

Senate Bill No. 1471

CHAPTER 848

An act to add Chapter 3.5 (commencing with Section 3040) to Title 14 of Part 4 of Division 3 of the Civil Code, relating to health care liens.

[Approved by Governor September 28, 2000. Filed with Secretary of State September 29, 2000.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1471, Schiff. Health care liens.

Existing law provides for the regulation of health care service plan contracts by the Department of Managed Care and for the regulation of health insurance policies issued by disability insurers regulated by the Department of Insurance, as specified.

This bill would provide that no lien asserted by a licensee of the Department of Managed Care or the Department of Insurance, and no lien of a medical group or an independent practice association, to the extent it asserts or enforces a lien, for the recovery of money paid or payable to or on behalf of an enrollee or insured for medical services provided under a health care service plan contract or disability insurance policy, may exceed specified amounts. These provisions would not apply to a lien made against a workers' compensation claim, against a 3rd party for Medi-Cal benefits, and for hospital services, as specified. The bill would declare that it would not create any lien right that does not currently exist at law and would not make a lien that arises out of an employee benefit plan or fund enforceable if preempted by federal law. The bill would prohibit its provisions from being admitted into evidence or given in an instruction in any civil action between an enrollee or insured and a 3rd party.

The people of the State of California do enact as follows:

SECTION 1. Chapter 3.5 (commencing with Section 3040) is added to Title 14 of Part 4 of Division 3 of the Civil Code, to read:

CHAPTER 3.5. HEALTH CARE LIENS

3040. (a) No lien asserted by a licensee of the Department of Managed Care or the Department of Insurance, and no lien of a medical group or an independent practice association, to the extent that it asserts or enforces a lien, for the recovery of money paid or payable to or on behalf of an enrollee or insured for health care



services provided under a health care service plan contract or a disability insurance policy, when the right of the licensee, medical group, or independent practice association to assert that lien is granted in a plan contract subject to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) or a disability insurance policy subject to the Insurance Code, may exceed the sum of the reasonable costs actually paid by the licensee, medical group, or independent practice association to perfect the lien and one of the following:

(1) For health care services not provided on a capitated basis, the amount actually paid by the licensee, medical group, or independent practice association pursuant to that contract or policy to any treating medical provider.

(2) For health care services provided on a capitated basis, the amount equal to 80 percent of the usual and customary charge for the same services by medical providers that provide health care services on a noncapitated basis in the geographic region in which the services were rendered.

(b) If an enrollee or insured received health care services on a capitated basis and on a noncapitated basis, and the licensee, medical group, or independent practice association that provided the health care services on the capitated basis paid for the health care services the enrollee received on the noncapitated basis, then a lien that is subject to subdivision (a) may not exceed the sum of the reasonable costs actually paid to perfect the lien, and the amounts determined pursuant to both paragraphs (1) and (2) of subdivision (a).

(c) If the enrollee or insured engaged an attorney, then the lien subject to subdivision (a) may not exceed the lesser of the following amounts:

(1) The maximum amount determined pursuant to subdivision (a) or (b), whichever is applicable.

(2) One-third of the moneys due to the enrollee or insured under any final judgment, compromise, or settlement agreement.

(d) If the enrollee or insured did not engage an attorney, then the lien subject to subdivision (a) may not exceed the lesser of the following amounts:

(1) The maximum amount determined pursuant to subdivision (a) or (b), whichever is applicable.

(2) One-half of the moneys due to the enrollee or insured under any final judgment, compromise, or settlement agreement.

(e) Where a final judgment includes a special finding by a judge, jury, or arbitrator, that the enrollee or insured was partially at fault, the lien subject to subdivision (a) or (b) shall be reduced by the same comparative fault percentage by which the enrollee or insured's recovery was reduced.



(f) A lien subject to subdivision (a) or (b) is subject to pro rata reduction, commensurate with the enrollee's or insured's reasonable attorney's fees and costs, in accordance with the common fund doctrine.

(g) This section is not applicable to any of the following:

(1) A lien made against a workers' compensation claim.

(2) A lien for Medi-Cal benefits pursuant to Article 3.5 (commencing with Section 14124.70) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code.

(3) A lien for hospital services pursuant to Chapter 4 (commencing with Section 3045.1).

(h) This section does not create any lien right that does not exist at law, and does not make a lien that arises out of an employee benefit plan or fund enforceable if preempted by federal law.

(i) The provisions of this section may not be admitted into evidence nor given in any instruction in any civil action or proceeding between an enrollee or insured and a third party.

