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Third Party Liability and the Medi-Cal Program: Administratively Inconsistent, Judicially Inequitable

The California Medical Assistance Program, entitled Medi-Cal, was enacted by the California State Legislature in 1965 to provide state-funded medical care to indigents. The intent of the Legislature was to provide "mainstream" medical care to those in need. Since the program was enacted, it has undergone many changes, adapting its structure to meet the needs of the recipients and to encourage health care providers to participate. Nevertheless, both providers and beneficiaries remain somewhat dissatisfied with the Medi-Cal program. One area in particular with which providers are dissatisfied is the program's relatively low reimbursement rates. Providers are effectively locked into rates established by the program since they must agree to accept Medi-Cal payment as payment in full for services provided to Medi-Cal beneficiaries. The provider is prohibited from "balance billing" the beneficiary or any other person.

The State, however, has carved out an exception to this law that serves as a marginal incentive to providers. If the recipient has other health insurance coverage, the provider or Medi-Cal may bill the insurer. If the provider bills the insurer and the insurer pays more than Medi-Cal, the provider may retain the entire amount paid to him or

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1. 22 CAL. ADM. CODE §50003.
2. CAL. STAT. 1965, c. 4, §2, at 103.
3. CAL. WELF. & INST. CODE §14000.
5. See CAL. DEPT. OF HEALTH SERVICES, CENTER FOR HEALTH STATISTICS, DATA MATTERS TOPICAL REPORT, 4-27 (July 1980) [hereinafter cited as TOPICAL REPORT].
7. 22 CAL. ADM. CODE §§1002, 51471; CAL. WELF. & INST. CODE §14019.4.
8. Balance billing is the term commonly used to describe the practice whereby a provider of health care under the Medi-Cal program bills a beneficiary for the "balance" of his or her bill remaining unpaid after Medi-Cal's payment to the provider. See CAL. DEPT. OF HEALTH SERVICES, MEDI-CAL BULLETIN No. 62, at 2 (Nov. 1976).
9. 22 CAL. ADM. CODE §§1002, 51471; CAL. WELF. & INST. CODE §14019.4.
10. See CAL. WELF. & INST. CODE §§14019.3, 14019.4.
11. Id.; CAL. DEPT. OF HEALTH SERVICES, MEDI-CAL BULLETIN No. 106 (Nov. 1979).
Conversely, if Medi-Cal collects from the insurer more than it paid the provider, the program must pay the provider the excess, up to the amount the provider billed the program. Many providers would like to see the creation of a second exception to this rule. This exception would allow providers to receive up to their “usual and customary fee” in those cases in which a recipient is injured by a liable third party and subsequently receives a tort recovery for the injuries. Under the current interpretation of the law by the State providers are not allowed to receive compensation above the Medi-Cal payment rate from tort recoveries once the provider has accepted Medi-Cal as payment for the services. Nevertheless, two recent trial courts have differed on the interpretation of this law.
section will provide a brief history of the Medi-Cal program.

**MEDI-CAL: CALIFORNIA’S MEDICAID PROGRAM**

In 1965, under Title XIX of the Social Security Act, commonly referred to as Medicaid, Congress authorized grants to states for medical assistance programs for the purpose of enabling each state, as far as practicable under the conditions in the state, to furnish medical assistance to eligible persons. The intent of the Legislature in enacting the Medicaid law was to provide “mainstream” medical care to indigents so that they could have access to private practitioners of their choice and not be relegated to a county or municipal hospital program. This legislation resulted in a comprehensive federal-state program for medical care, whereby states are partially reimbursed by the federal government for medical assistance programs. Although the Medicaid program is federally funded, it is administered by the individual states. Participation by a state is voluntary, but if the state elects to participate, it must comply with federal statutes and regulations to remain eligible for federal funds for the state’s Medicaid program.

The Medi-Cal program was enacted in California to take advantage of the federal funds made available by the Title XIX amendments to the Social Security Act. The purpose of Medi-Cal was to provide health care and related remedial or preventive services to indigent persons. To qualify for federal funding under Title XIX, the Medi-Cal program is required to submit a state plan to the Department of Health

plus professional component (drugs); (5) fee for service schedule (physicians, other individual practitioners, non-institutional providers, e.g., medical transportation, other hospital services, e.g., hospital out-patient, and medical equipment). This comment will analyze the inequities of the current law as applied to providers paid using a fee for service schedule. The inequities would exist with the other methods of payment, however, it would be more difficult for the reader to comprehend without a detailed understanding of the Medi-Cal program. See California Department of Finance, Program Evaluation Unit, Medi-Cal Rate Development and Review (Oct. 1977) [hereinafter cited as Rate Development].

27. Id.
31. Id.
32. 22 CAL. ADM. CODE §50003.
33. TOPICAL REPORT, supra note 5, at 1.
34. CAL. WELF. & INST. CODE §14000.
and Human Services, which must be approved by the Secretary of Health and Human Services.\textsuperscript{35} This plan provides assurance of state compliance with federal Medicaid requirements.\textsuperscript{36} A portion of the plan must specifically address the area of third party liability.\textsuperscript{37} The following section will focus on how California has met the federal requirements regarding third party liability and the subsequent impact on Medi-Cal providers.

**Third Party Liability and the Medi-Cal Program**

Title XIX of the Social Security Act\textsuperscript{38} and the California Welfare and Institutions Code\textsuperscript{39} require Medi-Cal to be the payer of last resort for the beneficiary's medical services. Medi-Cal is not finally liable for payment for the medical services until other third party resources, such as available health or casualty insurance, have been fully exhausted.\textsuperscript{40} California's implementation of these requirements gives rise to the present controversy in this area, since the impact of these requirements on the provider community has been economically undesirable and legally open to question.

Federal law requires states participating in the Medicaid program to take all reasonable measures to ascertain the legal liability of third parties for Medicaid covered services.\textsuperscript{41} Specifically, states are to treat this legal liability as a resource of the individual\textsuperscript{42} and seek reimbursement when legal liability is found to exist after medical assistance has been made available through the program.\textsuperscript{43} Federal regulations refer to any entity that is or may be liable to pay all or part of the medical cost of the injury, disease, or disability of a Medicaid applicant or recipient as a liable third party.\textsuperscript{44}

In implementing this federal requirement, California chose not to refer to all legal liability for medical services as strictly third party liability.\textsuperscript{45} Instead, the State separated the concept into two distinct

\textsuperscript{38} Id.
\textsuperscript{42} Id.
\textsuperscript{43} Id.
\textsuperscript{44} 42 C.F.R. §433.135 (1980).
categories: "other coverage" and "third party liability." Other coverage is defined as contractual or legal entitlements to health care services existing at the time the recipient obtained the medical services. Third party liability refers only to potential liability in tort. The State makes the distinction between the terms "other coverage" and "third party liability" purportedly because the State believes that the federal statutory language is extremely general and requires specificity. Moreover, the State claims the existence of other coverage bars the recipient from Medi-Cal eligibility as to the covered service, whereas the existence of potential third party liability only gives the State a right to indemnification while the recipient remains covered by Medi-Cal.

The intent of the State to distinguish between these two characterizations of liability is exemplified by separate provisions in the Welfare and Institutions Code for "other coverage" and "third party liability." Sections 14023 and 14024 of the Welfare and Institutions Code refer to "other coverage." Section 14023 makes it a misdemeanor for a recipient who has or acquires any other contractual or legal entitlement to any health care service to fail to disclose and to fail to use and exhaust such other entitlements. Section 14024 provides that when health care services are provided to a person under this program, who at the time the service is provided has any other contractual or legal entitlements to the services, the director may recover either the amount that would have been paid to the person or the reasonable value of the services.

50. Id. at 9.
51. Id.
52. California Welfare and Institutions Code Section 14023 provides:
   (a) Any applicant for public assistance or coverage under this chapter who at the time
   of application has any other contractual or legal entitlement to any health care service
   defined in Section 14053, and who wilfully fails at that time to disclose the fact of such
   other entitlement, or falsely represents that he does not have such other entitlement, is
   guilty of a misdemeanor.
   (b) Any public assistance recipient or person eligible under this chapter who, subse-
   quent to the date of application for such assistance or coverage under this chapter, ac-
   quires any other contractual or legal entitlement to any health care service defined in
   Section 14053, and wilfully fails or refuses to give notice thereof to his county welfare
   department within 10 days of such acquisition, is guilty of a misdemeanor.
   (c) Any public assistance recipient or person eligible under this chapter who has any
   other contractual or legal entitlement to any health care service defined in Section 14053,
   and who knowing that he must use such entitlement first, obtains any such service under
   Medi-Cal without first having utilized and exhausted his other contractual or legal enti-
   tlement thereto or therefor, is guilty of a misdemeanor.
53. California Welfare and Institutions Code Section 14024 provides:
Welfare and Institutions Code Sections 14124.70-14124.79 contain the provisions relating to "third party liability." These sections do not require the beneficiary to use third party liability first, nor do they require a provider to bill persons potentially liable in tort. This distinction between "other coverage" and "third party liability" has a limiting effect on the provider's ability to receive the usual and customary fee for his or her services. The following section will analyze the rationale of the State for this distinction and will discuss why the result is unfavorable to providers.

**Medi-Cal’s Distinction Between Other Coverage and Third Party Liability: An Inconsistent Result**

Federal law requires the state to limit provider participation in the program to those providers who accept Medicaid's fee schedule as payment in full. The law prohibits providers from billing the beneficiary or any other person a fee in excess of the rates established by the state. Thus, in compliance with federal law, California requires providers to accept Medi-Cal payment as payment in full for Medi-Cal covered services. Providers are specifically prohibited from "balance billing" the beneficiary or anyone else.

**A. Other Coverage**

While the law in California prohibits the provider from receiving payment from sources other than the program, Section 14019.4 of the Welfare and Institutions Code carves out an exception to this prohibition. This code section allows providers to bill third party payers who provide a contractual or legal entitlement to health care services. The

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When health care services are provided to a person under this chapter who at the time the service is provided has any other contractual or legal entitlement to such services, the director shall have the right to recover from the person, corporation, or partnership who owes such entitlement, the amount which would have been paid to the person entitled thereto, or to a third party in his behalf, or the value of the service actually provided, if the person entitled thereto was entitled to services. The Attorney General may, to recover under this section, institute and prosecute legal proceedings against the person, corporation, or partnership owning such entitlement in the appropriate court in the name of the director.

56. See 22 CAL. ADM. CODE §§51002, 51471; CAL. WELF. & INST. CODE §§14019.3, 14019.4.
57. See note 8 supra.
58. 22 CAL. ADM. CODE §§51005, 51471.
59. See 22 CAL. ADM. CODE §§51002, 51471; CAL. WELF. & INST. CODE §§14019.3, 14019.4.
60. Section 14019.4 of the Welfare and Institutions Code specifically states in pertinent part: (a) Any provider of health care services who obtains a label or copy from the Medi-Cal card or other proof of eligibility pursuant to this chapter shall not seek reimbursement or attempt to obtain payment for the cost of such covered health care services from the eligible applicant or recipient, or any person other than the department or third party payer who provides a contractual or legal entitlement to health care services.

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provider has the option of billing Medi-Cal or billing the other insurer. If the provider bills the other insurer, and the insurer pays more than Medi-Cal, the provider may retain the entire amount. If the provider bills only the Medi-Cal program, and the program subsequently bills the other insurer, the provider may receive additional funds. This would occur if the other insurer paid Medi-Cal more for a particular procedure than Medi-Cal had previously paid to the provider. In this case, the Medi-Cal program would be required to pay the excess of any amount received from the other insurer to the provider, up to the amount the provider billed the program.

The question arises as to how this statutory exception overcomes federal law that specifically states that the provider is prohibited from this practice. The rationale of the State for this exception was recently articulated in the trial court case of Palumbo v. Myers. In the defendant State’s post trial brief, the California Attorney General reasoned that, given the federal law on this matter and California’s exception, one of two conclusions must be reached, either: (1) the State is not in compliance with the federal law; or (2) allowing a provider to bill other contractual or legal entitlements when Medi-Cal has been fully reimbursed is not the type of billing federal law prohibits.

The brief stated that this exception is consistent with federal law since a person who had full coverage for the services received was obligated to use the other coverage before Medi-Cal paid for the services. In addition, although the determination of eligibility for these services obviously is made retroactively, this result is nevertheless compelled by federal law which requires other coverage to be treated as a resource

(emphasis added).

61. The California Department of Health Services has interpreted Section 14019.3 of the California Welfare and Institutions Code and Sections 51005 and 51471 of Title 22, California Administrative Code, as allowing the provider the option of billing either Medi-Cal or the other coverage. Under no circumstances, however, is the provider allowed to bill Medi-Cal and the other coverage simultaneously. CALIFORNIA DEPARTMENT OF HEALTH SERVICES, MEDI-CAL BULLETIN No. 106 (Nov. 1979).

62. Notice of Intended Decision & Memorandum Opinion, Palumbo v. Myers, No. 287983 (Super. Ct., Sacramento, 1981). The court stated that the parties agreed that a provider is entitled to recover the difference between the usual fee and the Medi-Cal allotment when the Medi-Cal beneficiary has other insurance which pays for Medi-Cal coverage.

63. 22 CAL. ADM. CODE §51005(d).

64. See 42 U.S.C. §1396h(d) (Supp. III 1979).


68. Id. The Attorney General stressed that, to reach this conclusion, would lead to termination of federal funding for Medi-Cal. Id.

69. Id.

70. Id. at 7-9.
barring eligibility. Further, state law requires other coverage to be used first. Thus, once the Medi-Cal program has been reimbursed by the other insurer, the medical bills have actually been paid for by another insurer source and not by the Medi-Cal program.

B. Third Party Liability

Although providers are allowed to bill other insurers under the above exception, this has not been interpreted to mean that providers are allowed to also bill liable third parties. The State makes a clear distinction between “other coverage” and “third party liability” thus when a Medi-Cal beneficiary receives a judgment or settlement in a tort action, his or her providers are prohibited from receiving any compensation from the judgment or settlement proceeds for the difference between the amount charged and the amount actually paid by Medi-Cal, even though the State has been reimbursed in accordance with Sections 14124.70-14124.79 of the Welfare and Institutions Code.

The State argues that an exception similar to the exception for “other coverage” would not be proper in the case of a tort recovery since the inherent qualities found with contractual liability of other coverage are lacking in the case of “contingent” third party liability. Specifically, the potential right to a tort recovery does not bar Medi-Cal eligibility to services. Further, the potential liability cannot be treated as a resource or be required to be used first since it is inchoate. Also, in the overwhelming majority of tort cases involving Medi-Cal beneficiaries, the State does not recover the full amount of its lien for tort-related medical care, and therefore, the Medi-Cal program still pays for part of the beneficiary’s medical services. The State claims that once it has been reimbursed from the other insurer, it is no longer involved with the services. The State, however, fails to explain how its rationale allows the provider to bill both the other insurer and Medi-Cal in a situation when the other insurer’s payment for a service is less than Medi-Cal’s. In this case, the provider would be able to keep the payment from the other insurer and bill Medi-Cal for the difference, up to

71. Id. at 12.
72. Id.; see CAL. WELF. & INST. CODE §14019.3.
73. See note 67 supra.
75. Id. at 13.
76. Id.
77. Id.
78. Id.
79. See id. at 14.
the fee schedule allowed by Medi-Cal. It appears that Medi-Cal would continue to be involved with the payment for services in this situation.

The State further supports the distinction with various policy considerations. The State claims the prohibition against balance billing or billing the liable third party in a tort recovery is necessary to protect the beneficiary from undue influence and pressure by creditors, including physicians. Further, the State believes that physicians may refuse to treat a patient who does not agree to sue an alleged tortfeasor or agree to pay the full fee upon acquiring a settlement. In addition, the physician who seeks funds from the tortfeasor's insurer may compete with the beneficiary for limited settlement proceeds. This last argument seems ironic since a provider may bill any other insurance the beneficiary may have had at the time of the accident, and if that other insurer has subrogation rights, the insurer will place a lien on the beneficiary's tort settlement, thus competing with the beneficiary for the settlement proceeds and defeating this policy interest.

The state appears to have ignored the fact that any tort judgment or settlement will be based on the judicial principles of tort liability and damages, thereby ensuring that the medical bills of a wrongfully injured person are paid for by the liable third party. Furthermore, the value that the judicial system places on the medical services may be significantly different from the value Medi-Cal has placed on the same services since the policy considerations of each system are not the same. Thus, to allow the Medi-Cal program to limit the amount a provider may receive in this situation effectively permits Medi-Cal to dictate judicial policy. This concept becomes more apparent when viewing a hypothetical situation in which the theory of tort law is brought into play.

MEDI-CAL'S THIRD PARTY LIABILITY LAW IN RELATION TO TORT LAW

The impact and unjustness of the exclusion by the State of third party liability cases from balance billing can be examined by considering the following hypothetical:

80. Id.
81. Id.
82. Id.
83. Id.
84. Id.
85. See generally Morris v. Williams, 67 Cal. 2d 773, 749, 433 P.2d 697, 708, 63 Cal. Rptr. 689, 700 (1967); California Ass'n of Nursing Homes Inc. v. Williams, 4 Cal. App. 3d 800, 817, 84 Cal. Rptr. 590, 602 (1970); CAL. WELF. & INST. CODE §§14000, 14000.1, 14075, 14076, 14079, 14105; Rate Development, supra note 20. See note 90 infra.
86. See note 8 supra.
A Medi-Cal beneficiary is injured by a third party. The beneficiary receives services from a Medi-Cal provider. The provider bills the Medi-Cal program for the services provided. Medi-Cal pays for the services based on the Medi-Cal fee schedule. Subsequently, the beneficiary receives a tort recovery from the liable third party.

To demonstrate how California's treatment of third party liability interferes with basic tort law and the underlying policy considerations, two questions of prime importance concerning this fact pattern must be asked: (1) What measure of damages was used to compute the special damages, \( i.e., \) medical expenses; and (2) Which parties are entitled to receive compensation from the proceeds?

A. Measure of Damages

A principal element of damages in a personal injury action is the value of medical services. \( ^{87} \) Generally, the plaintiff may recover as special damages \( ^{88} \) the reasonable value of the medical services made necessary by the injury. \( ^{90} \) Special damages may include the value of medicines and medical attendance, \( ^{91} \) hospital services, \( ^{92} \) and care and nursing. \( ^{93} \) Recovery for medical attendance and nursing is usually controlled by the reasonable worth of the services \( ^{94} \) and not by the amount actually paid or contracted to be paid. \( ^{95} \) Normally, the reasonable worth is established by introducing expert testimony that the amount of the bill, or the value of the service, is reasonable in view of the services performed. \( ^{96} \)

\( ^{87} \) Medical expenses are special damages that must be specifically pleaded. Large v. Williams, 154 Cal. App. 2d 315, 320, 315 P.2d 919, 923 (1957); Sills v. Soto, 124 Cal. App. 2d 539, 545-46, 269 P.2d 98, 102 (1954).

\( ^{88} \) 154 Cal. App. 2d at 320, 315 P.2d at 923; 124 Cal. App. 2d at 545-46, 269 P.2d at 102. See notes 91, 93 infra.

\( ^{89} \) See note 85 supra.


\( ^{91} \) Vicksburg & M.R. Co. v. Putnam, 118 U.S. 545, 554 (1886); 154 Cal. App. 2d at 320, 315 P.2d at 923.

\( ^{92} \) 160 F. Supp. at 30; 95 F. Supp. at 49-50.


\( ^{94} \) See note 88 supra.

\( ^{95} \) Evidence as to what was actually paid for medication is competent, but failure to prove by further testimony the reasonableness of the payment constitutes a failure of proof which will render inmaterial the proof of what was actually paid. Ross v. Foss, 77 S.D. 358, 366-67, 92 N.W.2d 147, 152 (1958); Klingman v. Fish & Hunter Co., 19 S.D. 139, 147-48, 102 N.W. 601, 603 (1905); The proper measure of damages is the reasonable value of such services, not the amount paid or incurred therefore, although the amount paid or incurred would be some evidence of the value. 127 Cal. App. 2d at 520, 274 P.2d at 448; 34 Cal. App. at 565, 168 P. at 403.

\( ^{96} \) L. JOHNS, CALIFORNIA DAMAGES LAW & PROOF 22 (2d ed. 1977).
I. Does the Medi-Cal fee schedule reflect the reasonable value of the services?

Under federal law, the amount of payment to a provider of services under the state's medical assistance program is largely within the discretion of the state, subject to provisions of the Social Security Act and Medicaid regulations. A state is not required to establish minimum payment rates to providers but is only required not to exceed certain upper limits of payment. The state must, however, be cognizant that the payment rates should be adequate to attract a sufficient number of qualified providers to ensure "mainstream" medical care to Medicaid beneficiaries.

The California Welfare and Institutions Code Section 14075 states that it is the intent of the Legislature, to the extent feasible and permitted by federal law, that physicians should be reimbursed equally state wide for comparable services at a rate sufficient to provide Medi-Cal recipients with reasonable access to medical care. In September 1976, the Legislature established a new statewide uniform reimbursement method to pay for Medi-Cal physician services. The California Department of Health Services was directed to review annually physician reimbursement rates under this new method and to report to the Legislature each January on the results of this review. The most current report, dated January 1981, reveals that the Medi-Cal level of payment is strikingly lower than other third party payers for 21 common procedures. The report states in relevant part:

The Medicare maximum allowances for Los Angeles County are on the average approximately 70% greater than the Medi-Cal maximums. The minimum fee schedule used by the California Division of Industrial Accidents for remuneration of physicians who treat industrial injuries under the workers' compensation laws is approximately 70% higher than the Medi-Cal fee schedule.

California Blue Shield declined to provide data for this report regarding their payment levels. However, their average reimbursement

98. See note 97 supra.
99. See note 97 supra.
100. A particular limit is that Medicaid reimbursement may not exceed Medicare reimbursement. See note 97 supra.
102. Id.
103. Id.
104. Id. §14079 (added by CAL. STATS. 1976, c. 1207, §2.5, at 5496).
105. Id.
106. REPORT TO THE GOVERNOR, supra note 6, at 6.
level is presumably the actual charge since their reimbursement policy is to pay “usual, customary, and reasonable”. The maximum payment levels for the United Foundations for Medical Care under their contract with the Public Employees Retirement System are about double the Medi-Cal reimbursement levels.\textsuperscript{107}

This report clearly shows that Medi-Cal payments are substantially lower than payments by other third party payers.\textsuperscript{108}

Since the rates paid by Medi-Cal are much lower than other third party payers,\textsuperscript{109} it follows that the amount of tort recovery allocated to medical expenses would be far greater than Medi-Cal actually paid since damages are based on “reasonable” value.\textsuperscript{110} In fact, the amount allocated\textsuperscript{111} should be closer to the amount charged, provided the amount charged is reasonable. Under the current interpretation of the law by the State, the beneficiary is only obligated to reimburse the state for the amount it actually paid. Some may argue that the plaintiff's medical expenses should be reduced to the amount actually owed to the state.\textsuperscript{112} To do otherwise would allow the beneficiary to be unjustly enriched since he or she would be better off financially than before the injury.\textsuperscript{113}

2. May the Value of the Medical Damages be Reduced Because Plaintiff is not Personally Obligated to Pay for the Services?

Courts generally have held that benefits received by a plaintiff from a source wholly independent of and collateral to the wrongdoer will not diminish the damages otherwise recoverable from the wrongdoer.\textsuperscript{114} This is known as the “collateral source rule.”\textsuperscript{115} The Supreme Court of

\textsuperscript{107} REPORT TO THE GOVERNOR, supra note 6, at 6.
\textsuperscript{108} REPORT TO THE GOVERNOR, supra note 6, at 5.
\textsuperscript{109} REPORT TO THE GOVERNOR, supra note 6, at 5.
\textsuperscript{110} REPORT TO THE GOVERNOR, supra note 6, at 5.
\textsuperscript{111} See note 90 supra.
\textsuperscript{112} Cf. District of Columbia v. Woodbury, 136 U.S. 450, 466 (1890); Herrick v. Sayer, 160 F. Supp. 25, 29 (N.D. Ind. 1958); Melone v. Sierra R. Co., 151 Cal. 113, 115, 115 P.2d 522, 523 (1940); Townsend v. Keib, 34 Cal. App. 564, 565, 168 P. 402, 403 (1917); RESTATEMENT (SECOND) OF TORTS §924 (1977). All of the above cited authorities state that damages are to be awarded based on the reasonable value of the services. Therefore, if the attorneys choose to stipulate to this issue, thereby taking the determination of damages away from the factfinder, they too should base their stipulation amount on the reasonable value of the services.
\textsuperscript{115} See note 114 supra.
California has long adhered to this doctrine.\textsuperscript{116} The California courts, however, have not specifically ruled on the applicability of the collateral source rule when the benefit received is Medi-Cal. Nevertheless, the courts have decided similar issues which provide some indication of their posture on this matter.

\textbf{a. Independent Collateral Sources}

In \textit{Hefend v. Southern California Rapid Transit},\textsuperscript{117} the California Supreme Court reaffirmed its adherence to the collateral source rule in tort cases in which the plaintiff had been compensated by an independent collateral source such as insurance, pension, continued wages, or disability insurance for which the plaintiff had actually or constructively paid.\textsuperscript{118} The Court went on to state that the collateral source rule also applied in cases in which the collateral source would be reimbursed from the tort recovery through subrogation, refund of benefits, or some other arrangement.\textsuperscript{119} In a footnote in this case,\textsuperscript{120} the court stated that there were many sorts of collateral sources and a great variety of contexts in which the rule might be applied. In considering \textit{Hefend}, however, the court stated that it was not determining the appropriateness of the application of the rule in the myriad of possible solutions which were not presented by the facts of the particular case.\textsuperscript{121}

While the California courts have not specifically ruled on the applicability of the collateral source rule when the collateral source is Medi-Cal payments, the language in \textit{Hefend} supports the application of the rule in this situation since the beneficiary is obligated by statute\textsuperscript{122} to reimburse the State if he or she recovers payment from a third party.\textsuperscript{123} Further, several other states have specifically ruled on this matter and have determined that the rule does apply when the collateral source is Medicaid payments,\textsuperscript{124} and as a result, evidence that the Medicaid program has paid for the plaintiff's medical expenses is not admissible.\textsuperscript{125}

The Fourth Appellate District in California addressed a somewhat


\textsuperscript{117} 2 Cal. 3d 1, 6, 465 P.2d 61, 63, 84 Cal. Rptr. 173 (1970).

\textsuperscript{118} Id. at 13-14, 465 P.2d at 69, 84 Cal. Rptr. at 181.

\textsuperscript{119} Id.

\textsuperscript{120} Id. at 6 n.3, 465 P.2d at 63 n.3, 84 Cal. Rptr. at 175 n.3.

\textsuperscript{121} Id.

\textsuperscript{122} CAL. WELF. & INST. CODE §§14124.70-14124.79.

\textsuperscript{123} Id.


\textsuperscript{125} See note 124 \textit{supra}.

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similar matter in *Reichle v. Hazie*. In *Reichle*, the defendant attacked the award of special damages because the plaintiff was treated in a county hospital that charged according to the patient's ability to pay. The county hospital, however, had a policy of requiring the patient to pay the reasonable value of the services if the person received payment from a third party for the injuries treated. The court held that the plaintiff was entitled to an award of special damages to cover the reasonable charge for his care and services. The court noted that if the patient had been treated in a private hospital there would have been no question that the patient should receive the reasonable value of the services provided. Therefore, merely because the patient received the care in a county hospital with a reduced rate structure was held not to be a sufficient reason for reducing special damages below the reasonable value of similar services. The court further stated that since a recovery for services provided by a private hospital, which went to increase their profits, was permitted, there was as strong a reason to allow a similar recovery to a public institution when the money would relieve the burden of public taxes.

An analogy to the court's comparison of public and private hospitals would be a comparison between Medi-Cal and private medical insurance. Since the collateral source rule applies to allow private insurance to be reimbursed, no valid reason exists not to apply the rule to allow reimbursement to the publicly funded Medi-Cal program. Any money received by the program would go to relieve the burden of publicly financed health care. Further, in *Reichle* attention was called to the fact that the plaintiff was under an obligation to repay the county hospital for services provided if the patient received funds from a liable third party. A similar situation exists under Medi-Cal. The beneficiary is obligated by statute to reimburse the State for any benefits provided when the beneficiary receives payment from a liable third party. Given the above similarities between *Reichle* and Medi-Cal, the court could apply the rationale of the *Reichle* decision and reach a sim-

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127. Id. at 547-48, 71 P.2d at 850-51.
128. Id.
129. Id.
130. Id.
131. Id.
132. Id.
133. See note 116 supra.
134. Since Medi-Cal is a publicly funded health care program, any funds recovered by the program would decrease the burden on the public. See Morris v. Williams, 67 Cal. 2d 733, 749, 433 P.2d 697, 708, 63 Cal. Rptr. 689, 700 (1967); CAL. WELF. & INST. CODE §§10020, 14000, 14000.1, 14124.70-14124.79.
135. 22 Cal. App. 2d at 547, 71 P.2d at 850-51.
136. CAL. WELF. & INST. CODE §§14124.70-14124.79.
ilar holding in a Medi-Cal case. A further indication that a California court will apply the collateral source rule for Medi-Cal payments is exemplified by the Third District Court of Appeal's recent interpretation of section 3333.1 of the California Civil Code.

b. California Civil Code Section 3333.1

The court's interpretation of Section 3333.1 was articulated in Brown v. Stewart that involved a suit for medical malpractice. The plaintiff's medical benefits had been paid for by the Medi-Cal program. The defendant wanted to introduce this fact into evidence so that the jury might reduce the damages by that amount. In California, the measure of damages in a tort action is governed by section 3333 of the Civil Code. This code section provides that the amount of damages, except when otherwise expressly provided by this code, is the amount that will compensate for all the detriment proximately caused thereby, whether it could have been anticipated or not. Nevertheless, section 3333.1 of the Civil Code specifically allows a defendant, in an action for personal injury against a health care provider based upon professional negligence, to introduce evidence of some of the amounts payable to plaintiff as a result of the personal injury, for the purpose of reducing the special damages. For an amount payable to be introduced, it must have been made pursuant to one of the following: the U.S. Social Security Act; any state or federal income disability insurance; accident insurance that provides health care benefits or income disability coverage; or any contract or agreement of any group to provide, pay for, or reimburse the cost of health care services. Thus, section 3333.1 of the Civil Code becomes an exception to the collateral source rule by specifically allowing into evidence, for the purpose of reducing damages, the fact that the health services were paid for by a third party.

In Brown, the question presented was whether medical benefits paid by the Medi-Cal program came under the purview of this statute.

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137. See 22 Cal. App. 2d at 547-48, 71 P.2d at 851.
139. Id. at 651, 175 Cal. Rptr. at 513.
140. See id. at 658-59, 175 Cal. Rptr. at 518-20.
141. California Civil Code Section 3333 provides:
   For the breach of an obligation not arising from contract, the measure of damages, except where otherwise expressly provided by this Code, is the amount which will compensate for all the detriment proximately caused thereby, whether it could have been anticipated or not.
142. Id.
143. CAL. CIV. CODE §3333.1.
144. Id.
145. 121 Cal. App. 3d, at 653-54, 175 Cal. Rptr. at 517.
The court held that only those benefits specified in the statute were affected. Since Medi-Cal payments were not made by any of the organizations listed in the statute, evidence of Medi-Cal payment could not be used to reduce the damages. In Brown, the court was not willing to permit Medi-Cal payments into evidence under a statute that specifically allowed certain types of payments to be introduced. It seems logical to infer that absent a statute that specifically allows evidence of payment by Medi-Cal to be introduced, the court would be unwilling to permit this type of evidence to be admitted.

Based on the principles of Helfand, Reichle, and Brown, if a case were to come before a court in California regarding the applicability of the collateral source rule to Medi-Cal payments, the courts would undoubtedly apply the rule. Evidence of Medi-Cal’s payment for the medical services would therefore be excluded and the plaintiff’s special damages could not be reduced by any amount attributable to Medi-Cal’s payment. When a lien is subsequently placed on the tort recovery by the State for services paid by Medi-Cal, adequate funds should be available to cover the lien. Furthermore, if the recovery were based on the reasonable value of the services, an additional amount of money allocated to the medical expenses should be remaining, i.e., the difference between the reasonable value of the service and the Medi-Cal lien. An area of disagreement arises regarding which individuals should be allowed to receive payment from this recovery. The next section will discuss who is entitled to reimbursement from the tort recovery under the current application of the law.

B. Who is entitled to receive compensation from the damages?

Sections 14124.70-14124.79 of the California Welfare and Institutions Code provide that the California Department of Health Services has a right, in the case of injury by a tortfeasor to a Medi-Cal beneficiary, to sue the tortfeasor directly, join in the beneficiary’s action, or place a lien on the proceeds. When the Medi-Cal beneficiary receives a tort recovery, he or she must therefore reimburse the State for any tort-related services for which the Medi-Cal program paid, pro-

146. Id. at 658, 175 Cal. Rptr. at 518-19.
147. See id.
vided the State places a timely lien on the recovery. 150

Under Section 14124.74 of the California Welfare and Institutions Code, the beneficiary is required only to reimburse the State for the amount of the benefits actually paid on behalf of the beneficiary. 151 Since Medi- Cal's payment rate for medical services is far below the reasonable value of the services, 152 and a beneficiary's settlement for medical expenses should be based on the reasonable value of the services, 153 excess funds will remain after the State is reimbursed. 154 The question of who is entitled to receive the difference between the reasonable value of the services provided and Medi-Cal fees is currently disputed. 155

According to the interpretation of Section 14019.4 by the State, the provider of services is prevented from accepting payment for services, except from another insurer, after he or she has billed Medi-Cal. 156 Thus, the provider would be prohibited from receiving additional funds from a tort recovery. 157 The beneficiary would therefore be entitled to keep the "excess" medical payments as well as any general damages. 158 The interpretation by the State of this statute was recently tested in two cases. 159

Winter v. Gnaizda 160 involved a minor child injured in an automobile accident. The minor received medical services from a provider who billed and was subsequently reimbursed by the Medi-Cal program. 161 The claimant's attorney recovered insurance proceeds under an uninsured motorist claim. The provider then submitted a bill to the attorney and his client for the difference between the amount charged in the original bill and the sum paid by Medi-Cal. 162 Before honoring the

150. See note 148 supra.
151. California Welfare & Institutions Code Section 14124.74(a) states in part:
[alter payment of such expenses and attorney's fees the court or agency shall, on the
application of the director, allow as a first lien against the amount of such judgment or
award, the amount of the director's expenditures for the benefit of the beneficiary under
the Medi-Cal Program, as provided in subdivision (d) of Section 14124.72.
152. REPORT TO THE GOVERNOR, supra note 6, at 6.
153. See note 90 supra.
155. See text accompanying notes 17-19 supra.
156. See text accompanying note 74 supra.
157. See text accompanying note 74 supra.
158. See 22 CAL. ADM. CODE §51471(a)(1). See note 16 supra.
161. Id. at 753-54, 152 Cal. Rptr. at 703.
162. Id.
bill, the attorney contacted Blue Shield, the fiscal intermediary for Medi-Cal, and was told that the physician was not entitled to any additional amounts.163 The provider sought declaratory relief.164 The trial court held the provider was entitled to recover the difference between his full fee and the lesser amount paid under the Medi-Cal program.165

A contrary holding was reached in Palumbo v. Myers.166 In Palumbo, a provider treated a patient for injuries suffered in an automobile accident.167 The provider billed the Medi-Cal program and was paid in accordance with Medi-Cal's reduced fee schedule. Thereafter the patient filed a suit that was subsequently settled. Included in the settlement was $3,739.00 allocated for medical services rendered by Dr. Palumbo. Of that sum, $217.87 was paid to Medi-Cal to reimburse the program. Dr. Palumbo was given a check for $1,567.13 by the patient's attorney, that amount being the difference between his usual and customary fee and the Medi-Cal allotment.168 The provider did not cash the check, stating that to do so would violate the Welfare and Institutions Code Section 14019.4 and Title 22 California Administrative Code Sections 51005 and 51471.169 Dr. Palumbo sought declaratory relief from the court.170 The court held that the reference to contractual or legal entitlement contained in Section 14019.4 did not encompass the concept of third party liability, and thus additional recovery would not be allowed.171 The provider could not recover the difference between his usual and customary fee and the Medi-Cal payment from the proceeds of a personal injury suit won or settled by the patient.172 This case is presently under appeal.

The current state of the law is unsettled. The State contends that a provider may not accept additional payment from a tort recovery after he or she has accepted payment by Medi-Cal.173 The trial courts are in disagreement as to the application of the law. A major problem with the current interpretation by the State of the law is that it sharply deviates from the general theory of tort law and damages.

163. Id.
164. Id.
165. Id.
167. Id.
169. Id.
170. Id.
171. Id. at 3-6.
172. Id.
173. See note 16 supra.
DEROGATION OF THE THEORY OF TORT DAMAGES
BY MEDI-CAL

MEDI-CAL law in the area of third party liability does not adhere to the general theory of tort damages.\(^174\) The law of tort damages is based on the principle that a person injured by a wrongful or negligent act of another shall be justly compensated to a degree commensurate with the injury sustained.\(^175\) Compensation is the stated goal of the courts in awarding damages for tortious injury.\(^176\) Compensation most often takes the form of restoring the plaintiff to the same position he or she was in prior to the tort.\(^177\)

The plaintiff's recovery is usually limited to a fair compensation and indemnity for the injury sustained.\(^178\) When a person is injured by a liable third party and incurs medical bills, usually the award of special damages for the reasonable value of the services justly compensates the individual for the financial loss sustained.\(^179\) The individual will merely pay the medical bills or reimburse his or her medical insurance plan under the subrogation clause of the contract.\(^180\) This result is not reached under the MEDI-CAL program. Although the State has a statutory right to reimbursement for payment of any medical bills,\(^181\) it has denied the provider a right of subrogation or the ability to place a lien on the beneficiary's settlement or judgment.\(^182\) The result is that for purposes of determining tort damages, the value of the medical services will be determined in accordance with judicial criteria; but, when determining what amount of the tort recovery will be distributed to persons for payment of medical services provided, the value of the services will be determined according to MEDI-CAL's criteria.\(^183\) The problem with this application is that the MEDI-CAL value for the services is based on certain policy considerations that are different from those of tort

\(^{174}\) The plaintiff is entitled to be placed in the same position financially that he or she would have been in, if the injury in question had not been caused by the defendant. Dodds v. Buckman, 214 Cal. App. 2d 206, 212-213, 29 Cal. Rptr. 393, 396-97 (1963); Tremeroli v. Austin Trailer Equip. Co., 102 Cal. App. 2d 464, 481, 227 P.2d 923, 934 (1951); CAL. CIV. CODE §3333.


\(^{177}\) See note 147 supra.
\(^{178}\) See note 90 supra.
\(^{179}\) See note 90 supra.
\(^{181}\) CAL. WELF. & INST. CODE §§14124.70-14124.79.
\(^{182}\) See id. §§14019.3, 14019.4. See note 16 supra.
\(^{183}\) See Morris v. Williams, 67 Cal. 2d 733, 749, 433 P.2d 697, 708, 63 Cal. Rptr. 689, 700 (1967); California Ass'n of Nursing Homes v. Williams, 4 Cal. App. 3d 800, 817, 84 Cal. Rptr. 590, 602 (1970); CAL. WELF. & INST. CODE §§14000, 14000.1, 14075, 14078, 14079, 14105.
damages.\textsuperscript{184} The Medi-Cal program is funded on revenues generated by the state and federal government.\textsuperscript{185} Since this reserve is limited, the program must take all precautions to contain the costs of the program with the result being that providers' fees are not equal to the reasonable value of the services.\textsuperscript{186} Providers, well aware of this fact, agree to accept less money to perform the services. When Medi-Cal pays for the medical services, the funds are coming from the government; whereas, in the case of a tort recovery, the payment for the medical services are coming from the tortfeasor.\textsuperscript{187}

The value that the judicial system has placed on these services, for the purposes of ascertaining damages, is the reasonable value of the services. This is the value that the tortfeasor must pay.\textsuperscript{188} A person who is not eligible for Medi-Cal normally will be required to reimburse his or her physician for the reasonable value of the services provided, and therefore, any tort recovery received by the individual will be reduced accordingly. A Medi-Cal beneficiary, however, is only required to reimburse the Medi-Cal program for the amount the program paid the provider in accordance with its fee schedule.\textsuperscript{189} Obviously, the Medi-Cal beneficiary is obligated to pay lower medical bills than the individual who is not on Medi-Cal due to the intervention by the State. Nevertheless, the Medi-Cal beneficiary's special damages are based on the reasonable value of the medical services provided. The State law thus allows the beneficiary to keep the difference between the payment by Medi-Cal and the reasonable value of the services.\textsuperscript{190} The beneficiary ends up in a better financial position than before the injury since the medical care was received free of charge, and the Department's lien is approximately 50%-65% of the medical bills.\textsuperscript{191} The beneficiary, therefore, is allowed to retain the other 35%-50%. Due to this inequitable result between Medi-Cal beneficiaries and non-Medi-Cal beneficiaries, any change in the current law to allow providers to receive additional reimbursement from the proceeds of a tort recovery would follow the general theory of tort damages and should be acceptable to

\begin{itemize}
  \item \textsuperscript{184} See note 183 \textit{supra}.
  \item \textsuperscript{186} See note 108 and accompanying text \textit{supra}.
  \item \textsuperscript{187} See note 7 and accompanying text \textit{supra}.
  \item \textsuperscript{188} See note 90 \textit{supra}.
  \item \textsuperscript{189} \textit{Cal. Welf. & Inst. Code} \S\S 14124.70-14124.79.
  \item \textsuperscript{190} See notes 16 and 63 \textit{supra}.
  \item \textsuperscript{191} See \textit{Report to the Governor}, supra note 6, at 6. See note 16 \textit{supra}.
\end{itemize}
PROPOSED SOLUTION

The current situation could be resolved in two ways: (1) a court decision which would set precedent in the area; or (2) an amendment to the Welfare and Institutions Code, specifically allowing providers to receive up to their full payment in the case of a tort recovery.

A. Judiciary

Resolving this issue by judicial fiat has the disadvantage of a potentially undesirable result and a lengthy wait. The court may decide not to allow this type of recovery under the current statute. The Legislature has addressed the issue of contractual or other legal entitlement to medical care and third party liability in various provisions of the Welfare and Institutions Code. The State, in interpreting these sections of legislation, has specifically differentiated between third party liability and other coverage. To change the existing application of the law, the court would have to find the longstanding State interpretation unreasonable and unsupported by policy grounds. The position of the State is as follows:

The tortfeasor is not a “third party payor” as referenced in Section 14019.4 of the Welfare and Institutions Code. This term refers primarily to public or private health insurance carriers with whom the beneficiary has a policy of health insurance, or other forms of no-fault health insurance held by others against which the beneficiary could claim as a matter of right such as those contained in the “med-pay” portion of uninsured motorist auto insurance policies and some homeowners policies. These forms of entitlement are treated differently in the code from tort recoveries. Recoveries from tortiously liable third parties are the personal property of the beneficiary and subject to Medi-Cal’s right to assert a lien under Sections 14124.70-14124.79 of the Welfare and Institutions Code. An injury caused by


193. CAL. WELF. & INST. CODE §§14019.3, 14019.4, 14023, 14024, 14124.70-14124.79.


195. The construction of a statute by the officials charged with its administration must be given great weight, for their “substantially contemporaneous expressions of opinion are highly relevant and material evidence of the probable general understanding of the times and of the opinions of men who probably were active in the drafting of the statute” Whitcomb Hotel, Inc. v. California Employment Comm’n, 24 Cal. 2d 753, 756-57, 151 P.2d 233, 235 (1944); see Gibson v. Unemployment Ins. Appeals Bd., 9 Cal. 3d 494, 498 n.6, 509 P.2d 945, 947 n.6, 105 Cal. Rptr. 1, 3 n.6 (1973); Bodinson Mfg. Co. v. California Employment Comm’n, 17 Cal. 2d 321, 325-26, 109 P.2d 933, 938-40 (1941).
another does not give rise to a "legal entitlement" per se; only the right to bring an action wherein liability to pay may or may not be legally established.\textsuperscript{196}

Since the law specifically gives the State the right to payment in both the area of third party liability\textsuperscript{197} and other legal entitlements,\textsuperscript{198} and only gives the provider the right to collect additional compensation in cases of other legal entitlements,\textsuperscript{199} the law could be reasonably interpreted to mean that the Legislature did not intend to give providers the right to receive full compensation in the case of third party liability. The courts, therefore, probably will not overturn the interpretation by the State of the current law. Further, in deciding this issue the courts may take some time, and in the interim providers are subjected to the interpretation of the law by the State.

B. Legislation

The enactment of a statutory amendment to the Welfare and Institutions Code would be the most effective means of achieving the desired results. The code could be amended to allow the provider to receive compensation from the tort recovery.

The current organization of the Welfare and Institutions Code distinctly separates the right to reimbursement by the State from the rights and restrictions regarding providers\textsuperscript{200}. Legislation which would increase the provider's right to reimbursement would logically affect only those sections of the Welfare and Institutions Code concerning providers. Specifically, sections 14019.3 and 14019.4, that affect the provider's ability to receive additional compensation, should be amended to allow providers to receive additional compensation in the instance of a tort recovery where the patient has been compensated for the injury by a liable third party. This comment proposes an amendment to these two code sections as set forth in the appendix.

One problem which must be addressed when proposing an amendment in this area is that federal law requires the provider to accept payment by the Medicaid program as payment in full.\textsuperscript{201} This obstacle, however, can be overcome by analogizing "third party liability" to "other coverage." Although the State presents several reasons why bill-

\textsuperscript{196} Letter from Richard H. Koppes, Chief Counsel, Dept. of Health Services to Mary R. Solbakken (Nov. 24, 1978).
\textsuperscript{197} CAL. WELF. & INST. CODE §§14124.70-14124.79.
\textsuperscript{198} Id. §§14023, 14024.
\textsuperscript{199} Id. §§14019.3, 14019.4.
\textsuperscript{200} Id. §§14019.3, 14019.4, 14023, 14024, 14124.70-14124.79.
\textsuperscript{201} See 42 U.S.C. §1396h(d) (Supp. III 1979).
ing the other insurer is allowable in light of federal law, the main focus seems to be that once the actual flow of funds is complete, the beneficiary's medical bills are paid for by someone other than Medi-Cal, i.e., the other insurer. This is also true, however, when the beneficiary receives a tort recovery since once the Medi-Cal program has been reimbursed, the medical bills have actually been paid for by someone other than Medi-Cal, i.e., the liable third party. The State would argue that this rationale does not apply to third party liability since the State is seldom totally reimbursed from the tort recovery, and therefore, has still paid for part of the services. One reason this occurs, however, is because the State is prohibited by statute from receiving more than a certain portion of the recovery. In addition, the State may determine that it is in the best interest of those involved to compromise the claim, thus reducing the amount the State would normally receive. Further, the State is required to pay for a portion of the attorney's fees incurred. Thus, as a result of statutory prohibitions as well as compromises by the State, the reimbursement of the State often will not be an amount equal to the money paid for medical services by the State. This certainly does not justify the argument that, since the State has not been fully reimbursed, the provider should not be allowed to receive any payment from the recovery, when in fact Medi-Cal has the right to be fully reimbursed up to the amount legally permissible. Furthermore, the argument by the State is not consistent with the fact that theoretically the State is not always fully reimbursed from the other insurer. Moreover, if the provider billed the other insurer first and the insurer paid less than the Medi-Cal amount for that particular service, the provider could still bill the program for an amount up to the Medi-Cal allowable charge. If the current law, that allows providers to bill other insurers, has not come under the federal prohibition, then proposed legislation regarding third party liability also would not be prohibited by federal law.

CONCLUSION

The purpose of the Medi-Cal program is to ensure that medical

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202. See notes 51-61 and accompanying text supra.
203. See text accompanying note 77 supra.
204. CAL. WELF. & INST. CODE §14124.78.
205. Id. §14124.71.
206. Id. §14124.72.
207. Id. §§14124.71, 14124.72, 14124.78.
208. The other coverage is only obligated to pay the amount that it contracted to pay for, therefore, even if this contractual amount is less than Medi-Cal's fee, that is all the State will recover. This will leave the State to absorb the excess.
209. See 22 CAL. ADM. CODE §51471; CAL. WELF. & INST. CODE §14019.4.
treatment is made available to individuals who cannot otherwise obtain medical care. Providers of medical services are encouraged to participate in the program, yet the payment for their services is relatively low. Further, Medi-Cal prohibits the provider from billing the beneficiary or any other person for the provision of medical services, once the provider has accepted Medi-Cal payment. This policy protects beneficiaries from being held personally liable for the medical services provided.

A problem occurs when a third party, such as other health insurance or casualty insurance, is legally liable to pay for the medical services. In this case, the question arises as to whether the provider may bill the liable third party for the difference between his or her usual and customary fee and the amount Medi-Cal has paid.

A close examination of the current application of the law regarding third party liability and the Medi-Cal program has shown that an inconsistent result is reached by distinguishing between “other coverage” and “third party liability.” Providers are allowed to receive additional compensation when a beneficiary has other insurance coverage. Nevertheless, when the beneficiary receives special damages in a tort recovery, designed to compensate him or her for medical expenses, the beneficiary is only required to reimburse Medi-Cal for the amount it paid the provider, which is approximately 50%-65% of the provider’s usual and customary fee.\(^\text{210}\) The beneficiary is not required to pay the remainder of the special damages to the provider, but rather is allowed to retain it, thereby placing the beneficiary in a better position financially than before the injury.

State law has thus resulted in the Medi-Cal value for services being interjected into a judicial system where the value for medical services should be based on the reasonable value of the services provided as a result of the tortious injury. An individual whose medical bills were not paid for by Medi-Cal will be required to pay his or her provider the reasonable value of the services rendered; whereas, the Medi-Cal beneficiary is only required to pay the State a reduced Medi-Cal value for the same services. In both cases, however, the special damages of the tort recovery is based on the reasonable value of the medical services.

An equitable resolution to this problem would be to amend the current law to allow the provider, when the beneficiary receives a tort recovery, to recover the difference between the amount paid by the Medi-Cal program and the amount billed. This solution would allow the

\(^{210}\) See Report to the Governor, supra note 6, at 6.
proceeds of a tort recovery to be applied in the manner intended by the judicial system which made the recovery possible.

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APPENDIX

Sections 14019.3 and 14019.4 of the California Welfare and Institutions Code should be amended (strike out indicating omit; underscore indicating additions) to read as follows:

§14019.3 Return of payment for services otherwise covered by Medi-Cal program; submission of claim for Medi-Cal reimbursement

A beneficiary or any person on behalf of the beneficiary who has paid for health care services otherwise covered by the Medi-Cal program received by the beneficiary shall be entitled to a return from the provider of any part of such payment which:

(1) Was rendered during any period prior to the receipt of his Medi-Cal card, for which such card authorizes payment under Section 14018 or 14019;

(2) Was reimbursed to the provider by the Medi-Cal program, following all audits and appeals to which the provider is entitled;

(3) Is not payable by a third party under contractual or other legal entitlements; and

(4) Was not used to satisfy his paid or obligated liability for health care services or to establish eligibility.

Upon presentation of the Medi-Cal card or other proof of eligibility, the provider shall submit a Medi-Cal claim for reimbursement, subject to the rules and regulations of the Medi-Cal program. Payment received from the state in accordance with Medi-Cal fee structures shall constitute payment in full. The provider shall return any and all payments made by the beneficiary, or any person on behalf of the beneficiary, for Medi-Cal program covered services upon receipt of Medi-Cal payment.

§14019.4 Proof of eligibility; prohibition against provider seeking reimbursement or payment for covered services; receipt; exemption

(a) Any provider of health care services who obtains a label or copy from the Medi-Cal card or other proof of eligibility pursuant to this
chapter shall not seek reimbursement nor attempt to obtain payment for the cost of such covered health care services from the eligible applicant or recipient, or any person other than the department or third party payer who provides a contractual or legal entitlement to health care services/ or any other liable third party.

(b) Whenever a service or set of services rendered to a Medi-Cal beneficiary results in the submission of a claim in excess of five hundred dollars ($500), and the beneficiary has given the provider proof of eligibility to receive such service or services, the provider shall issue the beneficiary a receipt to document that appropriate proof of eligibility has been provided. The form and content of such receipts shall be determined by the provider but shall be sufficient to comply with the intent of this subdivision. Skilled nursing facilities and intermediate care facilities are exempt from the requirements of this subdivision.