S280018

IN THE SUPREME COURT OF CALIFORNIA

TAYLOR CAPITO,
Plaintiff and Appellant,

v.

SAN JOSE HEALTHCARE SYSTEM LP,
Defendant and Respondent.

Sixth Appellate District
H049646

Santa Clara County Superior Court
20CV366981
Hon. Sunil R. Kulkarni

Answer Brief on the Merits

Glenn Solomon, No. 155674
*Paul R. Johnson, No. 115817
pjohnson@kslaw.com
+1 213 443 4370 (direct)
Amanda L. Hayes-Kibreab, No. 224403
Ariana E. Fuller, No. 301797
KING & SPALDING LLP
633 West 5th Street, Suite 1600
Los Angeles, California 90071
+1 213 443 4355
+1 213 443 4310 (fax)

Attorneys for Defendant and Respondent
SAN JOSE HEALTHCARE SYSTEM, LP

Service on the Attorney General and the District Attorney
required by Bus. & Prof. Code, § 17209

TABLE OF CONTENTS

ISSUE PRESENTED 6

INTRODUCTION 6

RELEVANT FACTS 10

ARGUMENT 14

A. A hospital does not have a duty to disclose emergency department fees to patients beyond its statutory duty to make its chargemaster publicly available, including notice of how to access the chargemaster 14

1. The limited and specific chargemaster disclosures prescribed by the Legislature avoid interference with immediate emergency services 14

2. Federal law also prioritizes immediate emergency services 19

3. Plaintiff's special notice regarding EMS costs would interfere with immediate emergency services 20

4. Federal law follows the limited chargemaster approach regarding emergency services, rejecting additional cost notices as plaintiff proposes 22

5. Plaintiff's special notice for EMS fees would conflict with the state and federal statutory and regulatory structure 25

6. Plaintiff's proposed rulemaking by litigation should not displace the state and federal statutory and regulatory structure 25

B. Disclosing evaluation & management services fees only through Health and Safety Code sections 1339.51, 1339.55, and 1339.56 is not unfair, unlawful, or fraudulent 27

C. The CLRA and the UCL do not impose an additional duty of disclosure beyond what the lawmakers have required 33

CONCLUSION 41

TABLE OF AUTHORITIES

CASES

Bardin v. DaimlerChrysler Corp.
(2006) 136 Cal.App.4th 1255 ..... 34, 36

Bigler–Engler v. Breg, Inc.
(2017) 7 Cal.App.5th 276 35

Capito v. San Jose Healthcare System, LP
(Apr. 6, 2023, H049022, H049646)
unpub. slip opn. 6–7, 9, 11, 18, 21–22, 28, 39

Cel-Tech Communications, Inc. v. Los Angeles Cellular Telephone Company (1999) 20 Cal.4th 163 39

Collection Bureau of San Jose v. Rumsey
(2000) 24 Cal.4th 301 40–41

County of Santa Clara v. Superior Court
(2023) 14 Cal.5th 1034 ..... 7, 18, 30

Gray v. Dignity Health
(2021) 70 Cal.App.5th 225 ..... 6–7, 9, 16–18, 21, 26, 29, 31, 36, 39

Gutierrez v. Carmax Auto Superstores California
(2018) 19 Cal.App.5th 1234 35

Kendall v. Scripps Health
(2017) 16 Cal.App.5th 553 14

Mirkin v. Wasserman
(1993) 5 Cal.4th 1082 36

Moran v. Prime Healthcare Management, Inc.
(2023) 94 Cal.App.5th 166 ..... 6, 8, 14, 18, 22, 25–26, 31, 39–40

Naranjo v. Doctors Medical Center of Modesto, Inc.
(2023) 90 Cal.App.5th 1193 ..... 26, 35

Noel v. Thrifty Payless, Inc.
(2019) 7 Cal.5th 955 14

Nolte v. Cedars–Sinai Medical Center
(2015) 236 Cal.App.4th 1401 ..... 38, 40

Saini v. Sutter Health
(2022) 80 Cal.App.5th 1054 ..... 6, 18, 22, 26, 31, 37–39

Torres v. Adventist Health System/West
(2022) 77 Cal.App.5th 500 .....26, 35–37

Wang v. Massey Chevrolet
(2002) 97 Cal.App.4th 856 34

STATUTES

42 U.S.C. § 1395dd..... 7, 19

Bus. & Prof. Code, § 17200 ..... 33, 38

Civ. Code, § 1709 36

Civ. Code, § 1711 36

Civ. Code, § 1750 33

Civ. Code, § 1770 33–36

Evid. Code, § 664 28

Health & Saf. Code, § 1317 ..... 7, 16, 18

Health & Saf. Code, § 1339.50 14

Health & Saf. Code, § 1339.51 ..... 7, 14–15, 20, 25, 27, 33, 38, 40

Health & Saf. Code, § 1339.55 ..... 15, 20, 25, 27–28, 33, 38, 40

Health & Saf. Code, § 1339.56 .....8–9, 15, 20, 25, 27–28, 33, 38, 40

Health & Saf. Code, § 1339.585 ..... 7–8, 16–17

Health & Saf. Code, § 1339.59 14

Pub.L. No. 111-148 (Mar. 23, 2010) 124 Stat. 119 22

Public Health Service Act, § 2718..... 22–23

Stats. 1973, ch. 1202, § 2 18

Stats. 1987, ch. 1225, § 1 18

Stats. 2003, ch. 582, § 6 14

Stats. 2005, ch. 532, § 3 17

OTHER AUTHORITIES

26 C.F.R. § 1.501(r)-4 19

42 C.F.R. § 489.24 ..... 7, 19

45 C.F.R. § 180.20 22–23

45 C.F.R. § 180.40 22

45 C.F.R. § 180.50 ..... 22, 27

45 C.F.R. § 180.60 23

64 Fed.Reg. 61353 24

65 Fed.Reg. 18434 29

72 Fed.Reg. 66580 ..... 8–9, 28–29

80 Fed.Reg. 70298 28–29

83 Fed.Reg. 41144 22

83 Fed.Reg. 58818 29

84 Fed.Reg. 65524 ..... 22–24, 26

Assem. Bill No. 1045 (2005–2006 Reg. Sess.) 17

ISSUE PRESENTED

as stated in the Court's pending issues summary

Does a hospital have a duty to disclose emergency room fees to patients beyond its statutory duty to make its chargemaster publicly available?

INTRODUCTION

Californians make about 12 million to 15 million trips each year to hospital emergency departments.[1] Delivering critical emergency medical services on such a large scale, at approximately 320 emergency departments statewide, is an essential concern of the Legislature, shared by Congress and state and federal agencies.

The "multi-faceted statutory and regulatory scheme 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 v. Dignity Health* (2021) 70 Cal.App.5th 225, 240–241 (*Gray*), emphasis in opn.; *Capito v. San Jose Healthcare System LP* (Apr. 6, 2023, H049022, H049646) unpub. slip opn. pp. 11–12 (*Capito*); *Saini v. Sutter Health* (2022) 80 Cal.App.5th 1054, 1059–1063 (*Saini*); *Moran v. Prime Healthcare Management, Inc.* (2023) 94 Cal.App.5th 166, 186 (*Moran*).) To ensure that emergency departments and patients focus on the immediate provision of care:

---

[1] The California Health & Human Services Agency, Department of Health Care Access and Information (HCAI), shows over 14 million trips to hospital emergency departments in 2022, nearly 13 million in 2021, nearly 12 million in 2020, and, pre-COVID, nearly 15 million in 2019. (See annual reports at https://data.chhs.ca.gov/dataset/hospital-emergency-department-characteristics-by-facility-pivot-profile; Request for Judicial Notice, Exhibit 5 [2022 data summary].)

- Emergency screening and care required to stabilize a patient must be provided *prior* to discussing the patient's ability to pay with the patient or with anyone else. (Health & Saf. Code, § 1317, subd. (d)[2]; 42 U.S.C. § 1395dd(h); 42 C.F.R. § 489.24(d)(4)(ii); *Gray*, *supra*, 70 Cal.App.5th at pp. 240–241; *Capito*, *supra*, opn. p. 11.)

- Emergency services are expressly exempted from the requirement that hospitals provide cost estimates to uninsured patients admitted for hospital procedures. (§ 1339.585; *Gray*, *supra*, 70 Cal.App.5th at p 231; *Capito*, *supra*, opn. pp. 11–12.)

- "Hospitals and other medical providers are required by law to provide emergency medical services without regard to the patient's insurance status or ability to pay." (*County of Santa Clara v. Superior Court* (2023) 14 Cal.5th 1034, 1037 (*Santa Clara*) [citing 42 U.S.C. § 1395dd(b) & (h); § 1317, subds. (a) & (b)].)

Statutory provisions for billing and pricing disclosures are balanced with the overriding priority not to discourage or intimidate patients from immediately pursuing emergency medical evaluation and care. Thus, the only cost notice the Legislature requires a hospital to post in an emergency department informs patients that the hospital's "charge description master," or "chargemaster" (its "uniform schedule of charges represented by the hospital as its gross billed charge for a given service or item, regardless of payer type") is available on the hospital's Internet website or at the hospital location. (§ 1339.51.) Accompanying

[2] All further statutory references are to the Health and Safety Code unless otherwise indicated.

provisions require hospitals to report to regulators, and make available on request, lists of the average charges for 25 most common inpatient procedures (which would not include emergency services) and 25 common outpatient procedures (which could include emergency services). (§ 1339.56.)[3] The Legislature's decision not to require cost estimates for emergency services reflects "a careful balancing of transparency … and not discouraging uninsured patients from seeking necessary emergency care …." (*Moran*, *supra*, 94 Cal.App.5th at p. 176; § 1339.585.)

Dissatisfied with the balance struck by the Legislature, plaintiff here and others in nearly identical actions by brought the same attorneys, seek to use the courts to impose additional disclosure requirements and accompanying damages liability on hospitals. These lawsuits seek to require that hospitals provide a *special cost notice*, directed to every patient presenting at an emergency department, regarding emergency evaluation and management services (EMS) fees—duplicating information already provided by disclosures pursuant to the charge disclosure statutes and regulations.

Contrary to plaintiff's narrative, EMS fees are well-established in the law. For emergency department visits by Medicare patients, the federal Centers for Medicare & Medicaid Services (CMS) set standard billing codes for EMS fees and directed hospitals to bill them at one of five different levels, taking into consideration the hospital resources required for a given emergency department encounter. (72 Fed.Reg. 66580,

---

[3] HCAI's form to list charges for outpatient procedures starts with evaluation & management services at four of the five different levels for emergency room visits. (Request for Judicial Notice, Exhibits 2 and 4; download at: https://hcai.ca.gov/document/25-common-optional-reporting-form-template-2023/.)

66581, 66789–66790 (Nov. 27, 2007); *Capito*, *supra*, opn. pp. 11–13.) Implementing section 1339.56, HCAI recognizes them as well.

The disclosure requirements set by state and federal statutes and regulations provide a bright line. Plaintiff would force hospitals to cross that line, redirecting every patient's attention from the immediate health emergency—the priority set by the lawmakers—to cost concerns about EMS fees, which could (and, plaintiff believes, often should) dissuade patients from pursuing immediate treatment at the nearest emergency facility. By calling out EMS fees, and what they cost, before rendering emergency treatment, such notices would beg the question in the patients' minds of how they will pay and how much—disrupting the statutory and regulatory scheme, and encouraging patients to walk away from needed emergency care.

Private-party litigation should not be used to ask courts to rewrite the rules that the legislative and regulatory process carefully established for disclosing hospital fees. Plaintiff here is even unclear and uncertain about what notice requirements she would impose on hospitals. In *Gray*, the plaintiff insisted on disclosure of EMS fees by signage "in and around" the emergency department or "'verbally during the patients' registration process.'" (*Gray*, *supra*, 70 Cal.App.5th at pp. 229, 235–236.) Here, plaintiff also proposes insertion in the Conditions of Admission (COA) form and on the hospital website. Plaintiff even admits that the relief sought from the courts is unclear: "The scope of disclosures that the trial court might ultimately award (which is broadly discretionary) *is an unknown at this time* …." (Opening br. pp. 65–66, emphasis added.) The rules that govern the delivery of critical emergency services ought not be subject to the caprice of counsel's creativity from case to case.

The variable process of regulation by litigation is problematic, not just for this single issue of a separate disclosure of EMS fees. Plaintiff's approach—letting litigants submit ad hoc notice requirements for court approval beyond what the lawmakers already decided—has no limiting principle. If hospitals must post the additional notice this plaintiff wants, and post further notices that future plaintiffs and their counsel come up with in subsequent lawsuits, each alleging some "special" need for something (anything) more, emergency departments will become wallpapered with myriad warnings beyond the legislated requirements, losing all intelligible meaning.

Plaintiff does not dispute that defendant and respondent San Jose Healthcare System, LP, doing business as Regional Medical Center of San Jose (the Hospital), complied with the disclosure requirements set by the Legislature. The Hospital listed the EMS fees in its chargemaster, including on the separate smaller list of 25 common outpatient fees, exactly satisfying its legal duty, in a way that does not delay, discourage, or intimidate patients from seeking and obtaining emergency care.

RELEVANT FACTS

On June 18 and 20, 2019, the emergency department at Regional Medical Center of San Jose was there for plaintiff Taylor Capito. (1 AA 324.) Plaintiff received emergency services, including treatment. (*Ibid.*)

Plaintiff concedes the Hospital listed EMS fees in its chargemaster. "The Complaint is not that Defendant fails to list an EMS Fee as a line item in the Hospital's published Chargemaster, or that Defendant fails to list the price of such EMS Fees in the Hospital's Chargemaster, …." (1 AA 317, fn. omitted.) Plaintiff also acknowledges that emergency-

department EMS fees have standardized CPT (Current Procedural Terminology) codes: Level 1, CPT code 99281; Level 2, CPT code 99282; Level 3, CPT code 99283; Level 4, CPT code 99284; Level 5, CPT code 99285. (1 AA 324.)

The Hospital's EMS fees were published online by the state regulatory agency—and still are. Materials judicially noticed by the trial court and the Court of Appeal include excerpts of the Hospital's contemporaneous 2019 chargemaster, as published on the official website of the Office of Statewide Health Planning and Development (OSHPD)—which since became the Department of Health Care Access and Information (HCAI)[4]—part of the California Health & Human Services Agency. (Request for Judicial Notice, Exhibits 2 and 3; Motion for Judicial Notice (Ct.App., filed Aug. 1, 2022, H049646) Exhibits 2 and 3; *Capito*, *supra*, opn. p. 3, fn. 2; 2 AA 378–380, 414–427 [Exhibits 2 and 3], 888 [order].) Published hospital chargemasters, grouped by year, may be accessed at https://data.chhs.ca.gov/dataset/chargemasters.

The judicially noticed excerpts of the Hospital's published 2019 chargemaster included EMS fees, Levels 1 through 5:

Hospital Name: Regional Medical Center San Jose
OSHPD Facility No: 106430705
Effective Date of Charges: October 01, 2018

Procedure Code	Description	CPT Code	Charge Amount
. . .			
591505	LVL 1 EMER DEPT	99281	672
591500	LVL 2 EMER DEPT	99282	1,660
591508	LVL 3 EMER DEPT	99283	2,836
591509	LVL 4 EMER DEPT	99284	3,780
591510	LVL 5 EMER DEPT	99285	5,635

[4] Going forward, we refer to HCAI, including references to OSHPD as HCAI. See https://hcai.ca.gov/oshpd-becomes-the-department-of-health-care-access-and-information (Aug. 4, 2021).

(Request for Judicial Notice, Exhibit 3.)

Further, these judicially noticed materials included the HCAI form that listed "the average charge for 25 common outpatient procedures performed by hospitals, as required by AB 1045 (Chapter 532, Statutes of 2005)," completed with the amounts entered by the Hospital. At the top of the list, this form set forth the EMS fees for emergency room visits, Levels 2 through 5.

Evaluation & Management Services (CPT Codes 99201-99499)	**2019 CPT Code**	**Average Charge**
Emergency Room Visit, Level 2 (low to moderate severity)	99282	$1,660
Emergency Room Visit, Level 3 (moderate severity)	99283	$2,836
Emergency Room Visit, Level 4 (high severity without significant threat)	99284	$3,780
Emergency Room Visit, Level 4 [*sic*: 5] (high severity with significant threat)	99285	$5,635

(Request for Judicial Notice, Exhibit 2.) Thus, Evaluation & Management Services (EMS) fees for emergency room visits are so common that HCAI lists them at the top of its "highly encouraged" standard form for 25 common outpatient procedures, used by the Hospital here. (*Ibid.*; see also Request for Judicial Notice, Exhibit 4; https://hcai.ca.gov/data-and-reports/cost-transparency/hospital-chargemasters/ [with link to current form: List of 25 Common Outpatient Procedures for 2023 Template; download at: https://hcai.ca.gov/document/25-common-optional-reporting-form-template-2023/].)

Plaintiff's opening brief concedes that emergency-department EMS fees are systematically assessed industry-wide, including by virtually every hospital in California (that has an emergency department). (Opening br. p. 67.)

As for determining which level of the "Emergency Room Visit" fee would apply, the descriptions in the standard HCAI forms—used by the Hospital—provide as much information as the descriptions that plaintiff proposed in her operative second amended complaint as a "sufficient" notice:

Level 1 (CPT code 99281: minor) $ 672.00
Level 2 (CPT code 99282: simple) $1,660.00
Level 3 (CPT code 99283: moderate) $2,836.00
Level 4 (CPT code 99284: severe) $3,780.00
Level 5 (CPT code 99285: complex & life-threatening) $5,635.00

(1 AA 323–324 [second amended complaint, ¶ 17].)

Plaintiff does not allege that she requested cost information before receiving emergency services. (See 1 AA 324–325.) Plaintiff does not allege that she looked at the Hospital's chargemaster, or its report of 25 common outpatient procedures, before receiving emergency services. (See *ibid.*) Plaintiff simply does not like the sources determined by the Legislature as the appropriate vehicle for hospitals to disclose these charges in a manner that does not discourage patients from pursuing emergency care.

ARGUMENT

A. A hospital does not have a duty to disclose emergency department fees to patients beyond its statutory duty to make its chargemaster publicly available, including notice of how to access the chargemaster

The statutory and regulatory structure for emergency services balances the disclosure of costs with the overriding priority not to delay, discourage, or intimidate patients from receiving care. (See *Moran*, *supra*, 94 Cal.App.5th at p. 176 ["in the emergency room context, both state and federal lawmakers and regulators have sought a balance between transparent cost disclosure and discouraging potentially life-threatening decisions to forego emergency treatment due to its cost"].) Plaintiff proposes to shake up the Legislature's balance with a special, judicially imposed notice about EMS fees. Hospitals should not be compelled to give such notices.

1. The limited and specific chargemaster disclosures prescribed by the Legislature avoid interference with immediate emergency services

By statute, each California hospital maintains a chargemaster—its "uniform schedule of charges represented by the hospital as its gross billed charges for a given service or item, regardless of payer type." (§ 1339.51, subds. (a)(1), (b)(1); *id.*, subd. (a)(2) [exempting small and rural hospitals].) Chargemasters "contain code numbers, descriptions, and gross billing charges …." (*Kendall v. Scripps Health* (2017) 16 Cal.App.5th 553, 560, disapproved on other grounds in *Noel v. Thrifty Payless, Inc.* (2019) 7 Cal.5th 955, 986, fn. 15.)

The Payers' Bill of Rights (§§ 1339.50–1339.59)—first enacted in 2003 (Stats. 2003, ch. 582, § 6)—governs a hospital's disclosure of its charges, including provisions that:

- A hospital shall make a written or electronic copy of its chargemaster available online or at the hospital. (§ 1339.51, subd. (a)(1).)
- A hospital "shall 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" as described in section 1339.51, subdivision (a)(1). (§ 1339.51, subd. (c).)
- A hospital shall file a copy of its chargemaster annually with HCAI, in a format determined by HCAI. (§ 1339.55, subd. (a).) As noted, HCAI publishes hospital chargemasters on its website. (See https://data.chhs.ca.gov/dataset/chargemasters.)
- A hospital shall calculate an estimate of the percentage increase in gross revenue due to any annual increase in charges for patient services and shall file that calculation and supporting documentation with HCAI. (§ 1339.55, subd. (b).)
- A hospital shall compile a list of 25 common outpatient procedures and shall submit annually to HCAI a list of its average charges for those procedures, in a method determined by HCAI. (§ 1339.56, subd. (a).) HCAI shall publish this information on its website. (*Ibid.*) In fact, HCAI has published this information with the chargemasters. (See https://data.chhs.ca.gov/dataset/chargemasters.) HCAI may develop a uniform reporting form (*ibid.*); as shown, HCAI developed a voluntary uniform reporting form, used by the Hospital here. (Request for Judicial Notice, Exhibits 2 and 4.)

The state statutory scheme also expressly exempts emergency charges from additional disclosure requirements, even as it imposes a specific requirement regarding disclosures of estimated costs to persons (unlike Capito) "without health coverage" for various non-emergency services. (See *Gray*, *supra*, 70 Cal.App.5th at p. 231.)

> For 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 pursuant to Section 1317.

(§ 1339.585, emphasis added.)

Thus, the Legislature expressly chose not to burden patients seeking emergency services with advance cost advisements. This makes sense given the importance that patients who need emergency care not be dissuaded or intimidated from obtaining immediately needed services. The lawmakers recognized that focusing a patient presenting to an emergency room on additional cost disclosures would have a natural tendency to cause some people to hold back from staying to get the emergency care that caused them to go to the hospital. Plaintiff recognizes that too, but this is her objective rather than a result she would avoid.

Plaintiff argues the exclusion of emergency services in this statute signifies nothing because it would be impracticable to provide an estimate of emergency services. (Opening br. at pp. 51-52 ["Providing a reasonable estimate of the costs of diagnosis and treatment for an unknown medical condition, prior to the required initial medical

screening examination, is simply not feasible"].) But this impracticability recognized by plaintiff undercuts her conclusion. The uncertainty in an emergency situation demands priority be given to the screening and treatment being provided before the patient or anyone else considers or discusses cost.[5]

The Legislature confined the disclosure requirement for emergency services to the chargemaster and the notice posted in the emergency department regarding the availability of the chargemaster; HCAI includes EMS fees for emergency-room visits in its list of 25 common outpatient procedures. Plaintiff does not dispute that the Hospital complied. As the judicially noticed documents show, the Hospital listed its five levels of EMS fees on its chargemaster, and it further disclosed its pricing for Levels 2 through 5 EMS fees on HCAI's form for 25 common outpatient procedures. (Request for Judicial Notice, Exhibits 2 and 3.) HCAI's form listed "Evaluation & Management Services" fees for an "Emergency Room Visit," at different levels, at the very top of the list, as used by the Hospital in this case. (*Id.*, Exhibit 2.)

---

[5] Plaintiff criticizes the *Gray* court's observation that, when first introduced, the bill resulting in this statute did not have an exclusion for emergency services, but was amended to apply only to non-emergency patients, and was amended again to apply only to uninsured (non-emergency) patients. (See *Gray*, *supra*, 70 Cal.App.5th at p. 231 [citing Assem. Bill No. 1045 (2005–2006 Reg. Sess.) as introduced Feb. 22, 2005, as amended May 27, 2005, and as amended Sept. 6, 2005].) Plaintiff argues that because the bill, as originally drafted, referred to an estimate on request upon "admission" of the patient, the bill when introduced must not have contemplated application to emergency services. ("Admit" and "admission" are not defined in the statute. See also § 1596.846, subd. (a)(4) [legislative finding referencing "admitted to an emergency room"].) Even accepting plaintiff's assumption for the sake of argument only, it makes no difference because the next event in the legislative process was to add an explicit exemption for "emergency services." (§ 1339.585; Stats. 2005, ch. 532, § 3.)

HCAI's form continues that today. (*Id.*, Exhibit 4.)

The statutory disclosure rules fit with preexisting elements of the "multi-faceted statutory and regulatory scheme [which] 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*, *supra*, 70 Cal.App.5th at pp. 240–241, emphasis in opn.; *Capito*, *supra*, opn. pp. 11–12; *Saini*, *supra*, 80 Cal.App.5th at pp. 1059–1063; *Moran*, *supra*, 94 Cal.App.5th at p. 186.) Statutes and regulations prescribe particular duties regarding the delivery of emergency services. (See, e.g., *Santa Clara*, *supra*, 14 Cal.5th at pp. 1037–1038 [required services by out-of-network providers, and required reimbursement by health plans].)

Section 1317 requires hospital emergency departments to provide emergency medical services to all in need of care, without regard to the patient's insurance status or ability to pay. (§ 1317, subds. (a) & (b); see Stats. 1973, ch. 1202, § 2; Stats. 1987, ch. 1225, § 1; *Santa Clara*, *supra*, 14 Cal.5th at p. 1037.) Further:

> Emergency services and care shall be rendered **without first questioning** the patient or any other person as to his or her **ability to pay** therefor. However, 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 promptly **after** the services are rendered.

(§ 1317, subds. (d), emphasis added.) The statute requires the hospital to provide emergency services without pausing for financial questions.

The statute also requires the patient to agree to pay or to provide insurance or credit information only **after** services have been rendered.

Here, plaintiff signed the conditions of admission (COA), which included an agreement to pay for services rendered at rates stated in the chargemaster, while also noting the potential for discounting based on coverage through governmental programs or private health insurance plans or based on circumstances involving charity or lack of insurance. (1 AA 324, 337, 339–340, 346.)

2. Federal law also prioritizes immediate emergency services

Similarly, the federal Emergency Medical Treatment and Active Labor Act (EMTALA) requires that a hospital emergency department provide a medical screening examination to ascertain any emergency medical condition whenever an individual presents for examination or treatment. (42 U.S.C. § 1395dd(a).) While some federal provisions are framed in terms of hospitals that accept Medicare payments, that gives them sweeping application because few hospitals do not accept Medicare patients. (See 42 U.S.C. § 1395dd(e)(2).) A participating hospital **may not delay** the medical screening examination or further medical examination and treatment to inquire about the individual's method of payment or insurance status. (42 U.S.C. § 1395dd(h); 42 C.F.R. § 489.24(d)(4)(i).)

"Reasonable registration processes **may not unduly discourage** individuals from remaining for further evaluation." (42 C.F.R. § 489.24(d)(4)(iv), emphasis added.) Similarly, tax-exempt hospitals must prohibit actions that discourage individuals from seeking emergency medical care, such as by demanding that emergency department patients pay before receiving treatment for emergency medical conditions. (26 C.F.R. § 1.501(r)-4(c)(2).) During the COVID-19 Public Health Emergency, CMS issued guidance to hospitals about

placing signage outside an emergency department stating that "COVID-19 testing is not being offered to asymptomatic patients" stating:

> We emphasize that **it is a violation of EMTALA for hospitals and critical access hospitals (CAHs) with EDs to use signage that presents barriers to individuals**, including those who are suspected of having COVID-19, **from coming to the ED**, or to otherwise refuse to provide an appropriate MSE [medical screening examination] to anyone who has come to the ED for examination or treatment of a medical condition.

(See "Frequently Asked Questions for Hospitals and Critical Access Hospitals regarding EMTALA" (Apr. 30, 2020), accessed at https://www.cms.gov/files/document/frequently-asked-questions-and-answers-emtala-part-ii.pdf, emphasis added.)

The consistent underlying policy is that hospital emergency departments must not do anything, including discussing the cost of care or the patient's ability to pay for care, that would discourage or dissuade individuals from seeking emergency medical care.

3. Plaintiff's special notice regarding EMS costs would interfere with immediate emergency services

The disclosures prescribed by the Legislature in sections 1339.51, 1339.55, and 1339.56 already disclose emergency-department EMS fees in a manner that does not violate the letter or spirit of California and federal laws against dissuading individuals from seeking emergency care.

Plaintiff asks courts to change the method of disclosure that the Legislature has specified after it has already balanced the competing interests of disclosure and not dissuading patients from seeking emergency care.

Plaintiff hedges on what form this additional special cost notice would take. But plaintiff insists on form and delivery dramatically different from what the law requires, even if the content would repeat information already in the chargemaster and the accompanying 2019 HCAI form that the Hospital completed, or the 2023 HCAI form. (Compare 1 AA 324 with Request for Judicial Notice, Exhibits 2, 3, and 4.)

Plaintiff wants this information forced onto patients who show up in the emergency room, with large postings or other prominent notices that would redirect every patient's attention away from the health emergency, to thinking about the costs to get that care. Plaintiff's stated purpose is to get those individuals to consider leaving the emergency department before obtaining emergency care due to the posted costs, and then either delay care by traveling to another emergency department that might be cheaper, or not get emergency care at all. (See opening br. at pp. 60–61 ["a significant portion of the emergency room patient population, including Capito, would be perfectly capable of determining for themselves whether their ailment could be effectively treated less expensively elsewhere"].) In some instances, a patient's inability to process such information might be obvious. But in others, for example, a heart attack, the impairment resulting from an emergency might not be ascertained until a screening or even further examination.

What plaintiff advocates is dangerous and antithetical to the policies reflected in the state and federal statutes and regulations, which emphasize first providing emergency screening examinations and treatment, and only addressing costs after the patient has been stabilized. (*Gray*, *supra*, 70 Cal.App.5th at pp. 240–241; *Capito*, *supra*,

opn. pp. 11–12; *Saini*, *supra*, 80 Cal.App.5th at pp. 1059–1063; *Moran*, *supra*, 94 Cal.App.5th at p. 186.)

4. Federal law follows the limited chargemaster approach regarding emergency services, rejecting additional cost notices as plaintiff proposes

Pursuant to the Patient Protection and Affordable Care Act (Pub.L. No. 111-148 (Mar. 23, 2010) 124 Stat. 119), CMS has developed disclosure requirements similar to what the Legislature enacted for California. (45 C.F.R. §§ 180.20, 180.40, 180.50; see 84 Fed.Reg. 65524, 65526 [citing California disclosure rules].) CMS noted that "hospitals are required to either make public a list of their standard charges (whether that be the chargemaster itself or in another form of their choice) or their policies for allowing the public to view a list of those charges in response to an inquiry." (83 Fed.Reg. 41144, 41686 (Aug. 17, 2018) [citing § 2718(e) of Public Health Service (PHS) Act].) Regarding the comment cited by plaintiff about some patients being "surprised" by facility fees (opening br. pp. 9–10, 41), CMS continued to provide for use of the chargemaster. (*Ibid.*) CMS updated its guidelines to make current standard charges available via the internet in a machine-readable format, updated at least annually. (*Ibid.*) "This could be in the form of the chargemaster itself or another form of the hospital's choice, …." (*Ibid.*) CMS considered this appropriate and sufficient, declining to go further regarding emergency services disclosures.

As adopted, the final rule provides for public posting of standard charges as reflected in the hospital's chargemaster. (See 84 Fed.Reg. 65524 [Final Rule] (Nov. 27, 2019); *id.* at 65525 ["the publicly posted information should represent their standard charges as reflected in the

hospital's chargemaster"].) It was in this context—"mak[ing] public standard charges under section 2718(e) of the PHS Act"—that CMS made a statement plaintiff cites that someone "might" consider cost information before visiting an emergency department with "a non-life threatening condition." (84 Fed.Reg. at 65536; see opening br. pp. 57–58.) Plaintiff omits that CMS rejected what plaintiff proposes here: confronting emergency department patients with costs. (84 Fed.Reg. at 65536.)

As CMS explained: "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. at 65536, emphasis added.) In this way, CMS safeguarded EMTALA, by providing for publication of chargemaster information while taking care not to discourage patients from using emergency services. (84 Fed.Reg. at 65525, 65536.) Plaintiff simply does not like the method chosen by CMS for hospitals nationwide, and she wants additional judicial regulation of hospital emergency departments in California, at odds with CMS.

The final rule also provides for listing 300 "shoppable" services, including 70 selected by CMS and the others selected by the hospital. (See 45 C.F.R. § 180.60; 84 Fed.Reg. at 65564–65581.) "Shoppable" means "a service that can be scheduled by a healthcare consumer in advance" (45 C.F.R. § 180.20)—i.e., "typically those that are routinely provided in *non-urgent* situations that *do not require immediate action or attention* to the patient, thus allowing patients to price shop and schedule a service *at a time that is convenient* for them" (84 Fed.Reg. at

65564, emphasis added). In compiling its list of 70 shoppable services, CMS undertook "to ensure such services could be scheduled in advance …." (84 Fed.Reg. at 65568.) Thus, CMS wanted an additional listing for non-emergency services. By contrast, CMS only wanted emergency services addressed in the more limited fashion set forth for chargemaster publication—not what plaintiff wants.

Plaintiff also omits the context of a CMS comment that "any inquiry about financial liability should be answered as fully as possible by a qualified individual." (64 Fed.Reg. 61353, 61355 (Nov. 10, 1999); see opening br. p. 41.) This comment did not concern posting disclosures initiated by a hospital; rather, it addressed only specific inquiries raised by the patient. (64 Fed.Reg. at 61355.) Recognizing the need for medical screening and any stabilizing treatment, and that the patient's "limited information about his or her medical condition, may not permit an individual to make a rational, informed consumer decision," CMS expressly rejected the notion that a hospital should bring up costs. (*Ibid.*) "The best practice would be for a hospital **not** to give financial responsibility forms **or notices** to an individual, or otherwise attempt to obtain the individual's agreement to pay for services before the individual's stabilizing treatment is under way." (*Ibid.*, emphasis added.)

CMS further encouraged hospitals to shut down cost discussions if raised by a patient, stating: "We also recommended that hospital staff encourage a patient who believes that he or she may have an emergency medical condition to *defer any further discussions of financial responsibility* until **after** the provision of an appropriate medical screening examination and the provision of stabilizing treatment if the patient's condition warrants it." (64 Fed.Reg. at 61355, emphasis added.)

5. Plaintiff's special notice for EMS fees would conflict with the state and federal statutory and regulatory structure

What plaintiff advocates is contrary to existing state and federal law and public policy. Plaintiff wants the courts to create a ***new duty*** for hospitals to disclose emergency department fees to patients in ways beyond the statutory duties under sections 1339.51, 1339.55, and 1339.56 and federal disclosure laws. Plaintiff's advocacy contradicts the statutory and regulatory structure that intentionally put medical screening and treatment before raising costs. As *Moran* explained:

> "[T]he California Legislature, the United States Congress, and numerous rulemaking bodies have already decided what pricing information to make available in a hospital's emergency room. Just as importantly, they have decided what *not* to include in those requirements. The reason for this extensive statutory and regulatory scheme is to strike a balance between price transparency and dissuading patients from avoiding potentially life-saving care due to cost."

(*Moran¸ supra*, 94 Cal.App.5th at p. 186, emphasis in opn.)

6. Plaintiff's proposed rulemaking by litigation should not displace the state and federal statutory and regulatory structure

Dissatisfied with the state and federal statutory and regulatory processes, plaintiffs in these cases want to inject their own new regulation of emergency services by litigation. They want courts to write special cost notices regarding EMS fees, designed and formulated by the attorneys who represent the plaintiffs in all these cases. Plaintiff also seeks to have juries evaluate these notices, on a case-by-case basis, as plaintiff prays for damages and demands trial by jury. (1 AA 334–335.)

Even after *Gray*, *Torres v. Adventist Health System/West* (2022) 77 Cal.App.5th 500 (*Torres*), *Saini*, *Naranjo v. Doctors Medical Center of Modesto, Inc.* (2023) 90 Cal.App.5th 1193 (*Naranjo*), *Moran*, and other cases, including the trial-court and Court of Appeal proceedings in this case, plaintiff still cannot say precisely how a hospital must give such notice. Rather, plaintiff states: "The scope of disclosures that the trial court might ultimately award (which is broadly discretionary) is an unknown at this time …." (Opening br. pp. 65–66.) What plaintiff in this case might "deem sufficient" might not satisfy the plaintiff in the next case. (See 1 AA 323–324, ¶ 17.) Hospitals would never know for certain what type and extent of disclosure would be required to protect them from liability.[6] In this patchwork way, plaintiff hopes to have a continuing stream of these cases, just as her counsel have advanced over the years in a number of such lawsuits clogging up California courts.[7]

The state and federal legislative bodies are in a superior position to balance the competing interests. (*Gray*, *supra*, 70 Cal.App.5th at pp. 240–241; *Saini*, *supra*, 80 Cal.App.5th at p. 1063; *Moran¸ supra*, 94 Cal.App.5th at p. 183.) Litigation should not supersede the posting of clear and conspicuous notice in each emergency department that

---

[6] Exactly where would the sign or signs be placed "in and around" the emergency department? (See *Gray*, *supra*, 70 Cal.App.5th at pp. 229, 235–236.) What font? With or without serifs? What font sizes, and for which items? Why does plaintiff have the Hospital's name in large, all-capital letters? (See 1 AA 324.) Should the dollar amounts be bolded?

Same questions if placed in the COA.

Same questions if placed on a hospital's website. Where on the website must it be posted? First page? Next-level page? Should it displace the posting of the average ER wait time? Should it go before or after the website disclosures required by the Federal Price Transparency Rule? (84 Fed.Reg. 65524 [Final Rule] (Nov. 27, 2019).) Should a notice begin, "If you are having an emergency, first read this notice"?

[7] Plaintiff's counsel also has filed similar lawsuits in other states.

informs patients about the availability of the hospital's chargemaster, as prescribed by the Legislature in section 1339.51, subdivision (c). The Hospital posts the signs required by the law. The notice plaintiff wants is not one of them.

B. Disclosing evaluation & management services fees only through Health and Safety Code sections 1339.51, 1339.55, and 1339.56 is not unfair, unlawful, or fraudulent

Plaintiff cannot maintain that a hospital's disclosure of its schedule of charges generally, or even its disclosure of charges for emergency services generally—by making its chargemaster publicly available—is inadequate and thus unfair, unlawful, or fraudulent. Since July 1, 2004, that has been the method of disclosure prescribed by the Legislature. (§§ 1339.51, 1339.55.) And as shown, the applicable federal agency (CMS) has in recent years studied and followed that approach. (See, e.g., 45 C.F.R. § 180.50.)

Instead, plaintiff's case depends on arguing there is something special about emergency-department EMS fees that should require an additional, special notice, beyond what the lawmakers have required. (See 1 AA 323.) Plaintiff argues that charging an EMS fee—allegedly billed "on top of and in addition to the charges for the individual items of treatment and services"—is so shocking, so surprising, that a special notice is needed. (See opening br. pp. 13, 17.) Plaintiff's narrative about the EMS fees is false as a matter of law.

Federal and state agencies—including CMS and HCAI—expressly recognize emergency-department EMS fees as being for "services." They are not, as plaintiff advocates, simply on top of the services rendered. They are widely recognized by the government regulators as being a primary method to bill for emergency service.

HCAI, the agency designated by the Legislature to implement sections 1339.55 and 1339.56, in its 2019 form for 25 common outpatient procedures, listed "Evaluation & Management *Services*" fees for emergency-room visits, including four of the five different levels for such fees: low to moderate severity, moderate severity, high severity without significant threat, and high severity with significant threat. (Request for Judicial Notice, Exhibit 2, emphasis added.) For each such emergency-services charge, HCAI also listed the standardized CPT code. (*Ibid.*) And it put these emergency-services charges at the top of the list. (*Ibid.*)

HCAI's 2023 form template has done the same, describing the emergency-services levels as: straightforward, low level, moderate level, high level—still using the same CPT codes. (See Request for Judicial Notice, Exhibit 4.) HCAI's inclusion of EMS fees is presumptively correct. (See Evid. Code, § 664 [presumption that official duty has been regularly performed].)

CMS, too, has long recognized emergency-department EMS fees to be for "services" when authorizing them to be used in connection with payments for patients with Medicare coverage. CMS has provided for billing EMS fees at one of the five different levels, and hospitals are required to take into consideration the hospital resources required for a given emergency department encounter. (72 Fed.Reg. 66580, 66581, 66789–66790, 66805 (Nov. 27, 2007); *Capito*, *supra*, opn. pp. 11–13.)

In fact, since 2000, CMS has "instructed hospitals to report facility resources for clinic and emergency department (ED) hospital outpatient visits using the CPT E/M [Evaluation and management] codes and to develop internal hospital guidelines for reporting the appropriate visit level (65 FR 18451.)" (80 Fed.Reg. 70298, 70448; *id.* at 70300 ["E/M

Evaluation and management"]; 65 Fed.Reg. 18434, 18451.) In 2007, CMS set forth Healthcare Common Procedure Coding System (HCPCS) codes 99281, 99282, 99283, 99284, and 99285 to charge for the "Emergency department visit for the evaluation and management of a patient" at those five different levels. (72 Fed.Reg. 65580, 66789; see also 83 Fed.Reg. 58818, 58837.)[8] CMS expressly referred to these as "services," including emergency department visits as one of the types of "services" being addressed, and the use of emergency department visit codes to report "E/M services" provided in the emergency department. (72 Fed.Reg. at 66790.)

CMS reiterated that EMS fees encompass a "range and mix of *services* provided by hospitals" during the visits of emergency department patients. (72 Fed.Reg. 65580, 66790, emphasis added.) Internal hospital guidelines are directed "to reasonably relate the intensity of hospital resources to the different levels of effort represented by the codes." (*Ibid.*; 72 Fed.Reg. at 66805 [based on hospital facility resources; not based on physician resources]; see *Gray*, *supra*, 70 Cal.App.5th at p. 242, fn. 12 [noting that plaintiff did not claim that the amount of the EMS fee (the "ER Charge") was excessive].)

In other words, the level of an EMS fee is tied to the severity of the condition and the proportionate burden on hospital resources required to render emergency-room services. A patient who requires more complex services necessarily requires more hospital resources, warranting a higher-level charge for those services.

Thus, as recognized and required by the federal and state agencies regulating hospitals, EMS fees are fees for services—not separate

[8] The CPT codes now match these HCPCS codes. (See Request for Judicial Notice, Exhibits 2, 3, and 4.)

overhead charges "on top of" services, as plaintiff argues. (See opening br. p. 10.)

The charges for the items that plaintiff calls "actual" services—"such as lab tests, CT scans, x-rays, etc." (opening br. p. 10)—are just ancillaries to the main services rendered to patients in the emergency room. For example, some patients do not need lab tests, some do need lab tests, and when needed they often are different for each patient. The same is true of CT scans, x-rays, etc. But none of them is intended to capture the emergency "evaluation and management services" known as the EMS that each patient requires regardless of the different ancillaries that may be needed. The only charge that captures the EMS services is the EMS fee—as state and federal regulators have confirmed.

Plaintiff's argument that hospitals should not charge an EMS fee to her, or any other patients, is untenable. When she showed up at the Hospital's emergency department in the early morning hours of June 18, 2019, and showed up again when she returned on June 20, she required the Hospital to provide evaluation and management services to her each time. The notion, that she "should not have expected" her or her health insurance company to be asked to pay an appropriate fee for the appropriate level of hospital resources required, makes no sense. (See 1 AA 324, 346.)

Further, plaintiff's position would undermine the financing of the hospital emergency departments that serve millions of Californians. (See *Santa Clara*, *supra*, 14 Cal.5th at p. 1053.) The reason state and federal laws recognize EMS fees to be for emergency services is that they *are* for emergency services. Plaintiff's contrary theory is pure sophistry.

Plaintiff argues her special cost notice would be good public policy, but the Legislature and Congress are in a superior position to decide policy, and state and federal regulatory agencies have the expertise to implement those policies. (See *Gray*, *supra*, 70 Cal.App.5th at pp. 240–241; *Saini*, *supra*, 80 Cal.App.5th at p. 1063; *Moran¸ supra*, 94 Cal.App.5th at p. 183.)

It is again worth noting that plaintiff would give this notice to all patients—broadly risking that any of them could be discouraged or intimidated from receiving immediately needed emergency services. But it is difficult to identify many, if any, among the millions who go to emergency departments who could theoretically benefit from plaintiff's proposal. HCAI's 2022 Emergency Department Summary Report shows the expected payer groups regarding the more than 14 million trips by Californians to emergency departments. (Request for Judicial Notice, Exhibit 5.) The first table and the pie chart indicate:

- 42% of trips were made by indigent patients, covered by Medi-Cal. These patients do not pay charges themselves and Medi-Cal pays for emergency services in accordance with a fee schedule set by the State annually.
- Almost 23% of trips were made by elderly (or disabled) patients, covered by Medicare. These patients do not pay charges themselves and Medicare pays for emergency services in accordance with a fee schedule set by CMS annually.
- Over 27% were by patients with private coverage.
    - Among these, healthcare service plans predominate.[9] These patients do not pay charges themselves. (*Prospect*

[9] See Department of Managed Health Care, Enrollment Summary Report – 2022, at:

Medical Group, Inc. v. Northridge Emergency Medical Group (2009) 45 Cal.4th 497, 504–508.) Their health plans often pay for emergency services in accordance with a contractually agreed upon fee schedule, or the plan must reimburse the hospital pursuant to section 1371.4, but the patients' cost share is determined exclusively by the health plan according to the terms of the patient's health benefits.

    - While a traditional health insurance plan might require some patient contribution (e.g., pre-set deductibles or co-pays), the insurer typically reviews bills and generally negotiates discounted rates in advance.
- Just under 5% are listed as "Self-Pay/Uninsured."
- 3% are listed as "Other."

Thus, the 5% who are not elderly, disabled, or indigent, and elected not to buy any coverage, may be most likely to pay charges themselves. But those who chose not to buy coverage *and* expect to pay charges for their healthcare *and* are cost-sensitive—are unlikely to use the services of an emergency department unless reasonably convinced of a true emergency. And in that circumstance, it is particularly important that they not be confronted with costs in advance of services, with the risk of being dissuaded from receiving needed emergency services.

Charging EMS fees is not unfair, unlawful, or fraudulent. Neither is there anything unfair, unlawful, or fraudulent about disclosing EMS

---

https://www.dmhc.ca.gov/DataResearch/FinancialSummaryData.aspx; compare Health Insurance Covered Lives Report, at: http://www.insurance.ca.gov/01-consumers/110-health/coveredlivesrpt.cfm

fees exactly in the manner prescribed by the Legislature in sections 1339.51, 1339.55, and 1339.56.

C. The CLRA and the UCL do not impose an additional duty of disclosure beyond what the lawmakers have required

The Consumer Legal Remedies Act (CLRA) (Civ. Code, § 1750 et seq.) and the Unfair Competition Law (UCL) (Bus. & Prof. Code, § 17200 et seq.) do not impose a duty on a hospital to disclose emergency-department EMS fees, in addition to the duties already imposed under sections 1339.51, 1339.55, and 1339.56, including making its chargemaster publicly available.

The CLRA is not a general fraud statute; it bars enumerated acts. (Civ. Code, § 1770.) Plaintiff purportedly relies on two provisions that, by their terms, bar affirmative misrepresentations:

- "Representing 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." (Civ. Code, § 1770, subd. (a)(5).)
- "Representing that a transaction confers or involves rights, remedies, or obligations that it does not have or involve, or that are prohibited by law." (Civ. Code, § 1770, subd. (a)(14).)

(1 AA 332, ¶ 49; opening br. p. 18.)[10] Plaintiff also relies on these CLRA provisions to allege violation of the UCL prohibitions on

[10] Other provisions in the CLRA require specified disclosures when certain statements are made. (See Civ. Code, § 1770, subds. (a)(11) [advertising furniture without disclosing it is unassembled], (a)(12) [advertising price of unassembled furniture without disclosing price of

"unlawful" and "unfair" business acts and practices. (1 AA 330–331, ¶¶ 42–43.) Plaintiff also alleges violation of the UCL prohibition on "fraudulent" business practices. (1 AA 331, ¶ 44.)

Subdivision (a)(5) of section 1770 does not apply. It concerns misdescriptions about goods or services received (regarding sponsorship, approval, characteristics, ingredients, uses, benefits, or quantities) or persons providing them. Plaintiff complains she was not told in advance she would be charged an EMS fee. She does not complain that the services she received were misdescribed regarding sponsorship, approval, characteristics, ingredients, uses, benefits, or quantities—or that the persons providing them were misdescribed. (See *Bardin v. DaimlerChrysler Corp.* (2006) 136 Cal.App.4th 1255, 1276 (*Bardin*) [defendant had no duty to disclose use of tubular steel exhaust manifolds in vehicles, instead of those made of more durable and more expensive cast iron, in absence of representations about exhaust manifolds; plaintiffs failed to state cause of action under Civ. Code, § 1770, subd. (a)(5)].)

Subdivision (a)(14) of section 1770 does not apply either. There is no allegation anyone at the Hospital told plaintiff their transaction in the emergency department conferred or involved rights, remedies, or obligations that it did not have. (Cf. *Wang v. Massey Chevrolet* (2002) 97 Cal.App.4th 856, 870 [plaintiffs who leased vehicle could pursue claim under subd. (a)(14) against auto dealership for orally misdescribing their rights under the written lease].) There is, for example, no allegation that anyone misrepresented the contents of the COA.

---

assembled furniture if available], (a)(22)(A) [unsolicited prerecorded telephone message without preliminary information and consent].)

Arguing for the creation of a new duty of disclosure under paragraphs (5) and (14) of subdivision (a), plaintiff cites *Torres*. (Opening br. pp. 18–20.) *Torres* cited *Gutierrez v. Carmax Auto Superstores California* (2018) 19 Cal.App.5th 1234 (another opinion authored by the justice who authored *Torres* and *Naranjo*) for the proposition that failure to disclose a material fact could be actionable under the CLRA in certain circumstances—such as where the defendant has "exclusive knowledge" of material facts not known or reasonably accessible to the plaintiff. (*Torres*, *supra*, 77 Cal.App.5th at pp. 508–509 [also citing duty of disclosure where defendant is fiduciary, where defendant actively conceals material fact, and where defendant make partial representation that is misleading without disclosure of material fact]; see also *Bigler–Engler v. Breg, Inc.* (2017) 7 Cal.App.5th 276, 310–311 [without fiduciary duty, other three circumstances for duty to disclose must arise in transaction arising from direct dealings between parties].) While *Torres* agreed with the plaintiff on the issue of duty, it affirmed judgment on the pleadings in favor of the defendant hospital, holding the plaintiff had not pleaded facts showing the plaintiff would have sought emergency treatment elsewhere, even had the plaintiff known about the existence, imposition, and amount of the EMS fee. (*Torres*, *supra*, 77 Cal.App.5th at p. 514.)

The concurring opinion in *Torres* criticized "the extra-statutory expansion of omission-based liability under the CLRA by cases like *Gutierrez* …. I would reject the CLRA claims pursuant to the plain language of the statute." (*Torres*, *supra*, 77 Cal.App.5th at pp. 515–516 [concurring opn.].)

While *Torres* is unclear, it appears it would support importing into the CLRA any common-law claims for concealment involving a

consumer. That would be a sweeping rewrite of the CLRA.[11] *Torres* cited general circumstances in which a concealment claim might arise, but it did not define any particular duty of disclosure with reference to the enumerated list of representations prohibited by the CLRA. (See *Torres*, *supra*, 77 Cal.App.5th at p. 509.)[12] Both subdivision (a)(5) (misdescription of goods, services, or a person) and subdivision (a)(14) (mischaracterization of a transaction) require a representation. Neither is readily adaptable to a claim for concealment, except where a representation has been made—that is, a partial representation that is misleading in the absence of disclosing a material fact—which is not alleged here. (*Gray*, *supra*, 70 Cal.App.4th at pp. 244–245 [concluding no concealment claim under subd. (a)(5) where no facts show defendant gave out other, incomplete information with the likely effect of misleading the public; no claim under either (a)(5) or (a)(14)].) In sum, plaintiff's claim is not actionable under the CLRA.

Moreover, even if the CLRA were expanded well beyond its statutory language to include concealment claims generally, it still would not fit plaintiff's claim. To assert a duty to disclose, plaintiff argues the Hospital had "exclusive knowledge" regarding emergency-department EMS fees. The Hospital did not have "exclusive knowledge." For one reason, it disclosed its EMS fees. Further,

---

[11] Unlike the general fraud statutes, the CLRA was not written as a codification of the common law. (See *Mirkin v. Wasserman* (1993) 5 Cal.4th 1082, 1091–1092 ["the law of deceit in California is not purely statutory; it is a mixture of statutory and common law"; citing Civ. Code, §§ 1709–1711, noting intertwined common-law requirement].)

[12] By comparison, when *Bardin* considered whether there might have been a concealment in violation of subdivision (a)(5), it analyzed whether nondisclosure resulted in a misdescription of the goods sold. (*Bardin*, *supra*, 136 Cal.App.4th at p. 1276.)

emergency-department EMS fees at different levels have long been recognized by federal and state agencies, so much so that they have standard charge codes. They are so common that HCAI has placed them at the top of its list of common outpatient procedures. And despite what *Torres* said, an "objectively reasonable person" will realize that using hospital resources by getting examined and treated at the emergency room comes at a cost, and that the more severe a person's condition, the greater the cost. Further, the Hospital also disclosed its five different levels of emergency-department EMS fees in its publicly available chargemaster. And it reported its Level 2 through 5 emergency-department EMS fees on the form provided by HCAI, which HCAI published on its website. As *Saini* concluded, "there is no withholding of information that is provided on the hospital's chargemaster." (*Saini*, *supra*, 80 Cal.App.5th at p. 1962.)

Further, the standard forms published by HCAI for 25 common outpatient procedures—which the Hospital completed—show what plaintiff says she needed to know. They show the condition for charging an EMS fee: "Emergency Room Visit." And, for Levels 2 through 5, in addition to the CPT code, they state the basis for choosing a given level —with as much description as plaintiff has proposed:

2019 HCAI form	**2023 HCAI form**	**Plaintiff's SAC ¶ 17**
low to moderate severity	straightforward	simple
moderate severity	low level	moderate
high severity without significant threat	moderate level	severe
high severity with significant threat	high level	complex & life-threatening

(Request for Judicial Notice, Exhibits 2 and 4; 1 AA 324 [second amended complaint].)

The level is not determined until the emergency services have been rendered to the patient. But that simply confirms that before the patient receives emergency services, the Hospital does not have exclusive knowledge of what the patient's condition might be, what services will be provided, and what EMS fee level will be charged. It also underscores the confusion and disorientating effect that could result from raising this subject as the first communication to a patient presenting at an emergency department.

In sum, even if the CLRA were applied broadly, it still does not create any additional new duty of disclosure beyond compliance with sections 1339.51, 1339.55, and 1339.56.

Nor does the UCL impose a new duty on a hospital to disclose emergency-department EMS fees, in addition to its duty under sections 1339.51, 1339.55, and 1339.56, including making its chargemaster publicly available. This disclosure of EMS fees is not unlawful, unfair, or fraudulent. (Cf. Bus & Prof. Code, § 17200.)[13]

Plaintiff erroneously asserts that the courts rejecting the new duty she proposes have depended on a so-called "implied safe harbor" to avoid application of the UCL. Not so. Rather, the plaintiffs in these cases were unable to show that the hospitals' practices are unlawful, unfair, or fraudulent *in the first instance*; thus, safe-harbor analysis was irrelevant. (*Saini*, *supra*, 80 Cal.App.5th at p. 1065 [noting *Saini*

[13] Further, as noted in *Nolte* and *Saini*, there is no requirement under the UCL that reasonable notice has to be the best possible notice. (*Nolte v. Cedars–Sinai Medical Center* (2015) 236 Cal.App.4th 1401, 1409 (*Nolte*); *Saini*, *supra*, 80 Cal.App.5th at p. 1064.)

plaintiff's erroneous reading of *Gray*]; *Moran*, *supra*, 94 Cal.App.5th at p. 184 ["simply found no duty to post Moran's requested signage"]; *Gray*, *supra*, 70 Cal.App.5th at p. 242.)

Here, too, plaintiff cannot allege the baseline requirements of unlawful, unfair, or fraudulent conduct. As shown, plaintiff has failed to state a violation of the CLRA, so her reliance on the CLRA to claim unlawfulness and fraudulent practices fails as well. Her unfairness assertion is tethered to her failed CLRA claim as well. (1 AA 330–331, ¶¶ 42–43.)

Further, in light of the state and federal statutory and regulatory structure for emergency services, there is no basis to find a hospital's disclosure of EMS fees pursuant to the chargemaster statute to be unfair. To determine whether challenged conduct is unfair within the meaning of the UCL, "courts may not apply purely subjective notions of fairness." (*Cel-Tech Communications, Inc. v. Los Angeles Cellular Telephone Company* (1999) 20 Cal.4th 163, 184.) "Vague references to 'public policy,' for example, provide little real guidance." (*Id.* at p. 185.)

Here, the "multi-faceted statutory and regulatory scheme 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*, *supra*, 70 Cal.App.5th at pp. 240–241, emphasis in opn.; *Capito*, *supra*, opn. pp. 11–12; *Saini*, *supra*, 80 Cal.App.5th pp. 1059–1063; *Moran¸ supra*, 94 Cal.App.5th at p. 186, emphasis in opn.)

Disclosure of EMS fees through the publicly available chargemaster satisfies the specifically applicable statute, and it also conforms to the broader goals reflected in the state and federal statutory and regulatory

framework for emergency services fees and disclosures. "A hospital's duty to list, post, write down, or discuss fees it may or may not charge an emergency room patient starts and ends with its duty to list prices in the chargemaster, which must be available in accordance with state law." (*Moran¸ supra*, 94 Cal.App.5th at p. 186; accord *Nolte*, *supra*, 236 Cal.App.4th at pp. 1407–1409 [in non-emergency services context, finding disclosure of facility fee for registering patient was properly disclosed by listing on chargemaster and did not violate UCL, affirming sustaining of demurrer].)

Plaintiff has no cause of action for a UCL violation. "[T]he Hospital's policy of not providing additional signage or other warnings about the EMS fee does not state a claim for unfair, unlawful, or fraudulent conduct within the UCL." (*Moran¸ supra*, 94 Cal.App.5th at p. 186.)

This Court should not impose any new disclosure duties on hospitals pursuant to the CLRA or the UCL. As shown, the new duty that plaintiff seeks to impose on hospitals conflicts with the Payers' Bill of Rights and the broader statutory and regulatory structure for emergency services established by state and federal law. (*Moran¸ supra*, 94 Cal.App.5th at p. 186.) Even if plaintiff could find support in the CLRA and the UCL (she cannot), sections 1339.51, 1339.55, and 1339.56 of the Payers' Bill of Rights are far more specific about the obligations of hospitals to disclose charges, including the posting of signage in an emergency department that references availability of the chargemaster, than any general law of disclosure that plaintiff seeks to take from the CLRA and the UCL. (See *Collection Bureau of San Jose v. Rumsey* (2000) 24 Cal.4th 301, 310 ["If conflicting statutes cannot be reconciled, later enactments supersede earlier ones [citation], and more specific

provisions take precedence over more general ones [citation]"].) The CLRA and the UCL do not impose any new duty of disclosure.

CONCLUSION

The Court should affirm the decision of the Court of Appeal and confirm that hospitals do not have a duty to disclose emergency room fees to patients beyond the disclosure duties specified by statute.

November 29, 2023

Respectfully,

King & Spalding LLP

by /s/ Paul R. Johnson
Glenn Solomon
Paul R. Johnson
Amanda L. Hayes-Kibreab
Ariana E. Fuller

Attorneys for
Defendant and Respondent
San Jose Healthcare System, LP

CERTIFICATE RE LENGTH

I certify that the computer program with which the foregoing Answer Brief on the Merits has been prepared has generated a total count (for headings, main text, and footnotes) of 9,380 words (excluding the cover, the tables, the signature block, and this certificate).

November 29, 2023

/s/ Paul R. Johnson

PROOF OF SERVICE

Capito v. San Jose Healthcare System, LP, S280018, H049646
Superior Court, Santa Clara County, No. 20CV366981

I am a citizen of the United States, over 18 years of age, and not a party to the within proceeding. My business address is King & Spalding LLP, 633 W. 5th Street, Suite 1600, Los Angeles, California 90071.

On the date set forth below, I am serving the foregoing **Answer Brief on the Merits** by causing true copies to be distributed as follows:

To the Court of Appeal:

Clerk, Court of Appeal
Sixth Appellate District
333 West Santa Clara Street, Suite 1060
San Jose, CA 95113

To the trial court:

Hon. Sunil R. Kulkarni
c/o Clerk, Superior Court
191 North First Street
San Jose, CA 95113

To the Santa Clara County District Attorney:

Office of the District Attorney
for Santa Clara County
70 West Hedding Street
San Jose, CA 95110

BY U.S. MAIL, FIRST-CLASS POSTAGE PREPAID: I am readily familiar with the firm's practice in this office of processing correspondence for mailing. Under that practice, such correspondence is placed in a sealed envelope and deposited with the U.S. Postal Service on that same day with first-class postage thereon fully prepaid in the ordinary course of business.

To the Attorney General:

Office of the Attorney General
Consumer Protection Section

BY ELECTRONIC SERVICE: I uploaded an electronic copy of the above-referenced document at the Attorney General's webpage for uploading appellate briefs and petitions pursuant to Business and Professions Code section 17209 (https://oag.ca.gov/services-info/17209-brief/add).

To Plaintiff and Appellant:

ELECTRONIC SERVICE THROUGH TRUEFILING: This document is being submitted for filing through the Supreme Court's TrueFiling service, with designation that an electronic copy be served through a link provided by email from TrueFiling to the attorneys who are registered with TrueFiling for this proceeding.

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

Executed on November 29, 2023.

/s/ Paul R. Johnson
PAUL R. JOHNSON

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**

1. At the time of service I was at least 18 years of age and not a party to this legal action.

2. My email address used to e-serve: **pjohnson@kslaw.com**

3. I served by email a copy of the following document(s) indicated below:

Title(s) of papers e-served:

Filing Type	Document Title
BRIEF	Answer Brief on the Merits
REQUEST FOR JUDICIAL NOTICE	Request for Judicial Notice

Service Recipients:

Person Served	Email Address	Type	Date / Time
Barry Kramer Law Office of Barry Kramer	kramerlaw@aol.com	e-Serve	11/29/2023 8:29:32 PM
Lowell Brown Arent Fox LLP	lowell.brown@afslaw.com	e-Serve	11/29/2023 8:29:32 PM
Paul Johnson Filice Brown et al., LLP	paul.johnson@filicebrown.com	e-Serve	11/29/2023 8:29:32 PM
Paul Johnson King & Spalding LLP 115817	pjohnson@kslaw.com	e-Serve	11/29/2023 8:29:32 PM
Zuzana Ikels King & Spalding 208671	zikels@kslaw.com	e-Serve	11/29/2023 8:29:32 PM
Gretchen Carpenter Carpenter Law 180525	gretchen@gcarpenterlaw.com	e-Serve	11/29/2023 8:29:32 PM
Susan Sarff King & Spalding LLP	ssarff@kslaw.com	e-Serve	11/29/2023 8:29:32 PM
Carlo Aguilar Carpenter Law	carlo@gcarpenterlaw.com	e-Serve	11/29/2023 8:29:32 PM
Ariana Fuller King & Spalding 301797	afuller@kslaw.com	e-Serve	11/29/2023 8:29:32 PM
Glenn Solomon King & Spalding LLP	gsolomon@kslaw.com	e-Serve	11/29/2023 8:29:32 PM
Amanda Hayes-Kibreab 224403	AHayes-Kibreab@KSLAW.com	e-Serve	11/29/2023 8:29:32 PM

This proof of service was automatically created, submitted and signed on my behalf through my agreements with TrueFiling and its contents are true to the best of my information, knowledge, and belief.

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

11/29/2023

Date

/s/Paul Johnson

Signature

Johnson, Paul (115817)

Last Name, First Name (PNum)

King & Spalding LLP

Law Firm