreted the term "health insurance" to not include "government assistance" programs, the hospital is not *required* to first bill Medicare or Medicaid if that is the patient's only coverage. Because the hospital had the discretion to choose not to bill Smith's Medicaid, there was no conflict at first. Eventually, after Smith subsequently brought legal action against Parkview, she received her full third-party liability settlement in 2020, after a Superior Court judge in Fort Wayne ruled against Parkview's deceitful interpretation of the state lien law, stating that Medicaid should "plainly" be considered health insurance for the purposes of the statute's interpretation.[42] This was one of just a few cases in Indiana that are starting to push back on the historically permissive interpretation of the Indiana Hospital Lien Act. Parkview made a statement following this ruling that it would change its approach, now seeking reimbursement from Medicaid rather than fighting for the previously-held permissive interpretation of the Lien Act.[43] In this case, one hospital has been reprimanded at the lowest level of the state court system; much more expansive change at the legislative level

(or at least a more controlling ruling from a higher Indiana court) will be needed to effectuate long-lasting change in favor of patient rights.

Other states specifically mentioned in the Kliff & Silver-Greenberg article for their predatory hospital lien laws are Tennessee[44] and Georgia[45]. Georgia courts have shown little willingness to push back on hospitals that are placing liens on the settlement monies of un- or under-insured patients in accidents; the 2020 case of *Bowden v. Medical Ctr.* saw the Georgia Supreme Court giving the green light to a hospital to place a hospital lien on a patient's settlement at exorbitant chargemaster prices, denying any question of whether or not those charges were reasonable, stating that surely "the standardized chargemaster rate used by [the medical center] as a basis for the lien was based on real world factors such as the cost of [the hospital's] services to its patients and the hospital's overall costs."[46] In contrast, Tennessee hospital lien law helpfully limits the automatic lien that a hospital has on the third-party recovery up to only 1/3 of the amount of the settlement. However, Tennessee hospitals are still taking advantage of the state's lien laws in a way that necessitates a closer look.

IV. A Tennessee Case Study: *West* (2014) and *Dedmon* (2017)

In order to lay the foundation for the subsequent discussion of Tennessee hospitals' predatory lien practices, we must first establish the nuances of Tennessee's Hospital Lien Act, codified at Tenn. Code. Ann. § 29-22-101 et seq.

The Tennessee Hospital Lien Act (HLA) was first passed in 1970, "to create for hospitals a lien upon all causes of action for damages accruing to persons having received care and treatment for illness or injuries and to provide the procedure for the perfecting,

recording, enforcement and release of such lien."[47] Caselaw and legislative documents in the fifty years since its enactment have affirmed that, as previously discussed in the context of HLA law nationally, the initial motivation of the legislation was to keep hospital costs down, ensure that hospitals would be paid, and prevent hospitals from turning away emergency patients on the basis of an inability to pay.[48]

The most important textual features of Tennessee's HLA are outlined in this chart:

Statute Section[49]	**Key Language**
§ 29-22-101(a)	"Every . . . hospital . . . shall have a lien for **all reasonable and necessary charges** for hospital care . . . upon any and all **causes of action, suits, claims, counterclaims or demands** . . . accruing to the person whom such care . . . was furnished"
§ 29-22-101(b)	"**The hospital lien, however, shall not apply to any amount in excess of one third (1/3) of the damages obtained or recovered by such person**"
§ 29-22-102(a)	"In order to perfect such lien . . . the hospital, **before or within one hundred twenty (120) days** after any such person shall have been discharged . . . shall file in the office of the clerk of the circuit court of the county in which the hospital is located"
§ 29-22-102(b)	"A copy of claim shall, **within ten (10) days from the filing thereof be sent by registered mail** . . . to each person . . . so claimed to be liable on account of such illness . . . and to the attorney . . . representing the person to whom services were rendered"

a. Key Tennessee HLA Litigation: *West*

In Tennessee in 2006, Charles Garland suffered injuries as a result of another person's negligent operation of a motor vehicle in a car accident.[50] He was taken by

ambulance to Shelby County Healthcare Corporation's Regional Medical Center at Memphis for treatment.[51] This hospital's procedure for emergency patients was to "categorize" them by the nature of their injury – notably whether they were the victim of the accident caused by another person. The hospital does this so they can best evaluate the potential for recovering from a third-party tortfeasor, which is their right to do under Tennessee's Hospital Lien Act. The hospital saw an opportunity for a settlement recovery here, and timely filed a lien for the treatment of Mr. Garland's injuries in the full and unadjusted amount.

Because he was a recipient of TennCare, the state's version of Medicaid, Mr. Garland's insurance should have been charged at the discounted rate agreed to in the hospital services agreement for state-funded public insurance. However, by initially circumventing TennCare entirely, the hospital was able to place a hospital lien on Mr. Garland's potential third party settlement in an amount calculated at the hospital's chargemaster rates. While Mr. Garland was pursuing litigation against the third-party tortfeasor, his TennCare insurance actually paid the hospital at the amount pursuant to the hospital services agreement. However, the hospital declined to release its hospital lien on the grounds that it was authorized to seek this payment from the third party, and once received, would just reimburse TennCare for any amount it already paid to the hospital. This action would have equitably reimbursed TennCare for the amount it paid, but the real loser here would be Mr. Garland, who lost a larger portion of his potential settlement monies just because the hospital wanted to make a profit above and beyond the payment amount it already agreed to accept under its hospital services agreement.

In 2013, Mr. Garland joined with two other patients—Diane West and Jammie Heags-Johnson, both of whom had similar experiences with Shelby County Healthcare Corporation, though were covered by private insurance instead of Medicare or Medicaid—to sue the hospital. In the first hearing of this case (*West*), the court found that the hospital's liens it placed on Mr. Garland's settlement would be considered an effort "to collect from" the patient.[52] This makes the hospital's actions subject to the federal Medicaid law at §1396a(a)(25)(C), which bars such liens once a provider bills and accepts payment from Medicaid.[53] Here, the Court held, the hospital did accept payment from TennCare, and in doing so, received the "benefit of the bargain" it had contracted for with TennCare.[54] Once it did so, it could no longer legally maintain its lien under federal and Tennessee state law.[55] Seemingly, a victory for Mr. Garland.

The cases of Mr. Garland's co-plaintiffs, West and Heags-Johnson, were actually granted appeal to the Tennessee Supreme Court. The ruling at the Supreme Court in December of 2014 at first seemed to be another victory for patient protection, and gave hope to plaintiffs' attorneys hoping to usher in a new era of holding hospitals accountable for their reckless use of hospital liens against low-income patients. Interpreting the Tennessee HLA, the court determined that the hospital was not authorized to maintain its lien after the patients' insurance companies went back and paid the bill, at the reduced price navigated by the hospital services agreement. The Court determined that the non-discounted chargemaster prices used to calculate the amount of liens filed against the patients' settlements were not "reasonable" within the meaning of the HLA statute, because the charges did not reflect what their public insurer would "actually pay" in the marketplace.[56] The Court also denied that the HLA imposes a legally enforceable duty on

the third-party tortfeasors themselves to be responsible to the hospital that treats an injured party.[57] In other words, the hospital only has the right under the statute to file a lien, but once the underlying debt is extinguished, the tortfeasor is no longer personally bound to furnish any further payment to the treating hospital.

However, as Tom Waits said, the large print giveth, and the small print taketh away. Because Mr. Garland's case was not considered as part of this appeal at the Supreme Court level, the opinion notes: "Nothing in this opinion should be construed to apply to hospital liens filed against patients who are TennCare enrollees."[58] In other words, the court left Mr. Garland out of consideration on appeal to categorically distinguish how this law applies to the state's Medicaid enrollees. So, the aftermath of the *West* line of cases introduced more questions than answers into the HLA litigation landscape regarding whether liens could be filed before charging Medicaid, and what costs were reasonable under the meaning of the HLA statute.

b. Key Tennessee HLA Litigation: *Dedmon*

In November of 2017, the Tennessee Supreme Court released its opinion in a personal injury case called *Dedmon v. Steelman*, which didn't do much to further patient protections against predatory hospital liens – if anything, it slightly walked back the broad language initially used in the *West* case. The case didn't address whether hospitals had to bill insurance before placing hospital liens on settlements. And, with regard to the determination of what were "reasonable charges" by the hospital, Tennessee took a page out of Georgia's book and allowed the plaintiff to submit evidence of her full, undiscounted medical bills as proof of her reasonable medical expenses.[59] Despite the fact that this analysis occurred in a personal injury context, where a third-party tortfeasor was being

sued and not a hospital, this case still had ramifications for hospital lien law jurisprudence. *Dedmon* upheld the reasonableness of non-discounted billing charges, presumably making it harder for future plaintiffs fighting back against hospital liens to establish that the liens on their settlements, based on chargemaster pricing and not Medicare or Medicaid pricing, are unreasonable.

V. What is Colorado Doing Right?

In an effort to determine how Tennessee could modify or update its HLA laws to better protect low-income publicly insured patients, we could look to the judicial interpretation of statutory text that has been recently unfolding in the Colorado court system.

In *Garcia v. Centura Health Corp.*[60], decided in the Colorado Court of Appeals in March 2020, the court held that the defendant hospital violated the Colorado hospital lien statute by filing a hospital lien against a patient *before* billing her primary health insurance, Medicare. The court went out of its way to specifically invoke how this practice was contrary to the legislative intent of the hospital lien law, as amended by the state legislature in 2015: "because in amending the statute, the General Assembly sought to protect insured patients from unnecessary liens — not to protect maximum payments to hospitals serving insureds."[61]

The statute before its amendment in 2015 was broader, allowing hospitals to place liens on patient settlements, only barring liens placed on worker's compensation settlements or for unreasonable or unnecessary charges.[62] Much of the language mirrored the current Tennessee HLA language, stating that a hospital gets an automatic lien "for all reasonable and necessary charges for hospital care upon the net amount payable . . . as

damages on account of such injuries."[63] In 2015, seeking to stop the placement of liens against patients whose insurance coverage meant they weren't insolvent, the Colorado legislature "substantially" amended the hospital lien statute to require that hospitals bill both a patient's liability insurance and their primary health insurance prior to seeking any kind of hospital lien, in the same manner as the hospital would use for patients not injured by another's negligence. Only if the hospital could not recover from either form of insurance could they place a lien against the patient's recovery.[64] The amended statute also strengthened patient rights by granting a victim a claim against their billing hospital for twice the amount of the asserted lien if the hospital violated the statute by not submitting its bill initially to insurance.[65]

A more recent decision in Colorado has affirmed the court's interest in protecting the rights of insureds. The 2021 Supreme Court case *Harvey v. Catholic Health Initiatives* confirmed and solidified the *Garcia* decision by explicitly holding that hospitals must bill Medicare or Medicaid before they file a lien against an accident victim's settlement, if the victim is covered by one of those government programs. As previously mentioned, many hospitals around the country tried to get around their state's requirement to bill Medicare/Medicaid first by denying that these government programs could qualify as a "primary" payer of benefits under the wording of the given state hospital lien statute. If Medicare/Medicaid is a secondary payer, the hospital does not have to bill them first, per federal law.[66] Colorado swiftly recognized this workaround and, in order to close the loophole, asserted that when Medicare or Medicaid is a patient's primary health insurer, it must be enforced as such within the purposes of interpreting the state law, and "merely enforcing [the state's] Lien Statute does not make Medicare a primary payer of medical

benefits in violation of the [federal] statute."[67] To make this ruling, the Court looked to the legislative history of the state lien statute, and referenced testimony presented by Senate President Cadman at a hearing on the 2015 bill that amended the Colorado statute.[68] Various members of the senate recognized that hospitals within the state had a practice of filing liens instead of billing patients' insurance plans, resulting in significant impacts on those patients' lives, emotions, businesses and credit.[69] The Court states,

> In our view, this history reveals the General Assembly's primary intent to protect accident victims from the aggressive lien practices that some hospitals had employed at that time and tends to support the statutory construction advanced by Harvey and Manzanares in this case. Although the statute continues to protect the right of a hospital to be paid for the care that it provides, the statute also manifestly protects individuals from a "second injury, the lien. That comes with the insult." 2nd Reading on S.B. 15-265 before S., 70th Gen. Assemb., 1st Reg. Sess. (Apr. 21, 2015) (statement of Senate President Cadman).[70]

This reflects a statutory interpretation that is not only a common-sense reading, but also one that equitably takes into consideration the motivations behind amending this statute seven years ago. The Court does acknowledge a potential counterargument that this ruling could result in a hospital's inability to collect an adequate amount for an injured patient's care, while the patient themselves receives a large disbursement from their third-party recovery, but the Court asserts that in the few cases where this may occur, such an outcome is justified by a plain-meaning construct of the lien statute.[71] Other academics have opined similarly, stating that when given the choice between two parties (the hospital and the patient), the hospital seems better positioned to absorb a financial "loss" as a result of the medical care services provided, given the access that most modern hospitals have to corporate resources.[72] Of course, just for good measure, the Court mentions that should the legislature intend something different from this interpretation, it always has the discretion to go back and amend the statute once more, or create further legislation to prevent recovery

windfalls to patients, should they become such a problem.[73] But there is little evidence to suggest this is happening, given that lump sum tort settlements don't differentiate medical costs from other injuries, and rarely leave injured victims "whole" even before hospitals take a cut of the pie through the use of a lien. The impacts of court costs and plaintiff's lawyer fees often gouge the value of the settlement, especially when one considers that settlements may be capped by the liability limits of the defendant's insurance coverage.[74]

This plaintiff-protective interpretation also reads consistently with the expectations society holds for hospitals and the way they create revenue. For a non-profit hospital, at least, we expect it to stick with Medicaid-negotiated rates because a hospital's tax-exempt status (a huge financial boon for the business) is based on its willingness to accept Medicaid. Even for-profit hospitals still willingly accept Medicaid and its associated rates because, although these rates may be below the average value recouped from patients with standard private insurance, they are still significantly higher than the *marginal* costs of providing medical care, so the hospital is still contributing revenue to cover its fixed costs and other investments.[75]

And further, practices and patterns within state Medicaid subrogation[76] rights demonstrate that other agencies value the protection of plaintiff's rights to access as much of their settlement as possible. While Medicaid always has a subrogation right, it rarely exercises it against victims receiving settlement payments because of the program's consideration of elements of justice and fairness to the injured patient; the cases in which Medicaid is most likely to exercise the right are large-scale cases involving significant corporate payouts, for example, from tobacco or opioid companies.[77]

VI. Potential Amendments to Tennessee Law (And Lessons to Be Learned)

Nearly half a century after Tennessee's HLA was initially enacted, the rate of health insurance coverage nationally has skyrocketed, as compared to the percentage covered by any insurance before the implementation of Medicaid, and even compared to the rate of insured within the first decade of Medicaid's existence. Looking at the population under the age of 65, in 1972, for example, only 6.5 million people were covered by Medicaid, and over 16% of the population remained completely uninsured.[78] By 2007, 36.2 million people were using Medicaid, and by 2020, only 8.6% of the population did not have health insurance at any point during the year.[79] This changing landscape has stripped hospital lien law of one of its primary motivations for existence: to financially protect hospitals against large swaths of uninsured and insolvent patients. In light of this major societal change, all states should look to the demonstrated advances in patient protection that Colorado has undertaken by clarifying the interpretation of its hospital lien law. Tennessee (and other states with permissive, predatory HLAs) could and should make similar changes to better protect its patients. First and foremost, the state could amend its HLA to explicitly require hospitals to bill a patient's health insurance first, and specify that "health insurance" in this context is inclusive of Medicare or Medicaid, if that is the patient's only coverage. Although there is no *binding* precedent on the books for this argument, there is demonstrated persuasive precedent in the form of Colorado's *Harvey* decision. The more states that adopt this logic—that treating Medicare/Medicaid as the primary payer for purposes of a state hospital lien law, but not for the purposes of federal Medicare as Secondary Payer laws, is a tenable stance—the more self-reinforcing and stable it will become. Attorney Stuart Burkhalter, in his 2018 article "Who Pays?", suggests this change,

and also goes farther to suggest that Tennessee's HLA prohibit any recovery remedy for hospitals beyond what the patient's health plan will pay.[80] However, he correctly acknowledges that such a provision would leave hospitals with no recourse should a health plan deny reimbursement for care entirely, which presumably happens frequently enough that it may existentially threaten the profitability and sustainability of that hospital.[81]

Another route Tennessee could take, through legislative action, is clarifying and defining what constitutes "reasonable and necessary" charges, as that term of art is used in the HLA. As discussed in the line of *West* and *Dedmon* caselaw, there is currently ambiguity regarding whether or not the full chargemaster amounts listed by a hospital can be considered to be "reasonable and necessary", which would impact the size of a lien to be placed on the patient's third-party liability recovery. Arguments against the reasonability of chargemaster rates note that those prices are not determined through an arm's length negotiation with any patients, insurers, or other payers, thus cannot realistically represent fair, market-tested, competitive prices.[82] Further, since so few patients actually pay for care at the chargemaster rates, they are "not an accurate measure of a hospital's "standard charges" since [they] do not reflect the true price the hospital is willing to accept for payment."[83]

A more clearly written statute could limit the lien amount to either the equivalent reduced rates determined by the patient's specific insurance plan, or the value of one standard commercial health insurance plan selected to establish "market" rates (as opposed to chargemaster rates).[84] We saw this approach demonstrated in New Jersey in 2008, when the state legislature enacted a cap on the amount hospitals could attempt to collect from patients through lien or other methods. No hospital could charge a patient who was within

500% of the federal poverty level a price more than 115% above the Medicare reimbursement rate for given services.[85] The goal would be to establish a standard by which consumers of medical care can reasonably predict the size of the lien a hospital may place on their settlement.

Finally, a new strategy to strengthen patient rights could be to allow patients to sue hospitals for outrageous and exorbitant lien filing practices under the Tennessee Consumer Protection Act (TCPA). In fact, the Tennessee Supreme Court ruled in May of 2020 that medical consumers *do* have a cause of action to sue hospitals under the TCPA[86] when the person has lost money or property due to improper business practices of the hospital, including practices related to billing.[87] In *Franks v. Sykes*, plaintiffs sued a Tennova Healthcare hospital after receiving medical care at that hospital following a car accident.[88] The hospital failed to bill the plaintiffs' health insurance, instead filing hospital liens against plaintiffs' potential tort settlements.[89] Reversing the lower courts, the Court held that plaintiffs could state a claim here under the TCPA, because the underlying transaction—though it was a debt collection activity and not technically a "business" activity—was still sufficiently related to the hospital's business practices to fall within the scope of the TCPA. Also, the Court recognized that it had previously applied the TCPA to other debt collection activities in other realms of the law. Although this decision didn't reach the substance of plaintiffs' claims—that is, it only determined that plaintiffs *did* have a cause of action under the TCPA—this is a promising mechanism to arm patients in the future with recourse should a hospital aggressively pursue hospital liens without first billing the patient's insurance, whether Medicare, Medicaid or otherwise.

CHAPTER TWO: A BIOETHICAL COMMENTARY ON THE INEQUITY OF HOSPITAL LIEN LAWS

I. Why Should Medicaid Be Responsible in the First Place?

Despite the complex maze of possible legal fixes that could be proposed to close the loopholes hospitals use to gouge patients of their settlement proceeds, there remains an overarching ethical issue in this failure of equitable billing practices. Even when given the benefit of the doubt that these various legal interventions could improve the situation for publicly insured patients, there remains the fact that the hospitals' use of liens to get more money than they have actually agreed to accept is still an objective injustice.

To defend and support this assertion, one must first reckon with the question, "why do we saddle public, taxpayer-supported programs with the responsibility of paying for medical care rendered after someone has been harmed by a third party?" Presumably, if the responsibility for such reimbursement lay entirely in the hands of the tortfeasor, the hospital's recovery of marked-up amounts from the third-party settlement would not be a controversial practice. If anything, one could argue that it is the tortfeasor's responsibility to contribute doubly for the harm they've caused – to cover the damages that result in healthcare expenses, and the auxiliary costs incurred by the victim for accommodations that follow their injury, like lost wages and family care. H. Tristram Engelhardt takes this stance in his book *The Foundations of Bioethics* (1996), where he states:

> Insofar as an injured party has a claim against an injurer to be made whole, not against society, the outcome is unfortunate from the perspective of society's obligations and the obligations of innocent citizens to make restitution. Restitution is owed by the injurer, not society or others. There will be outcomes of the social lottery that are on the one hand blameworthy in the sense of resulting from the culpable actions of others, though on the other hand a society has no obligation to rectify them. The social lottery includes the exposure to the immoral and unjust

> actions of others. Again, one will need an argument dependent on a particular sense of fairness to show that the readers of this volume should submit to the forcible redistribution of their resources to provide health care to those injured by others.[90]

Although this is a common-sense argument, and is tempting to agree with, it misses the forest for the trees; public-insurance programs are meant to provide healthcare resources to those members of society who are reckoning with other social structures that have disproportionately affected their rights to achieve success as measured by social determinants of health. The practice of medicine is, primarily, to try to correct the damage of these social determinants of health, summarized in six categories by Dr. Michael Marmot: conditions of birth and early childhood, education, work, the social circumstances of elders, elements of community resilience, and fairness related to a redistribution of wealth and income.[91]

If these billing practices were allowed to continue without ethical reproach, simply on the basis of the logic that the injurer should be responsible for compensation without the assistance of any social support programs, the only "loser" in the future would be the individual victim. These hospital liens doubly rob these patients by taking away the primary benefit of their settlement monies and by compromising the intended benefit of their Medicaid coverage as a corrective measure against other healthcare disadvantages. Those healthcare disadvantages are, by and large, the downstream result of other macrolevel societal structures that have failed certain subcommunities of people in the United States, primarily people of color and low-income people. Even when the structural dysfunction is incapable of being assigned to one person or group of people as the sole responsible "injurers," we still seek to pool our own wealth to redistribute resources to those most in need. In the face of such blatant societal disintegration for these groups of

people, Engelhardt's argument can be rebutted by asserting that society does have an affirmative obligation to contribute to covering health expenses through publicly funded insurance schemes, regardless of who created the harm.

II. Health Equity and Distributive Justice

This affirmative obligation to serve as a safety net for medically underserved patients is a core tenet of the initial establishment, and subsequent expansion, of the Medicaid program over the last half-century. As the primary source of health insurance for low-income and medically vulnerable Americans, Medicaid grants eligibility for coverage to low-income children and adults, pregnant women, and people living with extensive health needs.[92] While the expansion and development of Medicaid has contributed to higher rates of insurance coverage in the American population than ever before, it is important to note that when considering a holistic view of health, direct clinical care only accounts for ten to twenty percent of health outcomes, with the rest being attributable to social determinants of health like socioeconomic factors, education level, citizenship status, geographic location and housing status, and access to clean resources and food.[93] Health is affected not only by how easy it is for one to see a doctor, and the quality of care administered, but because of the underlying inequalities of society that individuals face on daily basis.[94]

While the concept of distributive justice has been addressed in writings for thousands of years, it is John Rawls' work on the matter from the late 1970s that largely defined much of the boundaries we consider when discussing distributive justice in modern day bioethics. Rawls acknowledges that, in order to more equitably distribute healthcare benefits and burdens across society, we must sometimes break from a strictly "equal"

distribution of rights and liberties in order to make the most disadvantaged members of society better off than they would be in an equal distribution model.[95] Norman Daniels built on this understanding through his influential writings on health justice. He explains that society must attempt to treat disease and disability in order to protect individuals' "opportunity" in life – that is, to participate normally in all spheres of social life.[96] Further, he asserts that the cost of healthcare aimed at protecting this equality of opportunity must not be placed disproportionately on the ill, nor distributed according to ability to pay.[97] This maxim is the exact logical support underlying my assertion that hospital liens placed on Medicaid patients' accident settlements only serve to further repress patients who, by virtue of turning to Medicaid, are seeking more equitable access to care and opportunity. When hospitals cut a chunk out of a victim's settlement monies instead of accepting previously negotiated contractual prices from Medicaid, this is a direct example of the ill (the victim) bearing a disproportionate brunt of the cost of healthcare. Also, since many states' legal interpretations seem to distinguish between private health insurance and public-funded coverage for the purposes of hospitals' ability to place liens on settlements, the *de facto* result is that it is the Medicaid patients with a lesser ability to pay who receive less healthcare and fewer remedial resources to which they are entitled.

A plethora of research and data show that Medicaid patients are more likely to be disadvantaged across multiple categories of the social determinants of health. For example, more than one in three Medicaid enrollees have less than a high school education; this statistic's true import is revealed when we consider that people with higher educational attainment are more likely to be healthier, live longer, and be privately insured with better access to care.[98] Further, although Medicaid patients technically have coverage, they face

additional challenges in gaining access to regular and appropriate care because they may live in areas where fewer physicians accept Medicaid, deterred by the program's reduced reimbursement rate for care.[99] Medicaid enrollment has shown to have a net positive effect on enrollees' financial wellbeing, with the people receiving comprehensive care in states that expanded Medicaid under President Obama reporting an average of $3000 less in medical debt, as compared to states that hadn't expanded the program.[100,] However, it is also the lowest income patients who have higher likelihoods of bearing long-term medical debt; and in turn, a recent article in *JAMA* found that those who carry medical debt are more likely to have worsening social determinants of health like stable housing and food security, creating a self-fulfilling spiral of negative consequences.[101] Consider that statistic alongside the accompanying truth that people burdened most by medical debt tend not only to be low-income but also to be Black or Hispanic; the Peterson-KFF health system also found that 56% of Black adults and 50% of Hispanic adults say they currently carry medical debt, in contrast to only 37% of non-Hispanic white adults. People of color make up almost 60% of Medicaid enrollees despite representing only 13% of the US population.[102] In some parts of the country, people living in communities of color are four times as likely to have medical debt in collection as compared to people living in predominantly White areas within the same community.[103] And as one journalist put it, "it's hard to separate the disparities in medical debt from other inequities"; Black and Hispanic households, on the whole, have lower incomes and less saved wealth that could be used to absorb "unexpected shocks like medical bills."[104] Even worse, in states where Medicaid expansion was not adopted, over 2 million people have been locked out of health coverage, 60% of whom are people of color, and 25% of who are Black.[105]

There must be policy changes, beyond the constraints of directly reformulating state HLA laws and related caselaw, that can be implemented to curb the disproportionate impact of hospital liens and medical debt on low-income patients of color. Hospital liens allow healthcare institutions to distribute burden to, and deprive of benefit, the members of society already excessively saddled with greater comorbidities and fewer financial resources to fight them. These policy changes are necessitated by the pursuit of distributive justice espoused by Norman Daniels, as society strives to provide equitable opportunities for future health and wellbeing to our most disadvantaged populations.

III. A Policy Proposal to Address Hospital Liens, Motivated By Distributive Justice

States have already begun to create laws that ban hospitals and healthcare providers from placing liens on patients' homes in order to secure their medical debt. In May of 2022, the New York Legislature passed a bill through both the State Senate and Assembly banning the practice, with the sponsor of the bill recognizing that "people's lives have been destroyed by the unconscionable and shocking practices by some healthcare facilities of putting liens on patients' homes and garnishing wages for an average claim of $1900."[106] Other supporters of the bill correctly identify the moral impetus for such a bill, stating that "communities of color experience the most disproportionate rate of medical debt because of predatory financial practices in New York State. No one should fear seeking medical treatment for jeopardy of losing their home or wages."[107] In North Carolina, around the same time, state legislators proposed a bill called the Medical Debt De-Weaponization Act, which would implement a slew of protective provisions to limit hospitals' ability to collect from low-income patients.[108] For example, the bill prohibits home foreclosures related to

medical debt, and caps yearly out of pocket expenses at a reasonable $2300.[109] In its construction, the bill looked to the policies of other states – including New Mexico, where hospitals are not allowed to sue patients who have incomes below 200% of the federal poverty level, place liens on their property, or garnish their wages.[110]

I introduce these policies from other states simply to show that, where there is policy movement occurring on such closely-related hospital billing and financial wellness issues, it seems incredible that such logic cannot be imported and applied in parallel to the exact same inequities propagated by hospital lien laws. While hospital liens are distinguishable because they are not a matter of personal debt, they still similarly encroach on patients' ability to support themselves during a time of heightened financial burden. Any legal reform of hospital lien laws should see the same level of turnout and support from legislators, scholars and community organizations that these bans on property liens and wage garnishment are garnering, because at their core, they are premised on the same ethical principles.

The creation and widespread support of these new bills also reflects recognition by legislators and lay-people alike that aggressive hospital collection policies misbalance the respective harms and benefits to each actor in a debt scenario. In other words, these bills implicitly recognize that major healthcare institutions, with their deep pockets, face a relatively low threat of existential harm from the forfeiture of an average payment of $1900. In contrast, this is a significant amount for low-income patients that could keep them in a financially depressed state and prevent them from acquiring necessary follow-up care. This is a lopsided power dynamic; while I do not mean to suggest that healthcare institutions should be forfeiting invoices abundantly, I do mean to say that the sophisticated

funding structures of most of these predatory hospitals are a far cry from the quaint "doctor just trying to protect against insolvent patients" that motivated the first development of hospital lien laws a century ago. If, at the very least, this power imbalance tips in favor of leniency with low-income patients, it should also support the contention that hospitals should not be actively going above and beyond to collect *more money* from a patient's accident settlement instead of accepting the negotiated Medicaid rate. After all, the patient population that is incurring these predatory liens from hospitals is quite small in comparison to the number of patients any hospital sees in a given year, so the potential monies the hospital may recoup from the settlement will not be a make-or-break influx for the hospital's continued fiscal health, while a loss of such settlement proceeds could mean decades of financial instability for injured patients.

IV. The Role of Compensatory Justice and Restitution

If the rhetoric of distributive justice is not sufficiently convincing to justify bioethics' interest in reforming the practice of hospital lien placement on Medicaid patients' settlements, this issue can also be analyzed with the principles of compensatory justice. Compensatory justice acknowledges the importance of re-distributing resources more equitably, but goes beyond this duty to more assertively pinpoint the importance of redressing past wrongs, and restoring victims to a sense of "wholeness."[111] Compensatory justice in the bioethics sphere can be closely linked with the concept of compensatory damages within the legal context, which seeks to compensate a victim for the value of any loss as well as provide additional reimbursement for injury done.[112]

In the context of the settlements received by low-income patients after being injured in an accident caused by a third-party tortfeasor, the settlement proceeds are intended to

compensate the victims and restore them to wholeness. These damages can be in the form of economic damages to make up for monetary losses caused by the crash, e.g., medical bills, surgical expenses and damage to property; they can also include non-economic damages for emotional and mental distress brought to the patient and their family as a result of the accident.[113] This is the application of the word "compensation" as it is literally meant, from both a lay interpretation and a legal construction. However, the concept of compensatory *justice* goes beyond this straightforward definition and implies systemic redressing of wrongs done on a societal level, not just those inflicted upon an individual victim. Compensatory justice often appears in discussions of research ethics, where the intentional involvement of previously abused research populations in modern day studies is debated by scholars on both sides of the issue; one is wont to readily find discussions of compensatory justice against the backdrop of the Tuskegee Experiment.[114]

But in our case here, at first it may not seem there is a coherent population missing out on some sort of owed compensation to restore them to wellness. However, when you consider the aforementioned, co-occurring ways in which low-income, Medicaid-covered accident victims are systemically suppressed within all categories of social determinants of health, it becomes clear that a paradigm of compensatory ethics would demand the abolition of a practice where corporations can target these patients and rob them of their much-needed settlement monies. This "robbery" by hospital lien steals from the patient the compensation they would use to implement practical remedies in their life following an accident. But more importantly, the hospital liens also rob a patient of the metaphysical condition of "not being hurt." If we harken back to Daniels' logic that society provides medical care to protect individuals' opportunity to participate normally in life, we must be

uniquely concerned about the likelihood that low-income Medicaid enrollees face a notably *greater* risk of falling into the "cycle of poverty trap"[115] in the absence of adequate compensatory reimbursement. "When poor people become ill or injured, the entire household can become trapped in a downward spiral of lost income and high health-care costs," as the World Health Organization wrote in a 2003 guidance document on poverty and health.[116] Thus, the targeted poaching of Medicaid patients' accident settlements is likely to metaphysically "hurt" these patients more than patients who experience the same accident, but are privately insured and have a sufficient number of social and financial resources to support their recovery independent of any recovery from a third party. Furthermore, as if the withdrawal of financial resources and resulting injurious suppression in poverty were not harmful enough, such hospital lien practices may have a chilling effect on low-income patients who may be dissuaded from enrolling in Medicaid, or who are already enrolled and may be deterred from seeking emergency care out of fear that they will have to fight against over-reaching billing practices of their hospital. Ultimate compensatory justice would see hospitals entirely ceasing their collection of Medicaid patients' accident settlement monies. Some might criticize that approach, wondering why such a subsection of patients should benefit "more" from a car accident settlement, when that type of recovery in itself is not unique to the low-income Medicaid-enrolled population. In other words, why should the scales of justice tip in favor of allowing a greater windfall for the patient? Compensatory justice justifies a person's "getting more in the present than would be fair if his past losses were not considered."[117] The past losses for our low-income Medicaid enrollees are the additional barriers to achieving health and wellness that have been erected against them by societal structures built on discrimination.

Compensation steps in where reparation stops; we rely on others in society—blameless as they may be—to assist those who are worse off because of misfortune. In our case, the taxpayers who contribute to Medicaid funding are the source of the social safety net for the worst-off in our country, despite not being the direct cause of their suffering.

CHAPTER THREE: CONCLUSION

Returning to the hypothetical Medicaid patient presented at the beginning of this thesis, one might consider the alternate experience of this patient's physical and financial recovery under the more protective, anti-hospital-lien regime proposed *infra*. Shortly after he is discharged from the emergency room, the hospital would be legally required (under a Colorado-type statute) to bill the patient's Medicaid at pre-negotiated prices, just as the hospital would do for patients enrolled in "traditional" private coverage. Any subsequent settlement the patient receives in court could be subrogated by Medicaid, but is unlikely to be, as previously discussed. This doesn't mean the patient will ultimately experience a "windfall" of settlement monies – after factoring in legal costs and other caps set by the tortfeasor's insurance, the patient will likely receive an amount that offers modest support for the daily challenges he or she is to face in the aftermath of the accident.

There is no reason that Medicaid and other publicly-insured patients should be treated anomalously in this context as compared to the privately insured, or compared to patients who present to the ER but not as the result of third-party liability. If anything, there are strong public policy arguments that demand that these patients—who already are more likely to face obstacles to physical and financial well-being—be actively and affirmatively protected against any opportunistic price-gouging done by hospitals. The "wrongness" of these practices is rooted in the fantastically inflated chargemaster prices that hospitals attempt to conflate with "cost" of medical services, despite having no market substantiation of those values. While it is true that the hospital's "burden" to bear may be the difference between *average market rates* for treatment and lower Medicaid rates, it is reasonable to ask the multi-billion-dollar healthcare industry to be responsible for distributing any

negative impact of the shortfall. Medicaid enrollees, who are too often fighting an uphill battle against various intersectional systems of discrimination and repression, deserve a fair chance at achieving wellness, and should not be obligated to give up the settlements they deserve to make a rich hospital even richer.

REFERENCES

[1] Rebekah E. Gee, *Medicaid Eligibility Expansion Is Also Associated With Improved Fiscal Health of Families*, 111 AM. J. PUB. HEALTH 1385-86 (Aug 2021).

[2] Kuroki Masanori, *The effect of health insurance coverage on personal bankruptcy: evidence from the Medicaid expansion*, 19 REV. ECON. HOUSEHOLD 429-51 (Jun 2021).

[3] *Third Party Liability*, MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION, https://www.macpac.gov/subtopic/third-party-liability.

[4] George A. Nation III, *Hospitals Use The Pernicious Chargemaster Pricing System To Take Advantage Of Accident Victims: Stopping Abusive Hospital Billing*, 66 DRAKE L. REV. 645, 679 (2018).

[5] Sarah Kliff & Jessica Silver-Greenberg, *How Rich Hospitals Profit From Patients in Car Crashes*, N.Y. TIMES (Feb. 12, 2021).

[6] *Id.*

[7] Steve H. Nickles, *The Brendan Brown Lecture: Radical Reductionism in Debtor-Creditor Law*, 39 CATH. U. L. REV. 765, 765 (1990).

[8] In re Morris, No. 17-31593(1)(7), 2017 Bankr. LEXIS 3289 at *4 (Bankr. W.D. Ky. Sep. 28, 2017).

[9] State Farm Mut. Auto. Ins. Co. v. Huff, 157 Cal. Rptr. 3d 863, 866 (2013).

[10] *See, e.g., id.*

[11] *Hospital Lien Law In All 50 States*, MATTHIESEN, WICKERT & LEHRER, S.C, https://www.mwl-law.com/wp-content/uploads/2019/09/HOSPITAL-LIEN-LAWS-IN-ALL-50-STATES-CHART-00215685x9EBBF.pdf (last updated Jan. 13, 2022).

[12] Michael A. Morrisey, *History of Health Insurance In The United States*, *in* HEALTH INSURANCE, 3, 3-10 (2d ed. 2013), https://account.ache.org/iweb/upload/Morrisey2253_Chapter_1-3b5f4e08.pdf. By the end of the 1930s, only 25 states had enabled legislation allowing for (and regulating the criteria of) Blue Cross hospital coverage plans. Right before World War II, only 9% of the American population had any sort of health insurance; that rate saw a precipitous jump to 23% by the end of the war, and by less than ten years later, that percentage increased again to over 50%. *Id.*

[13] Meta Calder, *Florida's Hospital Lien Laws*, 21 Fla. St. U. L. Rev. 341, 362 (1993).

[14] Buchanan v. Beirne Lumber Co., 124 S.W.2d 813, 815 (Ark. 1939).

[15] Community Hosp. v. Carlisle, 648 N.E.2d 363, 365 (Ind. Ct.App.1995).

[16] CALDER, *supra* note 13 at 351; *see also Hospital Lien Law In All 50 States*, *supra* note 11.

[17] *Hospital Lien Law in All 50 States*, *supra* note 11.

[18] *Id.*

[19] Omnibus Budget Reconciliation Act of 1980, Pub. L. No. 96-499, 94 Stat. 2599 (1980).

[20] A chargemaster is a hospital's list of all the medical goods or services provided by the hospital, and the amounts it would charge for a given service, even knowing that those prices will be discounted in negotiation with insurance companies. *See* Sarun v. Dignity Health, 41 Cal. App. 5th 1119, 1124 (2019).

[21] Ge Bai & Gerald F. Anderson, *Extreme Markup: The Fifty US Hospitals With The Highest Charge-To-Cost Ratios*, 34 HEALTH AFFAIRS 922 (2015).

[22] *Id.*

[23] 42 U.S.C.A. § 1396a(a)(25)(C)

[24] 42 U.S.C.A. §§ 1396a(a)(25), b(o).

[25] *MACPAC Third Party Liability*, *supra* note 3.

[26] Yanez v. Jones, 361 F. Supp. 701, 706 (D. Utah 1973).

[27] *See, e.g.*, Evanston Hospital v. Hauck, 1 F.3d 540 (7th Cir. 1993); Mallo v. Public Health Trust of Dade County, 88 F.Supp.2d 1376 (S.D. Fla. 2000); Olszewski v. Scripps Health, 135 Cal.Rptr.2d. 1 (Cal. 2003).

[28] Manjusha P. Kulkarni, *Fact Sheet: State And Provider Liens Asserted Against The Recoveries of Medicaid And Medicare Beneficiaries*, NATIONAL HEALTH LAW PROGRAM (June 2004), https://healthlaw.org/resource/state-and-provider-liens-asserted-against-the-recoveries-of-medicaid-and-medicar.

[29] Joiner v. Med. Ctr. E, 709 So. 2d 1209, 1220 (Ala. 1998) (quoting an August 21, 1995 HCFA memorandum, which was in turn quoted in a March 12, 1996 HCFA memorandum).

[30] Roberts v. Univ. of Ala. Hosp., 27 So. 3d 512, 517-518 (Ala. Civ. App. 2008).

[31] Rabun v. St. Francis Med. Ctr., 206 So. 3d 323, 328 (La. Ct. App. 2016).

[32] Wis. Stat. Ann. § 49.49(3m)(a) (2022).

[33] Gister v. Am. Family Mut. Ins. Co., 818 N.W.2d 880, 891 (Wis. 2012).

[34] NATION, *supra* note 4.

[35] Ala. Code. Ann. § 35-11-370 (2022).

[36] H.B. 11, 2019 State Leg., Reg. Sess (Ala. 2019); *see also* Ala. Code. Ann. §§ 35-11-370 through 35-11-375 (2022).

[37] Ala. Code. Ann. § 35-11-371 (2022).

[38] *See Joiner*, 709 So. 2d. at 1219; *see also* Alabama Medicaid Agency Administrative Code 560-X-1-.07(03) ("Providers have freedom of choice to accept or deny Medicaid payment for medically necessary services rendered during a particular visit.").

[39] KLIFF & SILVER-GREENBERG, *supra* note 5.

[40] *Id.*

[41] Ind. Code Ann. § 32-33-4-1 et seq. (2022).

[42] KLIFF & SILVER-GREENBERG, *supra* note 5.

[43] Wanda Pasquale, *Parkview Health denies another charge to the New York Times*, BOLLYINSIDE (Feb. 01, 2021), https://www.bollyinside.com/news/parkview-health-denies-another-charge-to-the-new-york-times.

[44] Tenn. Code Ann. §§ 29-22-101 to 29-22-107 (2022).

[45] Ga. Code Ann. §§ 44-14-470 to 44-14-477 (2022).

[46] Bowden v. Medical Ctr., 845 S.E.2d 555, 565 (Ga. 2020).

[47] Shelby Cnty. Health Care Corp v. Nationwide Mut. Ins. Co., 325 S.W.3d 88, 92-93 (quoting 1970 Tenn. Pub. Acts 529).

[48] *See* Shelby Cnty. Health Care Corp v. Baumgartner, Tenn. App. LEXIS 24 (Jan. 26, 2011).

[49] *See* Tenn. Code Ann. § 29-22-101 to § 29-22-107 (2022).

[50] West v. Shelby Cnty. Healthcare Corp, 2013 Tenn. App. LEXIS 88 (Feb. 11, 2013).

[51] *Id.*

[52] *Id.* at 50.

[53] *Id.* at 61; *see also* U.S.C.A. § 1396a(a)(25)(C).

[54] *Id.* at 71.

[55] *Id.*

[56] West v. Shelby Cnty. Healthcare Corp, 459 S.W.3d. 33, 44-45 (Tenn. 2014).

[57] *Id.* at 47.

[58] West v. Shelby Cnty. Healthcare Corp, 2013 Tenn. App. LEXIS 88 (Feb. 11, 2013).

[59] Dedmon v. Steelman, 535 S.W.3d 431, 466 (Tenn. 2017).

[60] Garcia v. Centura Health Corp., 490 P.3d 629 (Colo. Ct. App. 2020).

[61] *Id.* at 631.

[62] Colo. Rev. Stat. §38-27-101 (2014).

[63] Colo. Rev. Stat. § 38-27-101 (2019).

[64] Raj Chohan, *Colorado Hospitals Get The Green Light To Pursue Aggressive Collections Tactics Against Medicare And Medicaid Recipients Who Have Been Injured By The Negligence Of Others. The Biggest Losers – The Elderly And The Poor*, THE MAX LAW FIRM (Feb. 1, 2020), https://www.maxinjurylaw.com/colorado-hospitals-get-the-green-light-to-pursue-aggressive-collections-tactics-against-medicare-and-medicaid-recipients-who-have-been-injured-by-the-negligence-of-others-the-biggest-losers---the-elderly-and-the-poor.

[65] Colo. Rev. Stat. § 38-27-101 (2019).

[66] 42 U.S.C.A. §1395(y)(b)(2).

[67] Harvey v. Catholic Health Initiatives, 495 P.3d 935, 937 (Colo. 2021).

[68] *Id.* at 941.

[69] *Id.*

[70] *Id.*

[71] *Id.* at 943.

[72] Darien J. Covelens, *The California Hospital Lien Act and "Balance Billing": Protecting Innocent Patients' Right to Limit a Medical Care Provider's Recovery by Statutory Lien*, 56 HASTINGS L. J. 319, 336 (2004).

[73] *Id.*

[74] Email from Mark Hall, Dir., Health Law and Policy Program, Wake Forest University School of Law, (Nov. 15, 2022) (on file with author).

[75] *Id.*

[76] Subrogation is a state Medicaid agency's right to be reimbursed for funds it spent on an enrollee's medical care, when a third party tortfeasor (or their insurer) owes money to the enrollee because of injury. *See Subrogation*, DIVISION OF TENNCARE, https://www.tn.gov/tenncare/legal/subrogation.html (last accessed Dec. 1, 2022).

[77] Email from Mark Hall, *supra* note 74.

[78] *NHIS Health Insurance Coverage Estimates – Table* 2, NATIONAL CENTER FOR HEALTH STATISTICS, https://www.cdc.gov/nchs/health_policy/healthcare_coverage_table2.htm (last updated Nov. 6, 2015).

[79] Katherine Keisler-Starkey & Lisa N. Bunch, *Health Insurance Coverage In The United States: 2020*, U. S. CENSUS BUREAU (Sept. 14, 2021), https://www.census.gov/library/publications/2021/demo/p60-274.html.

[80] Stuart Burkhalter, *Who Pays?*, TENN. BAR ASSOC.: TBA L. BLOG (Apr. 1, 2018), https://www.tba.org/index.cfm?pg=LawBlog&blAction=showEntry&blogEntry=30565.

[81] *Id.*

[82] Email from Mark Hall, Dir., Health Law and Policy Program, Wake Forest University School of Law, (Nov. 15, 2022) (on file with author).

[83] Comment to Centers for Medicare & Medicaid Services (June 25, 2018), http://spbatpa.org/node/4428.

[84] *See* Daniel L. Saar, Note, Blindsided (Again): Iowa Hospitals' Abuse Of The Hospital Lien Statute And What Has Been Done To Correct It, Drake L. Rev. 463 (2008).

[85] Tamara R. Coley, Note, *Extreme Pricing Of Hospital Care For The Uninsured: New Jersey's Response And The Likely Results*, 34 SETON HALL LEGIS. J. 275, 278 (2010)

[86] Tenn. Code. Ann. § 47-18-101 et seq (2022).

[87] Franks v. Sykes, 600 S.W.3d 908 (Tenn. 2020).

[88] *Id.* at 910.

[89] *Id.*

[90] H. TRISTRAM ENGELHARDT JR., THE FOUNDATIONS OF BIOETHICS 381 (Oxford University Press, Jan 4. 1996).

[91] Donald M. Berwick, The Moral Determinants of Health, 324 J. Am. Med. Assoc. 225 (2020).

[92] Sara Rosenbaum et al., *Medicaid And Safety-Net Providers: An Essential Health Equity Partnership*, The Commonwealth Fund (Apr. 6, 2022), https://www.commonwealthfund.org/publications/fund-reports/2022/apr/medicaid-safety-net-providers-equity-partnership.

[93] Carlyn M. Hood et al., *County Health Rankings: Relationships Between Determinant Factors And Health Outcomes*, 50 Am. J. Preventive Med. 129 (2016), https://pubmed.ncbi.nlm.nih.gov/26526164.

[94] Norman Daniels, *Justice, Health, and Healthcare*, 1 AM. J. BIOETHICS 2 (Feb. 2016), https://pubmed.ncbi.nlm.nih.gov/11951872.

[95] Julian Lamont & Christi Favor, *Distributive Justice*, STAN. ENCYC. PHIL. https://plato.stanford.edu/entries/justice-distributive (last updated Sept. 26, 2017).

[96] DANIELS, *supra* note 94.

[97] *Id.*

[98] Lekisha Daniel-Robinson & Jennifer E. Moore, *Innovation and Opportunities to Address Social Determinants of Health in Medicaid Managed Care*, INST. FOR MEDICAID INNOVATION (Jan. 2019), https://www.medicaidinnovation.org/_images/content/2019-IMI-Social_Determinants_of_Health_in_Medicaid-Report.pdf.

[99] Sandra L. Decker, *In 2011 Nearly One-Third Of Physicians Said They Would Not Accept New Medicaid Patients, But Rising Fees May Help*, 31 HEALTH AFFAIRS 1673 (Aug. 2012), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6292513.

[100] Sabrina Moreno, *Study: Medical Debt Threatens People's Health, Housing*, AXIOS (Sept. 19, 2022), https://www.axios.com/2022/09/19/medical-debt-risks-health-housing.

[101] David U. Himmelstein, *Prevalence And Risk Factors For Medical Debt And Subsequent Changes In Social Determinants Of Health In The* US, 5 J. AM. MED. ASSOC. NETWORK OPEN 1 (Sept. 16, 2022), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2796358.

[102] Anne Karl & Luis Bourgeois, *Making Medicaid Estate Recovery Policies More Equitable: State Toolkit*, STATE HEALTH & VALUE STRATEGIES (Apr. 2022), https://www.shvs.org/wp-content/uploads/2022/04/Medicaid-Estate-Recovery-State-Toolkit.pdf.

[103] John Tozzi, *Medical Debt Is Crushing Black Americans, And Hospitals Aren't Helping*, BLOOMBERG (Nov. 22, 2021), https://www.bloomberg.com/news/features/2021-11-22/medical-debt-collection-tactics-disproportionately-hit-black-americans.

[104] *Id.*

[105] Noam Levey, *Why Black Americans Are More Likely To Be Saddled With Medical Debt*, GPB NEWS (Oct. 28, 2022), https://www.gpb.org/news/shots-health-news/2022/10/28/why-black-americans-are-more-likely-be-saddled-medical-debt.

[106] Press Release, Community Service Society, Hospitals Must Stop Putting Liens On Patients' Homes and Garnishing Their Wages (May 9, 2022), https://www.cssny.org/news/entry/hospitals-must-stop-putting-liens-on-patients-homes-and-garnishing-their-wa.

[107] *Id.*

[108] H.B. 1039, Session 2021 (N.C. 2021), https://www.ncleg.gov/BillLookUp/2021/h%201039.

[109] Aneri Pattani, *North Carolina Considers New Laws to 'De-Weaponize' Medical Debt And Protect Patients*, NPR (June 21, 2022), https://www.npr.org/sections/health-shots/2022/06/21/1106307307/north-carolina-considers-new-laws-to-de-weaponize-medical-debt-and-protect-patie.

[110] *Id.*

[111] ANNA C. MASTROIANNI ET AL., *Justice in Clinical Studies: Guiding Principles, in* WOMEN AND HEALTH RESEARCH: ETHICAL AND LEGAL ISSUES OF INCLUDING WOMEN IN CLINICAL STUDIES: VOLUME I (1994), https://www.ncbi.nlm.nih.gov/books/NBK236544/

[112] *Compensatory damages*, Legal Information Institute, https://www.law.cornell.edu/wex/compensatory_damages (last visited Nov. 30, 2022).

[113] *What To Expect From Auto Accident Settlements*, David Bryant Law, https://davidbryantlaw.com/blog/auto-accident-settlements (last visited Nov. 30, 2022).

[114] MASTROIANNI ET AL., *supra* note 111; *see also* REBECCA DRESSER, WHEN SCIENCE OFFERS SALVATION: PATIENT ADVOCACY AND RESEARCH ETHICS, 81-82 (2001).

[115] This term of art, as used in at least one article, refers to the recursive obstacles low-income patients face when they are injured, cannot heal from that state of injury, and subsequently begin to lose access to other resources that affect social determinants of health – childcare, education, and stable income and housing. *See The Cycle of Poverty Trap*, Children's HopeChest (July 20, 2022), https://www.hopechest.org/the-cycle-of-poverty-trap.

[116] *DAC Guidelines and Reference Series: Poverty and Health*, WORLD HEALTH ORG.: OECD, 14 (2003), https://www.oecd-ilibrary.org/docserver/9789264100206-en.pdf?expires=1669842952&id=id&accname=guest&checksum=08D07170DA509558BA070191001D626E

[117] James W. Nickel, *Preferential Policies in Hiring and Admissions*, 75 COLUM. L. REV. 534, 537, (1979).

CURRICULUM VITAE

Remy O. Servis
servisremy@gmail.com

EDUCATION

Juris Doctor, *magna cum laude* **August 2019 – December 2022**
Wake Forest University School of Law
Winston-Salem, North Carolina

Master of Arts, Bioethics **August 2019 – December 2022**
Wake Forest University
Winston Salem, North Carolina

Bachelor of Arts, **August 2012 – May 2016**
Philosophy-Neuroscience-Psychology
Washington University in St. Louis
St. Louis, Missouri

HONORS AND AWARDS

Order of the Coif **2022**
A national membership society honoring those in the top 10% of their graduating class.
Wake Forest University School of Law

Dean Suzanne Reynolds Award **2022**
Highest Grade in *FDA Law: Doctrine, Policy and Practice*
Wake Forest University School of Law

Dean Suzanne Reynolds Award **2021**
Highest Grade in *Taxation: Federal Income*
Wake Forest University School of Law

Dean Suzanne Reynolds Award **2020**
Highest Grade in *Health Care Law and Policy*
Highest Grade in *Selected Topics in Health Law*
Wake Forest University School of Law