IN THE INDIANA COURT OF APPEALS
CAUSE NO. 48A05-1412-CT-546

ST. VINCENT ANDERSON REGIONAL HOSPITAL, Appellant (Respondent below),	) Appeal from the Madison County) Circuit Court, Division 3)
v.	) Trial Court Case No.: 48C03-1407-CT-105)
RASHAUNA WHITE,	) The Honorable Thomas Newman, Jr.,) Judge.
Appellee (Petitioner below).	) The Honorable Christopher Cage,) Master Commissioner

BRIEF OF THE *AMICUS CURIAE*

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I. STATEMENT OF THE INTEREST OF AMICUS CURIAE

The mission of the Indiana Trial Lawyers Association (ITLA) is to preserve the constitutional principles of the right to civil trial by jury, and an independent judiciary, for the benefit of all persons in Indiana. ITLA is also the main voice ensuring that victims of negligence are not charged unreasonable amounts by their medical providers.

The ITLA is aware that, for many years, I.C. 32-33-4, the "Hospital Lien Statute," ("Statute") had allowed hospitals to charge different amounts to patients depending on the circumstances requiring the patients' care. The ITLA believes that the amount a hospital receives as payment, and the amount a patient is obligated to pay, should not change just because the patient was harmed due to the negligence of others.

The Statute was enacted in 1933 to make sure that hospitals are reasonably compensated for their services. But the ITLA believes that the Statute was never meant to be a profit generator for hospitals. The version of the Statute that existed prior to July 1, 2013, allowed just that. This was rectified with the July 1, 2013, amendments to the Statute. The ITLA has an interest in preserving the integrity of this new version of the Statute, which greatly enhanced the rights of all patients, like Rashauna White, who are qualified for Medicaid in Indiana. The interests of the ITLA in this appeal are aligned with Ms. White.

II. SUMMARY OF ARGUMENT

Indiana Code 32-33-4, the "Hospital Lien Statute" ("Statute"), allows a hospital to hold a lien for "the reasonable value of its services or expenses (including any amount designated as a

copayment or deductible) on any judgment for personal injuries rendered in favor of any person." I.C. 32-33-4-1.

The version of the Statute applicable to this lawsuit enacted on July 1, 2013, drastically enhances the rights of patients, and curbs prior abusive billing practices of hospitals. Now, before hospitals can file liens, the Statute requires them, among other things, to first reduce their charges by "the terms of any contract, health plan, or medical insurance." I.C. 32-33-4-3(b)(5). This forces hospitals to only file liens in fair amounts. The prior version of the Statute (the most recent of which was enacted in 2002) merely required hospitals to subtract from its gross charges the amount it received from the patient's "medical insurance," and file a lien for the remainder without giving patients credit for contractual adjustments.

Medicaid is not "medical insurance," so under the prior Statute hospitals were under no obligation to submit charges to this program. They could certainly elect to do so, but more often than not they would file liens for the full "gross" charges, otherwise known as "Chargemaster" rates. These rates had nothing to do with the actual cost of providing the care, and became a profit center for hospitals.

No version of the Statute has ever mentioned "Medicaid," but §3(b)(5) now specifically requires hospitals to reduce charges by "any benefits to which the patient is entitled." Medicaid is a "benefit," a fact St. Vincent Anderson Regional Hospital ("St. Vincent") admits. But instead of submitting the bills to Medicaid, St. Vincent ignored the Statute, and filed a lien against Rashauna White's personal injury case.

St. Vincent claims that the Statute is "ambiguous" and in need of interpretation. St. Vincent is wrong. The Statute's language is clear, and not in need of interpretation. St. Vincent should not be able to create an ambiguity by citing the prior draft of the unenacted version of the new Statute. A plain reading of the Statute is all that is required. If "interpretation" is necessary, a simple comparison of the prior Statute to the new one clearly shows the Legislature intended to expand patient rights, and reign in the billing practices of hospitals, all while maintaining the underlying purpose of allowing hospitals to have reasonable compensation for their services.

There is no Federal rule preempting the duty of hospitals to follow the new Statute. Indiana Medicaid administrative regulations have never barred hospitals from submitting bills to the program for patients harmed by negligence. Even if they did, such guidelines cannot trump plain statutory language. Medicaid will not be burdened by these payments. Enforcing the Statute will have no adverse fiscal impact on Medicaid, which also retains its own statutory right to file liens against patients' liability recoveries.

This Court should reverse the trial court's order denying White's Motion to Quash Hospital Lien.

III. ARGUMENT

A. HISTORICAL PERSPECTIVE OF THE HOSPITAL LIEN STATUTE.

Ind. Code 32-33-4, Indiana's Hospital Lien Statute ("Statute"), was originally adopted in 1933 during the Great Depression, long before private health insurance and other medical plans became widespread, and long before programs like Medicare were adopted. Meta Calder, *Florida's Hospital Lien Laws*, 21 Fla. St. University Law Review, 341, 370 (Fall 1993). The

underlying purpose of the Statute was to insure that hospitals are compensated for their services. *Parkview Hosp., Inc. v. Roese*, 750 N.E.2d 384, 387 (Ind. Ct. App. 2001).

The Statute has long given hospitals the right to file a lien for all reasonable and necessary charges for hospital care, treatment, or maintenance of patients if the injuries giving rise to the claim required the hospital care. *Id.* at 386-387. But from its laudable beginnings during the Depression, collection practices of hospitals over the years have become increasingly aggressive and, in many cases, have resulted in litigation.

1. ***Problems with the old version of the Statute***

Prior to July 1, 2013, the Statute certainly gave hospitals a means to be compensated for their services, but it also often put patients harmed due to the negligence of others in a much worse financial position.

The old version of I.C. 32-33-4-3(b)(5) [2002] required hospitals to reduce charges only by the "amount of any medical insurance proceeds" before filing the lien. But it did not require hospitals to give patients the benefit of pre-negotiated health insurance discounts normally required by the contracts between th insurers and the hospitals. That meant that hospitals could file liens for their "gross" charges, minus the amount received from insurers. The remainder left patients exposed to the collection of much higher sums than if they had not had a liability claim at all. The old Statute allowed a patient to keep 20% of a recovery. I.C. 32-33-4-3(c)[2002 version]. But this 20% was only after attorney fees, case expenses, and payoffs on properly perfected hospital liens. *Id.* The patients were still exposed to pay any other medical bills not covered by the Statute, like doctors' bills, out of this 20%. *Id.*

In addition, if a hospital was forced to reduce its lien recovery due to the "20%" provision, it could still go after the patient for the balance after the lien was released. *Cullimore v. St. Anthony Medical Center, Inc.,* 718 N.E.2d 1221 (Ind. Ct. App. 1999). This point, later affirmed in *Clarian Health Partners v. Evans*, 848 N.E.2d 763 (Ind. Ct. App. 2006), allowed this practice of "balance billing" to expose the patient to the collection of the entire unpaid balance.

That might have been fair, if the charges were reasonable. But hospitals often failed to give the insured patients the benefit of the insurance discounts, and claimed the full "Chargemaster" rates. A Chargemaster is a comprehensive listing of items billable to a hospital patient or a patient's health insurance provider. In practice, it usually contains highly inflated prices at several times that of actual costs to the hospital. *See* Steven Brill, *Bitter Pill: Why Medical Bills Are Killing Us,* Time (February 20, 2013).

The complexities of modern health care pricing now make it difficult to determine whether the amount charged, the amount accepted by providers, or some amount in between represents the "reasonable value" of medical services. One authority reports that hospitals historically billed insured and uninsured patients similarly. Mark A. Hall & Carl E. Schneider, *Patients As Consumers: Courts, Contracts, and the New Medical Marketplace*, 106 Mich. L. Rev. 643, 663 (2008). But with the advent of managed care, some insurers began demanding deep discounts, and hospitals shifted costs to less influential patients. *Id*. Insurers generally pay about forty cents per dollar of billed charges, with hospitals accepting such amounts in full satisfaction of the billed charges. *Id*.

As more medical providers are paid under fixed payment arrangements, hospital charge structures have become less correlated to hospital operations and actual costs. The Lewin Group, *A Study of Hospital Charge Setting Practices* (2005). Currently, the relationship between charges and costs is "tenuous at best." *Id*. at 7. In fact, hospital executives reportedly admit that most charges have "no relation to anything, and certainly not to cost." Hall, *Patients As Consumers,* at 665. Thus, based on the realities of modern health care finance, even our Indiana Supreme Court is unconvinced that the "reasonable value of medical services" is necessarily represented by either the amount actually paid or the amount stated in the original medical bill. *Stanley v. Walker*, 906 N.E.2d 852, 857 (Ind. 2009).

So the Indiana Hospital Lien Statute became a vehicle for hospitals to maximize their revenue by using the full gross Chargemaster rates. This was particularly helpful to hospitals where the patients were Medicare recipients. Ordinarily, a hospital would be obligated to submit bills of such a patient to Medicare, after which it would be discounted, some payment would be made, and the beneficiary would be left with some modest balance.

But the hospitals litigated for, and won, the right not to have to submit its bills to Medicare if the patient was the victim of negligence. *Parkview Hosp., Inc. v. Roese*, 750 N.E.2d 384 (Ind. Ct. App., 2001). Medicare had not been mentioned at all in the old Hospital Lien Statute, but the *Roese* Court held that Medicare is "medical insurance." *Id*. at 390. That Court even held that the Hospital Lien Statute (formerly codified at I.C. 32-8-26-3) section requiring a hospital's bills to first be reduced by medical insurance proceeds was "clear and unambiguous." *Id*. at 387. However, it found that the Statute was in conflict with federal regulations that bills

not be submitted to Medicare if payment may reasonably be expected "promptly" from another source, like liability insurance. *Id.* at 388, 390. Under the Medicare regulations, "Promptly" meant (and still means) within 120 days after filing the claim with the liability carrier or the last date of service. *Id.* at 388. So the *Roese* Court ultimately held that a hospital could only bill the liability insurer for the first 120 days, after which it had a choice to either pursue liability coverage, or submit the bills to Medicare. *Id.* at 390.

In practice, "prompt payment" by a liability insurance carrier is rare, so hospitals thereafter had the enviable (to other medical providers) right to either submit charges to Medicare after the 120 days, or file a Hospital Lien for the full Chargemaster amount. When the latter occurred, a Medicare beneficiary was treated no differently than an uninsured patient.

In the case of the wrongful death of a Medicare beneficiary, the statute thus exposed the general assets of the patient's estate to collection in satisfaction of hospital charges that did not have to be submitted to Medicare, and which were not satisfied in full through the lien mechanism, as allowed by *Clarian Health Partners v. Evans*, 848 N.E.2d 763 (Ind. Ct. App. 2006). Thus, making a wrongful death claim could have unwittingly bankrupted the patient's estate.

Like Medicare, no mention of Medicaid was made in the pre-July 1, 2013, version of the Statute. But case law similar to *Roese* never came about, most likely because Medicaid could not reasonably have ever been considered "medical insurance" per I.C. 32-33-4-3(b)(5) [2002 version]. In practice, hospitals would submit bills from accidents to Medicaid only if the liability coverage was very small, and the bills very large. Of course, if Medicaid made (and still makes)

such payments, it has its own independent right to file a lien against liability settlements pursuant to I.C. 12-15-8 *et seq.* The Indiana Family and Social Services Administration ("FSSA") has been successful in pursuing such liens. *Family and Social Serv. v. Schluttenhofer*, 768 N.E.2d 885 (Ind. 2002).[1]

The Hospital Lien Statute was a powerful tool for hospitals, ensuring that payment to them had priority over nearly everyone else in a liability claim, including ordinary doctors. But due to the aggressive tactics of hospitals, a groundswell of public support caused the Legislature to drastically amend it.

2. *New Hospital Lien Statute enacted on July 1, 2013.*

The new Hospital Lien Statute, still codified as I.C. 32-33-4, looks very different from the 2002 version. A simple comparison shows the Legislature wanted to ensure that the amount of money a hospital receives for its services would not depend on the circumstances that required the care (e.g., a third party liability claim). [*See* Appellant's App., pp.38-44]. Every substantive change expanded the rights of patients, and curtailed the rights of hospitals.

For instance, the Legislature nullified *Parkview Hospital, Inc. v. Roese*, 750 N.E.2d 384 (Ind. App. 2001) by adding Medicare to the list of exemptions under I.C. 32-33-4-3(b)(3). Now,

[1]It should also be noted that the independent Legislative Services Agency, Office of Fiscal and Management Analysis, determined that even a complete repeal of the Hospital Lien Act would have no impact on Medicaid or the Indiana Department of Insurance. *See* http://www.in.gov/legislative/bills/2013/PDF/FISCAL/SB0005.008.pdf.

if a patient is a Medicare recipient, the statute simply is not applicable.[2] In addition, it added a completely new Section (3.5) to enumerate several patient rights that must be considered after a lien is properly perfected.

The main change pertinent to this appeal is to I.C. 32-33-4-3(b)(5). The former statute required only that the hospital's charges "must first be reduced by the amount of any medical insurance proceeds paid to the hospital on behalf of the patient after the hospital has made all reasonable efforts to pursue the insurance claims in cooperation with the patient." However, the new version of I.C. 32-33-4-3(b)(5) expands the lien prerequisite greatly, stating that the hospital charges:

> (5) must:
>
> > (A) first be reduced by the amount of any benefits to which the patient is entitled under the terms of any contract, health plan, or medical insurance; and
> > (B) reflect credits for all payments, contractual adjustments, write-offs, and any other benefit in favor of the patient;
>
> after the hospital has made all reasonable efforts to pursue the insurance claims in cooperation with the patient.

The plain language of this revision thus requires hospitals to also submit their bills through *any benefits* to which the patient is entitled under the terms of any "contract" or "health plan". In addition, this section explicitly requires hospitals to give patients the benefits of all adjustments by the "contract" or "health plan."

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[2]Nothing prevents hospitals from still pursuing liability insurance during the 120 day "prompt payment" period, but they just cannot do it using the Statute.

This change eliminates the unfair practice of "balance billing", which had been allowed by *Clarian Health Partners v. Evans*, 848 N.E.2d 763, (Ind.App. 2006). But it also now specifically mandates the submission of bills by hospitals to "any benefit" the patient has. Medicaid is a "benefit." Medicaid qualified patients are beneficiaries under the contracts between Medicaid and providers. There is no language in the new statute exempting Medicaid from this requirement.

It should be noted that the Legislature had no reason to include Medicaid in the list of exemptions in Section 1 of the Statute. Medicare was listed as an exclusion to specifically repudiate the *Roese* case, which removes that program from this discussion. Since the Legislature did not list Medicaid under the exclusions in Section 1, its participants are still subject to the Statute. This simply means that hospitals may still file liens for the "amount designated as a copayment or deductible" after they comply with Section 3(b)(5) by submitting charges for payment and adjustment.

The Statute applies to Medicaid. This means that hospitals must first submit bills for payment and adjustment to Medicaid for qualified patients. Afterward, hospitals are free to file a lien if there is any remainder properly owed by the patient.[3]

[3]Indiana Medicaid currently requires members to pay premiums, contributions, and co-pays in many instances. *See* http://member.indianamedicaid.com/programs--benefits/important-things-to-know/payment-expectations.aspx.

B. I.C. 32-33-4, INDIANA'S HOSPITAL LIEN STATUTE, UNAMBIGUOUSLY APPLIES TO MEDICAID BENEFICIARIES

In this case, St. Vincent has argued that the current version of I.C. 32-33-4 is "ambiguous" as to its applicability to Medicaid, and that this Court should engage in statutory interpretation. This is unnecessary. The language of the Statute is plain.

1. *Medicaid is a "benefit" for the purposes of Sec.3(b)(5) under the plain language of the statute.*

The usual standard of review for the interpretation of statutes is *de novo*. *Parkview Hospital, Inc. v. Roese,* 750 N.E.2d 384, 386 (Ind.Ct.App.2001). In the case of Ms. White, the trial court erroneously denied White's Motion to Quash Hospital Lien. In so doing, the trial court failed to first examine whether the Statute truly had any ambiguity that required interpretation.

The Court should not interpret a statute which is clear and unambiguous on its face. *Peele v. Gillespie*, 658 N.E.2d 954, 958 (Ind.App. 1995). The Court must examine and treat it as a whole, giving the statute its apparent and obvious meaning. *Id*. The Court is to presume words appearing in the statute were intended to have meaning, and it should endeavor to give those words their plain and ordinary meaning absent a clearly manifested purpose to do otherwise. *Id.*

This Court should focus on the unambiguous wording of Section 3(b)(5) of the Statute. St. Vincent has conceded that White was a Medicaid "beneficiary" when she received treatment at its hospital after her automobile collision [Appellant's Brief, p.2]. The word "benefit" is generally defined as "payment made by an insurance company, public agency, welfare society, etc." WEBSTER'S NEW DICTIONARY, Third College Edition, p.129 (1988). It has similarly been defined as "Financial assistance received in time of sickness . . . either from insurance or

public programs." BLACK'S LAW DICTIONARY 143 (5th ed. 1979). Medicaid is a "benefit." Ms. White was a "beneficiary." Nothing else in this section is ambiguous either.

Ironically, in the case of *Parkview Hospital, Inc. v. Roese*, 750 N.E.2d 384 (Ind. App. 2001), this Court already closely examined Section 3(b)(5), and found it to be "clear and unambiguous." The Statute, the Court found, plainly required the hospital to submit bills to "medical insurance" to maintain the lien. *Id.* at 387. Although the Court went on to excuse hospitals from the duty to submit bills to Medicare for other reasons (conflict with federal regulations regarding "prompt payment"), the analysis is still valid. The wording of Section 3(b)(5) has been revised in the July 1, 2013, version, but the provision is still unambiguous.

Since Medicaid is a "benefit to which the patient is entitled," the Statute mandates that hospitals submit charges to Medicaid before filing a lien. St. Vincent seems to concede this point in its Brief, since it delves, *ab initio*, into a discussion of statutory interpretation. But that discussion is unnecessary.

Words in a statute are to be given their plain, ordinary, and usual meaning unless a contrary purpose is clearly shown by the statute itself. *Roese, Id*. at 386. Additionally, language employed in the statute is deemed to have been used intentionally. *Id.* The "plain, ordinary, and usual meaning" of the new Section 3(b)(5) leads only to the conclusion that Medicaid is a "benefit" that must be applied before filing a lien. There is no exception made for Medicaid. There is no "contrary purpose clearly shown by the Statute itself." We must assume the word "benefits" was used intentionally. No alternative definition of "benefits" is provided, nor is there any explicit exclusion of Medicaid.

No federally preemptive "120 day rule" similar to that employed in *Roese* applies to Medicaid. Congress established the Medicaid program in 1965 to provide federal financial assistance to states that choose to reimburse certain medical costs incurred by the poor. *Blum v. Yaretsky*, 457 U.S. 991, 993-94 (1982). But the State of Indiana administers Medicaid, not the federal government, a fact conceded by St. Vincent [Appellant's Brief, p.2]. It also concedes that even under the Indiana Health Coverage Program (IHCP) provider manual, it has a choice to either pursue liability insurance or submit bills to Medicaid. [Appellant's Brief, p.14].

Federal laws do not prohibit hospitals from following the Statute by submitting charges to Medicaid as a prerequisite for filing liens. And, when Medicaid makes payments, it has the statutory right to subrogate against third party recoveries, thereby retaining it fiscal integrity, and its status as a "secondary payor." I.C. 12-15-8-3. This is consistent with federal law requiring a medical provider who treats a patient covered under Medicaid to submit its bill to the agency for payment. 42 U.S.C. § 1396, *et seq.*

St. Vincent's great reliance on the IHCP Manual to create an "ambiguity" is misplaced. It does not prohibit hospitals from submitting bills to Medicaid. If anything in the Manual seems contrary to the Statute, the Statute must trump.

This Court should hold that the Statute unambiguously requires Indiana hospitals to submit charges of qualified Medicaid patients for payment and reduction before perfecting a lien.

2. *If the Court elects to interpret the Statute, and consider "Legislative Intent", it should disregard unenacted portions of the law.*

If this Court agrees to interpret the new Statute, certain established rules apply. *McCabe v. Commissioner, Ind. Dept. of Ins.*, 949 N.E.2d 816, 819-820 (Ind. 2011). Interpretation of a

statute usually involves examining whether a word or phrase of the law is ambiguous, and susceptible to more than one interpretation. *Id*. If an ambiguity is deemed to exist, a Court might then engage in "statutory construction" by comparing statutes, or parts of statutes, attempting to determine Legislative intent. *Id.* at 820. When so doing, the Court is to read the statutes of an act as a whole and attempt to give effect to all provisions. *Whitacre v. State*, 619 N.E.2d 605, 606 (Ind. Ct. App. 1993).

In this case, St. Vincent does not argue that there is any "ambiguity" within the Statute itself, nor between this Statute and others, nor between the 2002 and 2013 versions of the Statute. Rather, it argues that the "explicit" removal of the word "Medicaid" from Public Law 173-2013 by Public Law 205-2013 (the budget bill) is the ambiguity. St. Vincent's argument is not actually, then, that there is any "ambiguity," but that there is rather a change between the original Public Law and the version that finally went into effect on July 1, 2013. This "ambiguity" argument is thus misplaced, since it steps outside the normal bounds of this type of analysis.

Neither of these Public Laws, alone, were ever "the law", but were instead merely part of the normal Legislative process. Both "Public Laws" were signed by Governor Pence on May 7, 2013, but the net result was that only one new "law" went into effect on July 1, 2013.

Indiana keeps no record of "legislative history." Comparing different versions of a law before enactment in an attempt to divine "Legislative intent" is to walk on shaky ground. Our 150 citizen Legislators must, while making law, balance the competing interests on all sides of an issue and manage, among other things, the dynamics of policy, politics, personalities and power.

It is unreasonable to guess the reasoning behind why certain words or phrases are inserted or deleted prior to enactment.

It has been said that "For while it is possible to discern the objective 'purpose' of a statute (i. e., the public good at which its provisions appear to be directed), or even the formal motivation for a statute where that is explicitly set forth..., discerning the subjective motivation of those enacting the statute is, to be honest, almost always an impossible task." *Edwards v. Aguillard*, 482 U.S. 578, 636 (1987)**.** To look for the sole purpose of even a single legislator is probably to look for something that does not exist. *Id.* at 637.

St. Vincent's invitation to use prior drafts of laws as evidence of Legislative intent is not the norm. A more conventional way to discern Legislative intent is to compare several statutes to each other. *McCabe v. Commissioner, Ind. Dept. of Ins.*, 949 N.E.2d 816, 819 (Ind. 2011). In *McCabe*, for instance, our Supreme Court compared the three Indiana wrongful death statutes regarding the claimant's right to recover attorney fees. *Id*. at 820. Another is to examine whether the terms of the statute itself show any attempt to limit its own application. *United States Steel Corp. v. Northern Indiana Public Service Co.*, 951 N.E.2d 542, 559 (Ind. Ct. App. 2011).

St. Vincent's makes much of the fact that the word "Medicaid" was removed from the final version of the new statute which went into effect on July 1, 2013. But the word "Medicaid" has never been mentioned explicitly in any version of the Statute enacted since 1933. Reading "benefit" to include Medicaid for the purposes of Section 3(b)(5) does not conflict with the rest of the Statute when read as a whole, nor does it conflict with other statutes.

Although it is not among the list of exemptions in Section 1 of the Statute, that simply

means that hospitals may still file liens involving patients with Medicaid (or any other benefit or insurance they have). However, nothing excuses hospitals from the new requirement that they must first reduce their charges by any payments or adjustments through those benefits before filing the lien for the remainder.

The ITLA is concerned that at the heart of St. Vincent's position is a simple quest to obtain the highest profits possible. It seems to be doing quite well in this regard already, since it reported profits from operations totaling $167 million for the fiscal year ending June 1, 2013. J.K. Wall, *New St. Vincent CEO will inherit financially solid system*, Indianapolis Business Journal (January 6, 2014). The ITLA believes that it would be especially unfortunate, however, for it to pursue these profits at the expense of Medicaid beneficiaries.

IV. CONCLUSION

The ITLA respectfully requests that this Court reverse the trial court's denial of White's Motion to Quash Hospital Lien, and hold that Indiana hospitals must first submit their charges to Medicaid for payment and adjustment for qualified patients before filing a lien for any remainder pursuant to I.C. 32-33-4-3(b)(5).

Respectfully submitted,
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WORD COUNT CERTIFICATION

Pursuant to Rule 44(C), (E), and (F), Indiana Rules of Appellate Procedure, I verify that the Amicus Curiae Brief contains 5209 words as reflected by the word count system of Wordperfect.

I also verify that this brief contains no more than 7,000 words.

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The undersigned further certifies that the foregoing Brief of the Amicus Curiae was sent, pursuant to Appellate Rule 23(C)(3), postage pre-paid, via U.S. Mail, on the 7th day of May, 2012, properly addressed as follows:

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