S179115

IN THE SUPREME COURT OF CALIFORNIA

REBECCA HOWELL,
Plaintiff and Appellant,

v.

HAMILTON MEATS & PROVISIONS, INC.,
Defendant and Respondent.

AFTER A DECISION BY THE COURT OF APPEAL, FOURTH APPELLATE DISTRICT, DIVISION ONE
CASE NO. D053620

APPLICATION FOR LEAVE TO FILE AMICI CURIAE BRIEF; AMICI CURIAE BRIEF OF AMERICAN INSURANCE ASSOCIATION; ASSOCIATION OF CALIFORNIA INSURANCE COMPANIES; PERSONAL INSURANCE FEDERATION OF CALIFORNIA; CALIFORNIA STATE AUTOMOBILE ASSOCIATION INTER-INSURANCE BUREAU; CHARTIS, INC.; FARMERS INSURANCE EXCHANGE; INFINITY INSURANCE COMPANY; INTERINSURANCE EXCHANGE OF THE AUTOMOBILE CLUB; MERCURY INSURANCE GROUP; STATE FARM GENERAL INSURANCE COMPANY; STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY IN SUPPORT OF RESPONDENT

HORVITZ & LEVY LLP
H. THOMAS WATSON (BAR NO. 160277)
DAVID S. ETTINGER (BAR NO. 93800)
15760 VENTURA BOULEVARD, 18TH FLOOR
ENCINO, CALIFORNIA 91436-3000
(818) 995-0800 • FAX: (818) 995-3157
htwatson@horvitzlevy.com
dettinger@horvitzlevy.com

ATTORNEYS FOR AMICI CURIAE
(AS LISTED ABOVE)

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APPLICATION FOR LEAVE TO FILE AMICI CURIAE BRIEF

Under California Rules of Court, rule 8.520(f), the American Insurance Association, the Association of California Insurance Companies, the Personal Insurance Federation of California, the California State Automobile Association Inter-Insurance Bureau, Chartis, Inc., Farmers Insurance Exchange, Infinity Insurance Company, the Interinsurance Exchange of the Automobile Club, Mercury Insurance Group, State Farm General Insurance Company, and State Farm Mutual Automobile Insurance Company request permission to file the attached amici curiae brief in support of respondent Hamilton Meats & Provisions, Inc.

The American Insurance Association (AIA) is a leading national trade association representing major property and casualty insurers writing business in California, nationwide, and globally.

AIA members, including companies based in California and other states, collectively underwrote over $18 billion in direct property and casualty premiums in this state in 2006. AIA advocates sound and progressive public policies on behalf of its members in legislative and regulatory forums at the state and federal levels and files amicus briefs in cases before federal and state courts on issues of importance to the insurance industry and marketplace.

The Association of California Insurance Companies (ACIC) is an affiliate of the Property Casualty Insurers Association of America (PCI) and represents more than 300 property/casualty insurance companies doing business in California. ACIC member companies currently write 40.5 percent of the property/casualty insurance in California, including personal automobile insurance, commercial automobile insurance, homeowners insurance, commercial multi-peril insurance, and workers compensation insurance. ACIC members include all sizes and types of insurance companies — stocks, mutuals, reciprocals, Lloyds-plan affiliates, as well as excess and surplus line insurers.

The Personal Insurance Federation of California (PIFC) is a California-based trade association that represents insurers selling approximately 60 percent of the personal lines insurance sold in California. PIFC represents the interests of its members on issues affecting homeowners, earthquake, and automobile insurance before government bodies, including the California Legislature, the California Department of Insurance, and the California courts. PIFC's membership includes mutual and stock insurance companies.

The California State Automobile Association Inter-Insurance Bureau, Chartis, Inc., Farmers Insurance Exchange, Infinity Insurance Company, the Interinsurance Exchange of the Automobile Club, Mercury Insurance Group (which does business under Mercury Insurance Company, Mercury Casualty, and California Automobile Insurance Company), State Farm General Insurance Company, and State Farm Mutual Automobile Insurance Company are all major writers of automobile, homeowners, and/or commercial general liability insurance in California.

This issue presented in this case — the proper measure of damages for a personal injury plaintiff's medical expenses when a healthcare provider has agreed to accept as full payment for the plaintiff's medical services an amount negotiated with the plaintiff's health insurance company — is of great interest and importance to amici. Every year, amici or their member companies litigate many thousands of cases, and handle a far larger number of claims, that will be dramatically impacted by this court's resolution of the issue. The law stated by the Court of Appeal, if allowed to stand, will inflate the amount of premiums that the liability-insurance-buying public will have to pay. Premiums will rise as a direct result of an enormous increase in payments of hundreds of millions of dollars annually — required by the rule in the Court of Appeal's opinion — by amici or their member companies of medical expense "damages," even though they are "compensation" for phantom medical expenses that no one has paid or ever will pay.

As counsel for amici, we have reviewed the briefs filed in this case and believe this court will benefit from additional briefing. We have attempted to supplement, but not duplicate, the parties' briefs.

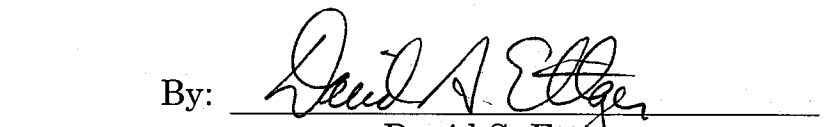
This application is timely. It is being submitted within 30 days of the August 2 filing of the reply brief on the merits. (See Cal. Rules of Court, rule 8.520(f)(2).)

Under rule 8.520(f)(4), amici state that no party or counsel for a party authored the proposed amici brief in whole or in part and that no one (including a party or counsel for a party), other than amici and their members, has made a monetary contribution to fund the preparation or submission of the proposed amici brief in support of the respondent.

Accordingly, amici request that this court accept and file the attached amici curiae brief.

August 30, 2010

HORVITZ & LEVY LLP
H. THOMAS WATSON
DAVID S. ETTINGER

By: 
David S. Ettinger

Attorneys for Amici Curiae
AMERICAN INSURANCE ASSOCIATION; ASSOCIATION OF CALIFORNIA INSURANCE COMPANIES; PERSONAL INSURANCE FEDERATION OF CALIFORNIA; CALIFORNIA STATE AUTOMOBILE ASSOCIATION INTER-INSURANCE BUREAU; CHARTIS, INC.; FARMERS INSURANCE EXCHANGE; INFINITY INSURANCE COMPANY; INTERINSURANCE EXCHANGE OF THE AUTOMOBILE CLUB; MERCURY INSURANCE GROUP; STATE FARM GENERAL INSURANCE COMPANY; STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY

AMICI CURIAE BRIEF

INTRODUCTION

This case asks the court to determine the proper measure of damages that the plaintiff here may recover for medical treatment of her tortiously caused injuries. Two elements of those damages are uncontested. Plaintiff may recover (1) amounts she paid out of her own pocket for treatment and (2) amounts her health insurance company paid on her behalf to those who provided her with medical services.

At issue here is an additional amount — the healthcare providers' so-called "usual and customary" charges that the providers unilaterally "billed," but never collected, for the medical services. No one paid these charges because the providers were bound by contracts they had entered into with the plaintiff's health insurer to accept a lower negotiated amount as full payment for their services. These "billed amounts" are thus properly viewed as phantom medical expenses.

The trial court ruled plaintiff's damages should include the amount her health insurance actually paid, but not the larger phantom expenses stated on bills that no one paid. The Court of Appeal, however, concluded that the unpaid billed amounts must be added to plaintiff's recovery under the collateral source rule. The Court of Appeal erred.

The collateral source rule allows the plaintiff to recover medical expenses that her insurer paid. Under that common-law

principle, "if an injured party receives some compensation for his injuries from a source wholly independent of the tortfeasor, such payment should not be deducted from the damages which the plaintiff would otherwise collect from the tortfeasor." (*Helfend v. Southern Cal. Rapid Transit Dist.* (1970) 2 Cal.3d 1, 6.)

In refusing to expand the collateral source rule to payments that plaintiff's insurer did *not* make, the trial court followed *Hanif v. Housing Authority* (1988) 200 Cal.App.3d 635 and its progeny. *Hanif* states a corollary to the collateral source rule, limiting a plaintiff's recovery to the actual amount paid by the collateral source. (*Id.* at pp. 643-644.)

As explained in this brief, the *Hanif* corollary is a sensible one, consistent with both general principles of compensatory damages and this court's common-law collateral-source-rule jurisprudence. The contrary rule adopted by the Court of Appeal in this case provides a windfall to plaintiffs and their lawyers. It is a windfall to them because the "billed" amounts they recover were not paid by anyone and because they, rather than the healthcare professionals who provided the services, keep the money.

Moreover, allowing windfall payments like the one plaintiff seeks here would cause dramatic harm. Statewide, the difference between what healthcare providers "bill" and what they accept as full payment for medical services for tortiously injured persons is likely *hundreds of millions of dollars every year*. Payment of that difference will of course not come out of thin air, but primarily from liability insurers, and that inevitable annual increase of hundreds

of millions of dollars in costs will undoubtedly raise liability insurance premiums substantially.

Under the Court of Appeal's decision here, then, the liability-insurance-buying public will bear the enormous expense of funding windfall payments to plaintiffs and to the plaintiffs' bar. Because imposing those societal costs is not only bad policy but contrary to basic legal principles of compensatory damages, the decision should be reversed.

I. THE TRIAL COURT'S RULING PREVENTED OVERCOMPENSATING PLAINTIFF WHILE ENSURING A MORE THAN ADEQUATE DAMAGE RECOVERY.

A. Courts have been rightfully wary of expanding the "controversial" and "criticized" collateral source rule as plaintiff proposes.

A plaintiff who wins a personal injury lawsuit is entitled to recover her medical expenses as damages. She recovers those medical expenses even if she paid none of them herself, but instead had them paid by her health insurance. That is the result of the common-law collateral source rule: "if an injured party receives some compensation for his injuries from a source wholly independent of the tortfeasor, such payment should not be deducted from the damages which the plaintiff would otherwise collect from

the tortfeasor." (*Helfend v. Southern Cal. Rapid Transit Dist.* (1970) 2 Cal.3d 1, 6 (*Helfend*).)[1]

The issue in this case is whether the collateral source rule makes the defendant liable not only for medical expenses that the plaintiff's insurance carrier has paid, but also for additional amounts that neither the plaintiff nor the insurance carrier (nor anyone else) has paid or ever will pay. Plaintiff here asserts entitlement to recovery of the "usual and customary charges" that her healthcare providers unilaterally "billed," even though the providers had accepted much less than those charges as full payment for plaintiff's medical services. The healthcare providers did so under the terms of health services contracts they negotiated with plaintiff's insurance carrier. The "billed" charges are thus phantom medical expenses. Plaintiff's proposal is an unwarranted extension of the collateral source rule, which is itself already in discord with basic compensatory damages principles.

"A plaintiff's remedy in tort is compensatory in nature and damages are generally intended . . . to restore an injured person as nearly as possible to the position he or she would have been in had the wrong not been done." (*Turpin v. Sortini* (1982) 31 Cal.3d 220, 232 (*Turpin*).) The collateral source rule as applied in any case is at odds with this general principle — if a plaintiff is never out-of-

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[1] It has been said that the collateral source rule derives its name from the Vermont Supreme Court's phrasing in *Harding v. Town of Townshend* (1871) 43 Vt. 536, 538: "The policy of insurance is collateral to the remedy against the defendant." (See, e.g., Note, *Unreason in the Law of Damages: The Collateral Source Rule* (1964) 77 Harv. L.Rev. 741, 741 & fn. 4.)

pocket for an expense, recovery of that expense as damages is not necessary to "restore [her] . . . to the position . . . she would have been in had the wrong not been done." (See *King v. Willmett* (Aug. 9, 2010, C059236) __ Cal.App.4th __ [10 D.A.R. 12341, 12344, fn. 4] (*King*) ["the collateral source rule may seem to operate on some occasions to supersede the general rule that '"[a] plaintiff in a tort action is not, in being awarded damages, to be placed in a better position than he would have been had the wrong not been done"'"].)

Not surprisingly, then, the collateral source rule has been described as "one of the more controversial rules in the law of damages." (Johns, California Damages (5th ed. 2009) Law and Proof, § 1.60, p. 1-81.) Even while approving the common-law collateral source rule, this court recognized that "[i]n this country most commentators have criticized the rule and called for its early demise." (*Helfend, supra*, 2 Cal.3d at p. 7.) Thus, a proposal like plaintiff's here to further expand the already "controversial" and "criticized" collateral source rule by permitting recovery of not only those amounts that another paid on a plaintiff's behalf but also phantom expenses that no one has paid, deserves careful examination with a skeptical eye.

Until the appellate decision in this case, the Courts of Appeal — starting with *Hanif v. Housing Authority* (1988) 200 Cal.App.3d 635 (*Hanif*) — had consistently held that claims like plaintiff's were overreaching. The *Hanif* court agreed that the plaintiff there could recover as damages those medical expenses paid by a collateral source — in that case, Medi-Cal — but held that any award above "the actual amount paid" by the collateral source was

"over-compensation." (*Id.* at pp. 639, 641, 643-644.) The court thus ordered the plaintiff's medical expense damages reduced to $19,317 (the amount Medi-Cal had paid for his medical services) from $31,618 (the "billed" amount that the trial court had awarded). (*Id.* at p. 644.)

Hanif applied basic remedies principles in support of its holding. The court noted the rules that "'damages are normally awarded for the purpose of *compensating* the plaintiff for injury suffered,'" that the object of damages is "'*just compensation . . . and no more,*'" and that a plaintiff, "'in being awarded damages, [is not] to be placed in a better position than he would have been had the wrong not been done.'" (*Hanif, supra,* 200 Cal.App.3d at pp. 640-641, original emphases.) The court also found its corollary to the collateral source rule to be "in harmony with other rules and practices" governing compensatory tort damages, "such as the practice of discounting future damages to present value [citation], the bar against double recovery [citations], the rule that damages not be imaginary [citation], the rule that when damages may be calculated by either of two alternative measures the plaintiff may recover only the lesser [citations], and the rule that damages be mitigated where reasonably possible [citations]." (*Id.* at p. 643.)

Other courts followed *Hanif.* (*Katiuzhinsky v. Perry* (2007) 152 Cal.App.4th 1288, 1290; *Greer v. Buzgheia* (2006) 141 Cal.App.4th 1150, 1157 (*Greer*); *Nishihama v. City and County of San Francisco* (2001) 93 Cal.App.4th 298, 306 (*Nishihama*); see also *Olsen v. Reid* (2008) 164 Cal.App.4th 200, 214-216 (*Olsen*) (conc. opn. of Fybel, J.) [defending the *Hanif* rule]; but see *id.* at

p. 204 (conc. opn. of Moore, J.) [disagreeing with *Hanif*]; *Yanez v. SOMA Environmental Engineering, Inc.* (2010) 185 Cal.App.4th 1313 (*Yanez*); *King, supra*, __ Cal.App.4th __ [10 D.A.R. 12341].)

The Courts of Appeal have also consistently applied the *Hanif* corollary to the collateral source rule in cases determining the appropriate amount of restitution to compensate crime victims. In *People v. Bergin* (2008) 167 Cal.App.4th 1166 (*Bergin*), the People — making an argument echoed by the plaintiff in this case — contended that the trial court had erred in not awarding the crime victim restitution in "the amount billed by [the victim's] medical providers[] rather than . . . the amount the medical providers accepted from [the victim's] insurer as full payment for their services, plus the deductible paid by [the victim]." (*Id.* at p. 1168.) The court disagreed, holding that it was the lesser amount that "fully complied with the [applicable] statute's mandate to 'order full restitution.'" (*Id.* at p. 1169.) Relying on *Hanif*, the court reasoned that, because "[n]either [the victim] nor her insurers incurred any economic loss beyond the amount identified in the trial court's restitution order," "we find it impossible to see any basis for concluding that [the victim] has not been '100 percent compensated.'" (*Id.* at p. 1172; accord, *People v. Millard* (2009) 175 Cal.App.4th 7, 27 ["To 'fully reimburse' the victim for medical expenses means to reimburse him or her for all out-of-pocket expenses actually paid by the victim or others on the victim's behalf (e.g., the victim's insurance company). The concept of 'reimbursement' of medical expenses generally does not support inclusion of amounts of medical bills in excess of those amounts

accepted by medical providers as payment in full"];[2] *In re Anthony M.* (2007) 156 Cal.App.4th 1010, 1017-1018 [applying *Hanif* rule in juvenile restitution case; restitution "order is not . . . intended to provide the victim with a windfall"].)

The common-law collateral source rule and the *Hanif* corollary are two sides of the same coin — both aim to ensure that a personal injury plaintiff is properly compensated for her medical expenses. Under both, the defendant is liable for whatever the plaintiff or her insurer pays to a healthcare provider for medical services. *Hanif* simply adds the common-sense qualification that the defendant is not liable for *more* than what plaintiff or her insurer actually pays.

B. This court's statement of the collateral source rule supports limiting recoverable damages to no more than the amount an insurer actually pays for a plaintiff's medical expenses.

Although this court has not yet directly addressed the issue presented here, it has suggested that the *Hanif* corollary applies at least when the collateral source payment is made by Medicaid. (*Olszewski v. Scripps Health* (2003) 30 Cal.4th 798, 827 (*Olszewski*) ["the Medicaid beneficiary may only recover the amount payable under Medicaid as his or her medical expenses in an action against

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[2] *Millard* was decided by the same Court of Appeal that decided the instant case below. The Court of Appeal in this case did not mention at all its earlier and contrary *Millard* decision.

a third party tortfeasor" (citing *Hanif*)]; see *Parnell v. Adventist Health System/West* (2005) 35 Cal.4th 595, 611-612, fn. 16 (*Parnell*) [declining to decide whether *Olszewski* and *Hanif* "apply outside the Medicaid context"].)

More importantly, this court's general statements of the common-law collateral source rule are consistent with *Hanif* and at odds with plaintiff's position in the present case. In stating the collateral source rule, this court has consistently focused only on ensuring that tort damages include *compensation paid* to or on behalf of a plaintiff by a collateral source. For example, most recently the court said that "the collateral source rule . . . prohibits the reduction of damages a tortfeasor owes to the plaintiff because the plaintiff *received compensation* from an independent source." (*21st Century Ins. Co. v. Superior Court* (2009) 47 Cal.4th 511, 526 (*21st Century*), emphasis added.)[3] Similarly, this court has

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[3] See *Lund v. San Joaquin Valley Railroad* (2003) 31 Cal.4th 1, 8 (*Lund*) ["If an injured plaintiff *gets some compensation* for the injury from a collateral source such as insurance, that *payment* is, under the collateral source doctrine, not deducted from the damages that the plaintiff can collect from the tortfeasor" (emphases added)]; *Hrnjak v. Graymar, Inc.* (1971) 4 Cal.3d 725, 729 (*Hrnjak*) [damages not reduced "if an injured party *received some compensation* for his injuries from a source wholly independent of the tortfeasor" (emphasis added)]; *Acosta v. Southern Cal. Rapid Transit Dist.* (1970) 2 Cal.3d 19, 25-26 [no reduction of damages where the plaintiff "had *received compensation* for some of her injuries from a source entirely independent of the tortfeasor" (emphasis added)]; *Helfend, supra,* 2 Cal.3d at p. 6 ["if an injured party *receives some compensation* for his injuries from a source wholly independent of the tortfeasor, such *payment* should not be deducted from the damages which the plaintiff would otherwise collect from the

(continued...)

explained the adverse consequences of "permit[ting] a tortfeasor to mitigate damages with *payments* from plaintiff's insurance." (*Helfend, supra*, 2 Cal.3d at p. 10, emphasis added.)

The question should thus be what "compensation" or "payment" the plaintiff "received" from a collateral source. In the present case, the only "compensation" or "payment" that plaintiff could reasonably be considered to have "received" from a collateral source are the amounts that her insurance carrier actually paid to her healthcare providers, amounts that the providers accepted as full payment for her medical treatment. Additional amounts that the healthcare providers may have stated on their bills as "usual and customary charges" over and above the amount accepted as payment in full were not "compensation" or "payment" that plaintiff

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(...continued)
tortfeasor" (emphases added)]; *id.* at p. 13 [reaffirming adherence to collateral source rule "in tort cases in which the plaintiff has been *compensated* by an independent collateral source" (emphasis added)]; *People ex rel. Younger v. Superior Court* (1976) 16 Cal.3d 30, 36, fn. 3 [same]; *Anheuser-Busch, Inc. v. Starley* (1946) 28 Cal.2d 347, 349 ["the amount of the [plaintiff's] damages [is not] reduced by the *receipt by him of payment* for his loss from a source wholly independent of the wrongdoer" (emphasis added)]; *De Cruz v. Reid* (1968) 69 Cal.2d 217, 223 [same]; see also *Fein v. Permanente Medical Group* (1985) 38 Cal.3d 137, 164 (*Fein*) ["a jury, in calculating a plaintiff's damages in a tort action, does not take into consideration benefits — such as medical insurance or disability *payments* — which the plaintiff has *received* from sources other than the defendant — i.e., 'collateral sources' — to cover losses resulting from the injury" (emphasis added)]; *Peri v. L. A. Junction Ry.* (1943) 22 Cal.2d 111, 131 [""Damages recoverable for a wrong are not diminished by the fact that the party injured has been wholly or partly indemnified for his loss by insurance effected by him""].

"received." Indeed, those additional amounts were not paid or received by anyone.

Besides the statement of the collateral source rule itself, another portion of the *Helfend* opinion further supports interpreting the rule as applying only to actual payments made by a plaintiff's health insurer. In rejecting the criticism that the collateral source rule leads to a double recovery for the plaintiff, this court explained that "insurance policies increasingly provide for either subrogation or refund of benefits upon a tort recovery, and such refund is indeed called for in the present case. [Citation.] Hence, the plaintiff receives no double recovery; *the collateral source rule* simply serves as a means of by-passing the antiquated doctrine of non-assignment of tortious actions[4] and *permits a proper transfer of risk from the plaintiff's insurer to the tortfeasor* by way of the victim's tort recovery." (*Helfend*, *supra*, 2 Cal.3d at pp. 10-11, fn. omitted, emphasis added.) If the collateral source rule is intended to make the plaintiff a conduit for the defendant's reimbursement of the plaintiff's insurer, then there is no reason to include in the plaintiff's recovery more than the insurer paid.

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[4] Regarding the non-assignability of personal injury claims, see *21st Century*, *supra*, 47 Cal.4th at p. 518. (See also *Olszewski*, *supra*, 30 Cal.4th at p. 823 ["a provider does not have a direct cause of action against a third party tortfeasor and may not independently recover any amount from that tortfeasor"].)

C. A healthcare provider's contractual agreement to charge an insurance carrier less is not a "benefit" for an insured under the collateral source rule.

The Court of Appeal below framed the issue in different terms than the way this court has stated the collateral source rule. Instead of determining how much "compensation" the plaintiff had "received" or what "payments" plaintiff's insurer had made, the Court of Appeal examined whether what it called the "negotiated rate differential" (i.e., "the difference . . . between (1) the full amount of the medical providers' bills, and (2) the lesser amount paid by the private health care insurer in cash payments to the medical providers that the providers have agreed to accept as payment in full pursuant to their agreements with the insurer") is a "*benefit*" under the collateral source rule. (*Howell v. Hamilton Meats & Provisions, Inc.* (2009) 179 Cal.App.4th 686, 689 (*Howell*), review granted March 10, 2010, S179115, emphasis added.) The court concluded that the negotiated rate *is* a benefit to plaintiff and that the defendant "should not garner the benefits of [plaintiff's] providence" in paying for medical insurance. (*Id.* at pp. 699-700.)

Even if the rule encompasses "benefits" from collateral sources (see Rest.2d Torts, § 920A(2) [discussing "[p]ayments made to *or benefits conferred on* the injured party from other sources"

(emphasis added)]),[5] plaintiff still should not recover more than her insurer actually paid to the healthcare providers on her behalf.

The "negotiated rate differential" is not a "benefit" to an insured plaintiff under the collateral source rule. If it is a "benefit" to anyone, a "negotiated rate differential" is a benefit to the insurance carrier. By paying less for the medical services provided to its insureds, the carrier's overall costs are lowered. For the insured, on the other hand, all that matters (in other words, the benefit to which she is entitled under her health insurance) is that her treatment is being paid for by her carrier; the price that the carrier pays, whether high or low, is of little consequence to her. This is illustrated in *Whiteside v. Tenet Healthcare Corp.* (2002) 101 Cal.App.4th 693 (*Whiteside*).

In *Whiteside*, a patient sued his healthcare provider for allegedly breaching its agreement with his insurance company by first accepting a negotiated amount from the insurance company and then accepting an additional payment from another insurer with which he was also insured (under a group policy). The patient

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[5] Section 920A of the Restatement generally states the collateral source rule, but another portion of the Restatement provides a specific rule that is directly relevant to the issue in this case and that is consistent with the *Hanif* corollary: "When the plaintiff seeks to recover for expenditures made or liability incurred to third persons for services rendered, normally the amount recovered is the reasonable value of the services rather than the amount paid or charged. *If*, however, *the injured person paid less than the exchange rate, he can recover no more than the amount paid*, except when the low rate was intended as a gift to him." (Rest.2d Torts, § 911, com. h, emphasis added; see *Hanif, supra*, 200 Cal.App.3d at p. 643 [relying on the specific rule].)

asserted that the healthcare provider had violated the agreement's term that prohibited collecting from the patient any payment above the negotiated amount received from the first insurer. The Court of Appeal concluded, however, that accepting the second insurance payment was not equivalent to collecting money from the patient himself. It recognized that "the insurance proceeds were not an asset legally equivalent to money in a bank account or a life insurance policy owned by [the patient]." (*Whiteside*, *supra*, 101 Cal.App.4th at p. 703.) The court explained that "[t]he basic obligation of the medical insurers is to pay the medical providers directly for their services and to insulate the insured from any monetary obligation for such medical care. [The insured] is entitled to no more than that under the terms of his coverage." (*Id.* at p. 705; see also *ibid* [describing the "benefits" the patient was eligible to receive from his health insurance as being "in the form of direct payment to the hospital"].) In other words, the plaintiff had no legal interest in what amount his health insurers paid for the services he received.

This court, too, has explained in a related context that the price an insurer pays to a healthcare provider is of no concern to the patient. In *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group* (2009) 45 Cal.4th 497 (*Prospect Medical Group*), the court held that when physicians and a health maintenance organization (HMO) dispute the amount to be paid for an HMO member/patient's emergency medical services, the physicians cannot bill the patient. The court said that "a patient will have little basis by which to determine whether a bill is reasonable and,

because the HMO is obligated to pay the bill, no legitimate reason exists for the patient to have to do so." (*Id.* at p. 508, emphasis added.)

Insureds could be said to indirectly benefit from a negotiated lower price because the insurance carrier's reduced expenses presumably will allow the carrier to charge lower premiums.[6] However, lowered premiums are not a benefit for purposes of the collateral source rule. The rule is relevant only when "an *injured party* receives some compensation *for his injuries*" from a collateral source. (*Helfend*, *supra*, 2 Cal.3d at p. 6, emphases added.) An insured "receives" the benefit of a lower premium not as an injured party and not for an injury, but before, and unconnected to, any injury or medical treatment.

D. Plaintiff did not "incur" liability for any amount above what her healthcare providers accepted from her insurers as full payment for medical services.

The Court of Appeal's decision was based in part on the conclusion that plaintiff here "incurred" more in medical expenses than the amounts her insurance carrier paid and her healthcare providers agreed to accept as payment in full. (*Howell*, *supra*, 179 Cal.App.4th at p. 699 ["the total amount of medical care debt

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[6] On the other hand, if the insurer had agreed to pay more, its insureds could benefit from having a choice of more and possibly better qualified healthcare providers. Thus, a carrier who demands the largest possible "negotiated rate differential" might do so to the detriment of its insureds, not to their benefit.

[plaintiff] incurred in this matter was . . . [the healthcare providers'] usual and customary charges for the medical care and services they provided to her"].) The conclusion is both off point and incorrect.

As explained, under this court's statement of the collateral source rule, the question is not what plaintiff "incurred," but rather what "compensation" the plaintiff "received" from, or what "payment" was made by, a collateral source. Additionally, however, the Court of Appeal is wrong that plaintiff ever "incurred" debt greater than what her insurance carrier paid on her behalf for her medical care.

In rejecting an argument similar to plaintiff's here, one Court of Appeal pointed out that "'incur' means 'to become liable or subject to' [citation], and there is no suggestion in the record that [the crime victim there] was at any time liable for the amounts billed by her medical providers." (*Bergin, supra*, 167 Cal.App.4th at p. 1170, fn. 2; see also *id.* at p. 1172 ["[n]either [the victim] nor her insurers incurred any economic loss beyond the amount identified in the trial court's restitution order [i.e., the amount accepted by the medical providers as full payment for their services]"].) Similarly, in holding that a lawyer representing himself could not recover attorney fees "'which are incurred to enforce [a] contract,'" this court reasoned, "To 'incur' a fee, of course, is to 'become liable' for it [citation], i.e., to become obligated to pay it. It follows that an attorney litigating in propria persona cannot be said to 'incur' compensation for his time and his lost business opportunities." (*Trope v. Katz* (1995) 11 Cal.4th 274, 280; accord, *Musaelian v. Adams* (2009) 45 Cal.4th 512, 516-517.)

Plaintiff here was never "obligated to pay" any amount above the prices that her medical insurer had negotiated with her healthcare providers. For its contrary conclusion, the Court of Appeal here relied on agreements plaintiff signed with the healthcare providers just before treatment began. (*Howell*, *supra*, 179 Cal.App.4th at pp. 691, 699.) But nothing in those agreements stated, and the healthcare providers never asserted, that the agreements superseded the earlier contracts the healthcare providers had made with plaintiff's insurer. Those contracts limited the amount the providers could charge for plaintiff's treatment and likely disavowed the right of the healthcare providers to hold plaintiff liable for charges. (See *Whiteside*, *supra*, 101 Cal.App.4th at p. 703 [quoting term in contract between healthcare provider and health insurer: "'Hospital shall not collect or attempt to collect from [insurer's] subscribers for any services covered under the applicable subscriber contract, except for deductibles and copayments'"]; see also *Prospect Medical Group*, *supra*, 45 Cal.4th 497 [HMO, not patient, is obligated to pay for emergency medical services].) The prices for plaintiff's medical services were set by contract before she ever sought treatment.

Because the healthcare providers agreed to not charge plaintiff any amount above what her health insurance paid, the providers had no legal expectation of payment for what they "billed." And because there was no expectation of payment for the "billed" amounts, plaintiff did not incur those amounts for purposes of the collateral source rule. This is illustrated in footnote 5 of the *Helfend* opinion.

In footnote 5, the *Helfend* court contrasted treatment by healthcare providers who had no expectation of payment with the gratuitous provision of services by a family member or friend, where the law presumes an expectation of payment (see *Kimball v. Northern Electric Co.* (1911) 159 Cal. 225, 231). The court praised a New York high court decision as "quite reasonably h[olding] that an injured physician may not recover from a tortfeasor for the value of medical and nursing care rendered gratuitously as a matter of professional courtesy. [Citation.] The doctor owed at least a moral obligation to render gratuitous services in return, if ever required; but he had neither paid premiums for the services under some form of insurance coverage nor manifested any indication that he would endeavor to repay those who had given him assistance. Thus this situation differs from that in which friends and relatives render assistance to the injured plaintiff with the expectation of repayment out of any tort recovery; in that case, the [collateral source] rule has been applied." (*Helfend, supra,* 2 Cal.3d at pp. 6-7, fn. 5.)

Plaintiff's healthcare providers here did not render any gratuitous services as a friend or relative with an expectation — actual or presumed — of later payment. Rather, their acceptance as full payment of less than their "usual and customary" charges was a business decision compelled by the contracts they had previously negotiated with plaintiff's insurer. Plaintiff thus did not incur those charges for purposes of the collateral source rule.

E. Limiting a plaintiff's recovery to what her health insurer paid on her behalf is consistent with the collateral source rule's rationales.

In reaffirming the viability of the collateral source rule in California, the *Helfend* court discussed the policy reasons supporting that common-law rule. Those rationales are consistent with the *Hanif* corollary to the rule.

The court begins with the statement, "The collateral source rule as applied here embodies the venerable concept that a person who has invested years of insurance premiums to assure his medical care should receive the benefits of his thrift. The tortfeasor should not garner the benefits of his victim's providence." (*Helfend, supra*, 2 Cal.3d at pp. 9-10.) Under *Hanif*, a plaintiff *is* receiving the benefits of her investment in health insurance — she is recovering from defendant amounts that her insurer paid on her behalf. If she were not receiving the benefits of her thrift — or, in other words, if the defendant were garnering the benefits of the plaintiff's providence — she would recover as damages only the amount that she herself had paid to the healthcare providers, not any payments made by her insurer. And, as explained above, the price that the insurer negotiated with the healthcare provider is not one of plaintiff's insurance benefits.

Plaintiff here has a misplaced sense of entitlement. Under her logic, a plaintiff who is a physician and who received gratuitous healthcare as a professional courtesy would be deprived of a benefit of his or her medical training if the defendant were not required to

pay him or her for the reasonable value of the healthcare services. (After all, if the physician-plaintiff had not invested many additional years and financial resources into his or her education, he or she would not have received medical treatment as a professional courtesy.) But, as already explained, this court found it to be "quite reasonabl[e]" to *not* include the unpaid value of the healthcare services in the physician-plaintiff's damages. (*Helfend*, *supra*, 2 Cal.3d at p. 6, fn. 5.)

In *Rotolo Chevrolet v. Superior Court* (2003) 105 Cal.App.4th 242 (*Rotolo Chevrolet*), the Court of Appeal relied on "equity and common sense" in rejecting a plaintiff's proposal to expand the collateral source rule (*id.* at p. 248), stating that courts should not "accept unfair applications of the rule with complacency" (*id.* at p. 247, fn. 3). The court stated it was acceptable for the rule to "result in a double recovery," but found "no reason to award yet another level of recovery" as the plaintiff there was requesting. (*Id.* at p. 247.) In this case, plaintiff is already being awarded damages for payments that she never made, but were made on her behalf by her health insurance. "[E]quity and common sense" counsel against giving her "yet another level of recovery."

Helfend also states that "[t]he collateral source rule expresses a policy judgment in favor of encouraging citizens to purchase and maintain insurance for personal injuries and for other eventualities. . . . If we were to permit a tortfeasor to mitigate damages with payments from plaintiff's insurance, plaintiff would be in a position inferior to that of having bought no insurance, because his payment of premiums would have earned no benefit."

(*Helfend, supra*, 2 Cal.3d at p. 10.) The *Hanif* corollary does not discourage the purchase of insurance at all. Under the corollary, a defendant does *not* "mitigate damages with payments from plaintiff's insurance," but, to the contrary, the plaintiff recovers those insurance payments as damages from the defendant.[7]

The *Helfend* decision concludes, "Defendant should not be able to avoid payment of full compensation for the injury inflicted merely because the victim has had the foresight to provide himself with insurance." (*Helfend, supra*, 2 Cal.3d at p. 10.) When the defendant is liable not only for all amounts that the plaintiff herself has paid, but also for all payments made on her behalf by her health insurance, the defendant is fully compensating the plaintiff and then some.

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[7] It is not clear that even eliminating the collateral source rule altogether would discourage the public from buying insurance. There are likely few, if any, people who, when deciding whether to buy health insurance, consider as a factor their potential recovery in a lawsuit should the insurance be used to pay for treatment of a tortiously inflicted injury. In any event, with the new federal health insurance law *mandating* the purchase of health insurance (Patient Protection and Affordable Care Act, Pub.L. No. 111-148 (Mar. 23, 2010) 124 Stat. 119), encouraging the purchase of healthcare insurance will soon become an obsolete policy consideration.

II. STATUTES LIMITING THE COLLATERAL SOURCE RULE IN CERTAIN TYPES OF CASES ARE IRRELEVANT TO DETERMINING WHETHER A NEGOTIATED PRICE IS A COLLATERAL SOURCE PAYMENT OR BENEFIT.

The Legislature has limited the application of the common-law collateral source rule in two circumstances. In a medical malpractice case, the defendant can introduce evidence of payments made to the plaintiff by collateral sources. (Civ. Code, § 3333.1, subd. (a); see *Fein, supra,* 38 Cal.3d at p. 164 [statute "alters [the traditional collateral source] rule in medical malpractice cases"].) In a case against a public entity, the trial court has discretion to reduce the judgment because of collateral source payments made to or on behalf of the plaintiff. (Gov. Code, § 985, subd. (b); see *Garcia v. County of Sacramento* (2002) 103 Cal.App.4th 67, 72-73 [statute allows public entity to "bring a posttrial motion to reduce a judgment against it by the amount a collateral source has paid or is obligated to pay for benefits provided a beneficiary prior to trial"]; *Scott v. County of Los Angeles* (1994) 27 Cal.App.4th 125, 154-155.)

The Court of Appeal below construed these legislative actions as a direction to not judicially undertake "any further abrogation of the collateral source rule." (*Howell, supra,* 179 Cal.App.4th at p. 704; accord, *King, supra,* __ Cal.App.4th __ [10 D.A.R. 12341, 12347] ["We decline to carve out any further limitations of the rule"].) This reasoning is flawed.

The issue in this case is different in kind from the topics addressed by the statutes. This court is here identifying what constitutes a collateral source payment or benefit. The statutes, on the other hand, deal with how already-identified collateral source payments or benefits are treated.

To label the *Hanif* corollary a "further abrogation of the collateral source rule," as the Court of Appeal does, begs the question. The very issue to be decided in this case is whether limiting a plaintiff's damages to the amount actually paid by insurance is in fact an abrogation of the collateral source rule. As explained above, it is not.

"'The general rule is that statutes do not supplant the common law unless it appears that the Legislature intended to cover the entire subject.'" (*McDonald v. Antelope Valley Community College Dist.* (2008) 45 Cal.4th 88, 110.) There is no evidence that the Legislature intended to cover either the entire collateral source rule in general or the issue now before this court in particular. The court is thus free to decide the common-law question presented here.

III. PLAINTIFF'S PROPOSED RULE WOULD RESULT IN WINDFALL PAYMENTS OF HUNDREDS OF MILLIONS OF DOLLARS EVERY YEAR TO PLAINTIFFS AND THEIR ATTORNEYS AT THE EXPENSE OF THE LIABILITY INSURANCE BUYING PUBLIC.

The impact that plaintiff's proposed rule would have is difficult to overstate. At issue is the difference between healthcare providers' "usual and customary" amounts unilaterally stated on bills that no one pays and the lesser amounts the providers accept from health insurance carriers as full payment for plaintiffs' medical services under negotiated contracts. When deciding the issue, it is important to keep in mind the statewide cumulative amount of that difference, to whom the difference would and would not go, who would pay the difference, and the effect of the payment.

The amount of money at stake statewide is enormous. In the present case, the Court of Appeal's opinion would more than triple the plaintiff's medical expense damages, from under $60,000 to almost $190,000. (*Howell, supra*, 179 Cal.App.4th at pp. 689-690, 708.) In *Nishihama*, the jury's award was more than quadruple the amount that the hospital had accepted from the plaintiff's insurer, $17,168 rather than $3,600. (*Nishihama, supra*, 93 Cal.App.4th at pp. 306-307, 309.) Not every California personal injury claim will have such dramatic differences (but see Ireland, *The Concept of Reasonable Value in Recovery of Medical Expenses in Personal Injury Torts* (2008) 14 J.Legal Econ. 87, 88 [a "5 to 1 ratio between

amount billed and the amount paid . . . is not unusual. The amount paid by third party payers is typically only a small fraction of the amount originally billed by medical care provide[r]s"), but the combined value of the differences in personal injury claims throughout the state is most probably in the *hundreds of millions of dollars every year*.[8]

Significantly, the hundreds of millions of dollars to pay the amounts "billed" *by* healthcare providers will not actually go *to* the

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[8] Precise figures are hard to come by, but data gathered by some of the amici and others in the insurance industry indicate that a $100,000,000 annual difference is a very conservative estimate. For example, Mercury Insurance Group reports that medical expense reductions under *Hanif* averaged $2,370 per claim in 2008 and 2009 over an average of 22,492 annual bodily injury and uninsured and underinsured motorist claims. (The per-claim average is consistent with a recent nationwide report by the Insurance Research Council, showing a difference of $2,446 between the average amount billed by medical providers and the average amount paid on claims by liability insurers. (Insurance Research Council, Hospital Cost Shifting and Auto Injury Insurance Claims (Feb. 2010) pp. 27-28.)) That equals $53,306,040 in annual *Hanif* reductions for just one carrier's automobile liability policies.

According to statistics gathered by the Property Casualty Insurers Association of America, in 2007 there were 232,400 California insurance claims under homeowners and private auto insurance that included medical expense payments. If Mercury's $2,370 average reduction is applied to that number, the annual statewide difference between what healthcare providers "bill" and what they accept from health insurers for treatment of personal injury claimants is $550,788,000.

Importantly, these statistics do not include any claims under commercial liability policies. It is not unreasonable, then, to estimate that the decision in this case will determine the disposition of *more than half a billion dollars a year*.

healthcare providers. Instead, the money will go only to plaintiffs and their attorneys. This is because providers do not collect any more than the amounts they have agreed to accept from plaintiffs' health insurance as full payment. (See *Parnell, supra*, 35 Cal.4th at p. 609.)

Thus, under plaintiff's proposed rule, the healthcare provider will still get no more than the amount it negotiated with the plaintiff's health insurer, but the plaintiff will recover as damages the larger amount "billed" by the provider even though neither the plaintiff nor anyone else has paid or ever will pay the "bill."[9] That recovery, of course, will be on top of what the plaintiff already recovers under the traditional collateral source rule for the amount her insurer — but not she — paid to the provider. The additional recovery of phantom expenses "billed" but never paid is a windfall under any definition of the word.

The *Helfend* court stated that "[t]he collateral source rule expresses a policy judgment in favor of encouraging citizens to purchase and maintain insurance for personal injuries and for other eventualities." (*Helfend, supra*, 2 Cal.3d at p. 10.) As already

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[9] In the Medicaid context, this court assumed that the *Hanif* corollary would apply and that the plaintiff would thus *not* recover the "billed" amount. (*Olszewski, supra*, 30 Cal.4th at p. 827.) The court criticized the result as "giv[ing] the third party tortfeasor a windfall at the expense of the innocent health care provider" and called for a legislative remedy. (*Id.* at pp. 826-827.) As explained below, there is no windfall to the defendant and the healthcare provider is not getting shortchanged because the "billed" amount is not an accurate measure of the reasonable value of the medical services.

explained, the *Hanif* corollary does not in any way discourage the purchase of health insurance. Plaintiff's proposed rule, on the other hand, could directly restrict the availability of all types of liability insurance — auto, homeowners, and commercial. The additional hundreds of millions of dollars in annual windfall payments to plaintiffs and their lawyers will be funded largely by liability insurance. These enormous new liability insurance costs will likely lead to dramatic increases in liability insurance premiums.

IV. IF MEDICAL EXPENSE DAMAGES ARE NOT LIMITED TO THE AMOUNT ACTUALLY PAID BY A PLAINTIFF'S HEALTH INSURANCE, THERE SHOULD AT LEAST BE A TRIAL TO DETERMINE THE REASONABLE VALUE OF THE MEDICAL SERVICES PROVIDED.

The measure of medical expense damages is sometimes stated as being the "reasonable value" or the "reasonable cost" of the medical services provided. (See CACI No. 3903A (2010) ["To recover damages for past medical expenses, [name of plaintiff] must prove the reasonable cost of reasonably necessary medical care that [he/she] has received" (emphasis omitted)].) As the *Hanif* court recognized, however, "'Reasonable value' is a term of limitation, not of aggrandizement." (*Hanif, supra,* 200 Cal.App.3d at p. 641.)

In *Dimmick v. Alvarez* (1961) 196 Cal.App.2d 211, quoted in the "Sources and Authority" section under CACI No. 3903A, the court explained that it is not "necessary that the amount of the

award equal the alleged medical expenses for it has long been the rule that *the costs alone of medical treatment and hospitalization do not govern the recovery of such expenses. It must be shown additionally* that the services were attributable to the accident, that they were necessary, and *that the charges for such services were reasonable*." (*Id.* at p. 216, emphases added.)

The "reasonable value" measure is thus not a substitute for the general damages principle of "restor[ing] an injured person as nearly as possible to the position he or she would have been in had the wrong not been done" (*Turpin, supra*, 31 Cal.3d at p. 232). Rather, it is a potential limitation of that rule. Thus, just as a plaintiff should not recover a windfall for phantom medical expenses that no one has ever paid, so a plaintiff should not recover more than the reasonable value of medical services that *have* been paid for.

In this case, the reasonable value of plaintiff's medical services and the amount paid for those services by her health insurance are one and the same. The medical service prices that the healthcare providers and plaintiff's insurer agreed to in arms-length negotiations should conclusively establish the reasonable value of those services.

If this court nonetheless determines a plaintiff can recover more than her healthcare providers contracted to accept as full payment for her medical services and that the prices the providers negotiated do not establish the reasonable value of the services, the "usual and customary" charges that the providers "billed" should not be automatically deemed the measure of her recovery. Rather,

the trier of fact should determine the reasonable value of those services.

Regarding the cost of emergency services by providers who have no prior agreement with the patient's HMO, this court said that, "[i]n a given case, a reasonable amount might be the bill the doctor submits, or the amount the HMO chooses to pay, or some amount in between." (*Prospect Medical Group, supra*, 45 Cal.4th at p. 505; see also *id.* at p. 508 ["emergency room doctors do not have unfettered discretion to charge whatever they choose for emergency services"]; see generally *Pacific Gas & E. Co. v. G. W. Thomas Drayage etc.* (1968) 69 Cal.2d 33, 42-43 [bills are hearsay and "are inadmissible independently to prove that liability . . . was incurred, that payment was made, or that the charges were reasonable"].) In practice, however, the "billed" amount is an unreliable indicator of reasonable value, because payment of that amount is the rare exception, not the rule.

The Ninth Circuit has recognized the reality that, "in a world in which patients are covered by Medicare and various other kinds of medical insurance schemes that negotiate rates with providers, providers' supposed ordinary or standard rates may be paid by a small minority of patients." (*Vencor Inc. v. National States Ins. Co.* (9th Cir. 2002) 303 F.3d 1024, 1029, fn. 9; see Nation, *Obscene Contracts: The Doctrine of Unconscionability and Hospital Billing of the Uninsured* (2005) 94 Ky. L.J. 101, 104 [Labeling hospital charges as "'regular,' 'full,' or 'list,' [is] misleading, because in fact they are actually paid by less than five percent of patients nationally"]; Ireland, *The Concept of Reasonable Value in Recovery*

of Medical Expenses in Personal Injury Torts, supra, 14 J.Legal Econ. at p. 88 ["only a small fraction of persons receiving medical services actually pay original amounts billed for those services"].)

Moreover, it is becoming increasingly unlikely that even those patients not covered by public or private health insurance will ever pay "full" charges. Because of lawsuits and state statutes, hospitals are accepting the same "discounted" rates for uninsured patients that they agree to accept for insured patients. (See, e.g., *Sutter Health Uninsured Pricing Cases* (2009) 171 Cal.App.4th 495, 499-500 [reporting settlements in other cases, and approving a settlement in the case before the court, under which uninsured patients would not have to pay more than insured patients]; Goldstein, *Exerting Their Patients* (May 1, 2009) 95 ABA J. 19 [noting similar settlements nationwide]; Health & Saf. Code, § 127405, subd. (d) ["A hospital shall limit expected payment for services it provides to a patient at or below 350 percent of the federal poverty level . . . eligible under its discount payment policy to the amount of payment the hospital would expect, in good faith, to receive for providing services from Medicare, Medi-Cal, Healthy Families, or another government-sponsored health program of health benefits in which the hospital participates, whichever is greater. If the hospital provides a service for which there is no established payment by Medicare or any other government-sponsored program of health benefits in which the hospital participates, the hospital shall establish an appropriate discounted payment"].)

The hypothetical "billed" charges that plaintiff wants to recover as damages in this case thus bear little relation to reality. "[A] hospital's price list doesn't reflect what hospitals expect to recoup for a given service. Instead the prices are the hospital's initial bargaining position from which insurers negotiate down." (Goldstein, *Exerting Their Patients*, *supra*, ABA J. at p. 19.) As such, the "full" price is a particularly unreliable measure of damages in a personal injury action where the plaintiff is not to be put in a better position than she would have been had she not been harmed. (See *Coalition for Quality Health Care v. New Jersey Dept. of Banking and Ins.* (N.J.App. 2003) 358 N.J. Super. 123, 128 [817 A.2d 347, 350] ["if . . . providers routinely accept significantly less than . . . they purport to charge, then paid fees are a realistically more accurate measure of reasonable and prevailing fees than billed fees"].)

Plaintiff might object that a trial on the reasonable value of medical services would involve admitting into evidence the amounts accepted by her healthcare providers as full payment, which would violate the evidentiary aspect of the collateral source rule (see *Hrnjak*, *supra*, 4 Cal.3d 725). This is wrong for two reasons.

First, evidence of the accepted amounts should be admissible. This court has not provided an absolute rule of evidence exclusion. To the contrary, the court has expressly acknowledged that evidence of collateral source payments can be admitted under certain circumstances. In *Hrnjak*, the court stated that, "[u]nlike evidence of defendant's liability insurance coverage, the admissibility of evidence of plaintiff's receipt of collateral insurance benefits is not

governed by specific statutory exclusion." (*Hrnjak, supra,* 4 Cal.3d at p. 729, fn. omitted.) Rather, such evidence is admissible upon a "persuasive showing" that it "is of substantial probative value." (*Id.* at p. 733; see *Lund, supra,* 31 Cal.4th at p. 12; see also *Rotolo Chevrolet, supra,* 105 Cal.App.4th at p. 249, fn. 8 ["The collateral source rule has never been held to completely bar the introduction of evidence regarding other benefits. . . . [T]he rule bends to the needs of equity and fairness"].) The negotiated accepted amounts are clearly "of substantial probative value" in determining the reasonable value of medical services.

Second, there is evidence relevant to determining the reasonable value of plaintiff's medical services other than the collateral source payments by plaintiff's insurance. As one Court of Appeal recently recognized, "[t]he pricing of medical services is a subject of tremendous complexity." (*Yanez, supra,* 185 Cal.App.4th at p. 1330; see also *All Things Considered, "How Should Medicare Pay Doctors?"* (NPR Radio Broadcast, Feb. 26, 2010) <http://www.npr.org/templates/transcript/transcript.php?storyId=124090475> [as of Aug. 25, 2010] ["Figuring out prices for health services is really hard. We have an idea of what we should pay for toothpaste. Back surgery, no idea"].) Expert testimony on that subject should thus be welcome. (See Evid. Code, § 801, subd. (a) [expert testimony allowed if "[r]elated to a subject that is sufficiently beyond common experience that the opinion of an expert would assist the trier of fact"].) Also, it would be relevant, and would not disclose that plaintiff had received collateral source benefits, if the jury heard evidence of what her healthcare providers

— or other similar healthcare providers — customarily accept as full payment for medical services like those that were provided to plaintiff. Indeed, arms-length negotiations between a healthcare provider and an insurer — before services are provided — regarding the value of the services are plainly a far better measure of reasonable value than an amount the provider unilaterally selects as its "billed" rate.

V. IF MEDICAL EXPENSE DAMAGES ARE MEASURED BY THE AMOUNT ACCEPTED AS FULL PAYMENT FOR HEALTHCARE SERVICES, THERE WOULD RARELY BE A DISPUTE ABOUT WHAT AMOUNT IS OWED. WHEN THERE IS A DISPUTE, THE PLAINTIFF SHOULD HAVE THE BURDEN OF PROOF ON THE ISSUE DURING TRIAL.

If the reasonable value of the plaintiff's medical services is a factual issue for trial, as discussed in the preceding section, the evidentiary proceedings necessary to make that determination could be quite lengthy. Indeed, a trial of even a routine rear-end auto collision case might be extended dramatically as jurors consider days of evidence on the intricacies of medical service pricing.

In contrast to prolonged trial proceedings to determine the reasonable value of medical services, it should take little court time to establish the amount that a healthcare provider accepted from a health insurer as full payment for a plaintiff's medical services. It

is a fact that will rarely be disputed and reasonable attorneys would be able to stipulate to the amount in most cases.

In the unusual case where the parties dispute the amount accepted by the healthcare provider, the jury should determine it unless the parties agree to have the question decided by the court, and in either case the plaintiff should have the burden of proof. Court of Appeal opinions have nonetheless developed a rule that, as happened in the present case, the plaintiff is allowed to introduce evidence of her healthcare provider's "billed" price and the court after trial entertains a defense motion to reduce the medical expense damages to reflect the lower actual amount the healthcare provider accepted from the plaintiff's insurance company as full payment for the plaintiff's medical expenses. The Court of Appeal here criticized the procedure. (*Howell*, *supra*, 179 Cal.App.4th at pp. 704-707.) The procedure is subject to criticism, but for different reasons than those stated in the court's opinion.

The courts backed into the posttrial method of handling medical expense damages. It started with one court's holding that introducing the "billed" price into evidence was not prejudicial error requiring a new trial. (*Nishihama*, *supra*, 93 Cal.App.4th at p. 309.) From there, another court concluded a trial court had not "abuse[d] its discretion in allowing evidence of the reasonable cost of plaintiff's care while reserving the propriety of a . . . reduction until after the verdict." (*Greer*, *supra*, 141 Cal.App.4th at p. 1157; see also *Olsen*, *supra*, 164 Cal.App.4th at p. 202 [trial court denied defense motion to admit evidence of amount actually paid for

medical treatment, "stating that any reduction in the amount of medical expenses would be handled after the trial"].)

A careful analysis should lead to a different procedure, however. Whether or not the court admits evidence of the "full" billed price (if there is a justifiable reason for doing so at all), unless the parties agree otherwise, the jury should hear evidence of the amount that the plaintiff or her insurer actually paid, and it should be instructed that the latter amount is the most it can award as damages.

In *Brandt v. Superior Court* (1985) 37 Cal.3d 813, 819-820, this court held that if attorney fees are recoverable as tort damages in an insurance bad faith case, the jury must determine the amount of those damages unless the parties stipulate to a posttrial award by the trial court. The same rule should apply to medical expense damages in a personal injury lawsuit — absent an agreement by the parties, the amount of damages to be awarded for a plaintiff's medical expenses should be decided by a jury. Alternatively, if the parties can agree on the amount that plaintiff and/or her insurer paid to her healthcare providers as full payment for medical services, the court can direct a verdict on the issue.

A posttrial procedure to reduce the jury's award is objectionable for another reason. The procedure not only deprives defendants of a jury trial on the issue of the amount of plaintiffs' medical expense damages, but it also improperly shifts to defendants the burden of proof on the damages element of plaintiffs' tort claims.

Plaintiffs have the burden of proof on damages. (*Cassim v. Allstate Ins. Co.* (2004) 33 Cal.4th 780, 813 ["the plaintiff bears the burden of proving by a preponderance of the evidence both the existence and the amount of damages proximately caused by the defendant's tortious acts or omissions"].) Yet, when the jury has based its verdict on a "billed" price (because that's the only evidence on the issue the jury has been allowed to hear) and the defendant then moves posttrial to reduce the jury's award, the burden is likely to fall on the defendant as the moving party to establish the actual price paid and accepted.

Indeed, one court reversed a posttrial reduction because the *defendant* did not produce sufficient evidence of what the plaintiff (or another on her behalf) had actually paid for medical services. (*Olsen, supra*, 164 Cal.App.4th at p. 203; see also *id.* at pp. 216-217 (conc. opn. of Fybel, J.).) In another case, the court refused to reduce the jury's award because the *defendant* had failed to request a special verdict form that would have specified plaintiff's medical expenses. (*Greer, supra*, 141 Cal.App.4th at pp. 1157-1159.)

It should not be the defendant's burden to produce evidence of the amount actually paid to satisfy the plaintiff's obligation to her healthcare providers. Nor should the defendant be penalized if the jury awards medical expense damages based on "billed" price evidence but the verdict does not disclose the exact amount of those damages. Such results improperly relieve the plaintiff of the burden of proof on that essential element of damages.

If a largely hypothetical price "billed" by a healthcare provider is at all relevant to any issue in a personal injury action, the

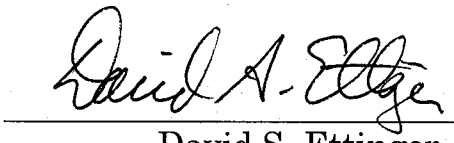
admission of that price into evidence should not eviscerate fundamental procedural principles. It should still be the plaintiff who is required to prove the amount of her medical expense damages — which can be no more than the actual amount paid for that expense — and she should have to carry that burden of proof before a jury.

CONCLUSION

For the reasons stated above, this court should reverse the Court of Appeal's judgment and remand the matter with directions to affirm the trial court's order reducing plaintiff's medical expense damages.

August 30, 2010

HORVITZ & LEVY LLP
H. THOMAS WATSON
DAVID S. ETTINGER

By: 
David S. Ettinger

Attorneys for Amici Curiae
AMERICAN INSURANCE ASSOCIATION; ASSOCIATION OF CALIFORNIA INSURANCE COMPANIES; PERSONAL INSURANCE FEDERATION OF CALIFORNIA; CALIFORNIA STATE AUTOMOBILE ASSOCIATION INTER-INSURANCE BUREAU; CHARTIS, INC.; FARMERS INSURANCE EXCHANGE; INFINITY INSURANCE COMPANY; INTERINSURANCE EXCHANGE OF THE AUTOMOBILE CLUB; MERCURY INSURANCE GROUP; STATE FARM GENERAL INSURANCE COMPANY; STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY

CERTIFICATE OF WORD COUNT

(Cal. Rules of Court, rule 8.520(c)(1).)

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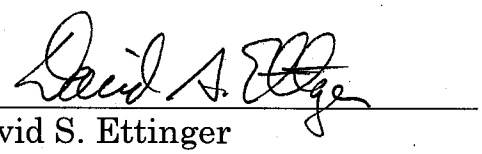

David S. Ettinger

PROOF OF SERVICE

STATE OF CALIFORNIA, COUNTY OF LOS ANGELES

At the time of service, I was over 18 years of age and not a party to this action. I am employed in the County of Los Angeles, State of California. My business address is 15760 Ventura Boulevard, 18th Floor, Encino, California 91436-3000.

On August 30, 2010, I served true copies of the following document(s) described as **APPLICATION FOR LEAVE TO FILE AMICI CURIAE BRIEF; AMICI CURIAE BRIEF OF AMERICAN INSURANCE ASSOCIATION; ASSOCIATION OF CALIFORNIA INSURANCE COMPANIES; PERSONAL INSURANCE FEDERATION OF CALIFORNIA; CALIFORNIA STATE AUTOMOBILE ASSOCIATION INTER-INSURANCE BUREAU; CHARTIS, INC.; FARMERS INSURANCE EXCHANGE; INFINITY INSURANCE COMPANY; INTERINSURANCE EXCHANGE OF THE AUTOMOBILE CLUB; MERCURY INSURANCE GROUP; STATE FARM GENERAL INSURANCE COMPANY; STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY IN SUPPORT OF RESPONDENT** on the interested parties in this action as follows:

SEE ATTACHED SERVICE LIST

BY MAIL: I enclosed the document(s) in a sealed envelope or package addressed to the persons at the addresses listed in the Service List and placed the envelope for collection and mailing, following our ordinary business practices. I am readily familiar with Horvitz & Levy LLP's practice for collecting and processing correspondence for mailing. On the same day that the correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the United States Postal Service, in a sealed envelope with postage fully prepaid.

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

Executed on August 30, 2010, at Encino, California.

Victoria Beebe

SERVICE LIST

Howell v. Hamilton Meats
Court of Appeal Case No. D053620
Supreme Court Case No. S179115

John J. Rice Lafave & Rice 2333 First Avenue, Suite 201 San Diego, CA 92101-1594	Counsel for Plaintiff and Appellant Rebecca Howell
J. Jude Basile Basile Law Firm 1334 Chorro Street San Luis Obispo, CA 93401-4006	Counsel for Plaintiff and Appellant Rebecca Howell
Gary L. Simms Law Office of Gary L. Simms 2050 Lyndell Terrace, Suite 240 Davis, CA 95616-6206	Counsel for Plaintiff and Appellant Rebecca Howell
Robert Francis Tyson Jr. Mark T. Petersen Tyson & Mendes 5661 La Jolla Boulevard La Jolla, CA 92037-7524	Counsel for Defendant and Respondent Hamilton Meats & Provisions Co.
Curtis A. Cole Cole Pedroza LLP 200 S. Los Robles Avenue, Suite 300 Pasadena, CA 91101-2483	Counsel for Amicus Curiae California Medical Association, California Hospital Association and California Dental Association
Hon. Adrienne Orfield San Diego Superior Court – North County 325 South Melrose Vista, CA 92081-6627	Case No. GIN053925
Office of the Clerk Court of Appeal Fourth Appellate District Division One 750 "B" Street, Suite 300 San Diego, CA 92101-8198	Case No. D053620