Nos. S279862 & S280018

IN THE

SUPREME COURT OF CALIFORNIA

TAYLOR CAPITO,

Plaintiff and Appellant,

v.

SAN JOSE HEALTHCARE SYSTEM LP,

Defendant and Respondent.

ANSWER TO PETITION FOR REVIEW

After a Decision by the Court of Appeal
Sixth Appellate District, Case Nos. H049646, H049022

On Appeal from the Superior Court,
County of Santa Clara, Case No. 20CV366981
Hon. Sunil R. Kulkani

KING & SPALDING LLP
Glenn Solomon (State Bar No. 155674)
E-Mail: gsolomon@kslaw.com
Ariana E. Fuller (State Bar No. 301797)
E-Mail: afuller@kslaw.com
633 West Fifth Street, Suite 1600
Los Angeles, California 90071
Telephone: (213) 443-4355
Facsimile: (213) 443-4310

Attorneys for Defendant and Respondent San Jose Healthcare System LP

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Introduction

The so-called "duty to disclose" issue presented by plaintiff Taylor Capito in her Petition for Review is misleading and incomplete.

In each of the cases cited by Capito in her petition, the plaintiffs—represented by the same attorneys in every case—argued that hospitals in California have a duty to disclose to patients in the emergency room, in advance of providing emergency care, the existence and amounts of emergency department level charges (also known as evaluation and management services fees or "EMS Fees"). The federal Centers for Medicare and Medicaid Services ("CMS") requires hospitals to include EMS Fees on every bill for emergency services. (80 FR 70448; 83 FR 58819, 58837; 65 FR 18451.) They range in levels from one to five, and hospitals are required to assess these fees for emergency department encounters and to ensure that each level fee correlates to the intensity of hospital resources utilized in providing care to that patient. (*Ibid.*) A level 1 EMS Fee is assessed for more minor injuries or illnesses, up to a level 5 EMS Fee, which is assessed for severe and life-threatening injuries and illnesses.

The Court of Appeal in this case found the EMS Fee *was* disclosed: "The five levels vary depending on the severity of treatment, ranging from minor to complex and life-threatening, and are disclosed in Regional's chargemaster." (*Capito v. San Jose Healthcare System LP* (Apr. 6, 2023, H049022) 2023 WL 2805481, at *2, reh'g denied (May 1, 2023), petn. for review filed (May 16, 2023) ("*Capito*").) Further: "Capito did not allege that the chargemaster was not available either online or at the hospital at the time she received treatment in June 2019." (*Id.* at *11 [referencing state and federal statutes and regulations, including the requirement "to 'post a clear and conspicuous notice in its

emergency department' informing patients that the chargemaster is available for review and how it may be accessed"].)[1]

The *real* question is whether disclosure should be made according to state and federal statutes and regulations—or whether, as Capito proposes—disclosure must be made by filling walls in emergency department entry ways with ad hoc signage designed by plaintiffs' counsel, juries, and the courts. Courts of Appeal have soundly rejected plaintiff's proposal here and similarly in *Gray v. Dignity Health* (2021) 70 Cal.App.5th 225 (*Gray*) (review denied, Jan. 26, 2022, S271918), and *Saini v. Sutter Health* (2022) 80 Cal.App.5th 1054 (*Saini*) (review denied, Sept. 14, 2022, S275688).

Plaintiff's proposal did not merit this Court's review in *Gray* or *Saini* and it does not merit review here. In fact, the small number of cases cited by plaintiff as raising this question have all been brought *by Plaintiff's counsel*. (See Petn. for review, pp. 6, fn. 1.)

Significantly, there is no conflict among holdings of the Courts of Appeal. Capito's petition for review cites *Torres v. Adventist Health System/West* (2022) 77 Cal.App.5th 500 (*Torres*) and *Naranjo v. Doctors Medical Center of Modesto, Inc.* (2023) 90 Cal.App.5th 1193 (*Naranjo*), but both cases are plainly distinguishable on their facts. The plaintiffs in both *Torres* and *Naranjo* alleged that the hospitals in those cases had not made their chargemasters available to them—as they are required to do under existing statutory and regulatory authority. Those facts are absent here, as they were in *Gray* and *Saini*.

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[1] Capito does not challenge these statements from the opinion in her petition for review. (CRC 8.500(c) ["on petition for review the Supreme Court normally will not consider an issue that the petitioner failed to timely raise in the Court of Appeal"].)

Moreover, *Naranjo* was wrongly decided and should be depublished as it improperly applied the "safe harbor" doctrine applicable to general unfair competition law claims to the more specific California Consumer Legal Remedies Act (CLRA). No California court has previously applied the safe harbor doctrine to the CLRA, and *Naranjo* appears to have done so as a matter of first impression with zero analysis. Further still, even if the "safe harbor" doctrine applies to CLRA claims, *Naranjo* ignored the California Supreme Court's counsel that safe harbors exist both if the Legislature has "permitted certain conduct" ***and also*** if it has "considered a situation and concluded that no action should lie." (*Cel-Tech Communications, Inc. v. Los Angeles Cellular Telephone Co*. (1999) 20 Cal.4th 163, 182 (*Cel-Tech*).) Both the trial court and the Court of Appeal below took judicial notice of the legislative history of various statutes governing hospital disclosures, which reflect that the Legislature specifically contemplated requiring hospitals to provide cost estimates to patients in the emergency department and ultimately determined not to. Thus, there is in fact a safe harbor that bars the requested relief.

Review should be denied.

Statement of the Case

A. Capito chose to receive emergency medical care at Regional Medical Center

Capito twice sought emergency care at Regional Medical Center[2] ("Regional"): once on June 18, 2019 and again on June 20, 2019. (Second amended complaint (SAC) ¶ 19, AA324.) During both visits, Capito signed the Hospital's Conditions of Admission form

[2] Defendant San Jose Healthcare System LP owns and operates the hospital named Regional Medical Center of San Jose.

("Contract"), which expressly incorporates the Hospital's "price list (known as the 'Charge Master')." (*Id.*, Exh. A, ¶ 8, AA339.) Capito further agreed that she was "given the opportunity to read and ask questions about the information in this form, **specifically** including but not limited to the financial obligation's provisions and assignment of benefit provisions" and had signed her agreement "freely and without inducement." (*Id.* at ¶ 23, AA346, emphasis added.)

Capito contends her bills showed a "Level 4" EMS Fee, which is one of five potential industry standard EMS levels. (SAC ¶ 20, AA325.) Undisclosed "discounts" were applied to Capito's bill, presumably from her unnamed insurance, reducing the bill by two-thirds, from over $33,000 to less than $8,100. (*Id.*) Capito is not and will never be financially responsible for the hospital's full billed charges for these services, including for the EMS Fee, because she had health insurance coverage for her visits and the amount owed as payment for the services provided to her was determined by agreement between the Hospital and Capito's insurer.

Capito does not complain or suggest that she did not need emergency care. Capito also does not allege that she concerned herself with the cost, ever checked the Hospital's website to determine costs or payment, "shopped around" or sought an estimate, or was asked to pay more than her insurer required her to pay. Capito also does not contend there were alternative appropriate emergency facilities that do not charge EMS Fees.

B. Legislative history and judicially noticeable facts confirm that EMS Fees are not billed "on top" of the treatment and services provided to patients

One of Capito's misguided theories is that the EMS Fee is billed "***on top of*** the individual charges for each item of treatment and service

provided." (SAC ¶ 10, AA320, emphasis added.) Capito contends that there is a "striking difference" between EMS Fees "and ***any of the thousands of other line items***" on the Chargemaster, because all of the other line items are "***solely*** dependent on the individual items of treatment and services ordered for the patient and which cannot be known by Defendant in advance." (SAC ¶ 16, AA323, emphasis added.)

Based on the legislative history, evaluation and management "level" charges vary depending on the resource intensity needed for each patient. The Chargemaster[3] demonstrates that the Hospital, like all hospitals throughout the country, impose different "level" charges for different types of services in a variety of different departments, including emergency departments. These different levels follow standards set by the American Medical Association. (*YDM Management Co., Inc. v. Sharp Community Medical Group, Inc*. (2017) 16 Cal.App.5th 613, 618-619 ["providers follow 'standard billing procedures that are set forth by the American Medical Association' which 'require the use of Current Procedural Terminology ('CPT') codes and other codes that identify, among other things, the type of services provided, and where the services are provided," and specifically noting that "[e]mergency

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[3]As discussed in more detail herein, hospitals must submit their Chargemasters to the California Department of Healthcare Access and Information ("HCAI"), formerly known as the Office of Statewide Health Planning and Development ("OSHPD"), a California state agency, which then publishes all California hospital Chargemasters on its website for the public to see. (Health & Saf. Code, § 1339.55(a) ["Beginning July 1, 2004, each hospital shall file a copy of its charge description master annually with the office"].) Thus, the prices for hospital services are subject to judicial notice. (The Court of Appeal took judicial notice of this, as did the trial court, AA888; *Capito*, 2023 WL 2805481, fn. 2.)

services are coded using the following CPT codes: 99281, 99282, 99283, 99284, and 99285"].)

Contrary to Capito's assertion, there is nothing unique about different level charges in an emergency room, nor are they billed "on top" of the services provided. Federal regulations since 2000 from the Centers for Medicaid and Medicare Services ("CMS") have required hospitals nationwide to bill emergency visits for Medicare patients using this five-level system. (83 FR 58819; see also 65 FR 18451, 80 FR 70448.) The five mandated emergency department levels, 99281, 99282, 99283, 99284, and 99285, are approved by CMS to capture the varying degrees of hospital resources required for a given emergency department encounter, which can range from minor dog bites to serious gunshot wounds with vital organ damage. (72 FR 66580.) CMS requires that "each hospital's internal guidelines should follow the intent of the CPT code descriptors, in that the guidelines ***should be designed to reasonably relate to the intensity of hospital resources to the different levels of effort represented by the codes***." (*Id.*, emphasis added; see also 80 FR 70448.) The Court of Appeal in this case recognized these requirements. (*Capito*, *supra*, 2023 WL 2805481, at *7.)

In other words, EMS Levels are tied to the severity of the condition and resources required to render care. A patient who requires more complex care necessarily requires more resources, and thus, will be subject to a higher-level charge. The other charges that Capito received in the emergency room, as CMS acknowledged, do not capture the many different services that a hospital provides which lack their own individualized charge—*e.g.*, the care provided by trained and licensed nurses, the use of hospital rooms specially equipped with medically appropriate diagnostic, monitoring, and treatment

equipment, and other services and material that are not separately billed.

CMS requires hospital guidelines for setting charges for EMS levels using standards that: (1) are designed to reasonably relate to the intensity of hospital resources to the different levels of effort represented by the code; (2) are based on hospital resources and not physician resources; (3) are clear to facilitate accurate payments and are usable for audits; (4) meet HIPAA requirements; (5) only require documentation that is clinically necessary for patient care; (6) do not facilitate upcoding or gaming; (7) are written; (8) are applied consistently; (9) do not change with great frequency; and (10) result in coding decisions that can be verified by hospital staff and others. (72 Fed.Reg. at 66805). Even assuming Capito could bring a private right of action, she does not allege that the Hospital's coding failed to meet CMS' standards. Thus, far from being a charge "on top of" charges for "treatment and services" rendered, EMS Fees represent the services provided in the emergency department. (Health & Saf. Code, § 1339.55(a); 42 U.S.C. § 300gg-18(e).)

C. The trial court found in favor of the Hospital

Capito filed her initial putative class action complaint against the Hospital on June 6, 2020, see AA14, and putative class action First Amended Complaint on July 20, 2020, see AA28. Both the initial complaint and the First Amended Complaint alleged a single cause of action against the Hospital on behalf of Capito and others similarly situated: alleging violation of the Consumer Legal Remedies Act ("CLRA"), on the grounds that the Hospital failed to disclose to Capito and the putative class members the existence and amount of ER Levels Fees in advance of providing emergency medical care.

The Hospital demurred to and moved to strike class allegations from the First Amended Complaint on December 4, 2020. (AA43; AA56.) In its demurrer, the Hospital argued that Capito's proposed duty to disclose EMS Fees in advance of providing emergency care does not exist as a matter of law. (AA58.) On February 24, 2021, the trial court overruled the demurrer, but granted the motion to strike class allegations from the First Amended Complaint, with leave to amend.[4] (AA307.)

Capito filed her Second Amended Complaint on March 23, 2021, wherein she realleged a violation of the CLRA, and added two more causes of action: one for declaratory judgment and a second alleging violation of California's Unfair Competition Law ("UCL"). (AA316.) Regional demurred on May 6, 2021. (AA352.)

The Hospital also moved to strike class allegations. Regional extensively briefed the legislative history behind the Payor's Bill of Rights (Assembly Bill 1627) and federal and state regulations governing pricing disclosures. (AA366-371).

The trial court heard argument on June 24, 2021. (AA854.) On July 29, 2021, the trial court issued an order *sua sponte* reconsidering its previous legal analysis concerning Regional's demurrer arguments to the FAC. (AA888.) The court requested supplemental briefing on two issues: a) "the relevance (or lack thereof) of the legislative history of

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[4] On April 14, 2021, Capito filed a notice of appeal of the trial court's February 24, 2021 Order granting Regional's motion to strike. (AA349.) That appeal, Case No. H049022, is one of the two appeals "considered together for purposes of briefing, oral argument, and disposition" in the Court of Appeal. See February 14, 2022 Order by the Court of Appeal. Capito's Petition for Review does not concern the trial court's ruling on the motion to strike class allegations from the FAC, nor the Court of Appeal's refusal to consider whether the trial court erred in striking the class allegations from the FAC.

Assembly Bill 1627 (2002-2003 Regular Session) — which eventually became Health & Safety Code section 1339.51 — on Capito's UCL claim; and b) if the Court were to find that Regional's failure to provide additional notice about the EMS is not 'unfair' under the UCL in light of the legislative history of Assembly Bill 1627, the effect of that finding on Capito's other claims." (AA888-889.) Capito and Regional each filed their responsive briefs on August 27, 2021. (AA890; AA906.)

On September 17, 2021, the trial court issued a Supplemental Order and sustained the demurrer without leave to amend, and held the motion to strike was moot. (AA928-938.) Relying on the legislative history behind Assembly Bill 1627, the trial court found that requiring the Hospital to provide further disclosures on demand for every emergency room patient would upset the "deliberate legislative balance" that the Legislature has struck between the benefits of providing patient information about emergency room fees to consumers with the burden on hospitals to make this information available on demand. (AA935.) The trial court recognized that the "Legislature has already decided what disclosures sufficiently serve public policy, and has concluded that further disclosures of the type Plaintiff seeks would not serve this public policy or consumers well." (AA935, Sept. 17, 2021 Order at p. 8.)

The trial court relied on two cases in particular: *Ramirez v. Plough, Inc.* (1993) 6 Cal.4th 539 and *Nolte v. Cedars-Sinai Medical Center* (2015) 236 Cal.App.4th 1401. In *Ramirez*, the California Supreme Court considered whether manufacturers must include foreign language warnings on their nonprescription drugs. After reviewing "the dense layer of state and federal statutes and regulations that control" nonprescription drug labeling and marketing, "in particular the necessity or propriety of foreign-language label and package warnings,"

the Supreme Court found that it was inappropriate to impose a duty upon manufacturers to include foreign-language warnings with their packaging materials. The trial court further noted that *Ramirez* observed that "[g]iven the existence of a statute expressly requiring that package warnings on nonprescription drugs be in English, we think it reasonable to infer that the Legislature has deliberately chosen not to require that manufacturers also include warnings in foreign languages." (AA936, citing *Ramirez*, at pp. 548-556.)

The trial court found that the case at bar is similar to *Ramirez* in that there is a "dense layer" of federal and state laws concerning emergency room billing and disclosures. (AA936.) In particular, the California "Legislature enacted a statute expressly requiring certain billing disclosures for emergency room patients." (AA936.) In light of this legislative history and *Ramirez*, the trial court found "it would be inappropriate for the Court to impose an additional duty requiring additional billing disclosures."

In relying on *Nolte*, the trial court noted that the Court of Appeal "employed a balancing test to hold that existing law does not require a hospital to specifically disclose every individual charge in advance before billing a patient." (AA937, citing *Nolte*, 236 Cal.App.4th at 1409.)

Accordingly, Regional's purported non-disclosure "was not wrongful or unlawful under the CLRA and was not 'unfair' under the UCL." (AA935-AA936.) "Regional did not actively conceal a material fact, as the key fact—the existence of an EMS fee—was disclosed in the Chargemaster, as required by the legislative scheme." (AA936, fn. 6.)

As for Capito's declaratory relief claim, the trial court recognized that her claim is premised on two theories: an alleged duty to disclose

the EMS Fee and breach of contract claim — that the EMS Fee is not authorized by the Contract. (AA937.) Because Capito's "duty to disclose" declaratory relief claim did not differ materially from her UCL or CLRA claims, that portion of her declaratory relief claim also failed. (AA937.) For her other contract theory, the trial court found that:

> [U]nder the Contract, a patient promises to pay at the rates stated in the hospital's price list (i.e., the Charge Master) (See SAC, Ex. A, ¶ 8.) And the EMS Fee is on Regional's Chargemaster, as Plaintiff admits. (SAC, ¶ 15.) Thus, in the Court's view, the Contract does authorize the EMS Fee."
>
> Plaintiff argues that the EMS Fee is somehow 'overhead' that does not fall within the costs she agreed to pay by signing the Contract. But as Regional explains, the EMS Fee is characterized under federal regulations as relating to specific procedures, and not as generalized overhead. (See Regional's 8/27/21 Supp. Brief at p. 20.)
>
> The Court therefore sustains Regional's demurrer to these declaratory relief claims.

(AA937-938.) Because the dispositive issues for the demurrer as to all three causes of action "are legal, not factual, the Court [found] it appropriate to sustain the Hospital's demurrer WITHOUT LEAVE TO AMEND." (AA938.)

On September 27, 2021, Plaintiff filed a motion for reconsideration of the Court's order sustaining the demurrer without leave to amend. (AA970.) Regional filed an Opposition, addressing the newly published decision of *Gray v. Dignity Health* (2021) 70 Cal.App.5th 225. (AA977-980.) On November 22, 2021, the trial court denied the motion for reconsideration. (AA1014, 1015, citing *Gray v. Dignity Health* (2021) 70 Cal.App.5th 225.)

D. The Court of Appeal found in favor of the Hospital

1. The Court of Appeal rejected Capito's UCL claim

The Court of Appeal first addressed Capito's claim that Regional's alleged failure to disclose the EMS Fee is an unfair business practice under the UCL. In finding that it is not, the Court of Appeal relied extensively on *Gray.* In *Gray,* the First Appellate District, Division One, found "Dignity did not owe Gray the duty he claims was owed in this case—to disclose, prior to providing any medical emergency treatment, that its billing for such treatment would include an ER Charge." (*Gray v. Dignity Health*, 70 Cal.App.5th at 244-245.)

Gray recognized that the California Legislature "has enacted a series of statutes, collectively known as the 'Payers' Bill of Rights,' setting forth numerous obligations California hospitals owe to consumers with respect to the pricing of medical services." (*Gray*, 70 Cal.App.5th at 229, citing Health & Saf. Code, §§ 1339.50 et seq.)

Under the Payer's Bill of Rights—a comprehensive set of rules and regulations governing hospital price disclosure requirements—hospitals are required to undertake the following price disclosure obligations:

1. Section 1339.51(a) requires hospitals to make a written or electronic copy of its Chargemaster available online or at the hospital;
2. Section 1339.51(c) requires hospitals to "post a clear and conspicuous notice in its emergency department, if any, in its admissions office, and in its billing office that informs patients that the hospital's charge description master is available;"

3. Section 1339.55(a) requires hospitals to file a copy of its Chargemaster with OSHPD, which in turn publishes the Chargemasters on its agency website;
4. Section 1339.55(b) requires hospitals to calculate an estimate of the percentage increase in revenue due to annual charge increases and file the calculation with OSHPD, which then publishes it on its agency website;
5. Section 1339.56(a) requires hospitals to compile a list of 25 common outpatient procedures and submit that list annually to OSHPD, which then publishes that information on its website; and
6. Section 1339.56(c) requires hospitals to provide this list of 25 common outpatient procedures to any person upon request.

In addition to these requirements, "the state statutory scheme imposes a specific disclosure requirement with respect to persons 'without health coverage,' stating in pertinent part:

> Upon the request of a person without health coverage, a hospital shall provide the person with a written estimate of the amount the hospital will require the person to pay for the health care services, procedures, and supplies that are reasonably expected to be provided to the person by the hospital, based upon an average length of stay and services provided for the person's diagnosis.... **This section shall not apply to emergency services** provided to a person under Section 1317."

(*Gray,* 70 Cal.App.5th at 231, citing Health & Saf. Code, § 1339.585, emphasis added.)

As the Court of Appeal noted, section 1339.585, as originally introduced, "required hospitals to provide an estimate of charges upon

the request of any patient—including those receiving care in the emergency department." (*Gray*, 70 Cal.App.5th at 231, citing Assem. Bill No. 1045 (2005-2006 Reg. Sess.) as introduced Feb. 22, 2005; see Motion for Judicial Notice, Ex. D at 3.) "As the bill moved through the legislative process, **it was amended first to apply only to non-emergency patients** [citation] and then amended again to apply only to uninsured persons [citation]." (*Id.* citing Assem. Bill No. 1045 (2005-2006 Reg. Sess.) as amended May 27, 2005) and Assem. Bill No. 1045 (2005-2006 Reg. Sess.) as amended Sept. 6, 2005.) This legislative history, as noted by the Court in *Gray* and the Court of Appeal in this case, confirms that the legislature considered and explicitly rejected introducing a requirement to discuss costs with emergency room patients.

Section 1317, by contrast, imposes obligations on California hospitals specifically with respect to *emergency services*. (See *Gray*, *supra*, 70 Cal.App.5th at p. 231 [discussing § 1317].) It requires hospitals to provide emergency care to any person presenting at the emergency department "for any condition in which the person is in danger of loss of life, or serious injury or illness," and to do so regardless of the "ability to pay …." (Health & Saf. Code, § 1317, subds. (a), (b), (d).) Indeed, section 1317 mandates that "[e]mergency services and care shall be rendered *without first questioning the patient or any other person as to his or her ability to pay therefor*." (*Id.*, subd. (d) (emphasis added).) Introducing a discussion of certain, not all, emergency room costs, is likely to lead to a discussion regarding payment of costs and inquiries regarding additional costs, which is likely to cause confusion and lead to the very delay that the Legislature has taken great pains to avoid. "After" emergency care is provided "the patient or his or her legally

responsible relative or guardian **shall execute an agreement to pay therefor** or otherwise supply insurance or credit information ….” (*Ibid.*, emphasis added.)

Federal law imposes similar obligations on hospitals, such as Regional, that participate in Medicare. (See *Gray*, *supra*, 70 Cal.App.5th at pp. 231–234.) EMTALA requires hospitals to provide “an appropriate medical screening examination” to all individuals who present to its emergency department and require treatment, and hospitals “may not delay provision of an appropriate medical screening … to inquire about the individual’s method of payment or insurance status.” (42 U.S.C. § 1395dd(a), (h); see 42 C.F.R. § 489.24(d)(4)(ii) (2021).)

Further, federal regulations effective January 2, 2021, known as the Price Transparency regulations, imposed additional pricing disclosure requirements on hospitals—namely that they must file, in addition to their Chargemaster, a “list” of “standard charges” in accordance with guidelines promulgated by the Secretary of Health and Human Services. (42 U.S.C. § 300gg-18(e).) The final rule issued by CMS requires hospitals to post not only their Chargemaster rates, but also a list of “payer-specific negotiated charges” and to disclose them in two different ways: a single digital file containing charges for all items and services, and a “consumer-friendly” list of charges for 300 “shoppable” services, meaning services that can be scheduled in advance. (*Price Transparency Requirements*, 84 Fed.Reg. 65524, 65540 (Nov. 27, 2019).)

During the rulemaking process, concern was raised “that if the hospital attempts to provide pricing information to patients prior to stabilizing them, it would not only constitute an EMTALA [Emergency

Medical Treatment and Active Labor Act] violation, but it could also potentially cause the patient's health to deteriorate since it would delay the patient receiving critical care." (84 Fed.Reg. 65536.) In response, CMS explained why the new regulatory requirements would not conflict with EMTALA:

> [W]e believe that the policies we finalize here that require hospitals to make public standard charges online are distinct from EMTALA's requirements and prohibitions and that the two bodies of law are not inconsistent and can harmoniously co-exist. To be clear, the price transparency provisions that we are finalizing **do not require that hospitals post any signage or make any statement at the emergency department regarding the cost of emergency care or any hospital policies regarding prepayment of fees or payment of co-pays and deductibles**.

(84 Fed.Reg. 65536, emphasis added.)

In ruling that hospitals do not owe patients a duty to disclose, *Gray* observed "that Dignity did disclose all hospital pricing required by statute and regulation, and that its ER Charges were included in those disclosures." (*Gray*, *supra*, 70 Cal.App.5th at p. 245, emphasis added.) The extensive disclosure requirements imposed on hospitals by both California and federal statutes "reflects a strong legislative policy to ensure that emergency medical care is provided immediately to those who need it, and that billing disclosure requirements are not to stand in the way of this paramount objective." (*Id.* at p. 241.)

The Court of Appeal in this case found the *Gray* court's "thoughtful deference to the complex legislative and regulatory system relevant to emergency medical services" to be "well-placed." (*Capito*, 2023 WL 2805481, at *8.) The Court of Appeal also relied on this Court's decision in *Ramirez v. Plough* (1993) 6 Cal.4th 539, just like the trial court did, in concluding that "defining the circumstances under

which hospitals should be required to disclose fees for services rendered to emergency room patients "is a task for which legislative and administrative bodies are particularly well suited," and "would involve matters that are peculiarly susceptible to legislative and administrative investigation and determination, based upon empirical data and consideration of the viewpoints of all interested parties." (*Capito*, 2023 WL 2805481, at *8, citing *Ramirez*, 6 Cal.4th at 552-553.)

2. The Court of Appeal Rejected Capito's CLRA Claim

The Court of Appeal further rejected Capito's CLRA claim. The Court of Appeal noted that *Gray* "held that the assertion that a hospital's failure to disclose an emergency room charge similar to the EMS fee at issue here does not state a CLRA claim." (*Capito*, 2023 WL 2805481, at *8.) The Court of Appeal addressed the two other cases published following *Gray* in 2021: *Torres v. Adventist Health System/West* (2022) 77 Cal.App.5th 500, and *Saini v. Sutter Health* (2022) 80 Cal.App.5th 1054.

In *Torres*, the Fifth District Court of Appeal said that a plaintiff had adequately alleged the hospital failed to disclose facts that were known exclusively to the hospital and were not reasonably accessible to the plaintiff, but nonetheless determined that the plaintiff's claim failed because she did not sufficiently allege reliance as was necessary to claim that the misrepresentation or omission of fact was material. The plaintiff's allegation that she "relied on not being billed" coupled with her failure to allege that she would have behaved differently if the information had been disclosed was "not sufficient to properly plead reliance for purposes of alleging a claim under the CLRA based on a failure to disclose a material fact." (*Torres*, 77 Cal.App.5th at 514.)

The Court of Appeal in this case found *Torres* distinguishable on its facts because, unlike Capito, the plaintiff in *Torres* alleged that the "chargemaster was 'unusable and effectively worthless for the purpose of providing pricing information to consumers'; the chargemaster failed to include the standardized CPT codes recognized in the industry; and the chargemaster used coding and highly abbreviated descriptions that are meaningless to consumers." (*Capito*, 2023 WL 2805481 at *9, citing *Torres*, 77 Cal.App.5th at 512.) Those facts, which were material to the holding in *Torres* that the hospital had exclusive knowledge of the EMS Fees, are absent in this case.

The Court of Appeal in this case further relied on *Saini*, which also found *Gray* to be a "well-reasoned opinion" and found that the hospital "did not have a duty to 'call attention to the EMS Fee by additional signage in the emergency room visible to a person seeking emergency care' in addition to disclosing the fee in its chargemaster 'to which signage in the emergency room directs those interested,' noting that there was 'no withholding of information that is provided on the hospital's chargemaster.'" (*Capito*, 2023 WL 2805481 at *10, citing *Saini*, 80 Cal.App.5th at 1061.)

The Court of Appeal rejected Capito's claim that failure to impose disclosure duty creates an "impermissible implied safe harbor," citing *Saini* for the proposition that *Cel-Tech Communications, Inc. v. Los Angeles Cellular Telephone Co*. (1999) 20 Cal.4th 163 (*Cel-Tech*) (*Cel-Tech*) did not address claims asserted under the CLRA, and in any event, the *Gray* court's conclusion that the proposed duty would interfere with the statutory and regulatory requirements that hospitals provide emergency care without first addressing the costs for care or the patient's ability to pay does not imply a "safe harbor" for the alleged omission.

Finding no disclosure duty exists, the Court of Appeal affirmed the trial court's dismissal of Plaintiff's UCL, CLRA and declaratory relief claims.[5]

Why Review Should Be Denied

A. Capito's proposal to displace state & federal statutes and regulations does not present an issue worthy of review

As set forth above, *Gray, Saini*, and the Court of Appeal in this case explain in detail the myriad reasons why Capito's proposed "duty to disclose" should not be adjudicated in courts. Principally, the state and federal Legislatures and their agencies—the experts in this area—have already determined in full the scope of price disclosures hospitals should provide patients, particularly when balanced against the legal and public policy requirements that hospitals provide emergency care to patients without first inquiring as to their ability to pay. In her petition for review, Capito does not even present a colorable argument.

Plaintiff's proposal would have lawyers, courts, and juries determining—on an ad hoc basis—the size of font, type of font, eye-level placement, and sign design of various price signs in emergency departments. These same courts would even re-design hospital websites. In essence, courts would be prescribing architecture for emergency departments—would signs be required on the ceilings for patients brought into the hospital on gurneys? Each case could determine a different disclosure requirement for a given hospital. *Gray, Saini*, and the Court of Appeal here correctly determined that such disclosures are properly governed by the state and federal statutory and regulatory

[5] Capito does not include in her Petition for Review her alleged "contract-based" claims or her argument that the trial court erred in reconsidering its tentative ruling. (See *Capito*, *supra*, 2023 WL 2805481, at *12-14.)

regime. The suggestion that this Court should supersede the balance already struck through the legislative and regulatory processes with a process of ad hoc litigation—*starting* with EMS Fees in this case, but with no clear end point on which specified fees might be argued to deserve special treatment and which should not—does not warrant review.

B. *Naranjo* does not create a split of authority because it is limited to its factual record

Capito argues in her petition for review that *Torres*, together with a new opinion, *Naranjo v. Doctors Medical Center of Modesto, Inc.* (2023) 90 Cal.App.5th 1193 (*Naranjo*)—both out of the Fifth District Court of Appeal—have created a "split of authority" with *Gray* and *Saini*, justifying this Court's intervention. This is inaccurate.

As the Court of Appeal in this case already found*, Torres* is plainly distinguishable on its facts. That case involved allegations by the plaintiff "that the chargemaster was 'unusable and effectively worthless,' that it failed to include the standard CPT codes, and that the coding and descriptions in the chargemaster were 'meaningless to consumers.'" (*Torres*, 77 Cal.App.5th at p. 512). In contrast, Capito, like the appellant in *Saini*, "expressly disavow[ed] any claim that 'defendant fails to list an EMS Fee as a line item in its published chargemasters, or that defendant fails to list the price of such fees in its chargemasters.' " (*Capito*, *supra*, 2023 WL 2805481 at *10.)

Naranjo, too, is distinguishable on its facts and limited to its incomplete factual record. There, the plaintiff made similar arguments as the case at bar, *Torres, Gray,* and *Saini*—contending hospitals owe emergency room patients a duty to disclose EMS Fees in advance of providing care. However, in *Naranjo,* the plaintiff unequivocally alleged that the hospital " 'does not make its Chargemaster ... reasonably

available on its own website or reasonably available to ... patients at the time of their emergency room visits.' " (*Naranjo*, 90 Cal.App.5th 1193.) The plaintiff further alleged that the link on the hospital's website to its "Hospital Pricing Information ... leads to a .json file which a typical consumer cannot even open on a computer, let alone on a cell phone which would typically be the internet source available to a patient while in the emergency room." (*Id.*) These allegations are absent from this case entirely—as they were in *Saini* and *Gray*.

As the Court of Appeal in this case reasoned, "Capito concedes in the SAC that the chargemaster complies with the applicable 'multifaceted statutory and regulatory scheme,' and as in *Saini*, our conclusion that the SAC does not state a cause of action for violation of the CLRA is 'consistent with the balance struck by the existing regulatory scheme.' [Citation.] Further, unlike the contract in *Torres*, in which plaintiff agreed to 'promptly pay all hospital bills in accordance with the regular rates and terms of the medical center...,' Regional's COA expressly referenced the chargemaster and invited Capito to request an estimate of costs before receiving treatment." (*Capito*, *supra*, 2023 WL 2805481 at *10.)

Naranjo and *Torres* are plainly distinguishable on their facts: there, the plaintiffs alleged that the hospitals had <u>not</u> made their chargemasters available to patients—allegations absent here. As such, there is no split of authority for this Court to address, and this Court should decline review here.

C. *Naranjo* was wrongly decided and should be de-published

The Court of Appeal in *Naranjo* made several errors warranting de-publication. *Naranjo*'s principle holding is that the trial court's ruling improperly "created a safe harbor by implication," citing *Cel-Tech*

Communications, Inc. v. Los Angeles Cellular Telephone Co. (1999) 20 Cal.4th 163 (*Cel-Tech*). This holding is wrong for several reasons.

First, procedurally, *Cel-Tech* is limited to claims for violation of the UCL. *Cel-Tech* has never been applied to the CLRA. *Naranjo* applied *Cel-Tech*'s holding to the CLRA without any analysis or discussion as to whether that would be appropriate. It is not. The CLRA is a narrower consumer protection act than the UCL—it prohibits 24 distinct business acts and practices and covers a narrower range of economic activity than the UCL.

Capito alleges that Regional violated two specific provisions of the CLRA: Civil Code section 1770(a)(5), which prohibits entities from "[r]epresenting that goods or services have sponsorship, approval, characteristics, ingredients, uses, benefits, or quantities that they do not have or that a person has a sponsorship, approval, status, affiliation, or connection that the person does not have" and section 1770(a)(14), which prohibits "[r]epresenting that a transaction confers or involves rights, remedies, or obligations that it does not have or involve, or that are prohibited by law." Of course, Capito has not alleged that Regional has made any affirmative representations that violate either of these provisions. *Naranjo* cited *Gutierrez v. Carmax Auto Superstores California* (2018) 19 Cal.App.5th 1234, 1250 (*Gutierrez*), which has previously concluded that the term "representing" in the CLRA "is ambiguous and does not have single plain meaning" and found that subdivision (a)(5), (7), and (9) of Civil Code section 1770 proscribe "material omissions in certain situations" and created a test for identifying which omissions or nondisclosures fall within the scope of the CLRA. (*Ibid*.)

Importantly, *Gutierrez*'s expansion of CLRA liability to also proscribe "omissions" of material facts in "certain situations" did not

also adopt *Cel-Tech*'s discussion of "safe harbors" or its prohibitions on "implied safe harbors." Indeed, no court has imported either the "safe harbor" or prohibitions on "implied safe harbors" from UCL claims to CLRA causes of action. That is, other than *Naranjo*, which did so without any analysis whatsoever as to this doctrine's applicability to CLRA claims.

Naranjo's application of the "implied safe harbor" prohibition from *Cel-Tech* and other UCL cases to a CLRA claim, which has never been done before, was incorrect. *Cel-Tech*'s analysis on the issue hinges upon the fact that the UCL's scope is "sweeping" but not "unlimited," which is **why** safe harbors exist for the UCL. (*Cel-Tech*, 20 Cal.4th at 182.) "[P]laintiffs may not use the **general** unfair competition to law to assault that harbor." (*Id.*, emphasis added.) The CLRA does not suffer from these same problems—it is neither sweeping nor general, but in fact narrow and specific. Neither the "safe harbor" nor prohibition on "implied safe harbors" should apply to the CLRA, and certainly without any analysis as the *Naranjo* court concluded.

The UCL claim at issue here—as in *Naranjo*—rises and falls on the theory that the hospital violated the CLRA, not vice versa. As such, *Naranjo* was wrongly decided, and it should be de-published.

Second, even if *Cel-Tech*'s prohibitions on "implied safe harbors" applied to CLRA claims, *Naranjo* ignored the California Supreme Court's instruction that safe harbors exist if the Legislature has "permitted certain conduct" ***and also*** if it has "considered a situation and concluded that no action should lie." (*Cel-Tech*, 20 Cal.4th at 182.) "In *both* of those instances, the *Cel–Tech* Court explained, 'courts may not override [the Legislature's] determination' and 'simply impose their own notions of the day as to what is fair or unfair.'" (*Barber v. Nestle*

USA, Inc. (C.D. Cal. 2015) 154 F.Supp.3d 954, 961, aff'd (9th Cir. 2018) 730 Fed.Appx. 464.)

In *Barber*, the plaintiffs argued that *Nestle USA* failed to disclose on its Fancy Feast cat food products that some of the seafood used to make Fancy Feast is likely produced by forced labor. *Nestle* argued that that a safe harbor from the plaintiffs' claims was created by the California Transparency in Supply Chains Act of 2010, which mandated the specific disclosures a retailer must make on its website, including disclosures about forced labor. The law specifically did not require *Nestle* to disclose whether its products were the result of forced labor. Just like the situation here, the Legislature had specifically considered what kinds of disclosures retailers were required to make on a particular subject matter and determined that the disclosures the plaintiffs sought were not required.

The federal court noted that the plaintiffs "put much weight on the California Supreme Court's statement that '[t]here is a difference between (1) not making an activity unlawful, and (2) making that activity lawful.' *Cel–Tech*, 20 Cal.4th at 183. But as an example of this principle, the California Supreme Court noted that "Penal Code section 211, which defines robbery, does not make murder unlawful. Most assuredly, however, that section does not also make murder lawful." *Id*. This is not a situation where Nestlé is pointing to one statute, which regulates one matter, in an effort to claim that it has safe harbor from liability on an entirely different matter. Instead, this is a situation where the Legislature specifically considered the question here—how much disclosure should companies with forced labor in their supply chains make to consumers, and how—and reached an answer contrary to the remedy Plaintiffs seek here." (*Barber*, 154 F.Supp.3d at fn. 3.)

The court was "persuaded that the California Legislature considered the situation of regulating disclosure by companies with possible forced labor in their supply lines and determined that only the limited disclosure mandated by § 1714.43 is required." (*Id.* at p. 963.)

The same is true here. The Court of Appeal in this case recognized that the Legislature has specifically considered whether to require hospitals to provide estimates to patients of the cost of emergency care prior providing services and concluded that they are not. Health & Safety Code section 1339.585 requires hospitals to provide uninsured patients with a written estimate of the cost of services upon request, but it specifically states that this section "shall not apply to emergency services."

"As originally introduced, this legislation required hospitals to provide an estimate of charges upon the request of any patient—including those receiving care in the emergency department. (Assem. Bill No. 1045 (2005-2006 Reg. Sess.) as introduced Feb. 22, 2005.) As the bill moved through the legislative process, it was amended first to apply only to non-emergency patients (Assem. Bill No. 1045 (2005-2006 Reg. Sess.) as amended May 27, 2005) and then amended again to apply only to uninsured persons. (Assem. Bill No. 1045 (2005-2006 Reg. Sess.) as amended Sept. 6, 2005.)" (*Capito*, 2023 WL 2805481, at *6, fn. 8, citing *Gray*, 70 Cal.App.5th at p. 231.)

The Court of Appeal noted that *Gray* "correctly described the evolution of the statute which ultimately included a specific exclusion of its application to emergency services' patients." (*Id.*)

Moreover, as noted by the Court of Appeal in this case, and in *Gray* and *Saini*, section 1339.585 is just one part of a "multi-faceted statutory and regulatory scheme [that] reflects a strong legislative policy

to ensure that emergency medical care is provided immediately to those who need it, and that billing disclosure requirements are not to stand in the way of this paramount objective." (*Gray*, at p. 241.)

Because the Legislature expressly considered whether to require hospitals to provide cost estimates to patients in the emergency room in advance of providing care—and determined ultimately not to require hospitals to do so—this is not a so-called "implied safe harbor" but in fact one that fits squarely within *Cel-Tech*'s safe harbor framework.

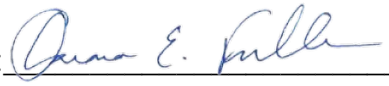
Naranjo was wrongly decided and should be de-published.

Conclusion

For the foregoing reasons, Regional Medical Center respectfully requests that this Court deny Capito's petition to review.

Dated: June 5, 2023

KING & SPALDING LLP

By: 

GLENN E. SOLOMON
ARIANA E. FULLER

Attorneys for Respondent San Jose Healthcare System LP

Certificate of Word Count Compliance

I certify that the computer program with which the foregoing Answer to Petition for Review has been prepared has generated a total count (for headings, main text, and footnotes) of 7,261 words (excluding the cover, the tables, the signature block, and this certificate)

Dated: June 5, 2023

KING & SPALDING LLP

By: _____
GLENN E. SOLOMON
ARIANA E. FULLER

Attorneys for Respondent San Jose Healthcare System LP

PROOF OF SERVICE

I am a citizen of the United States and resident of the State of California. I am employed in the County of Los Angeles, State of California, in the office of a member of the bar of this Court, at whose direction this service was made. I am over the age of eighteen years and not a party to the within action.

On June 5, 2023, I served the following documents in the manner described below:

ANSWER TO PETITION FOR REVIEW

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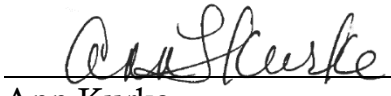
On the following part(ies) in this action:

Barry L. Kramer, Esq.
Law Office of Barry Kramer
9550 S. Eastern Avenue, Suite 253
Las Vegas, NV 89123
Email: kramerlaw@aol.com
Tel: (702) 778-6090

Gretchen Carpenter, Esq.
Carpenter Law
1230 Rosecrans Avenue, Suite 300
Manhattan Beach, CA 90266
Email: gretchen@gcarpenterlaw.com;
carlo@gcarpenterlaw.com
Tel: (424) 456-3183

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on June 5, 2023, at Los Angeles, California.



Ann Kurke

STATE OF CALIFORNIA
Supreme Court of California

PROOF OF SERVICE

STATE OF CALIFORNIA
Supreme Court of California

Case Name: **CAPITO v. SAN JOSE HEALTHCARE SYSTEM**
Case Number: **S280018**
Lower Court Case Number: **H049646**

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Lowell Brown Arent Fox LLP	lowell.brown@afslaw.com	e-Serve	6/5/2023 6:05:16 PM
Zuzana Ikels King & Spalding 208671	zikels@kslaw.com	e-Serve	6/5/2023 6:05:16 PM
Gretchen Carpenter Carpenter Law 180525	gretchen@gcarpenterlaw.com	e-Serve	6/5/2023 6:05:16 PM
Carlo Aguilar Carpenter Law	carlo@gcarpenterlaw.com	e-Serve	6/5/2023 6:05:16 PM
Ariana Fuller King & Spalding LLP 301797	afuller@kslaw.com	e-Serve	6/5/2023 6:05:16 PM
Glenn Solomon King & Spalding	gsolomon@kslaw.com	e-Serve	6/5/2023 6:05:16 PM

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Fuller, Ariana (301797)

Last Name, First Name (PNum)

King & Spalding LLP

Law Firm