
NOTES

TOWARD CORRECTING THE MISAPPLICATION OF SUBROGATION DOCTRINE IN CALIFORNIA HEALTHCARE

STEVEN FLOWER*

I. INTRODUCTION

A. TWO STORIES, ONE PROBLEM

Subrogation has been called a “sleepy, although significant subject,”¹ and perhaps consequently, many articles treating the topic begin with a prefatory example (either real or abstract) of the potential entanglements it can create.² In line with this established tradition, this Note begins with two such examples.

* Class of 2004, University of Southern California Law School; B.A. Wesleyan University; M. Phil. 1998, University of Cambridge. I thank W. David Slawson for his guidance, Katherine McKnight of the Department of Managed Healthcare for her insight, and Leslie Dumipace for her support.

1. Michael Sean Quinn, Book Review, 74 TEX. L. REV. 1361, 1361 (1996) (reviewing CHARLES MITCHELL, SUBROGATION, RESTITUTION, AND INDEMNITY: THE LAW OF SUBROGATION (1994)).

2. See, e.g., John Dwight Ingram, *Priority Between Insurer and Insured in Subrogation Recoveries*, 3 CONN. INS. L.J. 105, 105–06 (1996–97); Thomas G. Buchanan III, Case Note, *Franklin v. Healthsource of Arkansas: Arkansas Adopts the Made-Whole Doctrine*, 51 ARK. L. REV. 773, 773 (1998); Keith E. Edeus, Jr., Comment, *Subrogation of Personal Injury Claims: Toward Ending an Inequitable Practice*, 17 N. ILL. U. L. REV. 509, 509–10 (1997); Todd L. Fulks, Note, *The “Made-Whole” Doctrine: Its Effects on Tennessee Tort Litigation and Insurance Subrogation Rights*, 32 U. MEM. L. REV. 87, 88–90 (2001); Jeffrey A. Greenblatt, Comment, *Insurance and Subrogation: When the Pie Isn’t Big Enough, Who Eats Last?*, 64 U. CHI. L. REV. 1337, 1337 (1997).

Roy Block was injured in an automobile accident caused by another person.³ Like roughly 23 million other people in California,⁴ Block belonged to a managed care organization (“MCO”).⁵ His MCO agreed to pay for the treatment of his injuries on the condition that he agree to reimburse it from any eventual tort recovery.⁶ This might seem fair since Block might otherwise recover twice for his injuries; first when the MCO paid for his treatment and then again when he recovered from the tortfeasors. Yet, what if Block was not able to recover for all of his injuries, economic or otherwise? For example, what if he suffered a total of \$10,000 in damages, half of which was for medical expenses, but was forced to settle for \$7,000?⁷ Should his MCO still be allowed to recover its full \$5,000 claim first, even if this leaves him uncompensated for \$3,000 in pain and suffering and lost wages? How should a court interpret MCO contracts that provide for this very contingency? This is one of the problems discussed in this Note.

Paul McMeans was also injured in an automobile accident caused by another person,⁸ and he too belonged to an MCO.⁹ Pursuant to its contracts with McMeans and his hospital, the MCO paid the hospital that treated him at a price established by those contracts.¹⁰ McMeans later recovered \$35,500 for all of his injuries,¹¹ and the hospital filed a lien¹² against that recovery pursuant to the Hospital Lien Act (“HLA”)¹³ to recover the

3. See *Block v. Cal. Physicians’ Serv.*, 53 Cal. Rptr. 51, 52 (Ct. App. 1966).

4. See Benedict Carey, *A Referee in Disputes Between Patients, HMOs: A Year After Its Debut, a State Agency Offers a Glimpse of How Expanded Rights May Play Out Nationwide*, L.A. TIMES, July 30, 2001, at S1, available at 2001 WL 2506636.

5. See *Block*, 53 Cal. Rptr. at 52.

6. See *id.*

7. The numbers in this example are hypothetical because the total damages claimed by Block were not stated in the facts of the case. See *id.* (The court only considered the \$1,714.34 in medical expenses that California Physicians Service paid on behalf of Block and was silent as to noneconomic damages.).

8. See *McMeans v. Scripps Health, Inc.*, 123 Cal. Rptr. 2d 143, 148 (Ct. App.), *depublished by grant of review*, 58 P.3d 928 (Cal. 2002).

9. See *id.* McMeans belonged to a preferred provider organization (“PPO”). See *id.* For the purposes of this Note, PPOs, like health maintenance organizations (“HMOs”) are included in the definition of an MCO. Cf. Alan Bloom, *Risk Management in Health Maintenance Organizations*, 6 WHITTIER L. REV. 683, 683 (1984) (explaining that despite different labels, PPOs and HMOs are essentially the same when compared to the fee-for-service system involving traditional health insurance).

10. See *McMeans*, 123 Cal. Rptr. 2d at 148.

11. See *id.* Because the tortfeasors responsible for his injuries were uninsured, McMeans was forced to rely only on his own insurance to compensate him for his medical expenses, lost wages, and pain and suffering. See *id.*

12. See *id.*

13. CAL. CIV. CODE § 3045.1–6 (West 1993).

difference between the discounted rate paid by the MCO and its “ordinary full charge for the covered service.”¹⁴ This too might seem fair if we believe that the increasing costs of healthcare justify allowing hospitals to recover their costs by statutory means. Yet, should hospitals be allowed to do so at the expense of consumers who have prudently provided for their healthcare in advance? This is the second problem discussed by this Note.

These prefatory examples are two manifestations of a single problem: the misapplication of the principles of subrogation in California’s increasingly complex healthcare environment. California courts have ignored the equitable underpinnings of subrogation in the context of MCO contractual liens and failed to realize that subrogation is even an issue in the case of the HLA.

Subrogation doctrine permits a party who has paid a debt for which another is principally liable to the creditor to ascend to whatever legal remedies the creditor would have had against the principal debtor.¹⁵ The subrogor is thereby said to “stand in the shoes” of the subrogee.¹⁶ In the realm of insurance, an insurer who pays a claim of an insured who was injured by a third party tortfeasor is subrogated to the tort claim.¹⁷ This allows the insurer to recover its claim expense either directly from the tortfeasors or from any judgment or settlement the insured recovers from the tortfeasor.¹⁸

In the examples above, the MCO and hospital sought to recover the payments they made for another (the tort victim) who was injured by a tortfeasor. Yet neither was an insurer as such and, perhaps because of this, neither expressly relied on subrogation rights. Block’s MCO relied on a contractual term that gave it a lien on any recovery from the tortfeasor.¹⁹ Likewise, the hospital that treated McMeans relied on a statutory lien.²⁰ Although, in neither case did the party asserting the lien pursue a claim against the tortfeasor; in both cases, that party sought to be reimbursed on the implied basis that the actions of the tortfeasor was ultimately responsible for its loss. The result of these contractual and statutory terms is, in effect, subrogation, but without its means. This Note argues that the

14. See *McMeans*, 123 Cal. Rptr. 2d at 148–49.

15. See, e.g., ALLAN D. WINDT, *INSURANCE CLAIMS AND DISPUTES: REPRESENTATION OF INSURANCE COMPANIES AND INSURED* § 10.05, at 529–30 (2d ed. 1988).

16. See Roger M. Baron, *Subrogation on Medical Expense Claims: The “Double Recovery” Myth and the Feasibility of Anti-Subrogation Laws*, 96 DICK. L. REV. 581, 581 (1992).

17. See EDWIN W. PATTERSON, *ESSENTIALS OF INSURANCE LAW* 147–48 (2d ed. 1957).

18. See WINDT, *supra* note 15, § 10.05, at 531–32.

19. See *supra* text accompanying note 6.

20. See *supra* text accompanying note 12.

disconnect between means and ends has allowed MCOs and hospitals to achieve de facto subrogation while avoiding the ordinary limitations of the doctrine that might prevent unfairness to the healthcare consumer.

B. THE ARGUMENT

Part II of this Note demonstrates how the current treatment of reimbursement liens by California courts misapplies the traditional principles of subrogation. First, this Note outlines the principles of subrogation with specific focus on the successful efforts of insurers to avoid the rule against assignment of personal injury claims and the manner in which subrogated recoveries can and should be distributed between subrogor and subrogee. Second, this Note reviews and criticizes California's treatment of subrogation problems in the context of MCO contractual liens and the HLA. In the context of contractual liens, this Note argues that courts have been too quick to accept contractual terms on their face and at the expense of the consumer. In the context of the HLA, this Note finds that the California appellate courts are currently split on whether hospitals may use the HLA to recover the difference between MCO or insurance rates and their market rates.

Unfortunately, because judicial reasoning in both scenarios has been inconsistent, this Note concludes that no one solution is available to consumers confronted by these liens.

Part III of this Note therefore examines the several solutions—both judicial and administrative—necessary to effectively limit the multiple problems created by allowing these de facto subrogation rights to arise.

To confront the problem created by MCO contractual liens, this Note suggests that courts should reinterpret the problem in light of the doctrines of reasonable expectations and unconscionability. Because these remedies will help consumers only after a problem has arisen, however, this Note also suggests that the Department of Managed Healthcare (“DMHC”) adopt regulations limiting the use of subrogation terms through its licensure process.

To confront problems created by the HLA, this Note recommends that the California Supreme Court resolve the split between appellate districts by not allowing hospitals to use the HLA to “balance bill”²¹ consumers.

21. Balance billing is the practice of billing patients directly for the “difference between the reasonable value of the hospital services and the negotiated amount paid by the patient’s medical insurance carrier.” *Swanson v. St. John’s Reg’l Med. Ctr.*, 118 Cal. Rptr. 2d 325, 328 (Ct. App. 2002).

Part IV of this Note concludes that the problems identified herein result from the failure of the courts to see the implications of expanding subrogation rights beyond insurance in California's evolving healthcare market. In each case where subrogation rights have been expanded, a different rule has been applied, requiring a different solution.

II. SUBROGATION BY ANOTHER NAME

A. PRINCIPLES OF SUBROGATION

1. Origins and Purposes

Subrogation arose in equity,²² and as such is said to serve three equitable principles. First, it ostensibly prevents the insured from recovering twice for the same loss.²³ Without subrogation, it is said, the injured insured would be unjustly enriched by recovering once from the insurer and again from the responsible third party.²⁴ This rationale for subrogation is supported by the nature of indemnity whereby the insured has a right to be made whole, but not more so.²⁵ Second, subrogation reimburses the party who has in fact born the loss, i.e., the insurer.²⁶ Third, subrogation leaves the ultimate burden of compensation on the wrongdoer.²⁷ In these respects, subrogation's equitable purposes complement the corrective²⁸ and compensatory²⁹ goals of the tort system.

To establish a subrogation claim, a party must show (1) that the subrogor has paid a debt, (2) for which it was secondarily liable, (3) due to a legal obligation, and (4) that allowing subrogation will not result in an

22. The equitable origins of subrogation are accepted by a variety of commentators. *See, e.g.*, PATTERSON, *supra* note 17, at 148; WILLIAM R. VANCE & BUIST M. ANDERSON, *HANDBOOK ON THE LAW OF INSURANCE* 787 (3d ed. 1951); James Morfit Mullen, *The Equitable Doctrine of Subrogation*, 3 MD. L. REV. 201, 201 (1939). *But see* Greenblatt, *supra* note 2, at 1338. Greenblatt suggests the origin of subrogation may lie in Roman civil law, *id.* at 1339–40, or even possibly in Talmudic law, *id.* at 1339 n.10.

23. *See* 16 GEORGE J. COUCH, *COUCH CYCLOPEDIA OF INSURANCE LAW* § 61.18, at 93 (Ronald A. Anderson & Mark S. Rhodes eds., rev. vol. 1983).

24. *See id.* at 93–94. *But see generally* Baron, *supra* note 16 (arguing that double recovery, especially for personal injury claims, is largely a “myth”).

25. *See* Spencer L. Kimball & Don A. Davis, *The Extension of Insurance Subrogation*, 60 MICH. L. REV. 841, 842 (1962).

26. *See* COUCH, *supra* note 23, § 61.18, at 93.

27. *See id.*

28. *See* KENNETH S. ABRAHAM, *THE FORMS AND FUNCTIONS OF TORT LAW* 14–15 (1997).

29. *See id.* at 17–19.

injustice to the subrogee.³⁰ The requirement that the subrogor have a legal obligation to pay the debt is said to prevent subrogation by a party who has paid the debt voluntarily.³¹

The right to bring a subrogation claim can be established by operation of law, contract, or statute.³² Subrogation by operation of law is deemed legal subrogation, while subrogation by contract is deemed conventional.³³ Despite the existence of equitable rights, insurance policies today routinely rely on contractual terms.³⁴ The distinction between legal and conventional subrogation is most significant when the subrogor seeks to expand its rights beyond its equitable origins.³⁵

2. Subrogation of Personal Injury Claims

As applied to insurance, subrogation is a normal aspect of indemnity,³⁶ and has long been uncontroversially applied to property insurance.³⁷ Subrogation of medical payments, however, was initially limited by the courts because the practice was thought to violate the common law prohibition against the assignment of a personal cause of action.³⁸ Traditionally, causes of action for personal injuries are not assignable for several reasons. First, such assignments encourage champerty.³⁹ Second, personal injuries are “too personal to be assigned.”⁴⁰ Third, tortfeasors should not be held responsible to a party they did not harm.⁴¹ Fourth, such assignments result in excessive litigation.⁴² Thus, to the extent that the subrogation of medical payments is an assignment,⁴³ it, too, is subject to these criticisms.

30. See Greenblatt, *supra* note 2, at 1340.

31. See PATTERSON, *supra* note 17, at 149.

32. See Roger M. Baron, *Subrogation: A Pandora's Box Awaiting Closure*, 41 S.D. L. REV. 237, 238 (1996); Baron, *supra* note 16, at 582; Ingram, *supra* note 2, at 107; Fulks, *supra* note 2, at 92.

33. See COUCH *supra* note 23, § 61:2, at 76; WINDT, *supra* note 15, § 10.05, at 520–31. Contractual subrogation is said to be conventional because it is the product of a convention (i.e., contract or agreement) of the subrogor and the subrogee. See Ingram, *supra* note 2, at 107.

34. See WINDT, *supra* note 15, § 10.05, at 530.

35. See COUCH, *supra* note 23, § 61:3, at 76. Cf. Kimball & Davis, *supra* note 25, at 842–44.

36. See COUCH, *supra* note 23, § 61:8, at 83.

37. See Baron, *supra* note 16, at 581–82.

38. *Id.* at 583.

39. See Edeus, *supra* note 2, at 513 (citing *Berlinski v. Ovellette*, 325 A.2d 239 (Conn. 1973)).

40. *Id.*

41. *Id.*

42. *Id.*

43. See Mullen, *supra* note 22, at 201 (equitable assignment is synonymous with subrogation).

In *Fifield Manor Corp. v. Finston*, California courts rejected subrogation of personal injury claims, reasoning it would create an impermissible assignment of a personal cause of action.⁴⁴ *Fifield* had contracted to provide medical care to George Ross, who was injured in an automobile accident caused by a negligent third party.⁴⁵ *Fifield* attempted to recover its expenses paid on behalf of Ross via the subrogation provision in its contract with Ross.⁴⁶ The court held, however, that the subrogation provision was invalid because it violated the rule against assignment of a personal cause of action.⁴⁷ In doing so, the court relied on a statutory—as opposed to a common law—ban on assignment of personal injury claims.⁴⁸ The court implicitly accepted common law policy arguments, however, when it analogized subrogation to assignment.

While subrogation and assignment have certain technical differences, each operates to transfer from one person to another a cause of action against a third, and the reasons of policy which make certain causes of action nonassignable would seem to operate as forcefully against the transfer of such causes of action by subrogation.⁴⁹

Interestingly, the court's ruling disregarded the contractual basis of *Fifield's* subrogation claim. Thus, an insurance policy may not rely on contractual terms to expand subrogation claims into the personal injury context.

The rule in *Finston* was subsequently questioned by the court of appeals in *Peller v. Liberty Mutual Fire Insurance Co.*⁵⁰ Although *Peller* held that the subrogation of medical payments under an automobile policy violated the *Finston* rule against assignment, it cast doubt on the soundness of the rule when it noted that it might be obsolete as applied to medical payments that can be known to a greater certainty than can general damages.⁵¹ The *Finston* rule still stands, however, and the subrogation of personal injury claims is not allowed in California under either legal or conventional terms because it violates the rule against assignment. Insurers

44. *Fifield Manor Corp. v. Finston*, 354 P.2d 1073, 1079 (Cal. 1960).

45. *See id.* at 1074.

46. *See id.*

47. *See id.* at 1079.

48. *See id.* at 1077. The Court cited to section 956 of the California Civil Code, which was subsequently repealed and reenacted as section 573 of the California Probate Code. The language of the two provisions are essentially the same. *See Peller v. Liberty Mut. Fire Ins. Co.*, 34 Cal. Rptr. 41, 42 n.1 (Ct. App. 1963).

49. *Finston*, 354 P.2d at 1078.

50. *Peller v. Liberty Mut. Fire Ins. Co.*, 34 Cal. Rptr. 41 (Ct. App. 1963).

51. *Id.* at 44.

have circumvented the rule against assignability, however, by relying on contractual terms that establish not a right to subrogation, but rather a lien on any settlement or judgment recovered from the tortfeasor.⁵² The argument is that such a lien does not allow the insurer to actually bring a cause of action against the tortfeasor and, as such, creates no assignment problems.⁵³

In *Lee v. State Farm Mutual Insurance Co.*, the court of appeals held an insurer's reimbursement lien did not violate the rule against assignability.⁵⁴ State Farm's automobile insurance policy, on two conditions, would pay for the medical expenses arising from accidents caused by a third party. The first condition was that State Farm was "entitled to the extent of such payment to the proceeds of any settlement or judgment that may result from the exercise of any rights of recovery . . . against any person . . . legally responsible for the bodily injury because of which such payment is made."⁵⁵ The second was that the insured was required to "do whatever is proper to secure and . . . do nothing after loss to prejudice such rights."⁵⁶ These two requirements—that the insured bring a claim against the tortfeasor and allow the insurer to attach a lien to the recovery—effectively create a subrogation right.⁵⁷ The court nevertheless held that "[t]he reasons of policy against assignment or subrogation" of a personal injury claim did not apply, because the insurer retained no right against the third party.⁵⁸

Shockingly, the *Lee* court said that it was following the principle that substance rather than form should govern.⁵⁹ The court, arguably, was doing just the opposite. The form of the contract did not create a subrogation right per se. In substance, however, it created the economic equivalent to subrogation.⁶⁰ The rule nevertheless remains that reimbursement liens do not violate the *Finston* rule,⁶¹ despite how untenable this position seems.⁶²

52. See, e.g., *Lee v. State Farm Mut. Ins. Co.*, 129 Cal. Rptr. 271, 272–74 (Ct. App. 1976); ROBERT E. KEETON, *INSURANCE LAW* § 3.10(a), at 150 (1971).

53. See *Lee*, 129 Cal. Rptr. at 276.

54. See *id.*

55. *Id.* at 273 (emphasis omitted).

56. *Id.*

57. See *id.* at 278 (Friedman, J., concurring).

58. *Id.* at 276.

59. *Id.*

60. See *id.* at 278 (Friedman, J., concurring).

61. See *supra* notes 52–58 and accompanying text.

62. See KEETON, *supra* note 52, § 3.10(a), at 150.

The unfortunate result of such a rule is that insurance companies will disingenuously draft around the *Finston* rule.⁶³

3. Apportionment of Subrogated Recoveries

Once a subrogation claim has been established, a key question remains as to how any recovery from the responsible party should be apportioned between the insurer and the insured. Perhaps because the choice of rule here decides whether the insurer or the insured will bear the ultimate risk of nonrecovery,⁶⁴ the issue remains a key point of debate within the subrogation doctrine.

There are five possible methods of apportionment.⁶⁵ First, at one extreme, the insurer might be entitled to the full recovery from the third party regardless of how much or how little it paid out to the insured.⁶⁶ This would entail a complete assignment of the insured's claim to the insured. Second, at the other extreme, the insured might be entitled to the full recovery from the third party, regardless of any claim paid out by the insurer.⁶⁷ This would effectively deny any subrogation.⁶⁸ Third, the insurer might have first claim to recovery from the third party and the insured is only entitled to any remaining balance.⁶⁹ This is called the *pro tanto* rule⁷⁰ and has been adopted by a minority of jurisdictions.⁷¹ Fourth, the insured might first be entitled to reimbursement for any noncovered damages, and the insurer is then entitled to only the amount sufficient to reimburse it.⁷² This rule is called the "make-whole" rule⁷³ because it requires that the insured be made whole for his or her loss before the insurer is reimbursed.⁷⁴ This approach has been adopted by a majority of jurisdictions.⁷⁵ Fifth, the recovery might be prorated between the insurer

63. *Cf. Lee*, 129 Cal. Rptr. at 278 (Friedman, J., concurring).

64. *See generally* Greenblatt, *supra* note 2, at 1337–39 (claiming that optimal risk-allocation requires that the insurer recover first).

65. *See* KEETON, *supra* note 52, § 3.10(c)(2), at 160–62. Although this Note adopts Keeton's typology, it does not follow his enumeration.

66. *See id.* § 3.10(c), at 160–61.

67. *See id.* § 3.10(c), at 162.

68. *Id.*

69. *Id.* § 3.10(c), at 161.

70. *See, e.g.,* Greenblatt, *supra* note 2, at 1343.

71. *See* Elaine M. Rinaldi, *Apportionment of Recovery Between Insured and Insurer in a Subrogation Case*, 29 TORT & INS. L.J. 803, 807 (1994).

72. *See* KEETON, *supra* note 52, § 3.10(c), at 161.

73. *See* Rinaldi, *supra* note 71, at 807.

74. *See* WINDT, *supra* note 15, § 10.06, at 533.

75. Rinaldi, *supra* note 71, at 807.

and the insured in proportion to the percentage of the original loss paid out by each.⁷⁶ This is the “pro rata” rule.⁷⁷

The first two possibilities are generally disregarded because of the potential for inequitable windfalls created for either the insurer or insured.⁷⁸ Similarly, the pro rata approach has not found widespread acceptance by courts⁷⁹ despite its Solomonic appeal.⁸⁰ Consequently, debate is largely between the relative merits of the make-whole and *pro tanto* approaches.

A majority of jurisdictions applies the make-whole rule,⁸¹ providing in some form that the insured must be made whole before the insurer can receive reimbursement.⁸² “This is true even if the insurer is liable for only a part of the loss and pays its entire obligation. An insurer cannot recoup any part of its loss while the insured is still less than whole.”⁸³ The primary justification for the rule is that tort recovery rarely compensates a victim for all of his or her injuries.⁸⁴ This correlates with subrogation’s purpose to prevent double recoveries⁸⁵ and justifies denying subrogation where the insured’s recovery is insufficient to compensate for all injuries suffered. Furthermore, the rule gives the insured the full value of his or her foresight in buying insurance from the party who agreed to bear the risk.⁸⁶

The make-whole rule has nevertheless been criticized on a number of grounds. First, the rule requires a procedurally burdensome determination of when the insured has been made whole.⁸⁷ Case-by-case adjudication of the issue after the underlying action has been resolved is thought to burden the courts and erode the total recovery available to either party.⁸⁸ Second, the rule is thought to result in higher insurance rates for everyone because

76. See KEETON, *supra* note 52, § 3.10(c), at 161.

77. See Ingram, *supra* note 2, at 108.

78. See Rinaldi, *supra* note 71, at 806. *But see generally* Baron, *supra* note 16, at 587–91 (arguing for the denial of subrogation, at least in the context of personal injury claims, because it only complicates litigation and “double recovery” is rarely possible).

79. See Rinaldi, *supra* note 71, at 806.

80. See Ingram, *supra* note 2, at 108. Pro rata apportionment may occur more often in practice, however. *See id.* at 117 (suggesting that such agreements may be common when the insured’s loss is small, and the insurer initiates and prosecutes the underlying cause against the third party).

81. See Rinaldi, *supra* note 71, at 807.

82. See WINDT, *supra* note 15, §10.06, at 533.

83. *Id.*

84. See Baron, *supra* note 16, at 588–89.

85. See *supra* note 23 and accompanying text.

86. See Baron, *supra* note 16, at 587.

87. See *id.* at 589.

88. See *id.* at 590.

insurers cannot use subrogation windfalls to lower their rates.⁸⁹ Many argue, however, that subrogation is a pure windfall for the insurer and has no influence on insurance rates.⁹⁰

Despite some drawbacks, the make-whole rule is still popular among commentators, chiefly because judgments and settlements rarely cover a claimant's entire loss for personal injuries.⁹¹ One reason for this is because the determination of exact loss in such cases is difficult, and thus pain and suffering is rarely fully recoverable.⁹² In addition, tort claimants in personal injury actions are often forced to compromise their claims in settlements because the tortfeasor has either limited or no assets or liability coverage.⁹³

California is in the minority of jurisdictions that has adopted the *pro tanto* rule of apportionment.⁹⁴ In *Shifrin v. McGurie & Hester Construction Co.*, the court interpreted the subrogation provision in a standard-form fire policy to convey to the insurer a *pro tanto* recovery right. The court, in reaching this decision, did not argue the relative merits of the rule, and relied solely on the terms of the contract.⁹⁵

Shifrin was subsequently relied on in *Travelers Indemnity Co. v. Ingebretsen*⁹⁶ to allow an insurer to receive first right to recovery from homeowners who had suffered losses due to earth shifts caused by county construction.⁹⁷ The *Ingebretsen* court said it relied on the rule in *Shifrin*, but seemed to add a policy restriction to the *pro tanto* rule when it said applying this rule was justifiable because the insurer had participated in the underlying action against the county.⁹⁸

By implication, *Ingebretsen* left open the possibility that the *pro tanto* rule might not apply to reimbursement liens that do not allow for the insurer to participate in an action against the third party.⁹⁹ This suggestion

89. See Greenblatt, *supra* note 2, at 1354–55. *Accord* Ingram, *supra* note 2, at 125.

90. See, e.g., Baron, *supra* note 16, at 582 (noting that an insurer's prospect of recovering a subrogation claim is too speculative to be included in setting premium rates).

91. See *id.* at 589; Fulks, *supra* note 2, at 127.

92. See Baron, *supra* note 16, at 589.

93. See *id.*

94. See Rinaldi, *supra* note 71, at 807.

95. See *Shifrin v. McGuire & Hester Constr. Co.*, 48 Cal. Rptr. 799, 802–03 (Ct. App. 1966). The policy provided: "This company may require from the insured an assignment of all right of recovery against any party for loss to the extent that payment therefore is made by this company." *Id.* at 802 (quotations omitted).

96. *Travelers Indem. Co. v. Ingebretson*, 113 Cal. Rptr. 679 (Ct. App. 1974).

97. See *id.* at 684–85.

98. See *id.* at 685, 685 n.7.

99. See *id.*

was seemingly followed in *Sapiano v. Williamsburg National Insurance Co.*,¹⁰⁰ where an insurer's policy that contained a vaguely worded "Transfer of Rights of Recovery Against Others to Us"¹⁰¹ clause was held subject to the make-whole rule.¹⁰² *Sapiano* distinguished the policy from *Ingebretsen* on two grounds. First, the insurer's right was not based on a reimbursement lien.¹⁰³ Second, the insurer had not participated in the underlying litigation.¹⁰⁴ Thus, the make-whole rule applies to insurance policies where subrogation provisions do not provide for liens and the insurer does not participate in litigating the third party claim.

4. California's Law of Subrogation

To review, California does not recognize the subrogation of personal injury claims.¹⁰⁵ Courts will, however, generally uphold subrogation terms as written in contracts. Insurance policy writers may therefore draft around this rule by requiring that policy holders must secure their rights against third party tortfeasors and by requiring that the insurer is entitled to reimbursement from any recovery.¹⁰⁶ Likewise, insurers may draft around the make-whole rule and provide for priority rights to recovery in the event that the insured's suit against the third party results in less than full recovery, so long as the insurer participates in the underlying litigation.¹⁰⁷

B. REIMBURSEMENT LIENS BY NONINSURERS.

The previous section reviewed the law of subrogation as it is applied in California. This section will introduce in fuller detail how this law has been applied (and sometimes ignored) by courts in the healthcare market.

1. Reimbursement Liens in MCO Contracts

Managed care, which originally occupied only a small niche within the overall healthcare market, has expanded to become a widespread alternative to the traditional fee-for-service system.¹⁰⁸ It is viewed as a

100. *Sapiano v. Williamsburg Nat'l Ins. Co.*, 33 Cal. Rptr. 2d 659 (Ct. App. 1994).

101. *See id.* at 660.

102. *See id.* at 662.

103. *See id.*

104. *See id.*

105. *See supra* text accompanying notes 44–51.

106. *See supra* text accompanying notes 54–61.

107. *See supra* text accompanying notes 95–104.

108. *See* GAIL B. AGRAWAL, *Managing the Managers: An Introduction to the Challenge of Overseeing Managed Care*, in *THE CHALLENGE OF REGULATING MANAGED CARE* 4–5 (John E. Billi & Gail B. Agrawal eds., 2001).

solution to the continuing problem of rising healthcare costs caused by the combination of expensive technological advances and a tort standard for malpractice that encourages doctors and hospitals to provide ever greater levels of care to avoid liability.¹⁰⁹ Managed care, with its focus on cost controls, has therefore been viewed as an appropriate market-based response to rising costs.¹¹⁰

That MCOs are not insurers and that coverage under managed care is not based on indemnity received judicial recognition in *California Physicians' Service v. Garrison*.¹¹¹ The court observed that the purpose of MCOs is to provide "services" not "indemnity"¹¹² and that this arrangement was part of a broader state policy to provide affordable healthcare.¹¹³

In recognition of the rising importance of MCOs, and the fact that they are not insurers, California's legislature passed the Knox-Keene Health Care Service Plan Act of 1975¹¹⁴ to regulate MCOs operating in the state. The Act regulates MCOs through the DMHC,¹¹⁵ which has jurisdiction over licensure, oversight, and enforcement.¹¹⁶

Although the law in these respects recognizes that MCOs are not insurers in the commonly understood sense, MCOs continue to operate like insurers in their attempts to subrogate their members' claims against third

109. See E. HAAVI MORREIM, HOLDING HEALTH CARE ACCOUNTABLE: LAW AND THE NEW MEDICAL MARKETPLACE 18 (2001). See also AGRAWAL, *supra* note 108, at 5.

In the traditional fee-for-service delivery system, physicians ordered, payers paid, and insured patients largely avoided the economic consequences of their health-care choices. The professional model for health-care delivery reigned, and physicians, not patients, made decisions about the services that would be provided and the quality of those services. These traits combined to cause unsustainable levels of health-care spending.

Id.

110. See AGRAWAL, *supra* note 108, at 5.

111. See *Cal. Physicians' Serv. v. Garrison*, 172 P.2d 4 (Cal. 1946).

112. *Id.* at 16. But see MORREIM, *supra* note 109, at 45 (arguing that regardless of whether MCOs provide services or indemnity they are, in effect, risk spreaders and hence perform an insurance function).

113. See *Garrison*, 172 P.2d at 6.

114. CAL. HEALTH & SAFETY CODE § 1340 (West 2003). Among other things, the 2000 amendments removed MCO regulation from the state's Department of Corporations by creating a DMHC. See *id.* § 1341.

115. The code says the following:

[The DMHC] has charge of the execution of the laws of this state relating to health care service plans and the health care service plan business including, but not limited to, those laws directing the department to ensure that health care service plans provide enrollees with access to quality health care services and protect and promote the interests of enrollees.

Id. § 1341(a).

116. See Franklin Tom, *Current Developments in Health Care Regulation Under the Knox-Keene Act*, 6 WHITTIER L. REV. 625, 625-26 (1984).

party tortfeasors.¹¹⁷ This practice was first challenged in California in *Block v. California Physicians' Service*.¹¹⁸ California Physicians' Service ("CPS") agreed to pay for Block's injuries caused by third parties, but only if he agreed to reimburse CPS from any recovery obtained from the third party.¹¹⁹ The agreement did not require Block to secure any rights against the third party and is therefore partly distinguishable from the facts of *Lee*.¹²⁰

Confronted with a reimbursement lien based on an MCO contract, the *Block* court first relied on *Garrison* to establish that the MCO was not an insurer and thus not bound by any law governing subrogation of insurers.¹²¹ Moreover, it relied on the public policy endorsement of MCOs as a cost reduction mechanism to justify its validation of the lien.¹²²

As to the lien, the court said it did not violate the rule in *Finston* against assignability¹²³ because under the contract, CPS could not compel Block to bring a cause of action against the third party.¹²⁴ In doing so, the court failed to notice a truth that CPS probably knew: any person injured by another is likely to bring suit against the tortfeasor regardless of any contract provision requiring them to do so, if only to recover damages not covered by the MCO.¹²⁵ Thus an MCO need not require its members to secure their rights in order to recover under a reimbursement lien because the members will undoubtedly do so by their volition to recover for lost wages, pain and suffering, and so forth. This result arguably is more duplicitous than the practice permitted in *Lee*,¹²⁶ insofar as an MCO may become subrogated to its members merely by taking advantage of the hardships that tort victims are likely to face.

Subsequently, the situation has been made even worse for MCO members by the court's ruling in *Samura v. Kaiser Foundation Health Plan, Inc.*¹²⁷ Here, the court allowed an MCO to explicitly draft around the

117. See, e.g., *supra* text accompanying notes 5–7.

118. See *Block v. Cal. Physicians' Serv.*, 53 Cal. Rptr. 51, 51 (Ct. App. 1966). See also *supra* text accompanying notes 3–7, which outlines the basic facts of *Block*.

119. *Block*, 53 Cal. Rptr. at 52.

120. See *supra* text accompanying note 56.

121. *Block*, 53 Cal. Rptr. at 52–53.

122. See *id.* at 55 ("By becoming a member of the plan under a Group Health Service agreement plaintiff has voluntarily associated himself with the public policy of this state.").

123. See *supra* text accompanying notes 44–49.

124. See *Block*, 53 Cal. Rptr. at 54.

125. Though it is not clear if Block sued for noneconomic damages, see *id.* at 52, this does not change the truth that most plaintiffs will claim such damages.

126. See *supra* text accompanying notes 54–58.

127. *Samura v. Kaiser Found. Health Plan, Inc.*, 22 Cal. Rptr. 2d 20 (Ct. App. 1993).

default make-whole rule. Like the contract in *Block*, Kaiser's contract with Samura only provided medical coverage for injuries caused by third parties on the condition that he agree to reimburse Kaiser from any recovery from the third party.¹²⁸ Moreover, the contract specifically provided that Kaiser was "entitled to the payment, reimbursement, and subrogation as provided . . . regardless of whether the total amount of the recovery of the Member . . . is less than the actual loss suffered by the Member."¹²⁹ Interpreting this provision, the court analogized the lien terms to subrogation¹³⁰ and relied on the *pro tanto* rule in *Ingebretsen*.¹³¹ *Samura* ignored the suggestion in *Ingebretsen*, however, that the insurer must participate in the underlying action to qualify for *pro tanto* recovery.¹³²

Even if *Samura* had more carefully noted *Ingebretsen's* reasoning, it is likely that it would have ignored it in preference for the principle of freedom of contract.¹³³ "[T]he parties may reasonably agree to give the payment of medical costs a higher priority than the recovery of non-economic damages for pain and suffering."¹³⁴ To its credit, the *Samura* court recognized that the freedom of contract was not without limits, and noted that if the *pro tanto* terms of a reimbursement lien were strictly applied when the MCO member failed to attain full recovery, it might be limited by the doctrine of unconscionability.¹³⁵ Nevertheless, the issue of unconscionability was not raised on appeal in *Samura*, and the facts of the given case did not support such a finding because of Kaiser's unstated policies.¹³⁶ In practice, Kaiser considered whether enforcement of its lien would prove to be a hardship on the member and expressed a willingness to negotiate a reduction of its lien based on the degree of potential hardship caused by a member's incomplete recovery.¹³⁷

Although the judicial treatment of third party reimbursement liens in the context of MCO contracts has been a winding road, some conclusions are possible. First, courts will honor the terms of MCO contracts as written,

128. *See id.* at 22.

129. *See id.* at 23.

130. *See id.* at 25.

131. *See id.*

132. *See id.* *See also supra* text accompanying notes 97–98.

133. "[T]he courts have upheld third party liability provisions according to their terms." *Samura*, 22 Cal. Rptr. 2d at 24.

134. *Id.* at 27.

135. *See id.* at 27–28.

136. *See id.* at 28.

137. *See id.* at 23–24. The plan thus took into consideration, for example, lost wages, lost earning capacity, and the likelihood of the necessity of future medical care; though it refused to negotiate a reduction when a member's recovery was treble the size of the lien. *See id.*

and thus liens on tort recoveries do not violate the rule against assignability because their terms do not allow the MCO to sue the third party directly. This ignores the realities of tort, however, wherein victims will likely seek recovery for injuries not covered by their MCO contract. Consequently, MCOs are still, in effect, subrogated to their members' recoveries. Second, the court will not rely on equitable principles to alter the contractual terms of a lien that provide for a *pro tanto* apportionment regardless of whether the member has been made whole. This is true even when this right should arguably be limited because they do not rely on the MCO's participation in the underlying litigation. Third, if there is any judicial limitation on MCO liens, it must come from principles of contractual interpretation.

2. The Hospital Lien Act

California's Hospital Lien Act ("HLA")¹³⁸ provides that hospitals may seek reimbursement for the reasonable value of services provided to patients injured by the tortious acts of a third party.¹³⁹ Its original purpose was to assure a source of payment for hospitals that treated indigent accident victims.¹⁴⁰ As such, the HLA is part of a legislative movement that began during the 1930s, whereby states sought to ease the losses hospitals suffered by treating poor patients.¹⁴¹ It should be obvious at this point that the underlying principle of the HLA is subrogation. Under the act, a hospital that has paid for an injury to a patient that was caused by a third party is entitled to seek reimbursement from the third party.

The HLA has become increasingly relied on by hospitals with the rise of MCOs. One of the major ways that MCOs control costs is by leveraging their market power to negotiate health service rates that are below normal market rates. Thus, in some circumstances where a hospital treats a tort victim that belongs to an MCO, it is paid at the below-market rate and at an

138. CAL. CIV. CODE § 3045.1–.6 (West 1993).

139. *See id.*

Every . . . hospital . . . which furnishes emergency and ongoing medical 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 on the damages recovered . . . to the extent of the amount of the reasonable and necessary charges of the hospital . . . in which services are provided for the treatment, care, and maintenance of the person . . . resulting from that accident or negligent or other wrongful act.

Id. § 3045.1.

140. *See* *Mercy Hosp. & Med. Ctr. v. Farmers Ins. Group of Cos.*, 932 P.2d 210, 212 (Cal. 1997).

141. *See* *Parnell v. Adventist Health Sys./West*, 131 Cal. Rptr. 2d 148, 151 (Ct. App.), *depublished by grant of review*, 69 P.3d 978 (Cal. 2003).

expense to its profit margin.¹⁴² Hospitals have thus increasingly relied on the assertion of liens under the HLA to recover the difference.¹⁴³ The question presented is whether the HLA, which was written before MCOs became such a dominant market presence, should permit hospitals to assert liens when they have been paid some but not all of their normal fees.

The HLA was not, however, first interpreted in the context of the present question. In *Mercy Hospital v. Farmers Insurance*,¹⁴⁴ the court decided whether a tortfeasor's insurer breached its duty to pay to a hospital the amount owed to it under the HLA for its treatment of the tort victim.¹⁴⁵ The victim in the underlying case was apparently uninsured,¹⁴⁶ and the lien was the only means by which the hospital could seek reimbursement.¹⁴⁷ In interpreting the HLA, the court held that the basis of the lien is the combination of the hospital's performance of service¹⁴⁸ and the patient's right to recovery from a third party.¹⁴⁹ Thus, the court correctly recognized that the HLA, as applied to uninsured patients, is essentially about subrogation, and noted, consistent with this, that the HLA was to ensure "the patient retained sufficient funds to address other losses" stemming from the injury.¹⁵⁰ Though the principles of the HLA might have been settled, the complication of MCO involvement was not addressed in *Mercy Hospital*.

The issue of hospitals using the HLA to balance bill their MCO patients arose at first only tangentially in *Nishihama v. City and County of San Francisco*¹⁵¹ when the city disputed the amount of damages awarded the plaintiff.¹⁵² The city contended that the trial court had incorrectly allowed the plaintiff to recover for the full market rate of her medical expenses, even though her treatment had been covered by her MCO at reduced rates.¹⁵³ In response, the plaintiff asserted that the damage award was appropriate because the hospital that treated her had filed a lien under

142. See Laurence Darmiento, *Use of Liens by Hospitals Challenged: California's Hospital Industry Welcomes Ruling on Patient Payments*, L.A. BUS. J., Mar. 25, 2002, at 1, available at 2002 WL 100779656.

143. See *id.*

144. See *Mercy Hosp.*, 932 P.2d at 210.

145. See *id.* at 210.

146. See *id.* at 216. *Accord Parnell*, 131 Cal. Rptr. 2d at 154.

147. See *Parnell*, 131 Cal Rptr. 2d at 154.

148. See *Mercy Hosp.*, 932 P.2d at 211.

149. See *id.*

150. See *id.* at 212.

151. See *Nishihama v. City and County of S.F.*, 112 Cal. Rptr. 2d 861 (Ct. App. 2001).

152. See *id.* at 866.

153. See *id.*

the HLA against her recovery in an amount equal to the market rate of its services. Therefore, limiting her damages to the MCO rates would leave her less than whole.¹⁵⁴

Rejecting this argument, the court relied on an earlier ruling that set the limit of tort recovery for medical payments to the amount actually paid.¹⁵⁵ Thus, the plaintiff's damage award was set at the MCO rate.¹⁵⁶ The court justified this decision in connection to *Mercy Hospital's* ruling that the HLA lien was derivative of the patient's right. Unfortunately, the hospital that treated the patient in *Nishihama* was not a party to the action, and the court was compelled to recognize that its decision with respect to the HLA was not binding.¹⁵⁷ Thus, when the issue of hospital use of the HLA to balance bill patients arose again in *Swanson v. St. John's Regional Medical Center*,¹⁵⁸ the court of appeals felt free to ignore this holding as dictum.¹⁵⁹

The *Swanson* court took a diametrically opposite position to *Nishihama*, holding that the HLA "is a statutory lien and does not require that the patient owe the hospital a debt."¹⁶⁰ Moreover, the court said that the act did not on its face differentiate between insured and uninsured persons,¹⁶¹ and thus using it to balance bill patients was not inappropriate.¹⁶² The court reasoned that hospitals had not been banned from the practice under the legislature's move to ban balance billing by MCOs, and, thus, hospitals were implicitly allowed to do it.¹⁶³ The decision in *Swanson* is difficult to reconcile with the Supreme Court's ruling in *Mercy Hospital*,¹⁶⁴ however, and it is surprising that the court refused a petition for rehearing on *Swanson*.¹⁶⁵

154. *See id.* at 866–67.

155. *See id.* at 866 (citing *Hanif v. Hous. Auth. of Yolo County*, 246 Cal. Rptr. 192, 195 (Ct. App. 1988)).

156. *See id.* at 867.

157. *See id.* at 868.

158. *Swanson v. St. John's Reg'l Med. Ctr.*, 118 Cal. Rptr. 2d 325 (Ct. App. 2002), *review denied*, 2002 Cal. LEXIS 4370 (June 26, 2002).

159. *See Swanson*, 118 Cal. Rptr. 2d at 327 n.2.

160. *Id.* at 328.

161. *See id.* at 327.

162. *See id.* at 328.

163. *See id.* at 329 (discussing section 3040 of the California Civil Code).

164. *See supra* text accompanying notes 144–50.

165. *See Swanson v. St. John's Med. Ctr.*, 2002 Cal. LEXIS 4370 (June 26, 2002).

Swanson has not gone unchallenged by other courts, however. In *McMeans v. Scripps Health, Inc.*,¹⁶⁶ the court of appeals expressly relied on the dicta in *Nishihama* to rule that a hospital was barred from asserting a lien under the HLA where it had already recovered its contracted rate from an insurer.¹⁶⁷ This ruling does not necessarily ensure a fair result for all patients, however, because it made the terms of MCO contracts determinative of the application of the HLA. Relying on the terms of MCO contracts with Scripps, the *McMeans* court found that the HLA could be used in some situations, but not others.

McMeans involved three classes of plaintiffs, each of which had suffered injuries due to a third party tortfeasor and was treated for those injuries at a hospital operated by Scripps, and against whom Scripps had asserted a lien under the HLA.¹⁶⁸ The first class, represented by McMeans, consisted of individuals who belonged to MCOs whose contracts with Scripps forbade the latter from holding any of its members liable for the costs of covered services, including injuries caused by third parties.¹⁶⁹ The second class, represented by Mary Ann Shaul, included individuals who belonged to MCOs that had no contract with Scripps.¹⁷⁰ Upon treatment, each class member's MCO paid Scripps for services rendered.¹⁷¹ The third class, represented by Joseph P. Denny, included people who belonged to MCOs that covered injuries caused by third parties on the condition that it be entitled to a reimbursement lien.¹⁷² There was thus no provision in the MCOs contract with Scripps governing the amount Scripps could charge under this circumstance.¹⁷³ Upon treatment, class member's MCOs paid Scripps for services rendered, presumably at market rates.¹⁷⁴

As to the class represented by McMeans, the court held that Scripps was not entitled to an HLA lien because its contract with the MCOs forbade it from seeking payment from the MCO's members.¹⁷⁵ As to the Shaul and Denny classes, however, the court held that Scripps was within its right to assert the lien. In the case of the Shaul class, Scripps had no

166. *McMeans v. Scripps Health, Inc.*, 123 Cal. Rptr. 2d 143 (Ct. App.), *depublished by grant of review*, 58 P.3d 928 (Cal. 2002).

167. *See id.* at 150–52.

168. *See id.* at 148–49.

169. *See id.* at 152.

170. *See id.* at 153.

171. *See id.* at 148–49.

172. *See id.* at 153–54.

173. *See id.* at 154.

174. *See id.*

175. *See id.* at 153–55.

contract with the MCO. With respect to the Denny Class, Scripps' contracts with the MCOs did not limit the amount it could charge for services under the circumstances.¹⁷⁶

With regard to the principles of subrogation, the result reached in *McMeans* is arguably even less satisfying than the one reached in *Swanson*. At least the latter decision can be said to be completely wrong, because it denies that the HLA should be connected in anyway to an underlying obligation. *McMeans* clearly realized that there was some obligation underlying the HLA, but sought the terms of the obligation in MCO contracts. This clearly misses the mark. The obligation owed the hospital in these cases is for payment for services rendered. Scripps received payment from some source—whether at a preset contract price or at market rates—for each patient class in *McMeans*. When the hospital has been paid, whatever the source of payment, any obligation it is owed disappears. While *Swanson* clearly misses this point, *McMeans* implicitly views the obligation extinguished only when the MCO-hospital contract says it is. There is no other explanation why *McMeans* was able to escape the HLA, while *Shaul* and *Denny* could not.

Another court of appeals has weighed in on this issue, the court in *Parnell v. Adventist Health*, which ruled on facts similar to those in *Swanson*.¹⁷⁷ The *Parnell* court reviewed the history and legislative purposes of the HLA,¹⁷⁸ first noting that there is nothing to indicate that the legislature considered the implications of balance billing in the context of managed healthcare.¹⁷⁹ Moreover, looking at the plain language of the statute, it concluded that balance billing did not qualify as “necessary” because it is not needed to secure treatment for an MCO member. Most importantly, the court recognized that the source of the lien is the underlying obligation that the hospital is owed and a hospital may not use the HLA where it has already been paid to treat a patient.

Whether it makes the choice at the time of entering into a provider contract with a medical insurer or in negotiations with the patient after services have been provided to a particular patient, it is the hospital's choice to accept or refuse the level of payment offered by the payor.¹⁸⁰

176. *See id.*

177. *See Parnell v. Adventist Health Sys./West*, 131 Cal. Rptr. 2d 148, 150 n.2 (Ct. App.), *depublished by grant of review*, 69 P.3d 978 (Cal. 2003).

178. *See id.* at 151–52. *See also supra* text accompanying notes 141–42.

179. *See id.* at 157.

180. *Id.* at 158.

The result is parallel to the result reached for the McMeans class in *McMeans*. Because the hospital in each case agreed to accept a reduced level of payment from a patient's MCO, it was barred from resorting to the HLA. The holding in *Parnell* also offers the other classes in *McMeans* the same result. Because the underlying obligation to pay for medical services was extinguished for Shaul and Denny's classes by their MCOs (though at noncontract rates), Scripps should not have been allowed to assert liens seeking further payment.

The courts of appeal have thus offered three differing interpretation of the nature of the HLA. First, *Swanson* asserts that a hospital's lien rights are independent of any underlying obligation.¹⁸¹ Second, *McMeans* argues that a hospital's lien rights, when MCOs and insurers are involved, is determined by the terms of any contract between these parties and the hospital.¹⁸² Third, *Parnell* reasons that regardless of whether insurers and MCOs are involved, the hospital's right under the HLA are dependent on whether it has been already reimbursed for its treatment of the patient.¹⁸³

To resolve this three-way split among the courts of appeal, the California Supreme Court decided to hear an appeal of *Parnell*.¹⁸⁴ It is interesting to note that in doing so the Court delayed its hearing of an appeal of *McMeans*.¹⁸⁵ What this change in course might signal is unclear.

III. TOWARD CORRECTING THE PROBLEM

Clearly, the subrogation problems created by MCO contractual liens and the HLA stem from the court's misapplication of subrogation principles in a complex healthcare market. Unfortunately, there is no one easy solution to these problems. This section of the Note outlines a variety of approaches available to California's healthcare consumers when confronted with MCO contractual liens and liens brought under the HLA. The goal of these approaches is not to eliminate subrogation, but to limit it in order to protect consumers. Thus in the context of MCO contractual liens, the approaches are targeted at applying the make-whole rule where

181. See *Swanson v. St. John's Reg'l Med. Ctr.*, 118 Cal. Rptr. 2d 325, 327 (Ct. App. 2002).

182. See *McMeans v. Scripps Health, Inc.*, 123 Cal. Rptr. 2d 142, 152-55 (Ct. App.), *depublished by grant of review*, 58 P.3d 928 (Cal. 2002).

183. See *Parnell*, 131 Cal. Rptr. 2d at 160.

184. *Parnell v. Adventist Health Sys./West*, 69 P.3d 978 (Cal. 2003) (Extension of time granted to May 18, 2004 for respondents to file the consolidated answer to amicus curiae briefs. No further extensions of time will be granted.).

185. *McMeans v. Scripps Health, Inc.*, 58 P.3d 928 (2002), *reserved by McMeans v. Health*, 2003 Cal. LEXIS 6205, 2003 D.A.R. 9465 (Cal. Aug. 20, 2003).

possible so that tort victims who inevitably fail to obtain full recovery will not be twice victimized. Likewise, this Note is not suggesting that the HLA be repealed, only that it be interpreted and applied in such a way that consumers do not become victims of hospitals seeking to increase their profit margins.

A. MCO CONTRACTUAL LIENS

Because the California courts seem determined to allow MCOs to contractually subrogate the tort claims of its members,¹⁸⁶ the solutions offered here are based on the interpretation and regulation of those provisions. Uniting them requires an understanding of the disparate bargaining power of consumers and providers that justifies judicial or regulatory actions to limit the application of contractual terms that go against the interests of consumers.

Bargaining power is the ability of a given party to a contract to intelligently choose the consequences of the contract.¹⁸⁷ In modern society, the bargaining power of consumers is weak due to their necessary dependence on products and services provided by others with greater knowledge of those products and services.¹⁸⁸ This is most clearly manifested by the use of adhesion contracts with terms prepared by the producer that are not negotiable.¹⁸⁹ Such contracts embody the divorce between dependence and bargaining power that justifies intervention in the name of public policy.¹⁹⁰ Thus, the law is justified in intervening in private arrangements to protect consumers in the public interests to prevent “oppression and overreaching” by the stronger party.¹⁹¹

MCO contracts easily qualify as contracts of adhesion. Over 23 million Californians rely on such contracts to secure health services.¹⁹² In doing so they rely on contractual terms they cannot be expected to understand to provide medical services they also cannot be expected to go

186. See *supra* Part II.A.2–4.

187. See W. DAVID SLAWSON, *BINDING PROMISES: THE LATE 20TH-CENTURY REFORMATION OF CONTRACT LAW* 23 (1996).

188. See *id.* at 22–23.

189. See *id.* at 56–57. See also *Graham v. Scissor-Tail, Inc.*, 623 P.2d 165, 171 (Cal. 1981). “The terms signify a standardized contract, which, imposed and drafted by the party of superior bargaining strength, relegates to the subscribing party only the opportunity to adhere to the contract or reject it.” *Id.* (quoting *Neal v. State Farm Ins. Cos.*, 10 Cal. Rptr. 781, 783 (Ct. App. 1961)).

190. See SLAWSON, *supra* note 187, at 23.

191. See *Graham*, 623 P.2d at 171.

192. See *Carey*, *supra* note 4 (describing how California has the country’s largest HMO market with 23 million members).

without. There is obviously ample justification for scrutinizing and regulating MCO contracts in the name of public policy.

1. Reasonable Expectations

The reasonable expectations doctrine provides that a contract should be interpreted to give meaning to the reasonable expectations of the parties.¹⁹³ Thus, “a ‘contract or provision which does not fall within the reasonable expectations of [the] weaker or ‘adhering’ party’ will not be enforced against him.”¹⁹⁴ California’s application of reasonable expectations first manifested itself in the realm of insurance law, under the guise of *contra proferentem*, whereby any ambiguous provisions of an insurance policy was to be construed against the insurer.¹⁹⁵ It has since expanded beyond insurance law and is accepted as a judicially imposed limitation on the freedom of contract in the context of standard forms.¹⁹⁶ Application of the doctrine of reasonable expectations is very fact-specific, however, and it is hard to do more than speculate in this Note as to how the issue might arise.

What then, might be the possible reasonable expectations of MCO members as to their rights to treatment and reimbursement for injuries caused by third parties? A reasonable member might at first not expect that their contract would deny them coverage for medically necessary care solely because of the nature of the precipitating event. Even though some MCOs make it their practice to alert members claiming need for care because of third party acts of their reimbursement rights, they do so well after the member has agreed to the contract terms.¹⁹⁷ It should be the expectations of the member at the time the contract is made that govern, however, and actions of the MCO after that point should not be allowed to alter the reasonable expectations of the consumer. Moreover, even if a member was aware of the limitation on coverage created by reimbursement provisions, they may not reasonably understand the implications of the terms. The nature and implications of subrogation are foreign to most lay people. Thus, it is reasonable that an MCO member would not anticipate incomplete recovery from a third party, or that their assent to a *pro tanto*

193. See SLAWSON, *supra* note 187, at 44–45.

194. See *Graham*, 623 P.2d at 172.

195. See SLAWSON, *supra* note 187, at 44–45 (discussing the relationship between *contra proferentem* and reasonable expectations). See, e.g., *Gray v. Zurich Ins. Co.*, 419 P.2d 168, 171 (Cal. 1966).

196. See, e.g., *Graham*, 623 P.2d at 172.

197. See, e.g., *Samura v. Kaiser Found. Health Plan, Inc.*, 22 Cal. Rptr. 20, 23 (Ct. App. 1993).

provision would defeat their right to recovery for noneconomic damages. To the extent that an MCO contract offers coverage only on the condition that it be subrogated to any underlying tort claim, the contract might be said to defeat the reasonable expectation of the MCO member.

There are, nevertheless, two general drawbacks to the reasonable expectations doctrine that make its use in the current situation less than satisfying. First, decisions under the rule are very fact-specific and therefore have poor precedential value for future cases. What is reasonable in one case may not be reasonable in another. Second, reasonable expectations are a defense to the formations of a contract and are unlikely to have any deterrent effect. Thus, MCOs might reasonably judge that the few cases preventing them from subrogating are outweighed by the vast number of cases that go unchallenged.

2. Unconscionability

A court may declare void the terms of a contract that it determines to be unconscionable.¹⁹⁸ To do so, the court must find that the terms are both procedurally and substantively unfair.¹⁹⁹ A contract is procedurally unfair when a party to it lacked meaningful choice when he or she agreed to its terms.²⁰⁰ Thus, where a party lacks notice of the terms or to any alternative, or is unable to understand the terms, he or she has not reasonably assented to them.²⁰¹ A contract is substantively unfair if its terms are one-sided or unfair.²⁰²

That the rule of unconscionability should be applied to MCO contractual liens was suggested by the *Samura* court, which appeared ready to void a *pro tanto* lien provision if the MCO tried to enforce it on a member who had not been made whole.²⁰³

That *pro tanto* recovery is substantively unfair should seem obvious. By its terms, *pro tanto* recovery prefers the MCO who receives a greater likelihood of reimbursement at the expense of the member who thereby bears the ultimate risk of incomplete recovery. This result is all the more unfair when one recognizes that the MCO is the better loss spreader.

198. See CAL. CIVIL CODE § 1670.5 (West 1985).

199. See *Samura*, 22 Cal. Rptr. at 27.

200. See *id.*

201. See SLAWSON, *supra* note 187, at 57. In this respect, unconscionability is very closely linked to reasonable expectations. In both cases, the contract cannot be given a meaning to which a party could not have reasonably manifested his or her mutual assent. See *id.*

202. See *Samura*, 22 Cal. Rptr. at 27.

203. See *id.*

Pro tanto provisions are also procedurally unconscionable for a number of reasons. First, MCO members have little bargaining power with their MCOs. Many belong to group contracts whose terms were negotiated by their employers. Second, where alternative contract plans are presented, the only variables presented or considered refer to the size of co-payments or flexibility of provider choice, or both. There is no evidence that members can choose from plans that do or do not apply a rule of *pro tanto*. Third, even if consumers were aware of alternatives, they may not reasonably understand the implications of the difference between a *pro tanto* and a make-whole provision.

Courts should therefore employ the rule of unconscionability to limit the *pro tanto* application of reimbursement liens in MCO contracts when it matters most—that is, when the member has not obtained a complete recovery for all of his or her injuries.

Unconscionability shares the same drawbacks as reasonable expectations. Decisions based on the rule are very fact-specific, lack precedential value,²⁰⁴ and as a remedy in contract have no deterrent effect.

3. State Regulation

The poor deterrent and precedential values of reasonable expectations and unconscionability suggest that a better approach to subrogation provisions in MCO contracts would be an *ex ante* regulatory approach. The fact that these contracts are arguably items of commerce that consumers purchase justifies regulation to protect the public.²⁰⁵

In fact, California already singles out MCO contracts for regulation as part of its licensure program administered by the DMHC under the Knox–Keene Act.²⁰⁶ The DMHC is charged with “the execution of the laws of this state relating to health care service plans” and is to “ensure that health care service plans provide enrollees with access to quality health care services and protect and promote the interests of enrollees.”²⁰⁷ It does this in part by reviewing all MCO contracts with members and providers to make sure they are fair and reasonable.²⁰⁸

204. See SLAWSON, *supra* note 187, at 57.

205. See generally Arthur Allen Leff, *Contract as Thing*, 19 AM. U. L. REV. 131 (1970).

206. See CAL. HEALTH & SAFETY CODE §§ 1340–41 (West 2000).

207. *Id.* § 1341(a).

208. See *id.* § 1367(h)(1). DMHC intervention is even more justified when we consider a number of other requirements for MCO contracts already in place. First, all MCO contracts with members must provide coverage for basic healthcare services, which includes emergency services. See *id.* § 1345(b)(6). Second, no services covered by these contracts can be rendered illusory by a reduction or

Therefore, it should be appropriate for the DMHC to find that *pro tanto* reimbursement liens are not fair and reasonable when asserted against a member who has not been made whole because it is not fair that an MCO should receive a windfall while the member goes undercompensated. Moreover, it is not reasonable for MCOs to use *pro tanto* provisions when members have no available alternative.

The following language is therefore proposed for a regulation to be adopted by the DMHC:

§ 1300.67.X.

(a) Subscriber and group contracts may limit coverage of basic health services required by a third party's wrongful or negligent injury of a subscriber or enrollee if the contract offers to pay for such treatment on the condition that the subscriber or enrollee reimburse the plan from any judgment or settlement recovered from the third party on account of such injuries.

(b) Any subscriber or enrollee contract that adopts the limitation of coverage of basic health services available under Section 1300.67.X(a) is subject to the following conditions:

(1) The lien must give priority of reimbursement to the subscriber or enrollee, such that the plan is not entitled to reimbursement until the subscriber or enrollee has recovered for all injuries, economic and otherwise, caused by the third party.

(2) Plan must make available, and make reasonable efforts to alert subscribers and enrollees to, alternative contracts that do not adopt the limitation of coverage of basic health services available under Section 1300.67.X(a). Nothing in this Section shall restrict a plan from requiring greater co-payments from a subscriber or enrollee who chooses such an alternative contract.

The proposed language is consistent with both the objectives of the DMHC and the principles of subrogation. Section (a) explicitly allows

limitation of coverage. See CAL. CODE REGS. tit. 28 § 1300.67.4(a)(3)(A) (2003). Consider then an MCO contract that promises to cover emergency services but expressly denies coverage for injuries caused by third parties, and offers to pay for treatment only if a reimbursement lien is in place. See, e.g., *McMeans v. Scripps Health, Inc.*, 123 Cal. Rptr. 2d 143, 153–54 (Ct. App.), *depublished by grant of review*, 58 P.3d 928 (Cal. 2002). Next imagine a member of that MCO that is injured in a car accident and is taken via ambulance to a hospital's emergency room. Arguably, in this case, the reimbursement provision denies ordinary coverage for emergency treatment because it was needed as a result of third party acts. This would render the required promise of emergency services illusory. The DMHC would thus be within its mandate to declare the reimbursement lien invalid as neither fair nor reasonable. This hypothetical is slightly beyond the scope of this Note, however, and is raised only to add general support to the proposition that DMHC regulation in the area of MCO subrogation is appropriate.

MCOs to create conventional subrogation rights via a lien on member recovery. This is consistent with the goal of preventing a double recovery windfall for the member and ensuring that the MCO who bore the loss is compensated.²⁰⁹ Section (b)(1) prohibits *pro tanto* terms for MCO reimbursement liens such that MCOs are prevented from seeking reimbursement from a member's noneconomic damages. Simultaneously, Section (b)(2) ensures that MCO members have a real choice of plans, while allowing MCOs to charge more for terms that do not allow for subrogation by the MCO.

B. THE HOSPITAL LIEN ACT

The California Supreme Court will soon hear arguments on *Parnell*,²¹⁰ and should use the opportunity to square interpretation of the HLA with the principles of subrogation. Subrogation is based on the existence of an underlying obligation that is owed to the subrogor because its performance of an act that should have been satisfied by a third party. In the context of the HLA, the underlying obligation owed to hospitals is reimbursement for services rendered.

On review of *Parnell*, the court should therefore reject the *Swanson* court's reasoning that the lien granted to hospitals under the HLA is independent of any obligation the patient owes the hospital.²¹¹ The court should likewise reject the suggestion of the *McMeans* decision that the underlying debt owed to hospitals is extinguished only when a hospital's contract with an MCO or insurer says it is.²¹² Instead, the court should affirm the court of appeals in *Parnell* and adopt its reasoning. *Parnell* did not recognize that the HLA was analogous to subrogation, but it nonetheless correctly reasoned that liens against recoveries from third parties are grounded in a hospital's right to be reimbursed for its acts that should have been covered by the third party.²¹³ Thus, use of the HLA by a hospital to balance bill its patients is unjustified where it has already agreed to accept payment in some lesser form.²¹⁴ This reasoning is consistent with both the purposes of the act and principles of equity.

209. *Cf. supra* notes 22–29 and accompanying text.

210. *Parnell v. Adventist Health Sys./West*, 69 P.3d 978 (Cal. 2003) (Extension of time granted to May 18, 2004 for respondents to file the consolidated answer to amicus curiae briefs. No further extensions of time will be granted.).

211. *See supra* text accompanying notes 160–65.

212. *See supra* text accompanying notes 167–76.

213. *See supra* text accompanying note 180.

214. *See supra* text accompanying note 182.

IV. CONCLUSION

Subrogation can sometimes be confusing, so it is not surprising that courts have, at times, had trouble applying it in the increasingly complex setting of California's healthcare market. As this Note has shown, however, this confusion is not just a product of the doctrine itself, but is also a product of the overlapping statutory, contractual, and common law principles at play. The use of contractual provisions by MCOs to subrogate themselves to the third party claims of their members has gone essentially unchallenged by the California courts, which have failed to recognize that reimbursement liens create a de facto subrogation right due to their reticence to restrict the contracting freedom of MCOs. The use of the HLA by hospitals to balance bill their insured and MCO patients has likewise been problematic for the courts due to the confusion over what obligation, if any, formed the basis for the lien.

It is therefore time for California to come to grips with the complexity of subrogation in its healthcare market and this Note has outlined a series of measures that should both protect consumers and lead to a more principled application of subrogation.

First, the disparate levels of bargaining power between MCOs and their members justify judicial intervention in the name of public policy. Thus, courts should entertain defenses to reimbursement liens based on unconscionability and reasonable expectations. At the same time, the DMHC—the state's MCO regulatory agency—should carefully scrutinize MCO contractual liens ex ante, and consider adopting regulations limiting their use.

Second, the California Supreme Court should recognize the soundness of the Court of Appeal's interpretation of the HLA in *Parnell*, and find that hospitals may only use the HLA when they have not already accepted payment for treating patients injured by third parties.

The remedial measures outlined in this Note unfortunately do not easily coalesce into a single principle to guide the courts when confronting subrogation. Each is targeted to a specific manifestation of the misapplication of the doctrine and, as such, is only a step toward a more consistent use of subrogation in the healthcare market. If courts need a single principle, they would perhaps be better served by looking to the concept of equity from which subrogation originally arose, instead of always relying on prior cases.

