IN THE COURT OF APPEALS
FOR THE STATE OF GEORGIA

FRANCIS CLOUTHIER, Appellant, v. THE MEDICAL CENTER OF CENTRAL GEORGIA, INC. Appellee.	CASE NO. Court of Appeals No. A19A0848

BRIEF OF GEORGIA HOSPITAL ASSOCIATION, INC. and GEORGIA ALLIANCE OF COMMUNITY HOSPITALS, INC. AS AMICI CURIAE

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Pursuant to Georgia Court of Appeals Rule 26, the Georgia Hospital Association, Inc. and the Georgia Alliance of Community Hospitals, Inc. file this amici curiae brief in support of Appellee The Medical Center of Central Georgia, Inc. ("Appellee" or "MCCG"). For the reasons set forth herein, the Court should affirm the trial court's dismissal of Appellant Francis Clouthier's Complaint.

STATEMENT OF INTEREST

A. Amicus Curiae – The Georgia Hospital Association.

The Georgia Hospital Association, Inc. ("GHA") is a nonprofit trade association made up of member health systems, hospitals, and individuals in administrative and decision-making positions within those institutions. Founded in 1929, GHA serves 168 hospitals in Georgia, which in turn employ thousands of physicians and even more nurses and other healthcare providers. GHA's purpose is to promote the health and welfare of the public through the development of better hospital care for all of Georgia's citizens. GHA represents its members in legislative matters, as well as in filing *amicus curiae* briefs on matters of great gravity and importance to both the public and to health care providers serving Georgia citizens.

B. Amicus Curiae – The Georgia Alliance Of Community Hospitals.

The Georgia Alliance of Community Hospitals, Inc. (the "Alliance"), a Georgia nonprofit corporation, is an industry association comprised of

approximately 75 nonprofit community hospitals and health systems, urban and rural, large and small, located throughout the State of Georgia. The Alliance is dedicated to furthering the ability of community hospitals to fulfill their primary mission of serving their local communities. To that end, the Alliance represents its members in efforts to promote sound health care policy, laws, and regulations affecting Georgia's community hospitals.

C. Interest Of Amici Curiae.

GHA and the Alliance submit this amici curiae brief in the interest of carrying out their missions for their member hospitals and in furtherance of the overall health and welfare of the citizens of this State. This case calls into question whether GHA and Alliance members may continue the long-standing practice of filing hospital liens based on established charges that have been reported to and, in many cases, approved by federal and state agencies. GHA and the Alliance submit this brief because their member hospitals, and the communities and patients they serve, will suffer great harm if this Court were to reverse the trial court's well-reasoned decision granting MCCG's motion to dismiss.

For decades, and without controversy, Georgia hospitals have recorded liens for amounts due by using their established charges. If Appellant is permitted to create a new private cause of action out of the hospital lien statute where none exists, it would thwart the intent of the General Assembly and expose hospitals to

unintended risk and potential liability. Furthermore, because the question of what constitutes a "reasonable charge" for a particular service always is subject to debate, lawsuits like this one, if allowed to proceed, will have a chilling effect on hospitals' continued use of Georgia's lien statute, which will erode the very purposes of the statute to the detriment of hospitals and their patients alike. This case, therefore, involves issues of critical importance to hospitals and patients throughout Georgia.[1]

INTRODUCTION

This case presents the issue of whether a patient may lodge a private cause of action for damages based on the filing of a hospital lien consistent with its publicly available "chargemaster" rates — the detailed list of a hospital's charges for each service provided by that hospital. The chargemaster is the hospital-specific database of all billable items that go on patients' accounts, containing all of the descriptions, revenue codes, procedure and other service codes, department associations, and codes for different payors. See Am. Health Info. Mgmt. Ass'n, *Care and Maintenance of Chargemasters (Updated)*, 81 J. AHIMA (2010). These chargemasters contain specific prices for every specific service and supply the hospital provides, often containing tens of thousands of service-specific prices.

[1] The Amici incorporate MCCG's statement of facts, as well as the points raised at page 10 of MCCG's reply brief explaining why the Georgia Supreme Court's holding in Bowden II, see Bowden v. Med. Ctr., Inc., 297 Ga. 285 (2015), is distinguishable and does not control the outcome of this case.

By utilizing a chargemaster, a hospital ensures that it charges all patients, regardless of their financial status, the same amount. See Holland v. Trinity Health Care Corp., 791 N.W.2d 724, 729-30 (Mich. Ct. App. 2010) (acknowledging that the chargemaster is used to charge patients the same rate for the same services, regardless of whether the patient is uninsured, insured, or a beneficiary of a government program such as Medicaid or Medicare).

Hospitals' use of chargemasters originated from federal laws and policies that require hospitals to charge the same amount for the same service to all patients, regardless of their financial status or enrollment in various health benefit programs. What a hospital actually receives in payment, however, varies significantly based on the applicable payor. The existing hospital reimbursement structure includes not only legislatively determined payment rates for services provided to Medicare and Medicaid beneficiaries, but also contractually negotiated (often discounted) rates with certain private insurance carriers. Regardless of the payor, the hospital bills the same chargemaster rates, and the payor is the one that calculates the payment amount, including any potential reductions to the billed amounts, based on, for example, government-mandated reimbursement rates, a written contract negotiated between the payor and the hospital, or the patient's health benefit plan.

Once the payor calculates the payment amount, both the hospital and the patient typically receive an explanation of benefits, which is the documentary means by which government healthcare programs and commercial insurers notify beneficiaries and providers how an individual healthcare claim was processed for payment. Notably, while the explanation of benefits reflects both the billed amount and the allowable amount (*i.e.*, the payment amount per the written provider agreement or contract), to the extent those two amounts differ, the hospital's billed charges remain unchanged.

In this case, Appellant argues that hospitals may not similarly rely on their chargemaster rates when recording liens but, instead, must guesstimate at an amorphous "reasonable charge" in their lien filings. The trial court correctly rejected Appellant's argument. The trial court found that the applicable lien statute, O.C.G.A. § 44-14-470 *et seq.*, allows hospitals to perfect liens in the "amount claimed to be due for the hospital." Id. The statute does not, as Appellant would suggest, require hospitals to *record* liens in the amount of so-called "reasonable charges." For this reason, as the trial court correctly concluded, resolution of Appellant's claims does not require a determination whether the amount of the lien at issue in this case utilizes "reasonable charges."

Appellant contends that Sections 470 and 471 should be read *in pari materia* to mandate that a hospital filing a verified lien for an "amount claimed to be due"

must be able to prove that the amount "claimed to be due" is a "reasonable charge." (Appellant's Opening Br. at 8.) This contention misses the mark for several reasons. Appellant first ignores that Sections 470 and 471 serve uniquely different purposes. Section 470 establishes a type of hospital lien by operation of law. Specifically, when hospitals treat patients injured by a third party tortfeasor, the hospitals have liens for any services provided in the amount of reasonable charges. Section 471, on the other hand, outlines the steps hospitals must take to perfect liens, and expressly provides that hospitals should file their liens, not for "reasonable charges" but, instead, in the "amount claimed to be due." O.C.G.A. § 44-14-471. Appellant's argument ignores not only the distinct purposes of these two sections of the lien statute, but also the distinct terms the General Assembly chose to include in each section. Indeed, Appellant's proposed construction would render the phrase "amount claimed to be due" entirely superfluous. The General Assembly could have required hospitals to claim a "reasonable charge" for purposes of perfecting their liens, but did not. See Deal v. Coleman, 294 Ga. 170, 172 (2013) ("When we consider the meaning of a statute, we must presume that the General Assembly meant what it said and said what it meant.") (internal quotations omitted). In this regard, it is not a coincidence that the lien process mirrors the process hospitals use to bill all other types of payors (*i.e.*, hospitals uniformly bill at their respective chargemaster rates, but the amount actually received from the

payor ultimately *may* be reduced based on a host of factors, including contractually negotiated terms and conditions).

If Appellant's statutory construction prevails (which would require the Court to ignore the distinct terms in Sections 470 and 471 chosen by the General Assembly and wholly disregard the phrase "amount claimed to be due"), Georgia's hospitals cannot file liens under Section 471 without risk of liability because the question of what constitutes a "reasonable charge" for any particular service always will be subject to debate. This risk would not be inconsequential. Under Appellant's theory, if the amount specified in a lien notice later is reduced, the filing hospital would be subject to potentially unlimited liability, conceivably including punitive damages. This would have a chilling effect on hospitals' use of the lien statute, to the detriment of not only hospitals but also their patients who may be subjected to debt collection if the lien statute is no longer workable.

Importantly, Appellant's new theories of liability are manufactured. When enacting Georgia's lien statute in 1953, the Georgia General Assembly did not include any provisions designed to expose hospitals or other healthcare providers to such potential liability. Indeed, the lien statute contains no express or implied private right of action against hospitals for alleged violations of the statute. Nor is there any basis to conclude that the General Assembly intended that the lien statute should give rise to ancillary causes of action against hospitals based on such

alleged violations. See Best Jewelry Mfg. Co., Inc. v. Reed Elsevier Inc., 334 Ga. App. 826, 835 (2015) (common law causes of action that are simply recast as torts and are based entirely on alleged violations of statutes without private rights of action are subject to dismissal as a matter of law).

Of course, this does not mean that patients or other interested parties have no means to contest the amount of a hospital lien. For example, Georgia courts recognize that such challenges may be raised in an action to enforce or invalidate the lien. (Indeed, the trial court acknowledged that, despite the dismissal of Appellant's Complaint for damages, Appellant and MCCG will have the opportunity to litigate both the validity and the amount of MCCG's hospital lien due to MCCG's counterclaim in this case.) But the fact that the amount and/or validity of a particular hospital lien may be contested in a collection action does not mean that causes of action, including claims for fraud and negligent misrepresentation, may accrue to patients based on a hospital's mere act of filing a lien for the amount claimed to be due (*i.e.*, the chargemaster rates) if the patient is successful in reducing the amount due or it is otherwise determined that any particular chargemaster rate is not a "reasonable charge" for a particular service or supply.

For each of these reasons, this case presents questions of great concern, gravity, and importance to the public. The Amici therefore support Appellee and urge this to Court to affirm the trial court's dismissal of Appellant's Complaint.

ARGUMENT AND CITATION OF AUTHORITIES

A. Appellant's Construction Of the Lien Statute Places An Impossible Burden On Hospitals — One That Is Not Contained In The Lien Statute.

Focusing solely on the language of Section 470(b), Appellant erroneously contends that Georgia's lien statute permits hospitals to place a lien on any recovery for only the reasonable amount of charges. This contention is at odds with the plain language of the statute and ignores the provisions of Section 471. As explained below, while the hospital lien statute entitles hospitals to *recover* only their reasonable charges, the statute does not preclude hospitals from *perfecting* their liens consistent with their standard, undiscounted charges; nor does the statute require hospitals to speculate what some third party may ultimately determine constitutes a "reasonable charge" for the services provided.

1. Sections 470 And 471 Evince A Common Legislative Intent To Grant Lien Rights To The Hospital, And In Turn Provide For Perfection Of The Lien In The Amount Claimed To Be Due For The Hospital.

Section 470 governs the *creation* and *attachment* of the lien as a matter of law, providing that hospitals "*shall have a lien* for the reasonable charges." O.C.G.A. § 44-14-470(b) (emphasis added). Without any action on the part of the

hospitals, the "lien attache[s] at the moment [the patient] receive[s] treatment . . . ." Macon-Bibb County Hosp. Auth. v. National Union Fire Ins. Co., 793 F. Supp. 321, 323 (M.D. Ga. 1992); Thomas v. McClure, 236 Ga. App. 622, 624 (1999).

"The method for *perfecting* such an existing lien is set forth in O.C.G.A. § 44–14–471." Thomas, 236 Ga. App. at 625 (emphasis added); Macon-Bibb County Hosp. Auth., 793 F. Supp. at 323 ("O.C.G.A. § 44–14–471 governs the method for perfecting a hospital lien"). To perfect a lien, a hospital files a statement with the clerk of superior court, including among other things, "*the amount claimed to be due for the hospital*." O.C.G.A. § 44-14-471(a)(2) (emphasis added). Similarly, the clerk must then record the hospital's statement in a hospital lien book and enter "*the amount claimed*." O.C.G.A. § 44-14-472 (emphasis added). The hospital is required to file its lien statement "within 75 days after the person has been discharged from the facility." O.C.G.A. § 44-14-471(a)(2)(B). And, the hospital is required to provide written notice of the lien to the patient at least "15 days prior to the date of filing [that lien] statement." O.C.G.A. § 44-14-471 (a)(1).

Thus, when read *in para materia*, Sections 470 and 471 evince a common legislative intent to grant lien rights to the hospital, and in turn provide for the perfection of the lien in the amount claimed to be due for the hospital. The lien statute does not purport to establish the amount, in any given case, of the actual

"reasonable charges" that ultimately may be recovered by the hospital in a subsequent collection or declaratory judgment action.

2. The Purpose Of The Hospital Lien Filing Is To Provide Notice To Those Who May Be Liable; It Need Not Be Exact.

"The filing of the claim or lien shall be notice thereof to all persons, firms, or corporations liable for the damages . . . ." O.C.G.A. 44-14-471(b); see also Macon-Bibb County Hosp. Auth., 793 F. Supp. at 323 ("the purpose of the perfection statute" is to provide notice to all liable parties of the amount claimed to be due for the hospital).

The Legislature's use of the phrase "amount claimed to be due for the hospital" is consistent with the purpose of the verified statement—to give actual and constructive notice of the existence and amount of the lien claimed by the hospital. The potential in some circumstances for there to be a difference between "the amount claimed to be due for the hospital" and a "reasonable charge" should not cause confusion for anyone reading the verified statement and familiar with the requirements of Section 471. The purpose of the verified statement is to identify "the amount claimed to be due for the hospital" and nothing else. Patients receive notice at least 15 days before the lien is filed and can challenge the "amount claimed to be due for the hospital" at any time thereafter (or even before), either through negotiation or through court action. Similarly, any tortfeasor should be aware that the verified statement reflects the "amount claimed to be due for the

hospital" and can attempt to prove that this amount exceeds "reasonable charges." But, simply because the patient or tortfeasor ultimately may, in a given case, obtain a ruling that the amount claimed to be due for the hospital exceeds "reasonable charges," does not mean that the hospital violated the hospital lien statute by filing the lien based on its standard, published rates as Appellant contends.

Indeed, the Georgia Supreme Court has recognized that the information in the lien does not need to "be exact on the date it was filed." Kite v. MCG Health, Inc., 296 Ga. 687, 689 (2015). As the Supreme Court has explained, "[t]here is nothing in O.C.G.A. § 44-14-470 et seq. imposing such a requirement, and we will not judicially legislate one." Id. Thus, in Kight, the Georgia Supreme Court upheld the hospital lien and affirmed the ruling that the award of attorneys' fees against the hospital pursuant to O.C.G.A. § 13-6-11 was improper, even when the lien was later modified to reflect a reduced amount based on a partial payment. Kight, 296 Ga. at 690.

3. The Lien Statute Does Not Impose Upon Hospitals The Impossible Task Of Predicting What A Plaintiff Later May Assert Or A Jury Later May Conclude Is A "Reasonable Charge".

Appellant's theory is premised on the notion that there is (or should be) a legal prohibition against using a hospital's established charges (*i.e.*, chargemaster rates) as the "amount claimed to be due for the hospital." But, as explained above, the hospital lien statute includes no such prohibition.

While the Georgia Legislature could have chosen to require hospitals to give notice of "reasonable charges" (and established guidelines for making such a determination), it chose instead to require notice of the "amount claimed to be due for the hospital." O.C.G.A. § 44-14-471(a)(2). The Legislature's use of this language is only logical—to do otherwise would impose upon hospitals the impossible task of guessing (under the potential penalty of losing its lien or facing a claim for damages) what someone else may later argue or determine are the "reasonable charges" for the services provided. Indeed, after a hospital perfects its lien, the amount that eventually is paid, not charged, often is subject to numerous adjustments related to, *inter alia*, the nature of the payor, various financial considerations, and even the gross amount available from the tort recovery. [2]

Importantly, the lien statute does not define the term "reasonable charges." Nor does the statute contain any methodology or ascertainable standards by which hospitals would calculate or otherwise determine "reasonable charges." In the absence of such guidance or directives, the standard hospital practice of filing liens

[2] What hospitals and insurers ultimately agree upon for purposes of resolving a perfected lien is often the product of extensive negotiations. Such negotiations are not dissimilar to those where the hospital contracts with an insurer as an in-network provider or where the hospital does not have a contract with a certain insurer or health plan and bills as an out-of-network provider. Under any of these scenarios, however, the amount the hospital ultimately receives in payment is not necessarily equal to "reasonable" reimbursement for the care and services provided but, rather, is the product of complex negotiations.

consistent with established, undiscounted charges set forth on a chargemaster cannot rationally be construed as an automatic violation of the statute.

B. A Violation of The Lien Statute Does Not Support Ancillary Causes of Action For Fraud and Negligent Misrepresentation.

Each of Appellant's claims is based on an alleged violation of the lien statute. That is, absent a violation of the statute, each of Appellant's claims necessarily fails. But even assuming *arguendo* that a hospital's practice of filing liens consistent with its standard, undiscounted charges could somehow qualify as a violation of the lien statute (which it does not), there is no basis to conclude that the General Assembly intended that any such violation should give rise to ancillary causes of action, including claims for fraud and negligent misrepresentation. See Best Jewelry Mfg. Co., Inc. v. Reed Elsevier Inc., 334 Ga. App. 826, 835 (2015) (affirming dismissal of common law torts of conversion, money had and received, and civil conspiracy based on alleged statutory violations that provided no private right of action for damages arising from such alleged violations; "a party cannot survive a motion to dismiss merely by recasting alleged statutory or constitutional violations as torts."); cf. Bellsouth Telecomm., LLC v. Cobb Cnty., 342 Ga. App. 323, 329 (2017) (holding that two Georgia counties could pursue claims for damages against telecommunications providers based on alleged violations of statute that provided no private right of action because the statute nevertheless imposed specific duties on the telecommunications providers owing to the

counties), *rev'd on other grounds by* Bellsouth Telecomm., LLC v. Cobb Cnty., No. S17G2011, 2019 WL 654174, at *8 (Ga. Supreme Court Feb. 18, 2019) (holding that counties could not pursue tort actions under the general tort statute to recover charges under the 911 Service Act not collected by telecommunication service providers because the charges were a tax and not a fee).

The dismissal of Appellant's claims was appropriate for this reason as well. The lien statute creates no private right of action against hospitals, either express or implied, for alleged violations of the statute. See Best Jewelry Mfg. Co., Inc., 334 Ga. App. at 833 ("it is well settled that violating statutes and regulations does not automatically give rise to a civil cause of action by an individual claiming to have been injured from a violation thereof. Rather, the statutory text must expressly provide a private cause of action.") (internal citations and quotations omitted); see also Bellsouth Telecomm., 342 Ga. App. at 326 ("Georgia has 'longstanding precedential authority rejecting the creation of implied private rights of action.'"), citing Somerville v. White, 337 Ga. App. 414, 417 (2016).

Nor does the lien statute impose any duty on hospitals for the benefit of injured patients. At most, the lien statute merely requires hospitals to comply with certain notice provisions to perfect the lien, as outlined above. But even if the hospital fails to comply with a particular notice requirement (which is not the basis of Appellant's alleged harm), there is no statutory basis to conclude that such

failure gives rise to liability on the part of the hospital to the patient (or otherwise obligates the hospital to perform some act for the benefit of the patient). In such a case, the lien is simply rendered unenforceable as a matter of law. See O.C.G.A. § 44-14-471(b); Kennestone Hosp., Inc. v. Travelers Home and Marine Ins. Co., 330 Ga. App. 541 (2015). Had the General Assembly intended otherwise, it would have done so expressly.

Ironically, Section 477 (in conjunction with Section 473) is the only provision in the lien statute that arguably could support an ancillary cause of action for its violation, and that cause of action would exist against the injured party, not the hospital. Section 473 relates to instances where, for purposes of resolving his or her claims, an injured party provides an affidavit confirming that all hospital bills for treatment of the injuries for which a settlement is made have been fully paid. See O.C.G.A. § 44-14-473 ("any person, firm, or corporation which consummates a settlement, release, or covenant not to bring an action with the person to whom hospital … services were furnished and which first procures ***from the injured party an affidavit*** as prescribed in subsection (c) of this Code section shall not be bound or otherwise affected by the lien….") (emphasis added). Section 477 then makes clear that an injured party who provides a false affidavit commits the offense of a false swearing. O.C.G.A. § 44-14-477 ("Any person who gives any

false affidavit as provided by Code Section 44-14-473 commits the offense of false swearing.").

In these circumstances, the lower court appropriately dismissed Appellant's claims.

C. Filing Liens Consistent With Chargemaster Rates Cannot, As A Matter Of Law, Qualify As A False Statement.

1. Chargemaster Rates Provide A Reliable And Consistent Benchmark By Which Hospitals Perfect Their Liens.

In addition to ignoring the text of the lien statute allowing hospitals to file statements for the "amounts claimed to be due," Appellant's contention that filing liens consistent with chargemaster rates constitutes an actionable false statement is belied for several reasons.[3] First, under established Georgia law, hospitals may bill for and collect their standard, undiscounted charges separate and apart from the lien statute. Second, patients, like Appellant in this case, are allowed to recover the hospital's standard, undiscounted charges in their causes of action against the tortfeasors who caused their injuries. Third, Appellant's contention that hospitals' chargemaster rates are grossly excessive compared to what hospitals typically receive in payment from certain payors reflects a fundamental misunderstanding of hospital economics. Hospitals' use of chargemasters originates from federal laws

[3] MCCG did not swear that the amount of its filed lien constitutes "reasonable charges." Instead, the lien stated: "The amount claimed to be due for hospital care received by the patient [is] $56,856.89."

and policies that require hospitals to charge the same amount for the same service to all patients, regardless of their financial status or enrollment in various payor programs, and hospitals are required by state and federal law to publish their established charges. See O.C.G.A. § 31-7-11; 83 FED. REG. 41144 at 41686 (Aug. 17, 2018).

For each of these reasons, hospitals reasonably utilize these chargemaster rates in determining "the amount claimed to be due for the hospital."

a) Georgia Courts Allow Hospitals To Charge And Collect Rates Consistent With Their Established Charges.

Georgia law allows hospitals to bill for and collect their respective chargemaster rates. Indeed, where a patient agrees to pay for medical care, but the parties' agreement does not specify the prices for such care, Georgia courts have consistently held that hospitals may collect amounts consistent with the hospital's published rate structure, *i.e.*, chargemaster rates. See Morrell v. Wellstar Health System, Inc., 280 Ga. App. 1, 5 (2006) (affirming dismissal of patients' breach of contract and other claims where patient agreed to pay "all charges" and hospital subsequently billed patients at chargemaster rates); Cox v. Athens Regional Medical Center, Inc., 279 Ga. App. 586, 590-91 (2006) (affirming dismissal of patients' breach of contract and other claims where hospital charged patients at

higher "uninsured" rates based on admission forms that required payment but did not specify price for services).

Thus, consistent with such precedent, hospitals reasonably rely on their established chargemaster rates for purposes of setting forth the "amount claimed to be due for the hospital." Indeed, it would be illogical for a hospital to be permitted to recover its chargemaster rates in a contract action where the contract contains no specific price terms, yet be judged to have committed fraud for perfecting a lien — which merely provides notice of the amount claimed to be due for the hospital — in the same amount.

b) Georgia Courts Routinely Allow Patients To Recover Hospital Charges As Reasonable Damages In Their Personal Injury Claims.

Georgia courts have long held that, for a tort action seeking recovery of medical expenses, "'[t]he law requires proof that the medical expenses arose from the injury sustained, and that they are reasonable and necessary before they are recoverable." Allen v. Spiker, 301 Ga. App. 893, 896 (2009) (quoting Barnes v. Cornett, 134 Ga. App. 120 (1975)); Johnson v. Cook, 123 Ga. App. 302 (1971). Pertinently, this Court has found that charged rates, not discounted payments, are the appropriate measure for such expenses. Because the lien statute allows a hospital to "step into the shoes" of the personal injury plaintiff, O.C.G.A. § 44-14-473; Southern General Ins. Co. v. WellStar Health System, Inc., 315 Ga. App. 26

(2012), a hospital must be permitted to seek the same amount as a plaintiff, which often is based on charges.

More specifically, this Court has ruled that an injured plaintiff's "cause of action against [a] tortfeasor for injuries and economic damages . . . [is] not limited to seeking economic damages represented by the discounted amounts paid on the [h]ospital's billed charges under the contract with [the insurance provider]." MCG Health, Inc. v. Perry, 326 Ga. App. 833, 837 (2014). "Rather, [a plaintiff is] entitled to recover medical expenses arising from his injuries, including hospital charges, that [are] 'reasonable and necessary.'" Id. at 837-38. Thus, in the context of tort claims, this Court has already recognized that there is no equivalency between an insurer's discounted payment rate and the full reasonable and necessary medical expenses.

Thus, personal injury patients are permitted to, and typically do, seek to recover hospital charges as the basis for their personal injury damages (even in cases where the hospital actually accepted less because of a discount negotiated with a health insurer).[4] In this effort to obtain damages, a personal injury plaintiff

[4] In seeking to recover medical charges, a plaintiff-patient (or a family member responsible for his or her care), "shall be a competent witness to identify bills for expenses incurred in the treatment of the patient upon a showing by such a witness that the expenses were incurred in connection with the treatment of the injury . . . involved in the subject of the litigation at trial. . . ." O.C.G.A. § 24-9-921(a). And "***it shall not be necessary for an expert witness to testify that the charges were reasonable and necessary***." Id. at § 24-9-921(b) (emphasis added) (noting further

endorses and adopts the reasonableness of charges for the services provided by a hospital. Only when it is time to satisfy a hospital lien does a personal injury plaintiff typically challenge the reasonableness of a hospital's charges.

If this Court allows a patient to use one standard for the reasonableness of charges in her personal injury claim, but another in her dealings with the hospital, the patient will gain a windfall while the hospital will suffer a loss. (Appellant would further compound this loss by seeking multiples of damages from the hospital). Indeed, the Georgia Supreme Court previously cautioned that the statute would be frustrated if a patient could obtain payment directly from his insurer for "the full amount of an outstanding hospital lien and then turn around and negotiate a compromise settlement with the hospital and *pocket the change*." State Farm Mt. Auto. Ins. Co. v. Adams, 288 Ga. 315, 319 (2010) (emphasis in original).

The bottom line is that if it is permissible for a tort plaintiff to use a hospital's established charges as proof of medical expenses incurred (even if the hospital ultimately accepts a lesser amount as payment in full), then it must be permissible for a hospital to utilize the same charges in connection with its lien notice as "the amount claimed to be due for the hospital".

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that the defendant may challenge such testimony on cross examination); see also Emory Healthcare, Inc. v. Pardue, 328 Ga. App. 664, 673 (2014) ("[A]ll that is required is 'that it be shown that medical expenses were incurred in connection with the treatment of the injury, disease or disability involved in the subject of litigation at the trial, which may be done by lay testimony.'").

c) Chargemaster Rates Provide A Reliable And Consistent Benchmark By Which Hospitals Perfect Their Liens.

Appellant's challenge to one hospital's use of established chargemaster rates for purposes of perfecting its lien reflects a fundamental misunderstanding or misstatement of hospital economics that, if accepted, would be ruinous for all Georgia hospitals.

Georgia hospitals uniformly use their respective chargemaster rates for all patients and, accordingly, justifiably utilize such rates in stating "the amount claimed to be due for the hospital." Importantly, hospitals' uniform use of chargemasters originated from federal laws and policies that require hospitals to charge the same amount for the same service to all patients, regardless of their financial status or enrollment in various payor programs.[5] What each hospital receives in payment, however, varies significantly based on the applicable health plans or payors. The existing hospital reimbursement structure includes not only legislatively determined payment rates for services to Medicare and Medicaid

[5] For example, the Centers for Medicare and Medicaid Services ("CMS"), which oversees the Medicare program, requires hospitals to maintain an established charge structure and to supply a copy of the most current chargemaster to federal and state entities upon request. 42 C.F.R. § 413.20(d)(3). CMS then requires its contractors to evaluate each hospital's charging structure on a routine basis to confirm that the hospital's charges are appropriate for determining program payment. Id. And, CMS may reduce a hospital's customary charges for payment purposes if a hospital does "not actually impose charges on most of the patients liable for payment for its services on a charge basis" or if it "failed to make reasonable effort to collect those charges." 42 C.F.R. § 413.13(e).

beneficiaries, but also contractually negotiated (often discounted) rates with certain private insurance carriers or self-funded employers, which, in the latter case, often is the result of complex and lengthy negotiation processes.

In both cases, hospitals send every payor a bill consistent with the hospital's respective chargemaster rates. In most cases, the payor (whether a private insurer or government payor) runs the billed claim through its own "pricer" to determine the amount to be paid (the "allowable amount"). Irrespective of whether the claim is processed by a private or government payor, any associated discount applied by the private or government payor is not reflected anywhere on the hospital's bill. Instead, both the hospital and the patient receive documentation, most commonly referred to as an explanation of benefits, for the claim that reflects the hospital's billed charges and the amount deemed "allowable" by the payor.

The process for billing uninsured patients follows a similar process. Hospitals bill uninsured patients at full chargemaster rates for the care and services provided. Only if an uninsured patient applies for financial assistance or other discounts under a given hospital's publicly available financial assistance or other policies, will patient-specific determinations be made regarding eligibility for reduced charges (or free care in the case of indigent patients).

Thus, Appellant is complaining that he did not receive the same contractually negotiated discounts as other payors,[6] not that the hospital did not apply charges uniformly to all patients.

While the role of chargemasters has come under increased scrutiny in recent years in connection with efforts to curtail healthcare costs or improve pricing transparency, that is part of a broader healthcare policy debate that must also recognize that hospitals are struggling under the current reimbursement structure, particularly given challenges in collecting amounts due and the high and increasing

[6] Any discrepancies between chargemaster rates and amounts paid by government payors does not mean that chargemaster rates are unreasonably high. To the contrary, Medicare payments are too low and do not even cover costs. For twelve consecutive years, Medicare ***payments have fallen well below the cost of the hospital care*** provided to seniors and disabled Americans. Thus, hospitals are operating at a financial loss even after they receive payment for providing care to Medicare patients. The Medicare Payment Advisory Commission ("MedPAC"), a nonpartisan legislative branch agency that provides Congress with analysis and policy advice on the Medicare program, reported that hospitals' aggregate Medicare margin was a ***negative 9.6 percent*** in 2016, and that the losses were projected to increase to 10 percent by 2017. REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY, Chapter 3, Hospital Inpatient and Outpatient Services, p. 66 (March 2018) (available at http://medpac.gov/-documents-/reports). In 2016, for Medicare and Medicaid, hospitals received payment of only 87 cents and 88 cents, respectively, for every dollar spent caring for Medicare and Medicaid patients in 2016. See American Hospital Association, "*Underpayment by Medicare and Medicaid Fact Sheet*" (Dec. 2017) (available at https://www.aha.org/system/files/2018-01/medicaremedicaid underpmt%202017.pdf).

numbers of uninsured or underinsured patients served by hospitals.[7] Such broader policy debates do not alter the fact that hospital chargemasters continue to play a key role in health care delivery and reimbursement systems.[8] As noted above, hospitals are required to charge the same amount for the same services, regardless of whether the patient has the best commercial insurance coverage available, Medicare, or is uninsured and below the federal poverty level. In fact, certain private insurers make payments based on contractually negotiated discounts off of charges.

The ubiquitous use of chargemaster rates throughout the hospital industry is further evidenced by relatively new federal regulations. Effective January 1, 2019, the federal government requires all hospitals in the country to post their chargemasters online so that consumers may compare rates. See 83 FED. REG. 41144 at 41686 (Aug. 17, 2018) (requiring hospitals "to make available a list of

[7] To illustrate, in 2016, Georgia hospitals absorbed more than $1.8 billion in costs for care that was provided but not paid. See Georgia Hospitals' Economic Impact (April 3, 2018) (available at https://www.gha.org/Newsroom/Economic-Impact). In the same year, Georgia's uninsured rate was twelve percent, the third highest in the nation. Id. The Georgia Department of Community Health Hospital Financial Survey shows that, in 2016, forty percent (40%) of all hospitals in Georgia had negative total margins, and sixty-three percent (63%) of rural hospitals in the state lost money. Id.

[8] That said, an evolution in hospital billing practices is underway, with hospitals and governmental and private payors experimenting with alternative payment methodologies, including value based purchasing and bundled payments. Such experimentation and change further highlight the importance of the hospital lien law allowing hospitals to perfect liens in the "amount claimed to be due for the hospital."

their current standard charges via the Internet in a machine readable format and to update this information at least annually, or more often as appropriate"). These regulations recognize that hospital charges are not uniform across hospitals, and may vary greatly for individual services and deliverables. Given the lack of any standard charge for any particular supply or service, the federal government's posting requirements "enable patients to compare charges for similar services across hospitals." Id.

This wide variability of chargemaster rates throughout the United States further underscores the fact that what may constitute "reasonable charges" in any given case is subject to debate and may vary depending on circumstances unique to a given hospital and the community it serves.

In short, by asking this Court to find that lien notices utilizing published chargemaster rates will constitute false statements if a third party later determines that the published rates exceed "reasonable charges", Appellant is seeking rulings that would resonate throughout the complex hospital financing system and have wide-spread, unintended consequences. If accepted, Appellant's theories also would disrupt established pricing models that government and private payors previously reviewed and approved.

If Appellant prevails, hospitals throughout Georgia will be placed in a no-win situation. If they seek to recover monies owed under the hospital lien statute,

they will face significant new uncertainty, speculation, risk, and potential liability. The alternative, which is to potentially forego payment for services rendered, could threaten the viability of Georgia's most vulnerable hospitals, including trauma hospitals, rural hospitals, and other safety-net hospitals.[9] Too many Georgia hospitals are in a precarious financial state already, with nine hospitals closing within the last seven years. The financial strain on Georgia hospitals has increased exponentially over the past seven years as a result of dramatic cuts in Medicare payments, beginning with enactment of the Patient Protection and Affordable Care Act of 2010, 42 U.S.C. § 18001 (2010) (the "ACA") and continuing with subsequent legislative and regulatory changes to further reduce Medicare payments.[10]

In summary, for decades Georgia hospitals have perfected liens using their chargemaster rates as the amounts claimed to be due. Despite generally amending

[9] Hospitals that provide trauma services typically file more hospital liens than other hospitals. Rural and urban safety net hospitals typically serve higher percentages of Medicaid and uninsured patients, which makes collections very important when a payment source exists. If Appellant's theory of liability is allowed to proceed, these critical hospitals will suffer disproportionate harm as they must either forego payment or face potential liability.

[10] Although many enacted cuts are not yet fully implemented, Georgia hospitals experienced an estimated $3 billion in Medicare payment reductions since 2010. While some of the payment cuts in the ACA were intended to pay for the expansion of coverage for millions of uninsured patients, Georgia has not yet implemented a program to bridge the coverage gap. Georgia hospitals therefore are experiencing dramatic payment reductions while still serving high numbers of uninsured patients.

the lien statute six times (most recently in 2006), the General Assembly has not taken any action to restrict this widespread practice. In amending the statute, the General Assembly did not include a method for establishing "reasonable charges" or otherwise dictate that chargemaster rates are an inappropriate basis for claiming amounts due.

If the trial court's order is reversed, hospitals will have no reasonable means to determine how much to "claim to be due" when perfecting a lien.

D. Liability Exposure Under Georgia's Lien Statute May Prompt Unintended Consequences For Courts, Providers, And Patients.

Finally, Appellant's arguments ignore that Georgia's lien statute affords benefits and protections to providers and patients alike. The statute reduces the amount of litigation that otherwise would be necessary for hospitals to secure payment of health care debts. The statute also protects patients by attaching the lien only to the patient's cause of action against the third-party tortfeasor, rather than to the patient's property or to the patient personally. See O.C.G.A. § 44-14-470(b) ("only a lien against such cause of action and shall not be a lien against such injured person … or any other property or assets of such person and shall not be evidence of such person's failure to pay a debt"); see also O.C.G.A. § 44-14-471(a)(1) (hospital must include in its written notice of the lien "a statement that the lien is not a lien against the patient or any other property or assets of the patient and is not evidence of the patient's failure to pay a debt"). The lien statute thus is

designed to allow hospitals ultimately to be paid for services rendered without utilizing traditional debt collection activities against patients, including immediate collection efforts, personal judgments, reports to credit agencies, and personal litigation.

A judicial ruling that would subject hospitals to potential liability merely for utilizing chargemaster rates (or any other rates that ultimately are deemed in excess of some unknowable "reasonable charges") when perfecting a lien will erode these important policies of reducing litigation while protecting hospitals' ability to collect payment for services rendered to patients when another source of insurance covers these services. Appellant's arguments (if accepted) would render the lien statute too unworkable to use. As a result, hospitals would be placed in the untenable position of either proceeding immediately with traditional debt collection or foregoing payment altogether (to the detriment of their bottom lines and ability to serve patients).

CONCLUSION

For the reasons set forth above, GHA and the Alliance urge this Court to affirm the August 13, 2018 Order of the trial court dismissing Appellant's Complaint.

Respectfully submitted this 19th day of April, 2019.

"This submission does not exceed the word count limit imposed by Rule 24."

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I have this day caused the foregoing Brief of Georgia Hospital Association and Georgia Alliance of Community Hospitals as Amici Curiae to be served upon counsel for Petitioner and counsel for Respondents by depositing a copy of same in the United States Mail, with sufficient postage affixed thereto to ensure deliver, addressed to the following:

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