

Appellate Court of Illinois,
Third District.

**The METHODIST MEDICAL CENTER OF
ILLINOIS, an Illinois corporation,**
Plaintiff-

Counterdefendant-Appellee,

v.

Larry T. TAYLOR and Linda J. Taylor,
Defendants-Counterplaintiffs-Appellants.

Nos. 3-85-0388, 3-85-0390.

Jan. 14, 1986.

Private hospital brought action to recover from patient and his wife a portion of an unpaid hospital bill, and patient and wife filed several affirmative defenses and counterclaimed for alleged "cost shifting" by hospital. The Circuit Court, Peoria County, Thomas G. Ebel, J., dismissed the affirmative defenses and counterclaim, and patient and wife filed interlocutory appeals, which were consolidated. The Appellate Court, Scott, J., held that: (1) Social Security Act and regulations promulgated under that Act did not proscribe hospital from allegedly shifting portion of cost of caring for medicare patients to non-medicare patients; (2) patient was not intended beneficiary of medicare legislation, and, thus, had no private cause of action under the Act or regulation for alleged "cost shifting" by hospital; (3) hospital was not acting "under color of state law" so as to render its billing practices subject to equal protection and due process clauses of Federal and Illinois Constitutions; (4) Illinois Health Finance Reform Act did not proscribe hospital's alleged "cost shifting"; and (5) fact that document entitled "Patient Admission, Financial and Insurance Agreement" was allegedly a contract of adhesion did not preclude hospital from seeking to recover unpaid portion of hospital bill.

Affirmed.

West Headnotes

[1] Statutes ⇌ 181(2)

361k181(2) Most Cited Cases

In seeking to ascertain and give effect to legislative intent, court should not create new rights or limitations not suggested by the language of the statute.

[2] Health ⇌ 535(1)

198Hk535(1) Most Cited Cases

(Formerly 356Ak241.10)

Social Security Act, § 1861(v)(1)(A), as amended, 42 U.S.C.A. § 1385x(v)(1)(A), defining reasonable costs for medicare, and regulation promulgated pursuant to that statute merely provided direction to Secretary of Health and Human Services and did not proscribe billing practices of health care providers, including alleged "cost shifting" by which private hospital allegedly shifted portion of cost of caring for medicare patients to its nonmedicare patients.

[3] Health ⇌ 556(4)

198Hk556(4) Most Cited Cases

(Formerly 356Ak241.45)

Nonmedicare patient was not a member of any of the three classes of individuals who were intended beneficiaries of medicare legislation under Social Security Act, § 1811, as amended, 42 U.S.C.A. § 1395c, and, thus, had no private cause of action under the Social Security Act, § 1861(v)(1)(A), as amended, 42 U.S.C.A. § 1395x(v)(1)(A), for alleged "cost shifting" by which private hospital allegedly shifted portion of costs of caring for medicare patients to its nonmedicare patients.

[4] Constitutional Law ⇌ 213(4)

92k213(4) Most Cited Cases

[4] Constitutional Law ⇌ 254(4)

92k254(4) Most Cited Cases

Equal protection and due process clauses of Federal and Illinois Constitutions stand as a prohibition against governmental action, not action by private individuals. U.S.C.A. Const.Amend. 5, 14; S.H.A. Const. Art. 1, § 2.

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[5] Constitutional Law ⇌ 213(4)
92k213(4) Most Cited Cases

[5] Constitutional Law ⇌ 254(4)
92k254(4) Most Cited Cases

Fact that private hospital received substantial revenues through medicare and other government sponsored health care programs and was licensed, regulated, and inspected by government departments did not mean that hospital was acting "under color of state law" so as to render its billing practices subject to equal protection and due process clauses of Federal and Illinois Constitutions. U.S.C.A. Const.Amends. 5, 14; S.H.A. Const. Art. 1, § 2.

[6] Statutes ⇌ 152
361k152 Most Cited Cases

Statute which legislature has expressly voted to repeal does not embody current public policy of state.

[7] Health ⇌ 267
198Hk267 Most Cited Cases
(Formerly 204k5 Hospitals)

Illinois Health Finance Reform Act, S.H.A. ch. 111 1/2, ¶ 6501 et seq., creating and charging Illinois health care costs containment counsel with responsibility of studying health care financing in Illinois, did not proscribe alleged "cost shifting" by which private hospital allegedly shifted portion of cost of caring for medicare patients to its nonmedicare patients.

[8] Contracts ⇌ 1
95k1 Most Cited Cases

Adhesion contracts are not unlawful.

[9] Health ⇌ 953
198Hk953 Most Cited Cases
(Formerly 204k5 Hospitals)

Fact that document entitled "Patient Admission, Financial and Insurance Agreement" was allegedly a contract of adhesion did not preclude private hospital from collecting unpaid hospital bill for

services rendered to patient.

****352 *714 ***131** John C. Parkhurst and Vance C. Parkhurst, Bartley, Fraser, Parkhurst & Hession, Peoria, for defendants-counterplaintiffs- appellants.

Daniel L. Johns and Kevin D. Schneider, Westervelt, Johnson, Nicoll & Keller, Peoria, for plaintiff-counterdefendant-appellee.

SCOTT, Justice:

This action was commenced in the circuit court of Peoria County by the plaintiff, Methodist Medical Center, to recover from the defendants, Larry T. Taylor and Linda J. Taylor, a portion of an unpaid hospital bill. The defendants filed several affirmative defenses to the complaint and filed a countercomplaint against the plaintiff hospital. The circuit court dismissed the affirmative defenses and the countercomplaint. ****353 ***132** The matter is before this court on two interlocutory appeals, the dismissal of the counterclaim under Supreme Court ***715** Rule 304 and the dismissal of the affirmative defenses under Supreme Court Rule 308. Both appeals were consolidated pursuant to our order of August 26, 1985, and the consolidated appeal bears docket number 3-85-0388.

The plaintiff hospital rendered services to Larry T. Taylor and billed Mr. Taylor in the amount of \$30,032.45. Of that amount, a balance of \$6,486.11 remains unpaid. The plaintiff brought suit on a contract theory for the balance against Mr. Taylor, and against Linda J. Taylor, who at the time of her husband's hospitalization executed a document entitled "Patient Admission, Financial and Insurance Agreement."

The defendants responded to the complaint with six affirmative defenses. They allege in those defenses that the hospital's billing policy violates the Social Security Act (Medicare) and its supporting regulations, violates the equal protection and due process clauses of the United States and Illinois constitutions, violates the public policy of the State of Illinois and constitutes an unenforceable

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adhesion contract. The factual allegations which support these defenses are set forth in the pleadings:

"[T]he Plaintiff Hospital has engaged in a practice known as 'cost shifting' which consists of regularly accepting from the Secretary of the Department of Health and Human Services in full payment for delivering its supplies and services to its Medicare patients less than its necessary costs of such delivery to its Medicare patients and less than it is entitled to receive for treating its Medicare patients, while regularly and unfairly shifting a portion of the cost of caring for its Medicare patients, regardless of their ability to pay, to its privately insured patients, such as Defendant Larry Taylor, and other non-Medicare patients, regardless of their ability to pay."

The counterclaim, in which the counter-plaintiffs seek to recover for themselves and others similarly affected, alleges the same factual basis.

The circuit court, in an order dated April 4, 1985, dismissed each affirmative defense as well as the counterclaim.

The payment which the plaintiff hospital receives from the Secretary of the Department of Health and Human Services which was referenced in the defendants' above-quoted allegations is determined according to statute as follows:

"(v) Reasonable costs. (1)(A) The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient *716 delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services; * * * Such regulations shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs

established under this title (42 U.S.C. Sec. 1395 et. seq.)) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, * * * " 42 U.S.C. Sec. 1395x(v)(1)(A) (emphasis added)

The regulations referred to in the Code have been promulgated by the Secretary, and those regulations provide, in part:

"(a) * * * All necessary and proper expenses of an institution in the production of services, including normal and standby costs, are recognized. Furthermore, the share of the total institutional costs **354 ***133 that is borne by the program is related to the care furnished beneficiaries so that no part of their cost would need to be borne by other patients." 42 C.F.R. Sec. 405.402(a) (emphasis added)

The defendants contend that although the costs which the Secretary of Health and Human Services pays to hospitals through the Medicare program are intended to be that "share of the total institutional costs" related to the Medicare patient, they are in truth less and the non-Medicare patient is forced to pay the difference.

[1][2] In their first affirmative defense, the defendants allege that this cost-shifting by the plaintiff is unlawful under the above-quoted excerpts from the United States Code and regulations. A careful analysis of the language relied on by the defendants discloses that the Code and regulations are intended as a direction to the Secretary of Health and Human Services, not as a limitation on the billing practices of hospitals and other health care providers who receive reimbursement from the Medicare program. It is a cardinal rule of statutory construction that the court should seek to ascertain and give effect to legislative intent. However, in so doing, the court *717 should not create new rights or limitations not suggested by the language. (*Jackson v. Navik* (1974), 17 Ill.App.3d 672, 308 N.E.2d 143.) Nothing in the language of the Code indicates an intention to proscribe the billing practices of health care providers. To

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infer such an intention--to suggest that Congress would adopt a policy with such profound impact without a more explicit enactment--would be an abuse of the court's responsibility for statutory construction. We do not agree with the defendants that the cited sections of the Code and regulations were intended to make certain hospital billing practices to non-Medicare patients unlawful.

[3] The same Code and regulations are relied upon by the defendants as a basis for their countercomplaint against the plaintiff. Certain statutes imply a private cause of action. The U.S. Supreme Court has developed a four part test to determine whether a private cause of action may be implied. (*Cort v. Ash* (1975), 422 U.S. 66, 95 S.Ct. 2080, 45 L.Ed.2d 26.) The first part of that test requires the plaintiff to be a member of the class for whose special benefit the statute was enacted. The Medicare program was established for the benefit of:

" * * * (1) individuals who are age 65 or over and are eligible for retirement benefits * * * (2) individuals under age 65 who have been entitled for not less than 24 months to benefits under title II of this Act (42 U.S.C. Sec. 401 et seq.) * * * and, (3) certain individuals who do not meet the conditions specified in either clause (1) or (2) but who are medically determined to have end stage renal disease." 42 U.S.C. Sec. 1395c.

The allegations of the plaintiffs' countercomplaint do not establish that Mr. Taylor was a member of any of the three classes of individuals who were the intended beneficiaries of the Medicare legislation. Accordingly, the countercomplaint is not sufficient under *Cort* to allege an implied private cause of action, and the circuit court's order of dismissal was correct.

[4][5] In the defendants' second, third and fourth affirmative defenses, they allege that the plaintiff's billing practices violate the equal protection and due process clauses of the U.S. and Illinois constitutions. Both clauses under both constitutions stand as a prohibition against governmental action, not action by private individuals. (*USA, Etc. v. Cousins Club, Inc.* (1976), 64 Ill.2d 11, 348 N.E.2d 831; *Potter*

v. Judge (1983), 112 Ill.App.3d 81, 67 Ill.Dec. 585, 444 N.E.2d 821.) The plaintiff is a private Illinois corporation. The defendants posit that because the plaintiff hospital received substantial revenues from public tax dollars--*718 through Medicare and other government sponsored health care programs--and because it is licensed, regulated and inspected by government departments, the private institution is in fact acting under color of state law. In *Doyle v. Unicare Health Services, Inc. v. Aurora Center* (Ill.1975), 399 F.Supp. 69, aff'd 541 **355 ***134 F.2d 283 (7th Cir.1976), a similar contention was rejected. The *Doyle* court cited numerous authorities that unanimously reached the conclusion that being subject to state regulation and receiving public tax monies do not convert an otherwise private hospital into one acting under color of state law. Illinois reviewing courts are in accord. (*Jain v. Northwest Community Hospital* (1978), 67 Ill.App.3d 420, 24 Ill.Dec. 341, 385 N.E.2d 108.) While it is possible for a private individual or corporation to be bound by the prohibitions of the state and federal due process and equal protection clauses, the pleadings of the defendants measured in light of the authorities referenced above do not allege sufficient governmental action. The second, third and fourth affirmative defenses were properly dismissed.

[6][7] In their fifth affirmative defense, the defendants allege that the cost-shifting engaged in by the plaintiff is contrary to the laws and public policy of the State of Illinois. In support of their allegation, the defendants assert that the public policy of the state is set forth in the Illinois Health Finance Authority Act (Ill.Rev.Stat.1981, ch. 111 1/2, par. 161 et seq.), an act later repealed, and in the Illinois Health Finance Reform Act (Ill.Rev.Stat.1984 Supp. ch. 111 1/2, par. 6501 et seq.). We fail to understand how an act which the legislature has expressly voted to repeal can be said to embody the current public policy of the state. The Illinois Health Finance Reform Act creates the Illinois Health Care Cost Containment Council, a body charged with the responsibility of *studying* health care financing in Illinois. The act further requires

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that

"In its deliberations, the Council shall consider:

* * *

2. Minimizing cost shifting between publicly supported patients and private payors." Ill.Rev.Stat.1983, ch. 111 1/2, par. 6502-2(b)(2).

As we observed earlier in this opinion, the judiciary's responsibility in statutory construction is to ascertain and give effect to legislative intent. However, in so doing, the court should not create new rights or limitations not suggested by the language. (*Jackson v. Navik* (1974), 17 Ill.App.3d 672, 308 N.E.2d 143.) To infer a legal prohibition of cost-shifting from a mandate to "study" such practices would indeed create new limitations not suggested by the language of the *719 statute. We decline to do so.

[8]9] In their sixth affirmative defense, the defendants allege that the document entitled "Patient Admission, Financial and Insurance Agreement", dated April 25, 1983, and signed by Linda J. Taylor is a contract of adhesion and is not enforceable. Adhesion contracts are not unlawful. The defendants cite as authority for this proposition *Eisele v. Ayers* (1978), 63 Ill.App.3d 1039, 21 Ill.Dec. 86, 381 N.E.2d 21. The *Eisele* case, in dicta, states that

"Courts declare adhesion contracts unlawful because the party in the superior bargaining position has taken unfair advantage of the 'adherer' by making the desired product available only if the weaker party accedes to the form of the contract." 63 Ill.App.3d, 1046, 21 Ill.Dec. 86, 381 N.E.2d, 27.

In fact, the *Eisele* court concluded that no adhesion contract was in issue there and did not declare the subject contract unlawful. As authority for its aside, the *Eisele* court cited *Star Finance Corporation v. McGee* (1975), 27 Ill.App.3d 421, 326 N.E.2d 518, which only suggests that certain onerous clauses in adhesion contracts may be construed against the party with superior bargaining power. The same rule was followed in *Egyptian Seed Growers' Exchange v. Hollinger* (1925), 238 Ill.App. 178. The allegations of the sixth

affirmative defense are insufficient to state a complete defense to the contract, and no ambiguities in the agreement are alleged which might provide a partial defense. The circuit court properly dismissed this portion of the defendants' pleading.

In reliance on the reasoning and the authorities hereinbefore set forth, we affirm **356 ***135 the decision of the circuit court of Peoria County previously rendered herein.

Affirmed.

BARRY and STOUDEER, JJ., concur.

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