Kaiser Health Plans

Is Plaintiff's Real Measure of Recovery Zero Dollars?

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When a plaintiff is a Kaiser Health Plan member and is treated by a Permanente Medical Group, plaintiff may not be able to establish any damages. Because plaintiff may recover "damages for past medical expenses [that] *are limited to the lesser* of (1) the amount paid or incurred for past medical expenses and (2) the reasonable value of the services," (*Corenbaum v. Lampkin* (2013) 215 Cal. App. 4th 1308, 1325-1326), and because Kaiser traditionally does not pay its physicians on a fee-for-service basis, plaintiff may only be able to establish that she incurred either zero dollars or a small co-pay. Kaiser Health Plan witnesses may establish that the amount the Plan incurred was payment of a capitated amount to the doctors. This capitated rate should be less than the amounts presented in the consolidated statements or courtesy bills. Many defendants are submitting Motions in Limine to Preclude the Introduction of Kaiser statements at trial and to limit the jury to hearing the true incurred amount.

Personal injury plaintiffs who are Kaiser members usually present two types of documents as evidence of the amounts incurred for medical treatment: a "Consolidated Statement of Charges" and a "Courtesy Billing for Hospital Services." Each purports to reflect the amount charged for the use of the facility and the medical services. The Courtesy Billing usually contains some language to the effect of "this is not a bill." Plaintiff will claim that all figures are the amounts "incurred for medical expenses" and that these documents are the proof.

Some background about Kaiser is necessary. Kaiser health care is different from the traditional health insurance system. Wikipedia describes Kaiser Permanente's structure as "an integrated managed care consortium. Kaiser Permanente is made up of three distinct groups of entities: the Kaiser Foundation Health Plan and its regional operating subsidiaries; Kaiser Foundation Hospitals; and the autonomous regional Permanente Medical Groups.[1] According to one Kaiser HMO Plan Summary, "Kaiser Permanente provides Services directly to our Members through an integrated medical care program. Health Plan, Plan Hospitals, and the Medical Group work together to provide our Members with quality care."[2] The plan documents indicate that Health Plan providers are paid in a variety of ways "such as salary, capitation,[3] per diem rates, case rates, fee for service, and incentive payments." Members "are not liable for any amounts we owe. However, you may have to pay the full price of non-covered services you obtain from Plan Providers or Non-Plan Providers." Courts have recognized that Kaiser is not a traditional system, "it is well known that Kaiser is an HMO providing medical services to its members rather than a medical service provider with a conventional creditor-debtor relationship to its patients." (*In re Eric S.* (2010) 183 Cal. App. 4th 1560, 1565.)

The question in personal injury cases is whether the purported billing reflects the value of the medical services. Preliminarily, the answer should be "no:" "[t]he full amount billed by medical providers is not an accurate measure of the value of medical services" because "many patients ... pay discounted rates," and standard rates "for a given service can vary tremendously, sometimes by a factor of five or more, from hospital to hospital in California." (*State Farm Mutual Automobile Ins. Co. v. Huff* (2013) 216 Cal. App. 4th 1463, 1471, citing *Corenbaum v. Lampkin* (2013) 215 Cal.App.4th 1308 and *Howell v. Hamilton Meats & Provisions* (2011) 52 Cal. 4th 541.)

Next, can these documents be admitted at trial and are they evidence of the amount incurred?

At trial, it is plaintiff's burden of proof to establish past medical expenses. A party has the burden of proof as to the existence or nonexistence of each fact which is essential to the claim for relief or defense that he or she is asserting. (Evid. Code § 500.) *Corenbaum*, as indicated, limits plaintiff to the lesser of the amount incurred, or the reasonable value. So, for instance, if the logic of the argument is to be followed, if plaintiff cannot demonstrate that she (or her Health Plan) incurred anything (i.e. $0), then that would be the lesser of the two items. With this in mind, our expectation is that plaintiff will offer the Consolidated Statement of Benefits and the Courtesy Statement as evidence of the "amount incurred."

Initially, these documents alone, even if they are really bills, are not admissible as evidence of the incurred amount. Where invoices or accountings received from third parties are offered into evidence

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as proof of the transactions described, hearsay issues arise which may be resolved only by the testimony of a qualified witness. (*Jazayeri v. Mao* (2009) 174 Cal. App. 4th 301, 325.) Since invoices, bills, and receipts are hearsay, they are inadmissible independently to prove that liability for the medical services was incurred, that payment was made, or that the charges were reasonable. If, however, a party testifies that he or she incurred or discharged a liability for repairs, any of these documents *may be admitted for the limited purpose of corroborating* his or her testimony and if the charges were paid, the testimony and documents are evidence that the charges were reasonable. [Emphasis added.] (*Pacific Gas & E. Co. v. G. W. Thomas Drayage etc. Co.* (1968) 69 Cal. 2d 33, 42-43.) Such a rule may be supported by the observation that a party who receives a bill or invoice normally has every interest to dispute its accuracy or reasonableness if there is reason to do so. (*Imperial Cattle Co. v. Imperial Irrigation Dist.* (1985) 167 Cal. App. 3d 263, 272.)

Kaiser's documents are unique because of Kaiser's non-conventional provision of services, which is not based upon creditor-debtor relationship. To address whether the two documents from Kaiser can be used to corroborate the amount incurred, one looks to the restitution case of *In re K.F.* (2009) 173 Cal. App. 4th 655. This case involves a criminal defendant who was ordered to pay restitution. The victim was treated at Kaiser, and the prosecutor offered two Kaiser based documents as evidence of the loss incurred by the victim.

The court recited the first document as:

> [A] letter from Healthcare Recoveries in Louisville, Kentucky, stating, "KAISER CALIFORNIA NORTH is using the services of Healthcare Recoveries to obtain reimbursement of the medical benefits it has provided on your behalf relating to your 5/12/2007 accident. [¶] The purpose of this letter is to serve as the Health Plan's formal notice to you that in the event you receive settlement from an insurance carrier or other party, the plan may have a right of reimbursement for medical benefits provided. [¶] For your convenience, we have enclosed a Consolidated Statement of Benefits with the total provided benefits to date." The enclosed statement consisted largely of a table listing medical services and materials furnished to Mr. Rangel, with columns labeled "Billed Amt." and "Provided Benefits." The two columns contained identical numbers for each service provided. Above the table was the text, "Instructions: If remitting payment, make checks payable to: Healthcare Recoveries. [¶] Write the patient's name, GREGORY J. RANGEL, and event number [specified], on the check." At the end of the statement appeared the following sums: "Total Billed Charges $17,261.53;" "Total Benefits Provided $17,261.53;" "Amount Received $0.00;" and "Balance Due $17,261.53." (*In re K.F.* at 663.)

The second document was referred to as:

> ... "Explanation of Benefits" from Kaiser, apparently reflecting the value of ambulance service provided. It lists $ 582.32 in "Ambulance Charges." It also describes this sum as the "amount charged." **But it bears the prominent legend, "This is not a bill;"** it shows zeros in the column marked "Coinsurance/Copayment;" there is no entry in the column marked "Amount Paid;" and in the space marked "Your Obligation" appears the sum "0.00." [Emphasis added.] (*In re K.F.* at 664.)

For its legal analysis, the court used the dictionary definition of incurred: [t]o "incur" is "to become liable or subject to: bring down upon oneself." (Merriam-Webster's Collegiate Dict. (10th ed. 1999) p. 590.) To constitute evidence of a "loss incurred," there must be some basis to conclude that the victim is "liable or subject to" a charge. (*In re K.F.* at 663.)

Regarding the first document, the court analyzed that "[o]n its face this document reflects 'billed charges' of the specified amount," and therefore it demonstrated an amount incurred. (*In re K.F.* at 663.) The court expressed uncertainty as to whether this was actually evidence of an incurred amount because of Kaiser's aforementioned unconventional relationship to its patients. The court, therefore, qualified its ruling, noting that it was faced with a limited record and could only rule this way. "Apart from the described records, however, the present record is entirely silent on this subject. We are therefore left with the uncontested recital in the quoted document that the victim was "billed" for the stated amount." (*In re K.F.* at 664.) The court's statement suggests that if there had been additional evidence, for example, testimony that the patient was not billed and was not liable or subject to a charge, then the document would not be evidence of an amount incurred.

(Plaintiff may counter this by pointing the court towards *In re Eric S.* (2010) 183 Cal. App. 4th 1560, also a restitution case involving Kaiser statements. "Assuming the victim was not obligated to pay Kaiser any amount above his membership fee in the HMO, charges were nonetheless incurred on his behalf as a result of appellant's criminal conduct. The fortuity that the victim had purchased membership in an HMO, like the fortuity that a victim has purchased third party insurance, or the fortuity that a victim is covered by Medicare/Medi-Cal, should not shield appellant from paying restitution for the medical expenses in this case." [Citations.]) (*Id. at* 1565.)

As to the second document, the court had a much easier call, stating, that the document may "be substantial evidence that Kaiser furnished ambulance services it considered to be worth $582.32, but it is not substantial evidence that the victim incurred a debt or loss in that amount, or any amount. On the contrary, it explicitly shows an incurred loss of zero." (*In re K.F.* at 664.)

In short, the first part of the analysis is to demonstrate that the statements are hearsay, and that courts have ruled that Kaiser statements may not be evidence of an amount incurred. With this legal background, the question becomes, who will plaintiff present as the "qualified witness" contemplated under *Jazayeri*?

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First, let's look at plaintiff. Plaintiff cannot qualify the statements. She did not make any payments and cannot testify that she is "liable or subject to" a charge from Kaiser.[4] Plaintiff is not part of the Kaiser business system and so would never be able to qualify the document under the business records exception to hearsay.

This leads us to the next witness, a person from Kaiser. There are three possibilities: custodian of records, person most knowledgeable about billing practice, or a doctor. No one will be able to qualify the records. Note, with these witnesses, the defense is eliciting information and creating the record that the court in *In re K.F.* was looking for.

Beginning with the custodian of records, a request for a 402 hearing should be made asking the court to assess whether this custodian actually has any knowledge of how the documents are created. It is expected that the custodian will not have any knowledge of how or when the documents are created. He will not be able to testify that these "billing type" records were created at or near the time of the treatment. The business records exception won't be met.

The next witness to be marched to the stand is the person most knowledgeable "about the process of billing in third party cases." Again, the use of a 402 hearing to test foundation is in order. This witness will testify that the statements were not created at or near the time of the service. More than likely this sponsor will testify that the information contained was not generated because of a diagnosis or treatment code, but, more than likely, that they were created by someone reviewing information in medical records well after the event, and summarizing it into a billing format – hearsay upon hearsay. (A deposition during discovery may be in order to confirm, before trial, that this will be the testimony.)

Further, this person knowledgeable about the billing process will be forced to testify that plaintiff did not have to pay and, other than the lien, has no real responsibility to pay. Consequently, this witness will not corroborate that the plaintiff incurred a liability. Questioning will establish treatment was not provided as a "fee-for-service" (the traditional method). Next, it may be established that payment for treatment was simply the salary, which would indicate that not only plaintiff, but her health plan did not incur any liability. Finally, questioning may establish Kaiser Health Plan paid (incurred) a capitated rate for this individual, presumably an amount much less than the statements articulate. In all, this PMK testimony is should put the judge in a quandary as to whether the documents are reliable enough to be presented to the jury.

What about the treating physician? The doctor will have no idea (as defense has determined through earlier depositions) how patients are "billed." Not having to worry about billing, after all, is one of the reasons doctors go to work for Kaiser.

In conclusion, the documents are probably not admissible, and the plaintiff has no witnesses to qualify them. The information presented to the court is that plaintiff (or her health plan) has either not incurred any liability for damages or that it is less than the amounts in the documents. We will assume that that this amount now elicited is less than the "reasonable value of services." Under *Corenbaum*, the capitated payment or the fact that nothing was incurred, is the proper evidence for the jury. Plaintiff's measure of recovery could be zero. On the other hand, plaintiffs may argue that they should not get a lower level of compensation because they are Kaiser members rather than insured by other health insurers, and you should be prepared for that argument, which at the present, is contrary to the Supreme Court's holding in *Howell*.

ENDNOTES

1 Kaiser Permanente is an integrated managed care consortium. Kaiser Permanente is made up of three distinct groups of entities: the Kaiser Foundation Health Plan and its regional operating subsidiaries; Kaiser Foundation Hospitals; and the autonomous regional Permanente Medical Groups. (See, *http://en.wikipedia.org/wiki/Kaiser_Permanente*.)

2 Kaiser Permanente Traditional Plan, Evidence of Coverage for STANFORD UNIVERSITY. Group ID: 7145 Contract: 1 Version: 68 EOC Number: 12. January 1, 2014, through December 31, 2014.

3 According to the American Medical Association website, "Capitated payment systems are ... based on a payment per person, rather than a payment per service provided."

4 One argument plaintiff may make in this context is that she is subject to a lien. This opens its own door to confusion and misleading a jury. Assuming plaintiff is a Kaiser member, the only lien she is subject to is governed by Civil Code §3040. This code section has a detailed formula for the lien calculation. Generally, the HMO is only entitled to 1/3 of 80% of the usual and customary charges or its total lien amount, whichever is lesser based upon the judgment. This is a moving target because it depends upon the verdict result. It would mislead the jury to state that plaintiff is liable for the charged amount because we need a judgment before the lien can be calculated.

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