**IN THE COURT OF APPEALS**
**STATE OF ARIZONA, DIVISION ONE**

JACKIE ABBOTT; ROBERT BERGANSKY; RAYMOND BROWN; NICHOLAS BIGLER; RICHARD CAMPUZANO; DALTON GORMEY; TRACY JAMES; JOHN JAMES; STEPHANIE KRUEGER; ZAINAB MOHAMED; ROBERT PIERSON; LUCAS SMITH; ROBERT VAN STEENBURGH; AMBER WINTERS; CHRISTINA YERKEY, and STEPHEN YOUNG,

Plaintiffs/Appellants,

v.

BANNER HEALTH NETWORK, fka Banner Health Inc., an Arizona corporation; DIGNITY HEALTH fka Catholic Healthcare West, a California corporation; SCOTTSDALE HEALTHCARE CORP., an Arizona corporation; NORTHWEST HOSPITAL LLC, a Delaware corporation; NORTHERN ARIZONA HEALTHCARE CORP., an Arizona corporation; JOHN C. LINCOLN HEALTH NETWORK, an Arizona corporation; UNIVERSITY MEDICAL CENTER CORP., an Arizona corporation; CARONDELET HEALTH NETWORK, an Arizona corporation; TUCSON MEDICAL CENTER, an Arizona corporation; ORO VALLEY HOSPITAL, LLC, a Delaware corporation,

Defendants/Appellees.

# OPENING BRIEF OF PLAINTIFFS-APPELLANTS

**Case No. 1 CA-CV 13-0259**

Maricopa County Superior Court
Case No. CV 2012-007665, Hon. J. Richard Gama

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## Preliminary Statement

Arizona joined the federal Medicaid program in 1982. Since then, hospitals operating in Arizona have received money through the Arizona Health Care Cost Containment System ("AHCCCS")—Arizona's Medicaid agency—for providing health care to indigent Medicaid patients.

The defendant hospitals are Medicaid registered providers. After billing or accepting payment from Medicaid, the hospitals have a practice of asserting liens against the personal-injury settlements of their Medicaid patients. The hospitals base those liens on amounts they have billed their Medicaid patients *over and above* the amounts the hospitals contracted to receive from Medicaid to treat the patients. In other words, the hospitals engage in "balance billing."[1]

Under federal law, balance billing Medicaid patients is illegal. Over the last forty years, four states (including Arizona) have enacted statutes and adopted state regulations purporting to legalize that federally-illegal practice. Courts in all four states have held that the practice is unlawful and preempted by federal law.

Indeed, every court that has addressed balance-billing in the Medicaid context has held that the practice is illegal.

[1] "Balance billing" refers to a "healthcare provider's practice of requiring a patient or other responsible party to pay any charges remaining after insurance and other payments and allowances have been applied to the total amount due for the provider's services." *Black's Law Dictionary* 163 (9th ed. 2009). Some forms of balance billing are legal. But balance billing Medicaid patients is not.

Balance billing Medicaid patients is widely condemned. For instance, the Department of Health and Human Services regards balance-billing of Medicaid patients as illegal. AHCCCS itself classifies balance billing as a "fraud." Moreover, the Congressional Record is clear that Congress wants the practice prohibited. And if that were not enough, the practice of balance billing Medicaid patients also violates the plain language of the Medicaid hospital-provider contracts.

Two classes of Arizona Medicaid patients subjected to balance billing by hospitals operating in Arizona sued and sought class certification. Members of the first class of patients ("open-lien plaintiffs") had refused to pay the illegal hospital liens and thus could not access their personal-injury settlements.[2] The open-lien plaintiffs are seeking injunctive and declaratory relief. The trial court has recently certified that class.[3]

Members of the second class of patients ("closed-lien plaintiffs") had paid the hospitals to get their liens released so they could access their settlement funds.

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[2] The assertion of a balance-billing lien implicates ethical duties imposed by Ethical Rule 1.15, Rule 42, Rules of the Arizona Supreme Court. *See, e.g., State Bar of Arizona Ethics Opinion 98-06*. As a result, the mere assertion of such a lien—even if disputed—interferes with access to and disbursement of a patient's settlement funds until lien claims and other disputes over the settlement funds are resolved.

[3] *Minute Entry* in CV 2012-007665 (5/23/13) (copy attached as Exh. 1 to this Opening Brief). Appellants respectfully ask the Court to take judicial notice of that minute-entry order. *See, e.g.*, *United States v. Wilson*, 631 F.2d 118, 119 (9th Cir. 1980) (Appellate court may take judicial notice of records of trial court.).

As damages, the closed-lien plaintiffs seek, among other remedies, refunds of the money illegally procured from them by the hospitals' balance billing. The trial court, however, held that the hospitals had a valid accord-and-satisfaction defense that ended the closed-lien plaintiffs' rights to contest the illegality of the hospitals' actions. That dismissal foreclosed any remedy for the closed-lien plaintiffs. The trial court then entered a Rule 54(b) judgment for the closed-lien plaintiffs. They now appeal from that judgment.

**The Federal Regulation and Statute**

The Department of Health and Human Services adopted a regulation to prohibit Medicaid balance billing. The regulation is 42 C.F.R. § 447.15, which states, in relevant part:

> A State plan must provide that the Medicaid agency must limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency plus any deductible, coinsurance or copayment required by the plan to be paid by the individual.[4]

Two decades after HHS first adopted the regulation, Congress passed a complementary statute.[5] Published opinions that have resolved Medicaid balance-

[4] 42 C.F.R. § 447.15.

[5] The statute, 42 U.S.C. § 1396a(a)(25)(C), states: "A State plan for medical assistance must — (25) provide — (C) that in the case of an individual who is entitled to medical assistance under the State plan with respect to a service for which a third party is liable for payment, the person furnishing the service may not seek to collect from the individual (or any financially responsible relative or representative of that individual) payment of an amount for that service (i) if the

billing issues have primarily focused on the HHS regulation.

## The Issues

(1). Is an agreement based on an illegal subject matter or on illegal acts "an appropriate subject for agreement" or proper "consideration," as required for a valid and enforceable accord and satisfaction?

(2). Is balance billing a Medicaid patient an illegal act?

## Standard of Review

The trial court granted a motion to dismiss the closed-lien plaintiffs' first amended class-action complaint for failure to state a claim upon which relief could be granted. Appellate courts review that sort of dismissal de novo.[6] Dismissal is proper only if, as a matter of law, a plaintiff would not be entitled to relief under *any* interpretation of the facts susceptible of proof.[7]

In determining if a complaint states a claim on which relief can be granted, courts assume the truth of all well-pleaded factual allegations and indulge all

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total of the amount of the liabilities of third parties for that service is at least equal to the amount payable for that service under the plan (disregarding section 1396o of this title), or (ii) in an amount which exceeds the lesser of (I) the amount which may be collected under section 1396o of this title, or (II) the amount by which the amount payable for that service under the plan (disregarding section 1396o of this title), exceeds the total of the amount of the liabilities of third parties for that service."

[6] *Coleman v. City of Mesa*, 230 Ariz. 352, 356 ¶ 8, 284 P.3d 863, 867 ¶ 8 (2012).

[7] *Fidelity Security Life Ins. Co. v. State Dept. of Ins.*, 191 Ariz. 222, 224 ¶ 4, 954 P.2d 580, 582 ¶ 4 (1998).

reasonable inferences based on those facts in favor of the plaintiff.[8] In general, courts look only to the pleading itself when adjudicating a Rule 12(b)(6) motion.[9] But a complaint's exhibits, or public records on matters a complaint references, are not outside the pleading, and courts may consider those items without converting a Rule 12(b)(6) motion into a summary-judgment motion.[10]

## Statement of the Case

### Basis of Appellate Court's Jurisdiction

Jurisdiction exists under Ariz. Const. art. 6, § 9 and A.R.S. § 12-2101.

### Nature of the Case

This case is about a class of indigent patients who received treatment at hospitals operating in Arizona. The hospitals billed Medicaid in full and then asserted illegal liens against the patients' personal-injury settlements. To access those settlements, the indigent patients paid the hospitals to have the illegal liens released. The patients now seek equitable and legal remedies against the hospitals, including disgorgement of the balance-billing money paid to the hospitals.

### Factual Background

Ten hospitals operating in Arizona provided healthcare services to 15

[8] *Cullen v. Auto-Owners Ins. Co.*, 218 Ariz. 417, 419 ¶ 7, 189 P.3d 344, 346 ¶ 7 (2008).

[9] *Id*.

[10] *Strategic Dev. & Constr., Inc. v. 7th & Roosevelt Partners, LLC*, 224 Ariz. 60, 63 ¶ 10, 64 ¶ 13, 226 P.3d 1046, 1049 ¶ 10, 1050 ¶ 13 (App. 2010).

Arizona patients who had suffered personal injuries.[11] Because the 15 patients were indigent, they were enrolled in AHCCCS, the entity the State of Arizona had created to administer Arizona's participation in the federal Medicaid program.[12] The 10 hospitals billed Medicaid—through AHCCCS—to pay for the healthcare services they provided to their Medicaid patients.[13] Each of the 15 patients was able to obtain a personal-injury settlement from the insurance companies for the various tortfeasors.

AHCCCS paid to the hospitals the amount Medicaid had established for providing healthcare services to the Medicaid patients. The hospitals' total billings, however, exceeded what they had contracted to receive from Medicaid.[14] Each hospital recorded one or more liens against the personal-injury settlement proceeds that each patient recovered.[15] The hospitals filed those liens in violation of federal

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[11] The 10 hospitals are the Defendants-Appellees. *See also* First Amended Class Action Complaint ("FAC") at ¶¶ 35-44, 74 (5/11/12), IR-05. The 15 patients are the Plaintiffs-Appellants. *See FAC* at ¶ 47 (Abbott), ¶ 50 (Bergansky), ¶ 54 (Bigler), ¶ 49 (Brown), ¶ 61 (Campuzano), ¶ 52 (Gormey), ¶ 46 (James), ¶ 57 (Krueger), ¶ 62 (Mohamed), ¶ 55 (Pierson), ¶ 48 (Smith), ¶ 51 (Van Steenburgh), ¶ 45 (Winters), ¶ 56 (Yerkey), ¶ 53 (Young), and ¶ 74, IR-05. If class certification is granted for the other patients who have similarly been pressured to pay the hospitals based on illegal liens that the hospitals have asserted against them, there will be more plaintiffs.

[12] *FAC* at ¶¶ 34, 74, IR-05.

[13] *FAC* at ¶ 68(a), IR-05.

[14] *See Motion to Dismiss* at 3:7-9 (7/13/12) (The hospitals admit that "AHCCCS payments to hospitals cover only a portion of the hospital's total bill."), IR-18.

[15] *FAC* at ¶ 68(c), IR-05.

statutory and regulatory law, as interpreted by every court and regulatory agency, and in violation of public policy as expressed by Congress.[16]

Moreover, the hospitals filed and asserted the liens despite having billed or collected the full payment they were entitled to recover from Medicaid.[17] Most of the hospitals also filed and asserted the liens in violation of AHCCCS provider-participation agreements stating that the hospitals would "abide by Arizona Administrative Code R9-22-702 prohibiting [the hospital] from charging, collecting, or attempting to collect payment from an AHCCCS eligible person."[18] The other hospitals had either agreed to the same clause or had signed a contract containing a provision that they would comply with federal law.[19]

Because of the recorded liens, none of the patients could settle their tort cases with the insurance companies for the tortfeasors without obtaining a release of the hospital liens.[20] That is, the insurance companies for the tortfeasors refused

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[16] *FAC* at ¶¶ 85, 97, 102, IR-05.

[17] *FAC* at ¶ 34, IR-05.

[18] Exh. 1 to *FAC*, Provider Participation Agreements for Banner Baywood Medical Center, for Banner Boswell Medical Center, for Banner Del E. Webb Medical Center, for Banner Desert Medical Center, for Banner Estrella Medical Center, for Banner Gateway Medical Center, for Bannerwood Samaritan Medical Center, for Banner Heart Hospital, for Banner Ironwood Medical Center, for Banner Thunderbird Medical Center, for Chandler Regional Medical Center, for Catholic Healthcare West, for Scottsdale Healthcare Thompson Peak, for John C. Lincoln Health Network at ¶ 15, IR-06.

[19] *FAC* at ¶ 24, IR-05.

[20] *FAC* at ¶ 77, IR-05.

to pay the tort-victim patients while the hospital liens were still outstanding.[21] The funds were frozen. Moreover, under Ethical Rule 1.15, the lawyers representing the tort-victim Medicaid patients could not distribute any of the settlement proceeds until the liens were addressed.[22]

In the face of a denial of access to their tort recoveries, each patient paid to the hospitals money in excess of the money that the hospitals received from AHCCCS.[23] The following chart summarizes what each Medicaid patient finally paid to nullify the hospital liens asserted against him or her:

| **The 15 Patients** | **Hospital** | **Lien** | **Paid** |
|---|---|---|---|
| Abbott | Banner Health/Banner Baywood | $ 50,735.63 | $12,000.00[24] |
| Bergansky | John C. Lincoln Hospital | $184,035.67 | $ 2,000.00[25] |
| Bigler | University Medical Center | $ 41,390.37 | $ 4,000.00[26] |
| Brown | Scottsdale Healthcare | $ 36,586.29 | $ 1,811.29[27] |
| Campuzano (1)<br>Campuzano (2) | UMC Medical Center<br>Carondelet St. Mary's | $113,189.09<br>$ 12,520.75 | $ 4,173.58[28]<br>(total) |
| Gormey | John C. Lincoln N. Mtn. Hosp. | $ 54,118.00 | $ 3,938.00[29] |

[21] *FAC* at ¶¶ 45-57, 59, 61-62 (Each insurer conditioned release of the settlement funds on requiring each tort-victim patient to get a release of the hospital balance-billing lien for that patient.), IR-05. *See also* FAC at ¶ 75, IR-05.

[22] *See* Ethical Rule 1.15, Rule 42, Rules of the Arizona Supreme Court and *State Bar of Arizona Ethics Opinion 98-06*.

[23] *FAC* at ¶ 68(d), IR-05.

[24] *FAC* at ¶ 47, IR-05; Exh. A to *Motion to Dismiss* ("*MTD*") (7/13/12), IR-19.

[25] *FAC* at ¶ 50, IR-05; Exh. B to *MTD*, IR-19 .

[26] *FAC* at ¶ 54, IR-05; Exh. D to *MTD*, IR-19.

[27] *FAC* at ¶ 49, IR-05; Exh. C to *MTD*, IR-19.

[28] *FAC* at ¶ 61, IR-05; Exh. E to *MTD*, IR-19

[29] *FAC* at ¶ 52, IR-05; Exh. F to *MTD*, IR-19.

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|---|---|---|---|
| T. James (1)<br>T. James (2) | Sun Health Corp.<br>St. Joseph's Hospital | $ 21,146.27<br>$ 63,902.00 | $ 600.00[30]<br>$ 2,000.00 |
| Krueger (1)<br>Krueger (2) | Oro Valley Hospital<br>Northwest Medical Center | $ 3,764.30<br>$ 11,675.59 | $ 752.86[31]<br>$ 2,335.11 |
| Mohamad | Tucson Medical Center | $ 3,034.60 | $ 200.00[32] |
| Pierson | University Medical Center | $ 91,834.79 | $ 3,000.00[33] |
| Smith | Catholic Healthcare West | $140,998.00 | $13,950.00[34] |
| Van Steenburgh | Scottsdale Healthcare | $227,120.52 | $ 9,000.00[35] |
| Winters | Banner Gateway Medical Center | $ 1,849.00 | $ 1,000.00[36] |
| Yerkey | Northwest Medical Center | $ 4,941.27 | $ 414.88[37] |
| Young | Northern Arizona Healthcare | $199,660.00 | $ 2,500.00[38] |

The closed-lien plaintiffs ultimately sued the hospitals for injunctive and declaratory relief. In addition, they sought compensatory damages for the money that the hospitals had wrongfully obtained from them.[39] That is, the Medicaid patients sought to have the hospitals disgorge the money they had procured through the use of illegal liens and illegal demands for payment above what AHCCCS paid the hospitals.

**Procedural History**

The open-lien and closed-lien plaintiffs filed a joint Class Action Complaint

[30] *FAC* at ¶ 46, IR-05; Exh. G to *MTD*, IR-20.
[31] *FAC* at ¶ 57, IR-05; Exh. H to *MTD*, IR-20.
[32] *FAC* at ¶ 62, IR-05; Exh. I to *MTD*, IR-20.
[33] *FAC* at ¶ 55, IR-05; Exh. J to *MTD*, IR-20.
[34] *FAC* at ¶ 48, IR-05; Exh. K to *MTD*, IR-20.
[35] *FAC* at ¶ 51, IR-05; Exh. L to *MTD*, IR-20.
[36] *FAC* at ¶ 45, IR-05; Exh. M to *MTD*, IR-20.
[37] *FAC* at ¶ 56, IR-05; Exh. N to *MTD*, IR-20.
[38] *FAC* at ¶ 53, IR-05; Exh. O to *MTD*, IR-20.
[39] *FAC* at page 30, IR-05.

on May 8, 2012.[40] Three days later, they filed a First Amended Class Action Complaint.[41]

On July 13, 2012, the defendant hospitals filed a motion to dismiss the 15 closed-lien plaintiffs from the lawsuit, arguing that, under the interrelated doctrines of compromise, release, voluntary payment, and accord and satisfaction, the settlements the 15 closed-lien plaintiffs had made with the 10 hospitals prevented them from suing those hospitals.[42] The parties filed a response[43] and a reply.[44] Although both sides asked for oral argument, the trial court did not grant it.

In a minute-entry order filed September 28, 2012, the trial court granted the motion to dismiss.[45] The trial court reasoned that it was "irrelevant whether federal law preempts Arizona law and prohibits hospitals from enforcing statutory liens on AHCCCS accounts."[46] Thus, the trial court declined to address any preemption or illegality issues.[47] In fact, the trial court held that the accord-and-satisfaction defense "does not turn on whether Plaintiffs would have prevailed on the merits" of the settled disputes.[48] In reaching that conclusion, the trial court quoted from

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[40] *Class Action Complaint* (5/8/12), IR-1.
[41] *First Amended Class Action Complaint* (5/11/12), IR-05.
[42] *Motion to Dismiss* at 3 (7/13/12), IR-18.
[43] *Plaintiffs' Response in Opposition to Motion to Dismiss* (7/31/12), IR-24.
[44] *Reply in Support of Motion to Dismiss* (8/17/12), IR-32.
[45] *Minute Entry* (9/28/12), IR-40.
[46] *Minute Entry* at 1 (9/28/12), IR-40.
[47] *Minute Entry* at 1 (9/28/12), IR-40.
[48] *Minute Entry* at 1 (9/28/12), IR-40.

the Arizona Supreme Court's 1929 *Brecht v. Hammons* opinion concerning accord and satisfaction of untenable claims.[49] The trial court also cited to this Court's 1998 opinion in *Emmons v. Superior Court*.[50]

The trial court further ruled that the lien settlements were "final and binding regardless of the validity of the underlying claims."[51] In support of that holding, the trial court cited this Court's 1977 *Shelton v. Grubbs* and 1988 *Flagel v. Southwest Clinical Physiatrists, P.C.* opinions.[52] Finally, the trial court agreed with the hospitals that the cases the plaintiffs had relied on were inapposite, because, supposedly, "none involved accord and satisfaction vis-à-vis settlement of a lien."[53] There was no further analysis.

The trial court, in summary, dismissed the closed-lien plaintiffs from the case under the accord-and-satisfaction doctrine because the trial court found that it was "irrelevant whether federal law preempts Arizona law and prohibits hospitals from enforcing statutory liens on AHCCCS accounts."[54]

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[49] *Minute Entry* at 2 (9/28/12), IR-40 (quoting *Brecht v. Hammons*, 35 Ariz. 383, 390, 278 P. 381, 383 (1929), *overruled in part on other grounds*, *Arizona Public Service Co. v. Southern Union Gas Co.*, 76 Ariz. 373, 265 P.2d 435 (1954)).

[50] *Minute Entry* at 1-2 (9/28/12), IR-40 (citing *Emmons v. Superior Court*, 192 Ariz. 509, 513, 968 P.2d 582, 586 (App. 1998)).

[51] *Minute Entry* at 2 (9/28/12), IR-40.

[52] *Minute Entry* at 2 (9/28/12), IR-40 (citing *Shelton v. Grubbs*, 116 Ariz 230, 568 P.2d 1128 (App. 1977) and *Flagel v. Southwest Clinical Physiatrists, P.C.*, 157 Ariz. 196, 755 P.2d 1184 (App. 1988)).

[53] *Minute Entry* at 2 (9/28/12), IR-40.

[54] *Minute Entry* at 1 (9/28/12), IR-40.

On February 26, 2013, the trial court filed a "Rule 54(b) Judgment Against Closed Lien Plaintiffs."[55] A timely notice of appeal was filed on March 27, 2013.[56]

## Legal Argument

### 1. Purported settlement agreements that are based on illegal acts lack an "appropriate subject for agreement" and proper "consideration," both of which are required for a valid accord and satisfaction.

#### A. Introduction

Even contracts dealing with a *legal* subject matter and concerning acts that are entirely *legal* can be unenforceable or legally invalid. That may be because of poor drafting, expiration of the statute of limitation, or failure of a necessary condition precedent. Those sorts of invalid contracts can still form the basis for a valid accord and satisfaction—as long as they do not rest on an illegal subject matter or involve illegal acts.[57] Contracts to engage in or cease engaging in illegal acts, on the other hand, provide no basis for a valid accord and satisfaction.[58]

In this case, however, the trial court cited and relied on opinions finding

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[55] *Rule 54(b) Judgment Against Closed Lien Plaintiffs* (2/28/13), IR-113.

[56] *Notice of Appeal* (3/27/13), IR-129.

[57] *See, e.g.*, William F. Elliott, 3 *Commentaries on the Law of Contracts* § 2070 at 261 (1913) ("The accord and satisfaction may be founded on an untenable claim, if it be not illegal.").

[58] William F. Elliott, 3 *Commentaries on the Law of Contracts* § 2071 at 261 (1913) ("An illegal claim cannot be the consideration of an accord and satisfaction."); William Wait, 6 *A Treatise upon Some of the General Principles of the Law* ch. II, art. I, § 1 at 408 (1885) ("It is likewise essential to the validity of an accord and satisfaction that the thing agreed to be done be legal, or if the thing to be done, or the consideration, is illegal, the accord will be void.").

valid accord-and-satisfaction agreements for agreements involving untenable or potentially untenable claims that were based on legal acts. On that basis, the trial court mistakenly held that the legality of the activity involved in the underlying agreement is "irrelevant" to an accord-and-satisfaction defense.[59]

### B. To be valid, an accord and satisfaction must have four elements: (1) proper subject, (2) competent parties, (3) valid consideration, and (4) meeting of the minds.

To be valid and enforceable, an accord-and-satisfaction agreement, like any other contract, must have four elements: (a) a proper subject matter for agreement, (b) parties competent to enter in the agreement; (c) valid consideration; and (d) a meeting of the minds between the parties.[60]

### C. Agreements that are based on an illegal subject matter or on illegal acts cannot form the basis for a valid and enforceable accord and satisfaction.

The third element for accord and satisfaction, "consideration," fails if the only consideration is a promise to forbear from doing what a party is legally barred

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[59] *Minute Entry* at 1 (9/28/12), IR-40.

[60] *See Vance v. Hammer*, 105 Ariz. 317, 319, 464 P.2d 340, 342 (Ariz. 1970) ("Generally, the elements essential for valid contracts must be present in a contract of accord and satisfaction. Those elements are as follows: (1) A proper subject matter, (2) competent parties, (3) an assent or meeting of the minds of the parties, and (4) a consideration.") (citation omitted). *See also* 29 *A Treatise on the Law of Contracts by Samuel Williston* § 73:29 at 89 (4th ed. 2003) ("The essential elements of an accord and satisfaction are: (1) a proper subject matter; (2) competent parties; (3) mutuality of assent; and (4) consideration.").

from doing.[61] There is, after all, "no consideration for a promise for a man to forbear or to promise to forbear from doing what he is legally not entitled to do."[62] Moreover, under Arizona law, "giving a party something to which he or she has an absolute right is not consideration to support the party's contractual promise. Stated in slightly different terms, a promise to perform a preexisting duty is insufficient consideration."[63]

For each of the closed-lien plaintiffs, the hospitals proffered consideration that managed to be both illusory and illegal. For instance, the hospitals billed Medicaid for treating Lucas Smith and then agreed with Smith that if he paid them $13,950, they would not seek to enforce the remaining $127,048 on the filed lien.[64] But because Smith owed them nothing under federal law after the hospitals had

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[61] *Landi v. Arkules*, 172 Ariz. 126, 133, 835 P.2d 458, 465 (App. 1992), *review denied* (Sept. 15, 1992) ("An agreement is unenforceable if the acts to be performed would be illegal or violate public policy."). *See also* James F. Hogg, Carter G. Bishop, and Daniel D. Barnhizer, *Contracts: Cases and Theory of Contractual Obligation* 754 (2008) ("A promise to surrender a claim that has no legal merit . . . clearly cannot supply consideration for an agreement because the purported claimant has no real claim to begin with.").

[62] William L. Clark, Jr., *Handbook on the Law of Contracts* 169 (4th ed. 1931).

[63] *Hisel v. Upchurch*, 709 F. Supp. 1509, 1521 (D. Ariz. 1992) (citations and internal punctuation omitted). *See also Brewer v. Trust Co. Bank*, 424 S.E.2d 74, 76 (Ga. App. 1992) (Since consideration must support an accord and satisfaction, a person's agreement to do what that person "is already legally bound to do is not a sufficient consideration for the promise of another.") (citations omitted); *In re Marriage of Coufal*, 510 N.E.2d 25, 28 (Ill. App. 1987) (When the alleged consideration for an accord and satisfaction consists "wholly of preexisting duties," the consideration is not valid.).

[64] *FAC* at ¶ 48, IR-05; Exh. K to *MTD*, IR-20.

billed Medicaid for his care *and* because their lien was illegal, the proffered consideration was an agreement by the hospitals to refrain from doing something they could not legally do. Here, as for all of the closed-lien plaintiffs, there was no consideration to support any accord and satisfaction.

Moreover, the first element for accord and satisfaction, "an appropriate subject for agreement," also fails if the agreement is for one party to forbear from doing something illegal. An accord and satisfaction's subject matter "cannot be founded on an illegal or unlawful claim or agreement, or one in contravention of public policy."[65] Agreements that require acts that "violate legislation or other identifiable public policy" are not a proper subject for agreement and will not be enforced.[66]

In summary, contracts where one party agrees to refrain from doing what they were not legally entitled to do are not "an appropriate subject for agreement" and do not provide proper "consideration," two of the four essential requirements

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[65] *See* 1 C.J.S. *Accord and Satisfaction* § 13 at 374-75 (2005) ("The subject matter of an accord and satisfaction must be lawful, and an accord and satisfaction cannot be founded upon an illegal or unlawful claim or agreement, or one in contravention of public policy."); Alva Roscoe Hunt, 1 *A Treatise on the Law of Accord and Satisfaction, Compromise, and Composition at Common Law* § 23 at 39 (1913) (There can be no accord and satisfaction if "the contract sought to be supplanted" is "in violation of the law" or "in contravention of public policy.").

[66] *1800 Ocotillo, LLC v. WLB Group, Inc.*, 219 Ariz. 200, 202 ¶ 7, 196 P.3d 222, 224 ¶ 7 (2008) ("Contract provisions are unenforceable if they violate legislation or other identifiable public policy.").

for a valid and enforceable accord and satisfaction.[67] All of the hospital agreements with the closed-lien plaintiffs were based on illegal acts and lacked any sort of valid consideration. The hospital agreements were thus not valid and enforceable accord-and-satisfaction agreements.

### D. As long as the underlying acts and subject matter are legal, parties may make a valid and enforceable accord and satisfaction—even if any resulting settlement agreement turns out to be unenforceable, invalid, or untenable. But that is not true if the underlying acts and subject matter violate public policy or are illegal.

All of the cases the trial court relied on involved legal (as opposed to illegal) activities that did not violate public policy. On various grounds, one of the parties was arguing that the agreement was unenforceable—not that the underlying activity violated public policy or was illegal. The four cases the trial court relied upon were:

- *Brecht v. Hammons*, 35 Ariz. 383, 390, 278 P. 381, 383 (1929), *overruled in part on other grounds*, *Arizona Public Service Company v. Southern Union Gas Co.*, 76 Ariz. 373, 265 P.2d 435 (1954).
- *Emmons v. Superior Court*, 192 Ariz. 509, 968 P.2d 582 (App. 1998).
- *Shelton v. Grubbs*, 116 Ariz 230, 568 P.2d 1128 (App. 1977).
- *Flagel v. Southwest Clinical Physiatrists, P.C.*, 157 Ariz. 196, 755

[67] *See Best Choice Fund, LLC v. Low & Childers, P.C.*, 228 Ariz. 502, 510 ¶ 24, 269 P.3d 678, 686 ¶ 24 (App. 2011) ("Like any contract, an accord *must have* (1) an appropriate subject for agreement, (2) parties competent to enter in the agreement, (3) consideration, and (4) a meeting of the minds between the parties.") (emphasis added).

P.2d 1184 (App. 1988).

*Brecht* and *Emmons* involved parties who went to trial. The plaintiffs won a large verdict and the parties later settled. In general, and in those cases in particular, settling a lawsuit is neither illegal nor against public policy. In both cases, after agreeing to settle, the defendants learned about a legal error that (they contended) might have led to a more favorable settlement for them.[68] *Emmons* held that there was no evidence that the error would have affected the settlement, and thus refused to disturb the settlement.[69] And *Brecht* held that evidence suggesting the defendant would have had leverage to make a better bargain was not a basis for disturbing the settlement.[70] Neither case involved an agreement where one party agreed to refrain from doing what they were not legally entitled to do, as is the case here.

The other two cases the trial court relied on are similar. *Flagel* involved a settlement over the payment for physical therapy and *Shelton* involved payment for drilling a well. Flagel received a check (designated "payment in full") for part of his physical-therapy services. He cashed the check.[71] In *Shelton*, the defendant lost a motion for summary judgment, settled, then sought to undo the settlement by

[68] *Brecht*, 35 Ariz. at 390-91, 278 P. at 383-84; *Emmons*, 192 Ariz. at 509-11, 968 P.2d at 582-84.

[69] *Emmons*, 192 Ariz. at 511-13, 968 P.2d at 584-86.

[70] *Brecht*, 35 Ariz. at 387-90, 278 P. at 382-84.

[71] *Flagel*, 157 Ariz. at 200-02, 755 P.2d at 1188-90.

challenging the jurisdiction of the court.[72] Physical therapy and well-drilling are not illegal. But, as discussed in depth in the next sections, accepting Medicaid payments to treat a hospital patient, and then balance billing the Medicaid patient, *is* illegal. The four cases the trial court relied on are thus inapposite.[73]

### E. The Sixth Circuit's 2005 *Spectrum Health* case has directly resolved the questions at issue in this case.

At the trial court, the closed-lien plaintiffs cited the Sixth Circuit's 2005 opinion in *Spectrum Health v. Anne Marie Bowling*, for the proposition that a settlement agreement to pay a balance-billing lien, after a Medicaid provider has accepted Medicaid, provides no basis for accord and satisfaction.[74] As noted, the trial court distinguished the *Spectrum Health* opinion on the theory that it did not involve a lien.[75]

But the facts are otherwise. The Sixth Circuit's opinion explicitly stated that Spectrum Health was asserting "a lien on the proceeds" of the patient's tort recovery after billing Medicaid for the patient's care.[76] The Sixth Circuit stated that the parties had earlier reached an agreement to settle the lien for payment of money

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[72] *Shelton*, 116 Ariz at 231-32, 568 P.2d at 1129-30.

[73] Indeed, *Brecht* is contrary to the trial court's reasoning because it held that "the surrender of a claim which is known to be entirely without foundation either in law or at equity does not afford a sufficient consideration for a compromise." *Brecht*, 35 Ariz. at 390, 278 P. at 383

[74] *Spectrum Health v. Anne Marie Bowling*, 410 F.3d 304 (6th Cir. 2005).

[75] *Minute Entry* at 1 (9/28/12), IR-40.

[76] *Spectrum Health*, 410 F.3d at 307.

and then held: "Once it accepted the Medicaid payment, however, [the hospital] had been paid in full for the services provided to [the patient]. The mere fact that a prior voluntary agreement existed is without consequence. "[77]

*Spectrum Health* is directly on point in its holding that an agreement to settle a lien filed against a Medicaid patient's personal-injury recovery—made after the hospital billed Medicaid—is not a basis for accord and satisfaction.[78]

**2. Balance billing Medicaid patients is illegal under federal law, prohibited under the Medicaid provider contracts, and contrary to the intent of Congress, as interpreted by all regulatory agencies and every court that has considered the issue.**

**A. Congress has stated its intent to ban balance billing of Medicaid patients.**

During the first four years of Medicaid's existence (1965-69), the Secretary of Health Education and Welfare[79] approved some state Medicaid plans that let

[77] *Id.* at 316. The other two cases cited by plaintiffs to the trial court involved voluntary agreements by the patient to pay money over and above what Medicaid paid. Courts struck down both agreements as being illegal or against public policy, or both. *See Serafini v. Blake*, 213 Cal. Rptr. 207, 209 (App. 1985) ("Because enforcement of the agreement to pay for medical services covered by Medi-Cal would violate public policy, the agreement is unenforceable."); *Glengariff Corp. v. Snook*, 471 N.Y.S.2d 973, 978 (App. Div. 1984) ("There is also the concern that if the clause in the contract be deemed an effective waiver, such 'waivers' will rapidly find their way into all nursing home contracts, thereby rendering the public's protection of Medicaid recipients and their families totally ineffective.").

[78] *Spectrum Health*, 410 F.3d at 321 ("In summary, we conclude that . . . the lien on the settlement proceeds is prohibited by federal and state Medicaid law.").

[79] In 1980, the Department of Health, Education and Welfare was renamed the Department of Health and Human Services.

Medicaid providers bill Medicaid and then bill the patient or a responsible party for more money.[80] But in 1967, however, Congress stated that it wanted to stop the practice of providers billing Medicaid and then billing an additional sum to a Medicaid patient or a responsible party. For example, an influential Senate Report explained that "[a]s a matter of public policy, it would be best for all concerned . . . if the reimbursement made by the State" constituted the entire compensation received by Medicaid providers.[81]

Congress then stated that it would pass legislation to accomplish that, unless it received "assurance of the Department of Health, Education, and Welfare that existing supplementation programs will be permitted to continue until January 1, 1971" in most states and that the few states with the greatest difficulty in reimbursing providers would submit plans "phasing out such supplementation during a reasonable period of time subsequent to January 1, 1971."[82]

### B. Federal regulations bar balance billing of Medicaid patients.

In 1968, the Secretary of HEW promulgated 45 C.F.R. § 249.31, which read, in relevant part, that "participation in the [Medicaid] program will be limited to providers of service who accept, as payment in full, the amounts paid in

[80] *See* discussion in *Johnson's Professional Nursing v. Weinberger*, 490 F.2d 841, 843 (5th Cir. 1974).

[81] Sen. Rep. 744, 90th Cong., 1st Sess. 1967, at 187-88 (Nov. 14, 1967).

[82] *Id.* During the 1960's, the balance-billing practice was referred to as "supplementation."

accordance with the fee structure."[83] That regulation was repeatedly renumbered, but its substance has remained the same. It is now found at 42 C.F.R. § 447.15. Today, the federal regulation states that "the amounts paid by the agency" shall constitute "payment in full."[84] That regulatory language makes no provision for balance billing a Medicaid patient.[85]

### C. Regulatory agencies have repeatedly construed the relevant statutes and regulations to ban balance-billing of Medicaid patients.

#### 1. The Department of Health and Human Services regards any balancing billing of Medicaid patients as illegal.

The former general counsel of Health and Human Services provided a sworn statement to the trial court in this case establishing as a matter of fact that, from 1971 until the present day, HHS considers the balance billing of Medicaid patients to be illegal under 42 C.F.R. § 447.15.[86]

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[83] 33 Fed. Reg. 14894 (Oct. 4, 1968).

[84] 42 C.F.R. § 447.15. *See also* Centers for Medicare & Medicaid Services, *Medicare Managed Care Manual*, ch. 5, § 180 (rev. 107, 06/22/2012) ("There is no balance billing paid by either the plan or the enrollee."); Department of Health and Human Services, Center for Medicaid and CHIP Services, *Billing for Services Provided to Qualified Medicare Beneficiaries (QMBs)* (Jan. 6, 2012) ("Balance-billing Is Prohibited by Federal Law. Section 1902(n)(3)(B) of the Social Security Act (the Act), as modified by section 4714 of the Balanced Budget Act of 1997, prohibits Medicare providers from balance-billing QMBs for Medicare cost-sharing.").

[85] The parties agree that the "deductible(s), coinsurance or copayment(s)" referenced in the regulation are not at issue in this case. *Answer to FAC*, IR-42.

[86] *Response in Opposition to Motion to Dismiss*, IR-24, Exhibit 3.

### 2. AHCCCS also considers balancing billing of Medicaid patients to be illegal.

The former Inspector General of AHCCCS provided a sworn statement to the trial court explaining that AHCCCS considers the balance billing of Medicaid patients to be illegal under 42 C.F.R. § 447.15, that the hospitals did not have any waiver to do this, and he had not been aware that the hospitals were engaging in this practice until being contacted for this lawsuit.[87]

## D. Judicial decisions across the nation have uniformly held that the balance billing of Medicaid patients is illegal.

Nine judicial decisions have addressed whether a provider may bill Medicaid and then assert a lien against the Medicaid patient's personal injury settlement for the balance of the bill not paid by Medicaid. Opinions from the Federal District Court of Arizona, the Sixth Circuit, the Seventh Circuit, the U.S. District Court for the Southern District of Florida, the California Supreme Court, the Alaska Supreme Court, and the Courts of Appeal of Florida, California, and Tennessee have all held that the practice is illegal under 42 C.F.R. § 447.15.[88]

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[87] *FAC*, IR-5, Exhibit 3.

[88] *Spectrum Health v. Anne Marie Bowling*, 410 F.3d 304, 314 (6th Cir. 2005); *Olszewski v. Scripps Health*, 69 P.3d 927, 949-50 (Cal. 2003); *Lizer v. Eagle Air Med. Corp.*, 308 F.Supp.2d 1006, 1009-10 (D. Ariz. 2004); *Evanston Hosp. v. Hauck*, 1 F.3d 540, 542-44 (7th Cir. 1993); *Mallo v. Public Health Trust of Dade County*, 88 F.Supp.2d 1376, 1377-78 (S.D. Fla. 2000); *Smallwood v. Central Peninsula General Hosp.*, 151 P.3d 319, 320-21 (Alaska 2006); *Palumbo v. Myers*, 197 Cal. Rptr. 214, 224-25 (App. 1983); *Public Health Trust v. Dade County School*, 693 So.2d 562, 566 (Fla. App. 1996). The ninth case, although not

In addition, two other courts have correspondingly held that a voluntary agreement (as opposed to a lien) by the Medicaid patient to pay additional monies after Medicaid is billed is illegal under 42 C.F.R. § 447.15.[89]

Five other cases had fact patterns which did not involve personal-injury liens, but addressed the issue in *dicta*. All have stated that any attempt to collect more money, after billing Medicaid, is illegal under 42 C.F.R. § 447.15.[90]

Faced with the plain regulatory language and the clear Congressional intent, healthcare providers who wish to bill Medicaid—and then assert a lien against the Medicaid patient's personal-injury recovery—have no convincing arguments. Without fail, they have argued that the lien is only an attempt to collect from a

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presently published in the West system, appears as if it will be published there in due course. That case is *West v. Shelby County Healthcare Corp.*, No. W2012-00044-COA-R3-CV, 2013 WL 500777 (Tenn. App. 2013).

[89] *See Serafini v. Blake*, 213 Cal. Rptr. 207, 209 (App. 1985) ("Because enforcement of the agreement to pay for medical services covered by Medi-Cal would violate public policy, the agreement is unenforceable."); *Glengariff Corp. v. Snook*, 471 N.Y.S.2d 973, 978 (App. Div. 1984) ("There is also the concern that if the clause in the contract be deemed an effective waiver, such 'waivers' will rapidly find their way into all nursing home contracts, thereby rendering the public's protection of Medicaid recipients and their families totally ineffective.").

[90] *Nickel v. Workers' Compensation Appeal Board (Agway Agronomy)*, 959 A.2d 498, 506 (Pa. Cmwlth. 2008) ("The clear import of these words is that the Medicaid payment is the total amount owed to the provider for the services rendered, and thus the provider may not attempt to recover any additional amounts elsewhere."). *See also Kootenai Medical Center ex rel. Teresa K. v. Idaho Dept. of Health and Welfare*, 216 P.3d 630, 637 (Idaho 2009); *Bynum v. Magno*, 101 P.3d 1149, 1152 (Hawaii 2004); *Wright v. Smith*, 641 F.Supp.2d 536, 541 (W.D. Va. 2009); *Rehabilitation Association of Virginia, Inc. v. Kozlowski*, 42 F.3d 1444, 1447 (4th Cir. 1994), *cert. denied*, 516 U.S. 811 (1995).

third-party tortfeasor, not from the Medicaid patient, and that by collecting from third parties they are easing the financial burden on Medicaid.

But every court that has considered that argument has rejected it. For instance, the United States District Court for the District of Arizona held that "it is clear that Congress did not intend the narrow and formalistic interpretation posited by Eagle Air . . . [T]he pertinent regulation clearly mandates that states must require providers to accept Medicaid payments as payment in full. *See* 42 C.F.R. § 447.15. This language prevents providers from billing any entity for the difference between their customary charge and the amount paid by Medicaid. Providers are not merely prevented from balance billing patients themselves."[91]

The Sixth Circuit's *Spectrum Health* opinion cited *Lizer* and followed its holding, stating that "once the [plaintiff's personal-injury] settlement has been approved, the settlement proceeds are no longer the property of the tortfeasor either. Instead, the entirety of the settlement, regardless of how it is allocated, belongs to [the patient]; Spectrum's lien is merely an encumbrance upon that property . . . Therefore, by seeking to enforce its lien, Spectrum is attempting to recover its customary fee from the Medicaid patient herself in clear violation of both federal and state law."[92]

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[91] *Lizer* 308 F.Supp.2d at 1009-10.

[92] *Spectrum Health*, 410 F.3d at 317-18. *See also Olszewski*, 69 P.3d at 944 (A "provider does not have a direct cause of action against a third party tortfeasor

### E. The State of Arizona's Medicaid provider contracts also prohibit balance-billing of Medicaid patients.

As noted earlier, Paragraph 15 of the Arizona Medicaid provider contracts that the hospitals themselves signed ban balance billing of Medicaid patients.[93] The Alaska Supreme Court's 2006 *Smallwood* opinion held that Medicaid patients had third-party standing to seek enforcement of the balance-billing prohibition set forth in this provision.[94] Arizona has no case directly on point, but this Court has found third-party standing to enforce an identical balance-billing prohibition in a contract between Blue Cross/Blue Shield and a hospital.[95]

### F. Federal law preempts any contrary state law that purports to let hospitals balance bill their Medicaid patients.

Arizona has a state regulation that is consistent with 42 C.F.R. § 447.15. It bars healthcare providers from billing Medicaid and then asserting a lien against the Medicaid patient's personal-injury recovery.[96] Despite that fact, the Arizona Legislature passed a law purporting to create an exception to the ban against

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and may not independently recover any amount from that tortfeasor. Consequently, a lien filed under section 14124.791 does not attach until after the judgment, compromise, or settlement becomes the property of the Medicaid beneficiary.").

[93] Exhibit 1 to *FAC*, IR-06.

[94] *Smallwood v. Central Peninsula Gen.*, 151 P.3d 319, 320-21 (Alaska 2006) *Id*. at pp. 320-21 ("We conclude that Smallwood is a third-party beneficiary of the provider agreement between the hospital and the state; he can therefore sue to enforce the balance billing prohibition.").

[95] *Nahom v. Blue Cross*, 180 Ariz. 548, 552, 885 P.2d 1113, 1117-18 (App. 1994).

[96] Ariz. Admin. Code § R-9-22-702(b).

balance billing Medicaid patients—an exception solely for hospitals.[97]

The Arizona federal district court's *Lizer* decision resolved the dissonance by holding that, in Arizona, federal law preempted any attempt to balance bill a Medicaid patient.[98] Federal law is clear that the balance-billing ban applies equally to hospitals—and is clear that no special exemption exists for them.[99] The Florida, Tennessee, and California Legislatures have enacted similar laws, which have also been held preempted by 42 C.F.R. § 447.15.[100]

In its 2005 *Spectrum Health* opinion, the Sixth Circuit surveyed this area of the law, and concluded that: "All the courts which have considered the issue of

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[97] A.R.S. § 36-2903.01(G)(4).

[98] *Lizer v. Eagle Air Med Corp.*, 308 F. Supp. 2d 1006, 1009-10 (D. Ariz. 2004). Because non-Medicaid patients do not come under the protection of 42 C.F.R. § 447.15, it is legal to assert a lien against their personal-injury recoveries, after billing their insurers. *See Andrews v. Samaritan*, 201 Ariz. 379, 36 P.3d 57 (App. 2001), *disapproved on other grounds*, *Blankenbaker v. Jonovich*, 205 Ariz. 383, 71 P.3d 910 (2003).

[99] See 42 C.F.R. § 400.203 (defining "provider" as used in 42 C.F.R. § 447.15 to include hospitals). Every case that has considered the issue has held that the federal ban on balance billing applies to hospitals. *Spectrum Health*, 410 F.3d at 308-09; *Evanston Hospital*, 1 F.3d at 542; *Mallo*, 88 F.Supp.2d at 1378; *Olszewski*, 69 P.3d at 933; *Smallwood*, 151 P.3d at 320-21.

[100] *Public Health Trust*, 693 So.2d at 566 (Court concludes that Fla. State Reg. 59G-7.055(6), which stated that funds from a patient's personal-injury settlement "collected by a provider are permitted to be applied to provider charges that exceed Medicaid payment," was preempted by 42 C.F.R. § 447.15); *Olszewski*, 69 P.3d at 938, 942 (Cal. Welfare & Inst. Code §14124.74, which purported to allow a Medicaid provider to recover on a lien "against any judgment, award, or settlement obtained by the [Medicaid] beneficiary" after fully refunding the Medicaid payments received, was preempted by 42 C.F.R. § 447.15.); *West*, 2013 WL 500777 at **23 (Tenn. App. 2013).

whether a service provider, who has already accepted a Medicaid payment, may recover additional sums after a patient has received damages in a personal injury lawsuit have denied the provider's claim."[101]

## Conclusion

As long as it is based on a legal subject matter or legal acts, an untenable or unenforceable agreement can *still* be the basis for a valid accord and satisfaction. But an agreement to do something or to refrain from doing something that is illegal lacks consideration and is *not* a proper subject matter for a contract. That means it also cannot be the basis for a valid accord-and-satisfaction agreement or defense.

Asserting a lien against a Medicaid patient's personal-injury recovery—after billing Medicaid—violates federal law and violates public policy, as expressly stated by Congress. Indeed, scholarly comment uniformly condemns the balance billing of Medicaid patients as both contrary to public policy and contrary to federal law.[102] Agreeing not to pursue the entire amount of an illegal hospital lien

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[101] *Spectrum Health*, 410 F.3d at 314.

[102] *See, e.g.*, David J. Marchitelli, *Propriety and Use of Balance Billing in Health Care Context*, 69 A.L.R.6th 317 at § 2 (2011) ("Federal Medicaid laws require health care providers to accept Medicaid payments as 'payment in full' for supplies and services, and consequently prohibit providers who accept payment from billing Medicaid beneficiaries for any amount, other than allowable copayments."); David A. Super, *The Political Economy of Entitlement*, 104 Colum. L. Rev. 633, 679 (April 2004) (Medicaid "prohibits providers from accepting payments from beneficiaries or their responsible relatives."); Michael K. Beard, *The Impact of Changes in Health Care Provider Reimbursement Systems on the Recovery of Damages for Medical Expenses in Personal Injury Suits*, 21 Am. J.

is an agreement to refrain from doing something expressly prohibited by public policy and federal law. It thus cannot form the basis for any valid and enforceable accord and satisfaction.

The closed-lien plaintiffs therefore ask this Court to vacate the judgment entered against them and to remand this case to the trial court for resolution on the merits of their claims. They also respectfully ask the Court to award to them, under A.R.S. § 12-341, the reasonable costs they have incurred in this appeal.

Finally, the closed-lien plaintiffs respectfully ask the Court to award to them the reasonable attorney's fees incurred in prosecuting this appeal. In part, the closed-lien plaintiffs make this request for attorney's fees based on the private attorney-general doctrine. An award of attorney's fees under that doctrine is available to a party vindicates a right that: (1) benefits a large number of people; (2) requires private enforcement; and (3) has societal importance.[103] Here, the closed-lien plaintiffs prosecuted a superior-court action, and have appealed, in an effort to benefit a large class of Medicaid patients and to obtain remedies for the violations of law and public policy committed by the defendant hospitals. Private

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Trial Advoc. 453, 470 n. 98 (1998) (A "number of courts have considered whether a physician accepting a Medicaid payment could seek to recover additional sums after the patient had received a settlement of a personal injury lawsuit. Because of the balance billing prohibition, all courts considering the issue have denied such recovery.").

[103] *Arnold v. Arizona Dept. of Health Services*, 160 Ariz. 593, 609, 775 P.2d 521, 537 (1989).

enforcement has been necessary because no state or federal agency has acted to remedy the abuses that the hospitals have committed. Finally, the prosecution of this matter has societal importance because it will provide a remedy for many of the Medicaid patients (by definition indigent) who have been the victims of years of violations of law and public policy, and who have had their personal-injury settlements reduced in violation of the rule of law and in contravention of public policy. Under the private attorney-general doctrine, the closed-lien plaintiffs deserve an award of reasonable attorney's fees.

The closed-lien plaintiffs also request attorney's fees based on A.R.S. § 12-341.01, because the dispute between the closed-lien plaintiffs and the hospitals arises from the improper, purported settlement contracts that the hospitals procured from these Medicaid patients—although those improper, purported settlement contracts were based on hospital liens that were both contrary to public policy and contrary to federal law. Even in a case where the claim may involve avoiding or mitigating the consequences of an alleged contract that does not really exist (in a legal or equitable sense), a court may still properly award attorney's fees to the successful party under A.R.S. § 12-341.01.[104]

[104] *Harris v. Maricopa County Superior Court*, 631 F.3d 963, 974 (9th Cir. 2011). *See also Berthot v. Security Pacific Bank of Arizona*, 170 Ariz. 318, 324, 823 P.2d 1326, 1332 (App. 1991) (A party is entitled to an award of its attorney's fees under § 12–341.01 even if that party "is not entitled to recover on the contract on which the action is based, or if the court finds that the contract on which the

**DATED** this 24th day of July, 2013.

**KNAPP & ROBERTS, P.C.**

/s/ David L. Abney, Esq.
David L. Abney
Co-Counsel for Plaintiffs-Appellants

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/s/ David L. Abney, Esq.
David L. Abney

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