Case No. **C070475**

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IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

THIRD APPELLATE DISTRICT

DAMERON HOSPITAL ASSOCIATION,

Plaintiff and Appellant,

vs.

CALIFORNIA STATE AUTOMOBILE ASSOCIATION INTER-INSURANCE BUREAU, et al.,

Defendants and Respondents.

ON APPEAL FROM THE SUPERIOR COURT OF SAN JOAQUIN COUNTY,
HON. CARTER P. HOLLY, JUDGE, CASE NO. 39-2010-00245260-CU-MC-STK.

AMICUS CURIAE BRIEF OF THE CIVIL JUSTICE ASSOCIATION OF CALIFORNIA IN SUPPORT OF DEFENDANTS AND RESPONDENTS

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INTRODUCTION: IMPORTANCE OF ISSUE AND INTEREST OF AMICUS

The Civil Justice Association of California ("CJAC" or "amicus")[1] welcomes the opportunity to address the central issue this case presents:[2]

> **May a hospital prosecute a Hospital Lien Act (HLA, Civil Code §§ 3045.1-3045.6) claim against an automobile insurer for the difference between what the hospital was paid to provide emergency treatment to a patient under a contracted medical plan and the amount the hospital considers the "fair market value" of the services it provided?**

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[1] By separate application accompanying the lodging of this brief, CJAC asks the Court to accept it for filing.

[2] Two other issues this case raises are not briefed by amicus: whether (1) the hospital perfected its liens by properly serving them pursuant to Civil Code § 3045.3; and (2) whether as to some of the patients treated the one-year statute of limitations for the HLA (§ 3045.5) barred the hospital's lien claims.

In this case, Dameron Hospital Association ("Dameron") billed two companies, California State Automobile Association Inter-Insurance Bureau and Allstate Insurance, who provided liability coverage for the tortfeasors who injured the patients Dameron treated. Not surprisingly, these amounts were significantly more than what Dameron agreed to accept as a "discounted amount" for its medical services under the health plan with Kaiser Permanente to which the patients belonged and Dameron had a contract. When the automobile insurers refused to pay this "difference," Dameron filed suit against them for damages under the HLA and for equitable relief under the Unfair Competition Law ("UCL," Bus. & Prof. Code § 17200 *et seq.*).

The trial court tentatively ruled on a motion for summary judgment in Dameron's favor, but on further consideration reversed its tentative order and instead found in favor of the automobile insurers. In its final decision, the trial court explained that in California a hospital lien is not recoverable where a patient obtains medical services pursuant to a health insurance plan for which the hospital has agreed to accept a discounted amount. This "discounted amount," the trial court found, was the same as the hospital's "reasonable and necessary charges" and Dameron was not permitted to collect more from another source.

The resolution of the issue presented is key to CJAC' s purpose, which is to educate the public about ways to make our civil liability laws more fair, efficient, economical and certain. Toward these ends, we frequently petition the government for redress when it comes to determining who gets how much, from whom, and under what circumstances when the conduct of some is alleged to occasion harm to

others. We have recently done so in two cases that decided issues analogous to the one we discuss here: *Howell v. Hamilton Meats & Provisions* (2011) 52 Cal.4th 541 ("*Howell*")and *Corenbaum v. Lampkin* (2013) 215 Cal.App.4th 1308 ("*Corenbaum*").

Howell holds that a personal injury plaintiff can't recover the face amount of his or her medical bills when the plaintiff's medical service providers accepted lesser sums as payment. *Corenbaum* holds that evidence of the full amount billed for a plaintiff's medical care is not relevant to the determination of a plaintiff's damages for medical expenses, and therefore is inadmissible for that purpose if the plaintiff's medical providers, by prior agreement, contracted to accept a lesser amount as full payment for the services provided.

CJAC participated as amicus in *Howell* and *Corenbaum* for the same reason it seeks to do so here: tethering the financial value of medical services to the actual amounts paid for them is more fair, consistent and economical than allowing that value to be set by various health care providers. We weigh-in with the same concerns that animated our participation in *Howell* and *Corenbaum*: preventing satellite litigation to resolve economic value issues that, as a matter of practice and law, are readily and reasonably determined by market forces – i.e., by what hospitals are actually paid and accept from prepaid health plans for the medical care they render.

CJAC also enters this fray as a frequent participant with concerns over the scope and application of the UCL, a statute plaintiff wields to wrest amounts from the automobile insurers over and above what it accepted from its agreement with Kaiser Permanente for its treatment of the injured patients. By claiming that the automobile insurers' refusal to pay Dameron the full market value it billed for

services to these patients is against the law, Dameron seeks to "bootstrap" its claim to the "unlawful" prong of the UCL and compel the automobile insurers to pay it the difference between what it accepted as payment from Kaiser and the inflated amount it billed the auto insurers. Of course, if the automobile insurers are legally within their rights to not pay any additional amounts to Dameron, then there is nothing to "bootstrap" to the "unlawful" prong of the UCL and, hence, no UCL violation.

SUMMARY OF ARGUMENT

The HLA and the Knox-Keene Act ("Act") provide the statutory framework for determining, as a matter of law, whether a hospital can prosecute a lien claim against an automobile insurer for the difference between what the hospital was paid to provide emergency treatment to a patient under a contracted medical plan and the amount the hospital considers the "fair market value" of those services. Both the purposes of these two statutes and their literal language must be read literately, within context of each other and the entire statutory and judicial framework of which they are a part, harmonizing the pertinent statutory provisions.

When this is done, two conclusions can be drawn. First, for any statutory lien to "attach" and be enforceable by a hospital, there must be an underlying debt owed by the patient to that hospital. This includes amounts allegedly owed by a third–party liability insurer for damages to the patient treated as a result of the negligence of the insured tortfeasor who occasioned the patient's injury and necessitated medical treatment. Second, under the Knox-Keene Act, patients cannot owe a debt to a hospital that provides them emergency medical services. The Act requires health insurers to pay for emergency services and exonerates patients from liability to

hospitals for any costs owed over and above what the health plan actually paid and the hospital accepted as payment. Construed together and harmonized, the HLA and Knox-Keene Act establish that a hospital may not prosecute a lien against a patient it treats on an emergency basis for the difference between the "discounted" rate it was reimbursed by a health plan for that patient's medical care and the reasonable value it places on those services.

LEGAL ANALYSIS

I. THE HOSPITAL LIEN ACT, WHEN READ IN CONJUNCTION WITH THE KNOX-KEENE HEALTH CARE SERVICE PLAN ACT, MAKES CLEAR THAT A HOSPITAL CANNOT COLLECT FROM A THIRD-PARTY AUTOMOBILE INSURER THE DIFFERENCE BETWEEN WHAT THE HOSPITAL WAS ACTUALLY PAID BY A HEALTH INSURANCE PLAN TO TREAT THE PATIENT AND WHAT THE HOSPITAL DEEMS THE REASONABLE VALUE OF THOSE MEDICAL SERVICES.

Two statutes intersect to define the respective obligations of the parties enmeshed in this conflict: the Hospital Lien Act and the Knox-Keene Health Care Service Plan Act of 1975 ("Knox-Keene Act," Health & Safety Code §§ 1340 *et seq.*). Both statutes are, not surprisingly, limned by important gloss from judicial opinions as to their scope and application. Construing the plain language of both statutes, requires examination "in the context of the statutory framework as a whole . . . to determine [their] scope and purpose and to harmonize the[ir] various parts . . .." *Coalition of Concerned Communities, Inc. v. City of Los Angeles* (2004) 34 Cal.4th 733, 737. "[W]e look first to the words of the statute, giving them their ordinary meaning and *construing them in context*." *Fitch v. Select Products Co.* (2005) 36 Cal.4th 812, 818; emphasis added. This principle is embodied in the *pari materia* ("of the same matter")

canon of statutory interpretation. "It is a basic canon of statutory construction that statutes in *pari materia* should be construed together so that all parts of the statutory scheme are given effect." *LEXIN v. Superior Court* (2010) 47 Cal.4th 1050, 1090. Two "[s]tatutes are considered to be in *pari materia* when they relate to the same person or thing, to the same class of person[s or] things, or have the same purpose or object." *Walker v. Superior Court* (1988) 47 Cal.3d 112, 124, fn. 4.

We begin with the oldest statute, the HLA, under which plaintiff Dameron predicates its claims against the automobile insurers.

A. Judicial Opinions Construing the HLA Make Clear it Does not Permit a Hospital to Enforce a Lien Absent the Existence of an Underlying Debt Owed the Hospital by the Patient.

The California Legislature enacted the HLA, codified at California Civil Code sections 3045.1 through 3045.6, in 1961. That measure established a hospital's right to a statutory lien for the reasonable value of emergency services to parties. Civ. Code § 3045.1. Its purpose was "to secure part of the patient's recovery from liable third persons to pay his or her hospital bill, while ensuring that the patient retained sufficient funds to address other losses resulting from tortious injury." *Mercy Hosp. & Med. Ctr. v. Farmers Ins. Group of Cos.* (1997) 15 Cal.4th 213, 217 (limiting the amount of HLA lien liability). The Legislature intended for financially able persons to pay their medical bills, while providing protection for needy patients from medical bills "so burdensome as to pauperize [him] or his family." *Id.*

In 1992, the Legislature amended the HLA to give medical care providers the right to place a statutory lien on a patient's judgment "to the extent of the amount of the reasonable and necessary charges of the hospital." Civ. Code § 3045.1. A HLA

lien applies "whether the damages are recovered, or are to be recovered, by judgment, settlement, or compromise." *Id.* The 1992 amendment also sets forth the notice requirements that a medical care provider must meet to properly hold a HLA lien. Civil Code § 3045.3. Finally, the 1992 version of the HLA provides the method for paying the lien by a third-party tortfeasor to the medical care provider and limits the amount a hospital may recover by HLA lien. Civil Code § 3045.4.[3]

Nishihama v. City and County of San Francisco (2001) 93 Cal.App.4th 298 was the first appellate opinion to squarely address whether a hospital could use the HLA to recover a portion or all of the difference between its discount and customary rates from a patient. *Nishihama* held that a medical care provider asserting a HLA lien may only recover up to the contractual rates agreed upon with the health insurance carrier for the type of service rendered to the insured patient. Since the hospital in *Nishihama* had been paid its full discounted rates by the health insurance carrier, as happened here with Dameron and the Kaiser Permanente patients it treated, it had no HLA lien rights to any damages awarded the patient regardless of the amount of its customary rates. *Nishihama* dismissed the hospital's contention that the phrase "reasonable and necessary charges" in section 3045.1 (giving the medical care provider the right to place a HLA lien on a patient's judgment) could mean the

[3] This section provides, in pertinent part, that "[a]ny person, firm, or corporation, including... insurance carrier[s], making any payment to the injured person... for the injuries he or she sustained. . . without paying [the medical care provider]. . . the amount of its lien claimed in the notice, or so much thereof as can be satisfied out of 50 percent of the moneys due under any final judgment. . . shall be liable to the [medical care provider]... for the amount of its lien claimed in the notice which the hospital was entitled to receive as payment for the medical care and services rendered to the injured person."

hospital's customary rates. *Id.* Instead, the court said, the phrase "reasonable and necessary" is tied to the amount *actually charged* to the injured patient's insurance company, or the hospital's discounted rates. See also *Hanif v. Housing Authority* (1988) 200 Cal.App.3d 635, 641 ("when the evidence shows a sum certain to have been paid or incurred for past medical care and services, whether by the plaintiff or by an independent source, that sum certain is the most the plaintiff may recover for that care despite the fact it may have been less than the prevailing market rate.").

Swanson v. St. John's Regional Medical Center (2002) 97 Cal.App.4th 245, however, reached the opposite conclusion from *Nishihama*. There, the court held that the payment of discounted charges by the patient's health insurance carrier does not extinguish the hospital's statutory lien. *Id.* at 250-251. *Swanson* relied on a textual interpretation of the HLA, stating that in statutory construction "the office of the Judge is simply to ascertain and declare what is in terms or in substance contained therein, not to insert what has been omitted or to omit what has been inserted." *Id.* at 248. *Swanson* concluded that because medical care providers may assert HLA liens ""to the extent of the amount of the reasonable and necessary charges of the hospital . . . for the treatment, care, and maintenance of a patient injured by a tortfeasor," the HLA authorizes a hospital to seek from a third party insurer of the tortfeasor who injured the plaintiff, the difference between the amount billed for the patient's care and the amount paid for same by the patient's health plan with whom the hospital has a contract.

This split of authority between *Nishihama* and *Swanson* on the same point of law continued until resolution by *Parnell v. Adventist Health System/West* (2005) 35

Cal.4th 595 ("*Parnell* ") in favor of the holding by *Nishihama*. *Parnell* holds that a hospital cannot assert a lien against a patient's tort recovery for the difference between its "actual" costs and the amount paid by the patient and his or her insurer. In *Parnell,* as here, a patient injured in an automobile accident received medical treatment from a hospital that received payment from the patient and his health care insurer pursuant to a negotiated "discounted" amount specified in the hospital's provider agreement. Under that agreement, the hospital accepted a reduced or discounted amount, rather than its usual and customary charges, as payment in full for the medical services it provided. *Parnell, supra,* 35 Cal.4th at 598–599.

After Parnell brought a tort action against the driver who caused the accident and his injuries, the hospital sought to recover the difference between its "usual and customary" charges and the amount it received from Parnell and his insurer by filing a lien under the HLA against any judgment or settlement he might obtain in that underlying tort action. *Id.* In response, Parnell sued the hospital alleging unfair business practices and related causes of action. *Id.* at 600. The trial court granted the hospital's motion for judgment on the pleadings, and the Court of Appeal reversed. *Ibid.* The Supreme Court in *Parnell* affirmed the judgment of the Court of Appeal, holding that (1) a lien under the HLA may not attach absent the existence of an underlying debt, and (2) the hospital could not assert a lien under the HLA against the patient's recovery from the third-party tortfeasor because the patient's debt to the hospital had been extinguished by the hospital's receipt of payment from the patient's health plan. *Parnell, supra,* 35 Cal.4th at 609. In other words, *Parnell* establishes that the hospital's assertion of a lien under the HLA against the patient's *recovery from the*

tortfeasor was improper because it was essentially the same as seeking additional payments from the patient. *Ibid.*

B. The Knox-Keene Act Prohibits a Hospital from Enforcing a Lien for any Debt of a Patient Incurred for Emergency Medical Services.

Prospect Medical Group, Inc. v. Northridge Emergency Medical Group (2009) 45 Cal.4th 497 ("*Prospect Medical Group*") provides needed guidance because it decided the related issue of whether providers of emergency medical services who do not have contracts with health maintenance organizations (HMOs) can bill HMO members for the difference between what they bill the HMO for their services and what the HMO pays – in other words, whether emergency room providers can "balance bill" HMO patients for any difference. *Id.* at 503–504. Given the statutory and regulatory controls on the delivery of emergency medical services and on the payments to providers by HMOs, the court held providers of emergency medical services who have direct recourse against HMOs cannot "balance bill"[4] HMO members, but must resolve billing and payment disputes directly with the HMOs. *Id.* at 504–508.[5]

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[4] "Balance billing" occurs when "a medical care provider accepts a discounted payment from an insurance carrier as payment in full and then attempts to recover the balance of its customary rates from the patient." 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* (2004) 56 *HASTINGS L.J.* 319, 321.

[5] Before "balance billing" was outlawed in 2009 by the Supreme Court's opinion in *Prospect*, the practice was widespread and quite lucrative. According to the California Association of Health Plans, over a two-year period, 1.76 million patients paid approximately $528 million in balance billings sent to them from emergency room physicians for medical services for which the patients' insurers did not pay. Jason B. Shorter, *Final-Offer Arbitration for Health Care Billing Disputes: Analyzing One State's Proposed Dispute Resolution Process* (2010) 9 *APPALACHIAN J.L.* 191, 192.

In reaching its conclusion, the *Prospect Medical Group* opinion explained:

> Interpreting the applicable statutory scheme as a whole – primarily the Knox-Keene Act – we conclude that billing disputes over emergency medical care must be resolved solely between the emergency room doctors, who are entitled to a reasonable payment for their services, and the HMO, which is obligated to make that payment. A patient who is a member of an HMO may not be injected into the dispute. Emergency room doctors may not bill the patient for the disputed amount.

45 Cal.4th at 502.

The provisions of the Knox-Keene Act that *Prospect* found controlling and are clearly applicable to this case are Health & Safety Code § 1379(a) through (c):

> (a) Every contract between a plan and provider of health care services shall be in writing, and shall set forth that in the event the plan fails to pay for health services as set forth in the subscriber contract, the subscriber or enrollee shall not be liable to the provider for any sums owed by the plan.
>
> (b) In the event that the contract has not been reduced to writing . . . or that the contract fails to contain the required prohibition, the contracting provider shall not collect or attempt to collect from the subscriber or enrollee sums owed by the plan.
>
> (c) No contracting provider, or agent, trustee or assignee thereof, may maintain any action at law against a subscriber or enrollee to collect sums owed by the plan.

That the aforementioned statutory language does not permit a legal distinction between a hospital pursuing a third-party liability insurer who owes the treated patient money for his or her injury and pursuing the patient directly, is underscored by *Parnell*'s observation that the Legislature, in enacting the HLA, "intended that the debt *owed by the patient to the hospital* be the underlying basis for *any* lien under the HLA." *Parnell*, *supra*, 35 Cal.4th at 603-604; emphasis added. "[A] lien under the HLA is *based on a debt owed by the patient to the hospital* . . . [The] contention that any recovery on a lien under the HLA comes from the tortfeasor – and not from the patient – does not alter our conclusion." *Id.* at 607; emphasis added. Absent a debt by the patient to the hospital for emergency services, then, no HLA lien may be asserted, either directly or pursuant a bootstrapped UCL action.

C. *Howell* and *Corenbaum* Lend Further Credence to the Principle that a Hospital may not Pursue a HLA Claim for the Difference Between what it Billed for Treatment of a Patient and what it was Actually Paid for that Treatment.

Howell and *Corenbaum* provide further support for the proposition that the amounts actually paid a hospital by a health plan for treatment of an enrollee of that plan, and not amounts billed by the hospital for that treatment (or the difference between the two figures), is all a hospital may pursue under the HLA. To be sure, both opinions deal with whether the full amount billed for medical services, as opposed to the actual amount the medical provider accepted as payment for those services, is admissible to prove the damages to which a plaintiff is entitled. Both cases hold that the amounts paid, not charged, are the only amounts relevant to determine recoverable damages for past and future medical expenses and noneconomic loss. The total amounts charged cannot, *Howell* and *Corenbaum* both

hold, form a reasonable basis for an expert to opine on the realistic value of a plaintiff's future medical care or any aspect of noneconomic damages.

That is because, as both opinions emphasize, the amounts billed for medical services are all over the board, providing more confusion than clarity on their true value. "[P]ricing of medical services is highly complex and depends, to a significant extent, on the identity of the payer. . . [T]here appears to be not one market for medical services but several, with the price of services depending on the category of payer and sometimes on the particular government or business entity paying for the services. Given this state of medical economics, how a market value other than that produced by negotiation between the insurer and the provider could be identified is unclear." *Howell, supra*, 52 Cal.4th at 562. "[T]he negotiated rate may be the best indication of the reasonable value of the services provided and . . . it is unclear how any other 'market value' could be determined." *Corenbaum, supra*, 215 Cal.App.4th at 1326.

The Centers for Medicare & Medicaid Services (CMS) released data for 2011 showing a great disparity among California hospitals in the average amounts billed for common medical procedures. "[T]he CMS data . . . provid[es] concrete proof that the full amount billed for medical care is irrelevant because it does not accurately indicate how much Medicare pays for a [patient's] treatment." Jason Kort, *New Hospital Data Supports Medical Bills Decision*, *Daily Journal*, May 28, 2013. "*Corenbaum* rightly recognized that the amounts charged by medical facilities constitute nothing more than arbitrary and capricious amounts that bear no relation to a plaintiff's actual losses." *Id.*

Ironically, by arguing that it should be able to collect the difference between the amount it bills for treating injured patients and what it was paid by Kaiser Permanente for doing so, Dameron seeks greater rights for itself under the HLA than the law allows for the injured party's recovery. Something looks wrong.

D. Sound Public Policy Supports Preclusion of the HLA Lien in these Circumstances.

It is unfair to require a fully insured patient to pay additional amounts to cover customary charges, despite having adequate health insurance purchased specifically for this purpose. Such a patient has likely purchased medical insurance to limit exposure for medical costs to the deductibles or co-payments required by his or her insurance policy. If an insured patient's medical insurance is sufficient to pay the discounted rates, the insured patient who recovers from a tortfeasor any additional amounts for medical costs in a lawsuit may be perceived as receiving a "windfall." Such a patient made insurance payments to cover discounted rates, but has recovered more despite having received, in effect, pre-paid medical care. Conversely, a medical care provider receiving both its contractual discounted rates as well as its customary charges from a patient's judgment recovery has similarly received a "windfall." The medical care provider has, in effect, received more than the amount for which it specifically contracted with the health insurance carrier.

In choosing between these two potential windfall scenarios, the law makes clear that it is the hospital who is better able to absorb financial "loss" as a result of the medical care services provided. "Section 1342, subdivision (d) [of the Knox–Keene Act], expresses a legislative intent to "ensure the best possible health care for the public at the lowest possible cost *by transferring the financial risk of health care*

from patients to providers." *Prospect Medical Group, Inc., supra*, 45 Cal.4th at 506; emphasis added. In other words, a medical care provider can better bear the loss of medical care services under the cost/benefit economic model. Modern hospitals are often part of a larger corporate or non-corporate conglomerate of hospitals and medical care providers and, as such, are likely to have a much larger pool of resources than an individual patient and are able to absorb high medical care costs. While the medical care provider is essentially innocent, the patient has already suffered through his or her injuries and the resulting lawsuit against the third-party tortfeasor. Such a patient should not also be forced bear additional medical costs. Taking the cost/benefit economic model, together with the purpose of the HLA, the differential or "balance billing" costs of medical care should be borne by medical care providers instead of patients.

CONCLUSION

For all the aforementioned reasons, the judgment of the trial court should be affirmed.

Dated: October 2, 2013

Respectfully submitted,

/s/

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CERTIFICATE OF WORD COUNT

I certify that the WordPerfect® software program used to compose and print this document contains, exclusive of the caption, tables, certificate and proof of service, approximately 4,500 words.

Date: October 2, 2013

/s/
Fred J. Hiestand

PROOF OF SERVICE

I, David Cooper, am employed in the city of Sacramento, Sacramento County, State of California. I am over the age of 18 years and not a party to the within action. My business address is 3418 Third Avenue, Suite 1, Sacramento, CA 95817.

On October 2, 2013, I served the foregoing document(s) described as: *Amicus Curiae* Brief of the Civil Justice Association of California in Support of Defendants and Respondents in *Dameron Hospital Association v. California State Automobile Association Inter-Insurance Bureau, et al.,* C070475 on all interested parties in this action by placing a true copy thereof in a sealed envelope(s) addressed as follows:

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I declare under penalty of perjury under the laws of the State of California that the above is true and correct.

Executed this 2nd day of October 2013 at Sacramento, California.

/s/
David Cooper