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FEATURE ARTICLE

Hospitals Litigate Their Right to Place and Collect Third-Party Liens in Personal Injury Cases - With Mixed Results

By Barry S. Landsberg and Joanna Sobol McCallum
Manatt, Phelps, & Phillips LLP

INTRODUCTION

Faced with myriad and mounting financial pressures, California hospitals are closing at an alarming rate. Underfunded emergency rooms are a key factor in many closures. For years, hospitals have attempted to recoup some of their emergency room costs by exercising their right to collect under California's hospital lien statute, but now that important source of revenue is threatened by lawsuits claiming that hospitals have no right to collect more than the deeply discounted rates they receive from health plans and other payors – even if the hospitals' billed charges are far higher, and funds to pay the difference would be available from the tortfeasors who caused the injuries, or their insurers.

Federal and state laws mandate that hospitals provide emergency treatment to all patients, regardless of whether they are insured, uninsured or underinsured. Compounding the already overwhelming financial pressures on hospitals are the looming and potentially crippling costs of seismic retrofit requirements imposed by SB 1953, declining Medicare and Medi-Cal reimbursement, and California's high penetration of managed care discount payment arrangements that virtually compel hospitals to provide millions of dollars of treatment annually for which they receive no reimbursement whatsoever. This combination is lethal: as California's Attorney General has noted with concern, twenty-three California hospitals closed between 1995 and 2000, more than sixty emergency rooms have closed since 1990, and additional closures are expected.

California hospitals provide care to the State's millions of uninsured citizens – the third largest percentage nationwide[1]- as well as to millions more patients with insurance that is inadequate to cover their medical needs. The proliferation of managed care and rate capitation agreements – with high pressure on hospitals from business and purchasing alliances to participate – has slashed hospital revenues further.[2] Add in the effects of a statewide nursing shortage – just as more nurses are needed to comply with new nurse staffing requirements – and higher-than-average median salaries for full-time hospital employees, and it is no wonder that hospitals are struggling to stay afloat.[3]

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1 More than 20 percent of Californians have no health coverage at all, representing approximately one-sixth of the entire nation's uninsured population. See "Number of Uninsured Drops Slightly," *San Jose Mercury News*, Wednesday, March 13, 2002, at A17; Lisa Rappaport, "State Gain in Health Coverage," *Sacramento Bee*, Wednesday, March 13, 2002, at D1.

2 From the beginning of managed care, California led the nation in the number of state residents enrolled in health maintenance organizations ("HMOs"), one form of managed care arrangement. In 1990, 31 percent of 13.8 million people enrolled in HMOs nationwide were from California. *The Orange County Register*, Wednesday, January 29, 1992, NEXIS Database ALLNEWS, 1/29/02 OCREG F02. Now, although HMO enrollment in California declined last year for the first time in eight years (in favor of plans that provide greater choice), 48 percent of Californians with health plan coverage are HMO enrollees (compared to 23 percent nationally). 27 percent are enrolled with Preferred Provider Organizations ("PPOs") and 25 percent in Point-of-Service plans, both of which are less restrictive varieties of managed care. Ronald D. White, "Enrollment by Californians in HMOs Slipping," *Los Angeles Times*, Wednesday, February 20, 2002, at Part 3, Page 1. Thus, hospitals have no choice but to contract with managed care plans if they want to be eligible to provide care to substantial numbers of covered patients.

3 Source: California HealthCare Foundation, *Financial Challenges for California Hospitals* (Sept. 2001), available at http://www.chcf.org.

In this environment, it has become increasingly critical for hospitals to accumulate revenue from all available sources to make ends meet. The Hospital Lien Act ("HLA") is one important piece of this funding puzzle.[4] The statute was enacted in 1961, and has been amended only once, in 1992, at which time the Legislature materially expanded hospitals' lien recovery rights in recognition of their growing financial pressures. The HLA allows hospitals to place liens on personal injury lawsuit recoveries to recoup from the tortfeasors responsible for the injuries some portion of the hospitals' "reasonable and necessary charges" for treatment of emergency patients.[5] This is consistent with statewide healthcare policy imposing upon hospitals the obligation to provide emergency treatment for all patients, as well as with general principles of tort law to shift financial responsibility for wrongdoing to the wrongdoer. Thus, for the 41-year life of the HLA – and lately more than ever – hospitals have depended upon statutory liens to bring some measure of needed financial relief.

But HLA liens increasingly have come under fire in the courts from some of the hospitals' former emergency patients and their creative lawyers. They assert vehemently that hospitals have no lien rights under the HLA to recover sums beyond the greatly reduced contractual amounts paid by the accident victims' insurers for the treatment. Such payments frequently are labeled as "payment in full" for the patients' hospitalization under the patients' health plans. Patient/plaintiffs have attacked hospitals' statutory lien rights, wishing to secure for themselves the largest possible recovery for medical, special and other damages suffered. Ironically, these very same plaintiffs routinely prove up their damages by using the hospitals' full-charge bills, and they routinely eschew the steeply discounted sums paid by their insurers to the hospitals. They say, correctly, that the hospitals' charges – and not the discounted payments leveraged and paid by managed care plans – reflect the reasonable value of their medical special losses. Hospitals, virtual bystanders in personal injury cases, generally agree, because an HLA lien essentially depends upon the plaintiff's recovery (via settlement or judgment) of the extra sum reflected in the hospital's full charges; after all, the hospital already has been paid the discounted sum from the patient's insurer, and would have little incentive to process a lien if the patient could recover no more than what the hospital already was paid.

For most of the life span of the HLA, hospitals and their accident victim patients have accepted the symbiotic connection between them forged by statute; plaintiffs have convinced fact-finders and tortfeasors (or their insurance companies) to pay for the full value of their medical special losses based upon hospitals' full charges, and hospitals asserting timely HLA liens have been able to recoup a portion of those losses from the wrongdoers who caused the plaintiffs' injuries. Few patients grumbled, as the hospitals' full-charge bills produced lucrative settlements, frequently with tortfeasors' insurers paying medical special losses at three times the amount of the full-charge bill. Even for those plaintiffs who proceeded to verdicts that did not reward them multiples of the hospitals' bills, the use of the hospitals' bills as evidence of their losses served, nonetheless, to enhance their general verdicts for pain and suffering. Through it all, the wrongdoers whose conduct caused the patients' injuries and hospitalizations were being brought to account, just as the HLA and other laws intended.

The peaceful coexistence between hospitals and patients came to an abrupt halt a few years ago. For some hungry patients, having the cake was not enough. Rather, in a spate of more than twenty lawsuits against many California hospitals and health systems, patients complained that hospitals have no right to collect under the HLA as provided plainly in the statute. The reason, they contend, is that the HLA lien is a disguised second bill to the patient, who owes the hospital nothing under the terms of the managed care or other discount insurance agreement that paid the hospital "in full" for the patient's emergency room and ongoing

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4 Cal. Civ. Code § 3045.1 *et seq*.

5 *Id*.

medical care. They argue that without any patient debt to the hospital (other than co-payments or deductibles), no HLA lien exists in the first place.

Within the past year, HLA challenges have made their way through California's judicial system to reach appellate courts, which have produced directly contradictory decisions recognizing – or refusing to recognize – the propriety of HLA liens in factual settings where the patient's insurer has paid the hospital a reduced contractual rate. Thus, the law is in a state of confusion, and hospitals are unable to determine whether their liens will be challenged in court, or what the ultimate outcome might be. Fortunately, there is light at the end of this muddy tunnel. On November 26, 2002, the Supreme Court unanimously granted review of a case that refused to allow HLA liens in these factual settings, and, as such, resolution of this issue is imminent.

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THE HOSPITAL LIEN ACT

The HLA, Civil Code Section 3045.1 *et seq*., provides as follows:

> [A hospital] which furnishes emergency and ongoing medical care or other services to any person injured by reason of an accident or negligent or other wrongful act…shall, if the person has a claim against another for damages on account of his or her injuries, have a lien upon the damages recovered, or to be recovered, by the person…to the extent of the amount of the reasonable and necessary charges of the hospital…[6]

The HLA, by its terms, allows a hospital to place a lien to recover funds from a personal injury defendant when – for any number of reasons – the hospital was paid less than its "reasonable and necessary charges" for the patient's emergency room treatment and subsequent hospital care. Thus, the HLA offers hospitals a mechanism to recoup additional moneys for managed care, underinsured, and uninsured emergency patients who successfully sue the third parties responsible for their injuries. Given the dire state of hospital funding, it is no surprise that many California hospitals routinely notice HLA liens and count on such liens to fill part of the funding gap. The understanding that this form of recovery will be available in some percentage of cases is an essential element of the healthcare payment system, in which hospitals agree to give insurers contractual discounts that are designed to help keep healthcare costs down.

LEGISLATION AND HEALTHCARE POLICY

The California Legislature has established a policy requiring hospitals to provide emergency treatment to all without regard to a patient's insurance status, economic status, or ability to pay.[7] As a result, hospitals face substantial financial responsibility, and the Legislature has determined that it should be allocated according to fault to the extent possible. Thus, "it is the intent of the Legislature that the source of funding of emergency medical services be related to the incident of emergencies requiring immediate medical care" and that "the costs of emergency medical services shall be borne, to a degree, by those who have a relationship to creating the emergencies."[8] The HLA was intended to assist in shifting this burden: "The purpose of this bill

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6 *Id.*

7 Cal. Health & Safety Code § 1317 (describing hospitals' emergency room service requirements) and related Statutory Note, Stats. 1987 Ch. 1240, § 1(e) (the Legislature has determined, as a matter of public policy, "that emergency medical treatment should be provided to any person requesting care without regard to ability to pay and that the cost should, where possible, be shifted to the third-party tortfeasors responsible for the injuries").

8 Historical Derivation of Cal. Health & Safety Code § 1317.

is to make it possible for hospitals to seek payment, particularly from insurance companies whose clients have accidentally or negligently hurt another person, resulting in that injured person's hospitalization."[9] In its one prior decision directly involving the HLA, the California Supreme Court noted that the HLA accomplishes such a shift by creating "a statutory medical lien in favor of a hospital against third persons liable for the patient's injuries."[10]

Plaintiffs challenging HLA liens have urged courts to adopt an interpretation of the HLA that would not authorize liens if the patient's insurer has paid the hospital a reduced contractual rate in satisfaction of the patient's obligation. (Ironically, as noted above, these plaintiffs do not hesitate to present full, undiscounted hospital bills to tortfeasors as evidence of the plaintiffs' damages.) However, the reasons for managed care arrangements are unrelated to the policy of shifting costs to tortfeasors, and should not alter hospitals' ability to rely on the HLA to provide additional funds. There is nothing in the HLA that remotely compromises the hospitals' liens by limiting or foreclosing them in the predominant payment situation, in which health plans or other insurers have paid hospitals less than their reasonable and necessary charges. Indeed, the Legislature's silence on this point speaks volumes: in 1992, when the Legislature expanded the scope of hospital liens to include all reasonable and necessary charges for "ongoing medical care" (and deleted the limit that had been imposed by the 1961 law, *i.e.*, charges for a maximum 72-hour emergency stay), managed care and other forms of discounted insurance payments to hospitals had become the norm, especially in California.[11] Had the Legislature intended to limit hospital liens to amounts already paid by insurers – a decision that would have confined hospitals' statutory lien rights only to cases of uninsured patients – the Legislature easily could have implemented that choice with very little effort, by adding precious few additional words to the 1992 law. Instead, the Legislature opened the lien window wider to struggling hospitals, allowing liens for patients initially admitted for emergency room treatment, who then receive "ongoing medical care" in any unit of the hospital.

Since the proliferation of managed care, hospitals often have contracted on a "capitated" basis to provide services to a large group of insureds for a set price, which may be only a few dollars per person per month. That widens substantially the reality gap between what hospitals often get paid and what their reasonable and necessary charges are for treating accident victims and other patients. Of course, hospitals get paid far less than what they otherwise would charge because they have no choice: well-leveraged health plans provide the volume of patients, but only at a price that is certainly much less than the hospitals' charge masters. As one attorney representing hospitals wrote to the Legislature:

> Not in the [HLA], nor in the contract with the insurance plans, was it ever contemplated that these facilities were waiving their rights to recover from the third party responsible for the member's injuries. What was contemplated was that coverage would provide treatment for members at their selected facilities at a discount on the theory that a volume of patients would justify the appropriate reduced charges and an attention to a particular patient population; not discriminating against others, but providing a level of care at a price that would benefit all facets of the plan: the insured, the health insurance plan, the employer and the facility.[12]

If, as plaintiffs argue, these discounted prices set the standard for the hospital's "reasonable and necessary charges" – the amount lienable under the HLA – the reasonable and necessary charges for the treatment of any person covered under such an arrangement would be nonexistent. Thus, under this interpretation, an HLA lien for a hospital's reasonable and necessary charges

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9 Digest of Assembly Judiciary Comm. Third Reading on Assembly Bill 2733 (May 13, 1992).

10 *Mercy Hospital & Med. Ctr. v. Farmers Ins. Grp. Of Cos.*, 15 Cal 4th 213, 217 (1997); *see also Swanson v. St. John's Regional Med. Ctr.*, 97 Cal. App. 4th 245, 250 (2002), *review denied* (June 26, 2002).

11 *See* note 2, *supra*.

12 August 10, 2000, letter to Senator Adam Schiff from Meyer Gristian Associates, included in legislative history of Cal. Civ Code § 3040.

could exist only where the patient has no insurance at all; under this interpretation, if a patient is insured, then the hospital recovers its reasonable and necessary charges from the carrier and nothing remains to recover through the lien mechanism. The tortfeasor is spared the cost of paying for some of the victim's treatment and receives a windfall, a curious twist that confounds tort policy and the collateral source rule. (*See* discussion below.) That argument fails because the tortfeasor simply is not entitled to the benefit of the contractual discount.

In fact, recent legislative developments confirm the policy that a hospital discount cannot be enjoyed by any person not in privity with a contracting party – not even another insurer or healthcare provider. The rates that apply between a specific healthcare provider and a specific insurer relate only to that contract and that plan, and cannot serve as a formula for general market value for medical services provided to all patients or potential patients of a hospital. The Legislature has recognized that discounted provider rates may not be transferred to other payors unless the provider consents.[13] If one payor cannot free-ride on the bargain of another, it is quite clear that a tortfeasor – the wrongdoer who caused the injury – has no claim to such advantage.

Moreover, the Legislature already considered the issue of limiting hospital liens to the contractual amounts to be paid by the patient or insurer, and refused to impose that limitation. In late 2000, Civil Code Section 3040 was enacted as a legislative reaction to the practice of some HMOs of paying reduced negotiated rates to hospitals for patient treatment, then asserting liens against patient recoveries for the actual charges billed by those hospitals, attempting to recover the excess for themselves.[14] The proposed legislation initially included language that arguably would preclude the assertion of HLA liens for amounts in excess of payments under a rate agreement. The Legislature received a flurry of letters on both sides of the issue. In particular, the California Healthcare Association and others requested an amendment to the proposed legislation to clarify that the new statute did not limit the right of hospitals to assert HLA liens for their full reasonable and necessary charges. The Legislature responded by narrowing the scope of Section 3040 to *ensure* that hospitals were *not* included in the lien limits, expressly exempting hospital liens: "This section is not applicable to … [a] lien for hospital services pursuant to Chapter 4 (commencing with Section 3045.1").[15]

Thus, HLA liens to recover reasonable and necessary hospital charges from a tortfeasor, even in cases where the patient is insured and the hospital has been paid the full amount owed by contract with the insurer, are fully consistent with legislative healthcare and tort policy.

JUDICIAL INTERPRETATION OF THE HLA

Mercy Hospital

To date, the Supreme Court has only once considered the interpretation of the HLA, albeit in a different context from that addressed in this article.[16] In *Mercy Hospital and Medical Center v. Farmers Insurance Group of Companies*,[17] the Court considered

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13 *See*, *e.g.*, Cal. Health & Safety Code § 1395.6; Cal. Ins. Code § 10178.3; Cal. Labor Code § 4609. Even more recently, the Legislature enacted a new provision of the Business and Professions Code, which declares that if a healthcare provider gives a discount to an uninsured patient, the discounted rate is ***not*** deemed to be the provider's "usual, customary, or reasonable fee" for any other purpose. Cal. Bus. & Prof. Code § 367(c).

14 *See* Senate Judiciary Committee Report on SB 1471.

15 Cal. Civ. Code § 3040(g)(3). Ironically, in capitation cases, this law allows managed care plans to recover up to 80 percent of providers' usual and customary charges. Cal. Civ. Code § 3040(a)(2). In other words, the plaintiffs in the hospital lien cases say the HLA provides hospitals nothing to lien when there are discounted insurance payments, while new § 3040 – enacted to severely restrict managed care liens but not hospital HLA liens – allows for substantial lien recoveries by managed care plans in capitation cases. That anomalous result could not have been what the Legislature meant, either in the HLA, or in its carefully crafted provision to exempt HLA liens from § 3040.

16 With its November 26, 2002, grant of review of *McMeans v. ScrippsHealth*, the California Supreme Court will have the opportunity to address the pertinent HLA issues head-on.

17 *Mercy Hosp., supra*, 15 Cal 4th 213.

a provision of the HLA that limits a hospital's recovery on its lien to fifty percent of the proceeds of the personal injury suit.[18] The tortfeasor there had paid the entire settlement directly to the plaintiff without satisfying the hospital's properly noticed lien, in violation of the HLA's procedural requirements.[19] The hospital argued that as a result of the tortfeasor's failure to meet its obligation to the hospital, the statute required the tortfeasor to pay the hospital the entire original amount of its lien, without regard for the statutory fifty-percent limitation.

In rejecting that argument, the Court acknowledged a few key elements of HLA liens that dispel the typical arguments raised by challengers to HLA liens in the managed-care context. Specifically, the *Mercy Hospital* Court stressed the fact that an HLA lien is not a lien on the assets of the patient, but rather a lien on the assets of the tortfeasor. The Court noted that the HLA was "California's first statutory medical lien in favor of a hospital against third persons liable for the patient's injuries,"[20] that "the statutory scheme is applicable to any 'person, firm, or corporation known to the hospital and alleged to be liable to the injured person for the injuries sustained,'"[21] and that the purpose of the HLA was "to secure part of the patient's recovery from liable third persons to pay [the patient's] hospital bill ...."[22] This distinction as to the ownership of the assets is critical: because the lien is on the tortfeasor's assets, the hospital does not by its lien seek to recover any additional money from the patient (or insurer), and thus does not violate its contract with the insurer prohibiting seeking additional payment from the patient (a common argument of plaintiffs). *Mercy Hospital* makes it clear that the fact that an insured patient has already paid the hospital all that he or she owes per contract has no effect on the placement of an HLA lien in the personal injury suit.

Mercy Hospital also is significant for its acknowledgment that the existence of a lien does not depend upon the preexistence of a debt – which is absent in cases where the patient/insurer has paid the reduced contractual rate in full. Some plaintiffs attacking hospitals' HLA liens have argued that without a debt to the hospital from the patient, there is nothing for a lien to secure, and as such there can be no lien as a matter of law. But the *Mercy Hospital* Court understood otherwise, stating: "[w]hatever principles might generally apply to liens, [the HLA] is a statutory, not a common law, lien. The Legislature is, of course, free to define and limit such a lien, and has done so in this case".[23] Moreover, "Mercy's lien is provided for and defined by Sections 3045.1 through 3045.6."[24] The Civil Code sections cited by *Mercy Hospital* as defining the HLA lien make no reference to a debt owed by the patient, and instead simply provide that the lien is in the amount of the hospital's "reasonable and necessary charges."[25] In the HLA, the Legislature established that hospitals have lien rights *regardless* of whether the patient or his or her insurer is indebted to the hospital.[26] Nor is there anything unusual about the Legislature's formulation of the lien. The HLA is but *one* example of a statutory

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18 Cal. Civ. Code § 3045.4.

19 *Id*.

20 *Mercy Hosp., supra*, 15 Cal. 4th at 217.

21 *Id*.

22 *Id*.; *see also id*. at 228 ("As justice might suggest, the direct source of available assets, and the person obligated to ensure satisfaction of the lien, is not the innocent victim, but the one already responsible in damages for the victim's injuries") (Baxter, J., dissenting).

23 *Id*. at 222-23.

24 *Id*. at 217.

25 Cal. Civ. Code § 3045.1.

26 *See Swanson, supra*, 97 Cal. App. 4th at 249-50; *see also Andrews v. Samaritan Health System*, 36 P. 3d 57, 61 (Ariz. Ct. App. 2001) (interpreting a similar Arizona law and holding that "hospital[s] may enforce statutory liens even where there is no personal recourse available directly against a patient [and] … even though the hospitals were compensated according to the terms in the provider contracts").

lien that does not require a debt by the recipient of a service or fund from which the lien arises.[27] *Mercy Hospital* thus set important parameters for future interpretation of the HLA. As described below, only one appellate decision has observed them.

Swanson

The first outright challenge to the placement of an HLA lien where an insured patient's insurer has paid the bill "in full" was *Swanson v. St. John's Regional Medical Center*.[28] *Swanson*, an unfair business practices lawsuit brought by a representative plaintiff, challenged the notion that a hospital could recover any additional sum after receipt of a reduced contractual payment on the patient's behalf. The trial court sustained the hospital's demurrers and the Second Appellate District affirmed on various grounds, including that the HLA and Section 3040's text and legislative history established that the challenged liens fell within a statutory safe harbor and thus could not be an unfair business practice as a matter of law.[29]

The court also affirmed the dismissal on one ground that virtually all courts faced with such challenges have agreed upon: the absolute litigation privilege of Civil Code Section 47(b). The court reviewed cases where, as in the HLA lien cases, the only wrong alleged was the simple placement of a lien. The court found that the absolute litigation privilege protected "communicative acts" made in relation to pending or impending litigation, such as noticing a lien as a prerequisite to judicial action.[30] All other appellate courts considering this issue have acknowledged that the litigation privilege may bar at least some claims based on the placement of liens under the HLA.

The *Swanson* court fully considered and discussed all of the relevant sources of interpretive guidance: the language and history of the HLA and of Section 3040, policy arguments, and *Mercy Hospital*, as well as other appellate opinions purporting to interpret the HLA. Not surprisingly, the court concluded that these liens are allowed by the HLA. The Supreme Court denied the plaintiff's petition for review.

McMeans and *Nishihama*

Only a handful of other appellate decisions address the HLA at all, and only one, the Fourth Appellate District's decision in *McMeans v. Scripps Health*, [31] addressed the precise issue in *Swanson*. [32] *McMeans* disagreed with *Swanson*, and concluded that the HLA does not authorize liens in cases involving insured patients to recover sums in addition to the contractual reduced payment from the patients' insurers. However, in reaching that decision, the *McMeans* court did not perform the type of rigorous independent analysis found in *Swanson*; rather, it ignored legislative history and policy implications, and misread *Mercy Hospital*. This patent conflict with *Swanson* surely engendered the Supreme Court's unanimous decision to grant review of *McMeans*.

McMeans found its primary support in an October 2001 decision of the First Appellate District, *Nishihama v. City & County of San Francisco*.[33] *Nishihama* purported to declare illegal HLA liens in excess of the patient's obligation to the hospital,

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27 *See, e.g.*, Cal Health & Safety Code § 121270(k) (authorizing the AIDS Vaccine Victim Compensation Fund to place liens on amounts recovered from third parties by its compensated victims); Cal. Labor Code § 4417 (authorizing the Asbestos Workers Account to place liens on amounts recovered from third parties by its compensated victims); Cal. Labor Code § 3852 (authorizing employer's lien to recoup workers compensation benefits recovered by the worker: *see also Kain v. California Dept. of Health Servs*., 91 Cal. App. 4th 325, 331 (2001) (concluding that a vaccine victim's NVICP award may include an amount to reimburse Medi-Cal for its expenditures for the patient's care; "no other entity will pay the [Medi-Cal] lien if the NVICP award does not"), *rev. denied*.

28 *Swanson, supra*, 97 Cal. Appl 4th 245. The authors of this article were counsel for the defendant hospitals in *Swanson*.

29 *Id*. at 252 (citing *Cel-Tech Communs., Inc. v. Los Angeles Cellular Tel. Co*., 20 Cal 4th 163, 184 (1999)).

30 *Swanson, supra*, 97 Cal. App. 4th at 249.

31 *McMeans v. Scripps Health*, 100 Cal. App. 4th 507 (2002).

32 On February 25, 2003, the Fifth District issued a decision that dealt with the same issue and reached a conclusion diametrically opposed to that of *Swanson*. *Parnell v. Adventist Health System/West*, 131 Cal. Rptr. 2d 148 (2003). *See* discussion *infra*.

33 *Nishihama v. City & County of San Francisco*, 93 Cal. App. 4th 298 (2001).

but in fact the main issue before the court in that case had nothing to do with HLA liens, and no hospital even was a party to the case.

The plaintiff in *Nishihama* stepped into a pothole and fell as she was getting off a bus in San Francisco. She broke her leg in two places, and sued the City for negligence. After the jury awarded Ms. Nishihama nearly $100,000, the City appealed, arguing (*inter alia*) that the damages award was excessive because the amount awarded for medical costs was more than the plaintiff actually had incurred. The treating hospital had accepted a reduced payment from the plaintiff's insurer and had placed an HLA lien upon the tort recovery, but it had no involvement in the case apart from the placement of its lien.

The plaintiff sought only an affirmance of the judgment against the City, so that she could collect post-judgment interest. The amount of the hospital's lien either would be deducted from the judgment if the court found the lien invalid, or would be paid to the hospital if the lien were valid. Thus, the plaintiff had no reason to care, or to argue one way or the other on appeal, whether the hospital's lien was valid. Indeed, the principal issue on appeal in *Nishihama* was the propriety of certain closing arguments made by plaintiff's counsel to the jury, not the propriety of hospital liens. Because no hospital appeared in *Nishihama*, no hospital was heard from about the HLA and its legislative history, and the key HLA issues never were briefed or argued.

McMeans and *Swanson*'s divergent interpretations of the HLA cannot be reconciled, a circumstance ultimately conceded by the *McMeans* court: "[T]o the extent the analysis of the HLA in *Swanson* differs from the analysis in *Nishihama*, we find the reasoning of *Nishihama* more compelling."[34] Thus, *Nishihama* is the only basis for *McMeans*, but *Nishihama*'s cursory analysis is not strong enough to support either decision. The *Nishihama* court examined the HLA lien on an incomplete record, and concluded based on its uninformed analysis that the patient's monetary recovery for medical damages was excessive. Moreover, the *Nishihama* court itself was constrained to concede that "because [the hospital] is not a party to this action it is not bound to any ruling made concerning its lien rights."[35]

The *McMeans* court disregarded this caution and elevated *Nishihama*'s unsupported conclusion about the HLA – which the *Swanson* court appropriately characterized as *dicta* – to a guiding principle of law. Thus, *McMeans*, like *Nishihama*, is of doubtful legitimacy, but it nevertheless invites other courts similarly to rely upon the uninformed *Nishihama dicta* as proper grounds for decision on an issue of great statewide importance. Therefore, the Supreme Court's review of *McMeans* is welcome news to hospitals and the healthcare bar alike.

McMeans did agree with *Swanson*'s analysis on one key point – that the litigation privilege barred at least some of the claims.[36] However, the court was less than clear about exactly which claims were barred, stating only that the issue of "which causes of action are barred by the privilege was not raised in the trial court and has not been extensively briefed, [therefore] we decline to address it."[37]

Other Cases

Although at present the clash between *Swanson* and *McMeans* – and the Supreme Court's signal through unanimous grant of review of *McMeans* that it intends to intervene – is the center of attention, several other relevant cases are awaiting results throughout the California judicial system, which must necessarily depend on the ultimate *McMeans* result. For example, a decision from the Supreme Court is expected shortly in *Olszewski v. Scripps Health*.[38] In that case, the appellate court held that California's Medi-Cal lien statute,

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34 *McMeans, supra*, 100 Cal. App 4th. at 518.

35 *Nishihama, supra*, 93 Cal. App. 4th at 308.

36 *McMeans*, 100 Cal. App. 4th at 522.

37 *Id.*

38 *Olszewski v. Scripps Health*, 88 Cal. App. 4th 1268 (2001), *superseded on grant of review*. In fact, the Supreme Court's order granting review of *McMeans* specifically deferred briefing "pending consideration and disposition of a related issue" in *Olszewski*.

which allows providers of Medi-Cal covered services to place liens in personal injury suits, is preempted by federal Medicaid law prohibiting providers from "balance billing" – that is, seeking money from patients in additional to what Medi-Cal pays. [39] Both sides in *Olszewski* sought review of the Fourth District's decision, and in August 2001, the Supreme Court voted unanimously to accept the case for review. The hospital challenged the preemption holding. The plaintiff challenged the conclusion that the hospital had no tort or unfair business practice liability for placing the liens, because it was protected by the absolute litigation privilege, and also because the existence of the state statute authorizing the liens constituted a safe harbor at all times before the court declared it preempted. Briefing in *Olszewski* was substantially complete by early 2002, and the matter was argued on March 13, 2003.

At the appellate level, the Fifth District recently reversed a trial court's ruling, in line with *Swanson*, that hospital liens in the managed care context are authorized by the HLA. In *Parnell v. Adventist Health System/West*[40], the court reviewed the relevant authority, yet rejected the *Swanson* analysis out-of-hand. The *Parnell* court's confusion regarding the interpretation of the HLA was reflected in its addition of a new element to the mix. Throughout its opinion, the court purported to read into the HLA the phrase "usual and customary charges" in place of the statute's actual language, "reasonable and necessary charges."[41] Later, the court ignored the obvious meaning of "necessary," which refers to treatment that is *medically* necessary, and pronounced that an HLA lien in excess of amounts paid by a patient's insurer "in full" could never be a "necessary" charge because the patient had a right to receive the services at the lower rate.[42] This convoluted rejection of the statute's plain language and a term of art that, along with similar terms in the medical context, has enjoyed years of consistent interpretation, renders the *Parnell* decision an outlier in the realm of HLA jurisprudence.[43]

Grauberger v. Saint Francis Hospital,[44] which has had a tortured history up and down both the state and federal judicial systems, was placed on hold in the First District pending determination of the petition for review in *McMeans* and presumably will continue in abeyance until that case is resolved. Other cases against various California hospitals abound at the trial court level, and several are stayed, pending some resolution of the issue of the validity of HLA liens, as well as hospitals' Medi-Cal liens.

The Interplay of the HLA and the Collateral Source Rule

None of the HLA cases discusses the effect that disallowing HLA liens in cases where the patient has insurance would have on the well-established collateral source rule. It has been the law of this State for years that under the collateral source rule, a tortfeasor may not benefit from the injured victim's prudence in purchasing insurance. Therefore, the tortfeasor's liability for the injury the tortfeasor caused the plaintiff cannot be reduced based on the plaintiff's insurance coverage.[45] The collateral source rule has been affirmed by the

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39 *See* 42 C.F.R. § 447.15.

40 106 Cal. App. 4th 580, 131 Cal. Rptr. 2d 148 (2003).

41 *See*, *e.g.*, 131 Cal. Rptr. 2d at 152.

42 *Id.* at 157.

43 The issue of the litigation privilege was not argued before the trial court and as such the Fifth District did not reach it, although it noted that the privilege "undoubtedly precludes certain of appellant's causes of action to the extent they are based on the filing of such notice [of liens]". *Id.* at 160.

44 The authors of this article are counsel for the defendant hospitals in *Grauberger*. That case has generated two federal court opinions, and ultimately an order remanding the case to state court for plenary resolution of the HLA issue. *See Grauberger v. Saint Francis Hosp.*, 149 F. Suppl 2d 1186 (N.D. Cal 2001), *vacated in part by Grauberger v. Saint Francis Hosp.*, 169 F. Supp. 2d 1172 (N.D. Cal 2001).

45 *See Helfend v. Southern Cal. Rapid Transit Dist.*, 2 Cal 3d (1970).

Supreme Court and appellate courts on numerous occasions.[46]

Nevertheless, the *McMeans* and *Nishihama* courts both opined that a personal injury plaintiff's claim against a tortfeasor for medical special damages is limited to amounts actually paid by the plaintiff's private insurer, regardless of the reasonable *value* of the medical services received. This determination – which flies in the face of the collateral source rule – was the predicate to the courts' conclusions in both cases: the hospitals had no HLA liens because the plaintiffs themselves could seek no more than the discounted payments made by their insurers to the hospitals.[47]

This result cannot be squared with the collateral source rule, nor with the key policy behind it – that is, that the tortfeasor should not benefit from the victim's prudence in purchasing insurance. Under *McMeans* and *Nishihama*, tortfeasors are rewarded, because they never have to pay the full cost of the harm they caused. Patients are penalized for their prudence by being foreclosed from introducing evidence of the full value of their medical special damages. Meanwhile, hospitals also lose, as they are forced to absorb the difference between what the plaintiffs' insurers paid and the actual value of the medical care that the hospitals provided to the injured plaintiffs. The only winners, again, are the tortfeasors, who get the benefit of their victims' prudence, and also avoid the hospitals' statutory liens.

The court in *Swanson* had no reason to mention the collateral source rule, because the *Swanson* court held that the HLA applied, and the text of the HLA says nothing about that common law rule. Rather, the HLA concerns hospitals' liens for their reasonable and necessary charges, nothing more and nothing less. In *McMeans* and *Nishihama*, however, both courts adopted as a central premise the notion that a plaintiff may present only the amount of his or her discounted insurance payment as proof of medical special losses, and yet those courts never attempted to square their decisions with the collateral source rule. For that underlying proposition, both courts relied upon a single authority, *Hanif v. Housing Authority*.[48]

For a number of reasons, *Hanif* is of dubious continued validity and it cannot support the conclusions reached in *McMeans* and *Nishihama*. In *Hanif*, a personal injury plaintiff attempted to recover medical damages in excess of the charges paid by the publicly-funded Medi-Cal program. The court said no, and limited the plaintiff's medical special damages to the amount Medi-Cal had paid the hospital for the plaintiff's hospitalization.

Hanif has nothing to do with the collateral source rule. Rather, *Hanif* addressed recoveries by patients insured by Medi-Cal – where entirely different policy concerns regarding conservation of public moneys are at issue[49] - and thus *Hanif* cannot apply to cases involving benefits paid by privately purchased insurance, the keystone of the collateral source rule. Indeed, the *Hanif* court said as much when it stated that "the collateral source rule is not an issue in this case."[50]

Hanif also is inapplicable to the hospital lien cases for the obvious reason there was no hospital lien at issue in *Hanif*. To the contrary, the hospital in that case had written off its own bill in excess of what Medi-Cal had paid for the patient/plaintiff's hospitalization.[51] Indeed, the Medi-Cal lien law did not yet exist at the time Hanif was decided.[52]

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46 *See, e.g., Pacific Gas & Electric Co. v. Superior Ct. (Allen)*, 28 Cal App. 4th 174, 179 (1994) ("payment from the plaintiff's insurance company presents the strongest case for application of the rule"); *McKinney v. California Portland Cement Co*., 96 Cal. App. 4th 1214 (2002); *Arambula v. Wells*, 72 Cal. App. 4th 1006, 1015 (1999).

47 *See McMeans, supra*, 100 Cal. App. 4th at 514-15; *Nishihama, supra*, 93 Cal. App. 4th at 307.

48 *Hanif v. Housing Authority*, 200 Cal. App. 3d 635 (1988).

49 *See, e.g.*, *Arambula*, *supra* note 39, 72 Cal. App. 4th at 1015 ("[t]he question of gratuitous public benefits is not at issue here and invokes a host of other concerns, which must be considered in light of their specific factual contexts").

50 *See Hanif, supra*, 200 Cal. App. 3d at 641. The court made that statement in the course of distinguishing commentary to the BAJI 14.10 that allows personal injury plaintiffs to recover the reasonable value of their medical special losses.

51 *Id*. at 639.

Even by its own limited terms, *Hanif* also is difficult to square with Government Code Section 985. That 1987 statute (enacted after the trial court decision in *Hanif*) creates a specific, narrow exception to the collateral source rule for Medi-Cal payments in cases with public entity defendants, such as those in *Hanif* and *Nishihama*.[53] Such defendants are entitled to pursue a specific statutory exception to the collateral source rule to limit the damages payable. Section 985(b) initially states that, in a tort proceeding against a public entity, evidence of any payment of collateral source benefits "shall be inadmissible," but then goes on to provide that the public entity defendant may bring a *post-verdict motion* to reduce the judgment by any such collateral amounts paid before the trial.[54]

Section 985 apparently was as a legislative response to the California Supreme Court's seminal collateral source rule decision in *Helfend v. Southern California Rapid Transit District*,[55] which (among other things) held unequivocally that the collateral source rule applies to public entity defendants.[56] The Legislature presumably created the Section 985 exception because of the different policies at stake where public funds are involved. The *Nishihama* defendant could have, but did not, invoke the Section 985 exception; instead, it evaded the collateral source rule without going through the statutorily prescribed process that contemplates a limited, post-verdict exception to the rule in cases against public entities, such as the City and County of San Francisco. The *Nishihama* and *McMeans* courts' reliance on *Hanif*, and *Nishihama's* failure even to mention Section 985, effectively encourages public entities to bypass the statutory procedure and to confound the rule by inviting the introduction of collateral source payments as evidence before or during trial in order to reduce the overall verdict and recovery of pain and suffering losses. Allowing that tactic will severely undermine the collateral source rule. As the Supreme Court in *Helfend* acknowledged, evidence of collateral source payments would "irretrievably upset the complex, delicate and somewhat indefinable calculations which result in the normal jury verdict."[57]

The *Nishihama* and *McMeans* courts' disregard of the collateral source rule produces perverse consequences. These rulings dictate that uninsured patients may recover, without limit, the full value of all medical treatment received, while those patients with insurance – the persons whom the collateral source rule was designed to protect and reward – may receive only dramatically limited recoveries capped at the deeply discounted rates paid by insurers. From that incorrect premise, it is only a short step to the equally wrong conclusion that HLA liens cannot exist where the patient could recover only what the insurer already paid. *McMeans* and *Nishihama* fail to discuss how it is that the 41-year-old HLA does not apply to any case other than those involving uninsured patients, when the statute says plainly it applies to "any person" and with respect to the provision of "emergency and ongoing medical care or other services," without limitation to the amount insurance paid for such services.

Nishihama and *McMeans* demonstrate the Pandora's box of bad policy and thwarted legislative

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52 The future of *Hanif* is also uncertain because the now-superceded Fourth District decision in *Olszewski*, which is pending before the Supreme Court, relies on *Hanif* in its analysis and conclusion that the state law authorizing Medi-Cal liens was preempted by the federal Medicaid balance billing prohibition.

53 *See Scott v. County of Los Angeles*, 27 Cal. App. 4th 125, 154 (1994) (holding that Medi-Cal payments were protected collateral sources and recognizing the applicability of § 985's post-verdict procedure to reduce damages payable by a public entity for amounts paid by Medi-Cal).

54 *See* Cal. Gov't. Code § 985 (b), (f); see also *Scott*, *supra*, 27 Cal. App 4th at 154 (affirming trial court's exclusion of Medi-Cal payments from evidence as collateral source payments and noting the availability of the post-trial procedure to reduce the verdict).

55 *Helfend*, *supra* note 39, 2 Cal. 3d 1.

56 *Id*. at 14-16.

57 *Id*. at 11-12. *See also Montgomery Ward & Co. v. Anderson*, 976 S.W. 2d 382, 383-84 (S. Ct. Ark. 1998), (noting that the collateral source rule serves to exclude evidence that the treating hospital discounted its rate by fifty percent) (cited with approval in Arambula, *supra* note 39, 72 Cal. App. 4th at 1012).

intent that the courts have opened by disallowing HLA liens merely because the patient's direct obligation to the hospital has been satisfied. The HLA is intended to allow hospitals to recoup some of their costs, in those limited instances where former accident victims sue and recover damages from wrongdoers. That legislatively created opportunity evaporates under *Nishihama* and *McMeans*, which effectively rewrite the 41-year-old law to allow liens only in the still less common scenario of uninsured accident victim patients. That is not what the law says, nor what the Legislature intended.[58] Tortfeasors and their insurers should pay the full cost of the injuries tortfeasors cause. The courts should *not* force already struggling hospitals to absorb the lion's share of those costs when the law provides otherwise. These issues were placed squarely before the Supreme Court in the successful Petition for Review filed in *McMeans*.

CONCLUSION

The patent conflict among the appellate courts on the scope of the HLA has generated Supreme Court review to resolve the stalemate. The grant of review of *McMeans* dramatically changes the landscape. Without high court review, hospitals had no way of knowing which of the conflicting decisions trial courts in myriad personal injury actions would follow in deciding whether to allow HLA liens. Trial courts in the many other cases attacking hospitals' liens face the same uncertainty. Now, with the recent *Parnell* decision, the conflict with *Swanson* has been resurrected, pending the Supreme Court's decision in *McMeans*.

Equally important, hospitals must navigate this sea of legal uncertainty, and have been reluctant to process liens and risk litigation and attorneys' fees if liens were challenged. The price for forsaking their statutory lien rights might even be higher for those hospitals, as they leave on the table substantial sums intended by the Legislature to compensate them for their broad obligation to treat all emergency room patients, often at considerable loss. This judicial quagmire will now be resolved by the Supreme Court's review of *McMeans,* and hopefully a definitive ruling that the HLA means what it says.

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[58] *See supra*, note 9, and accompanying text.