S17

IN THE

SUPREME COURT OF CALIFORNIA

COURT COPY

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
(San Diego County Superior Court Case No. GIN053925)

SUPREME COURT
FILED
DEC 31 2009
Frederick K. Ohlrich Clerk
Deputy

PETITION FOR REVIEW

TYSON & MENDES, LLP
ROBERT F. TYSON (Bar No. 147177)
MARK T. PETERSEN (Bar No. 163962)
5661 La Jolla Boulevard
La Jolla, CA 92037
Phone: (858) 459-4400
Fax: (858)459-3864
RTyson@tysonmendes.com
MPetersen@tysonmendes.com

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

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
(San Diego County Superior Court Case No. GIN053925)

PETITION FOR REVIEW

TYSON & MENDES, LLP
ROBERT F. TYSON (Bar No. 147177)
MARK T. PETERSEN (Bar No. 163962)
5661 La Jolla Boulevard
La Jolla, CA 92037
Phone: (858) 459-4400
Fax: (858)459-3864
RTyson@tysonmendes.com
MPetersen@tysonmendes.com

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

TABLE OF CONTENTS

ISSUES PRESENTED 1

I. INTRODUCTION: WHY REVIEW SHOULD BE GRANTED 2

A. ISSUE NO. 1: Dispute Created On Recovery Of Phantom or Excess Medical Expenses 4

B. ISSUE NO. 2: Uncertainty Exists As To Trial Courts' Authority to Hold Post-Verdict Motion to Reduce Medical Expenses 7

C. The Disputed Issues Are Important In California 9

II. STATEMENT OF THE CASE 10

A. Underlying Accident 10

B. Pre-Trial Motion *In Limine* Filed by HAMILTON To Exclude Excess Medical Expenses Is Denied. 11

C. HAMILTON Filed Its "*Hanif*" Motion With Supporting Evidence of Non-Collected, Excess Medical Bills 13

1. Scripps Memorial Hospital Bills Reduced by $94,894.42 13

2. CORE Orthopedic Medical Center Bills Reduced By $35,392.48. 14

D. HOWELL Requested Continuance of The *Hanif* Motion 15

E. HOWELL Filed Her Opposition to the *Hanif* Motion 16

F. The *Hanif* Motion Was Heard on May 19, 2008 17

G. HOWELL Requested a Rehearing of the *Hanif* Motion 20

H. Court of Appeal Decision 22

III. LEGAL ARGUMENT 22

A. This Court Should Grant Review To Resolve The Express Conflict Concerning The Important Issue Of Whether A Plaintiff In A Personal Injury Case May Recover As Economic Damages An Amount Exceeding

What His Or Her Private Health Insurance Has Paid and The Relevant Healthcare Provider Has Accepted As Full Payment For Medical Services 22

B. This Court Should Resolve The Conflict In The Court Of Appeal Decisions By Holding That Plaintiffs In Personal Injury Cases Are Not Entitled To Recover Past Medical Expenses Never Pursued Or Collected By Plaintiffs' Healthcare Providers 24

C. A Post-Verdict Motion Is Appropriate To Reduce A Plaintiff's Medical Damages By The Amount Never Pursued By Or Paid To A Healthcare Provider 27

D. The Collateral Source Rule Should Be Abolished in California 28

IV. CONCLUSION 30

TABLE OF AUTHORITIES

CASES

Basin Oil Co. v. Baash-Ross Tool Co. (1954) 125 Cal.App.2d 578 25

Emerald Bay Community Ass'n v. Golden Eagle Ins. Corp. (2005) 130 Cal.App.4th 1078 26

Greer v. Buzgheia (2006) 141 Cal.App.4th 1150 8

Hanif v. Housing Authority (1988) 200 Cal.App.3d 635 .... 4, 5, 13

Helfend v. Southern Cal. Rapid Transit Dist. (1970) 2 Cal.3d 1 28

Howell v. Hamilton Meats & Provisions, Inc., 2009 WL 4021368 .... 6, 7, 23, 25

Metz v. Soares (2006) 142 Cal.App.4th 1250 24

Mozzetti v. City of Brisbane (1977) 67 Cal.App.3d 565 25

Nishihama v. City and County of San Francisco (2001) 93 Cal.App.4th 298 .... passim

Olsen v. Reid (2008) 164 Cal.App.4th 200 .... 8, 9, 19, 20

Safeco Ins. Co. v. J & D Painting (1993) 17 Cal.App.4th 1199 24

Valdez v. Taylor Automobile Co. (1954) 129 Cal.App.2d 810 25

STATUTES

Cal. *Code of Civil Procedure* §1033.5 20

Cal. *Code of Civil Procedure* §437c(a) 15

Cal. *Evidence Code* § 320 11

Cal. *Evidence Code* §402 11

Civil Code §1431.2(b)(1) 26

Civil Code §3281 26

Civil Code §3282 26

Civil Code §3333 25
Civil Code §3333.1 28

RULES

Cal. *Rules of Court*, rule 8.500(b)(1) 2

IN THE

SUPREME COURT OF CALIFORNIA

REBECCA HOWELL,

Plaintiff and Appellant,

vs.

HAMILTON MEATS & PROVISIONS, INC.,

Defendant and Respondent.

PETITION FOR REVIEW

ISSUES PRESENTED

Issue No. 1: May a personal injury plaintiff recover as economic damages an amount exceeding what his or her private health insurance has paid and the relevant healthcare provider has accepted as payment in full for medical services?

There is an express split of authority in the published Court of Appeal decisions addressing this issue.

Issue No. 2: Is a trial court authorized to hear a post-verdict motion to reduce a plaintiff's past medical expenses award by the amount which it exceeds what

a plaintiff's health care insurer has paid, and medical providers have accepted, as payment in full?

Again, there is an express split of authority in the published Court of Appeal decisions addressing this issue.

Issue No. 3: Should the collateral source rule be abolished in its entirety in the state of California?

No petition for rehearing was filed in the Court of Appeal by petitioning party.

I.
INTRODUCTION: WHY REVIEW SHOULD BE GRANTED

In this case, review is necessary both "to secure uniformity of decision" and "to settle an important question of law." (Cal. Rules of Court, rule 8.500(b)(1).) The Court of Appeal's published opinion here creates a conflict regarding whether a plaintiff in a personal injury case may recover as economic damages an amount exceeding what his or her private health insurance has paid and the relevant healthcare provider has accepted as full payment for medical services. This would include the difference between the agreed upon payment by the private health insurance and accepted by the healthcare provider, and the face amount of the bill from the healthcare provider.

This excess amount is not owed by anyone or sought by anyone, other than plaintiffs and their lawyers. The plaintiff and her health insurance carrier do not owe any money to the healthcare provider and the healthcare provider is not seeking any money, as it has been paid in full. This excess amount is also not a "collateral source" as defined in California. The excess amount does not represent *payment* from a source secured by the plaintiff. Rather, contrary to all other economic damages, the opinion here increased plaintiff's damages by amounts *not* paid and which never will be paid.

Second, a dispute exists in California case law whether a trial court is authorized to hear a post-verdict motion to reduce a past medical expenses award by the amount exceeding what his or her private health insurance has paid and the relevant healthcare provider has accepted as full payment for medical services. Case law indicates such a motion is proper, but disputes remain on its form and propriety.

Finally, the conflicting Court of Appeal opinions on this topic give rise to the bigger question of whether the so-called "collateral source rule" should be abolished in its entirety in the state of California. In California, the rule was judicially-created. The rule does not exist uniformly throughout the United States. Only this Court may determine whether it remains a worthwhile and useful rule in this State.

A. ISSUE NO. 1: Dispute Created On Recovery Of Phantom or Excess Medical Expenses

Before the Court of Appeal's decision here, the law was clear that a personal injury plaintiff is *not* allowed to recover past medical expenses that were not due or owing to a health care provider. In *Hanif v. Housing Authority* (1988) 200 Cal.App.3d 635 ("*Hanif*"), the 1st Appellate District Court held a damage award for past medical expenses in an amount greater than its actual costs **"constitutes overcompensation."** *Id.* at 641 (emphasis added). The maximum amount a plaintiff can recover for medical services is the amount "expended or incurred for past medical services," even if that amount "may have been less than the prevailing market rate." *Id.* at 641.

In *Hanif,* the court proceeded to the heart of the matter: What constitutes the "reasonable value" of the medical expenses a plaintiff may recover? The court concluded the *recoverable* "reasonable value" could *not exceed* "the actual amount [plaintiff] paid or for which [plaintiff] incurred liability for past medical care and services." *Id.* at 640 (emphases added). In the context of *Hanif,* the "reasonable value" of medical services recoverable by that plaintiff could not exceed the amount actually paid by Medi-Cal to satisfy the medical bills in full. *Id.* at 643-644.

Hanif is in accord with the purpose of an award of damages, which is to compensate the plaintiff for the loss or injury sustained as a result of the tortfeasor's actions. The object is to restore the plaintiff as nearly as

possible to his or her former position, without placing the plaintiff in a *better* position than he or she would have been if the wrong had not been done. *Id.* at 641.

Hanif acknowledged the collateral source rule and complied with the rule. *Id.* at 639-640. Specifically, the court declared "there is no question…that Medi-Cal's payment for all injury-related medical care and services does not preclude plaintiff's recovery from defendant, as special damages, of *the amount paid.*" *Id.* (Emphasis added.) The collateral source rule was satisfied, as it was in the current case, because the amount the plaintiff was not permitted to recover from defendant was only that portion which the healthcare provider could not pursue or collect. The plaintiff was obviously not liable for such amount, and therefore was obviously precluded from recovering such amount.

In a case most similar to the one at hand, *Nishihama v. City and County of San Francisco* (2001) 93 Cal.App.4th 298 (1st Dist.), the plaintiff was injured when she tripped on a sidewalk maintained by the defendant, City of San Francisco. *Id.* at 301. The jury awarded plaintiff approximately $20,000 for medical care costs, including approximately $17,000 for hospital care. The amount of $17,000 was the hospital's "normal rates" billed. *Id.* at 306.

Unlike *Hanif,* the plaintiff in *Nishihama* was insured by a *private* medical insurance provider, Blue Cross. *Id.* The insurer had a contract with the hospital by which the hospital agreed Blue Cross would pay reduced rates

for certain medical services to Blue Cross members and the hospital would accept Blue Cross's payment as payment in full for those services. *Id.* Accordingly, the hospital accepted $3,600 as full and final payment for the $17,000 in expenses billed. *Id.* at 306-307.

The *Nishihama* court held the contract between Blue Cross and the hospital obligated plaintiff (through her carrier) to pay the medical provider only $3,600. In turn, the plaintiff was permitted to recover no more than $3,600 for past medical expenses from the defendant, because the amount represented the "sum certain to have been paid or incurred for past medical care and services." *Id.* at 306.

The *Nishihama* court also held the hospital had no lien rights under California's Hospital Lien Act (HLA) against the plaintiff's recovery because it had accepted a lesser amount as payment in full for the medical services. Per *Nishihama,* a plaintiff may not recover past medical expenses in an amount greater than what his or her healthcare provider accepted as payment in full from a private healthcare insurer for medical services rendered to the plaintiff. *Id.* at 307.

In our case, the 4th District Court of Appeal expressly disagreed with the holding in *Nishihama* "and the reasoning upon which it is based." *Howell v. Hamilton Meats & Provisions, Inc.*, 2009 WL 4021368, at p. 11 ("*Howell*")(See **Exhibit "1," p. 24** attached hereto.). The Court of Appeal held that the issue of whether a plaintiff is entitled to recover these excess

medical expenses in *Nishihama* "should have been resolved based on an analysis of [plaintiff's] rights under the collateral source rule, rather than on an analysis of [the healthcare provider's] lien rights under the HLA." *Howell, supra,* p. 11 (**Exhibit "1," p. 24**). The Court of Appeal concluded the proper analysis in *Nishihama* would have been to determine whether plaintiff, before she received hospital care, entered into a financial responsibility agreement with the hospital, and thus whether "she incurred pecuniary detriment or loss in the form of personal liability for the medical expenses she would later incur at [the hospital's] normal rates." *Howell, supra,* p. 11 (**Exhibit "1," p. 25**).

Due to these directly contrasting opinions, this area of law is in a state of confusion. The Supreme Court of California should address this issue of conflicting opinions issued by various appellate districts.

B. <u>ISSUE NO. 2: Uncertainty Exists As To Trial Courts' Authority To Hold Post-Verdict Motion To Reduce Medical Expenses</u>

Separate from the dispute over the *substantive* rule concerning the correct amount of a past medical expenses award is the dispute over the *procedure* by which the award may be determined. California case law holds an award for past medical expenses may be reduced *after* trial by either the trial court or a reviewing court. The First District in *Nishihama, supra,* concluded the trial court "erred" in permitting the *jury* to award plaintiff the

billed medical expenses rather than the true amount accepted by the healthcare providers as payment in full. 93 Cal.App.4th 298, 309. Accordingly, the Appellate Court "simply modif[ied] the judgment to reduce the amount awarded as costs for medical care." *Id.*

The Third District Court of Appeal in the later decision of *Greer v. Buzgheia* (2006) 141 Cal.App.4th 1150 ruled the *trial court* can make such post-trial modifications as well. In *Greer,* the trial court denied a motion *in limine* to preclude submission of the non-discounted medical bills, but "made it clear that if the jury rendered an award that was excessive under *Hanif/Nishihama*, it would consider a post-trial motion to reduce the recovery." *Id.* at 1157. The Appellate Court concluded "the [trial] court's ruling was correct." *Id.* In affirming not only the substantive holdings of *Hanif* and *Nishihama,* the *Greer* court specifically affirmed the trial court's *procedural* authority to hold a post-trial motion to reduce the verdict in accordance with those cases. *Id.* However, the post-trial motion in *Greer* was doomed as the result of a defective special verdict form, not because of anything related to the *Hanif/Nishihama* rule. *Id.* at 1153, 1156.

The recent case of *Olsen v. Reid* (2008) 164 Cal.App.4th 200 , also confirms a post-trial hearing in the trial court is proper on the *Hanif/Nishihama* issue, wherein it stated:

> If the proper application of the collateral source rule includes reducing a verdict to the amount actually paid or incurred by the plaintiff or a collateral source such as a health plan, **a**

> **hearing is necessary and appropriate to determine the correct amount. … The propriety of such a hearing is not a separate issue. If such a hearing is to be held, the trial court has the statutory authority under Evidence Code sections 320 (order of proof) and 402 (procedure for determining evidentiary matters) to hold the hearing.**

Id. at 217-218 (emphasis added).

C. The Disputed Issues Are Important In California

In addition to securing uniformity of decision, review should be granted because the issue about which the Courts of Appeal disagree is an important one. The issue of whether a plaintiff in a personal injury case may recover as economic damages an amount exceeding what his or her private health insurance has paid and the relevant healthcare provider has accepted as full payment for medical services arises an untold number of times *every year in virtually every personal injury case in California*. Under this Court of Appeal's holding, plaintiffs can now recover windfall "compensatory" damages that, in fact, are not compensation to anyone for anything.

The allocation of millions, if not hundreds of millions, of dollars rests on this issue every year. This is money that will come out of the pockets of California citizens and their insurers. The result will be that defendants will have to increase the prices they charge to the public at large for goods and services they sell and insurers will have to raise premiums charged to the public. Thus, California citizens will ultimately bear the burden of

providing windfall profits to a select group – tort litigation plaintiffs and their attorneys. That is neither fair, just, nor good public policy.

This petition presents an important legal question of whether a plaintiff in a personal injury case may recover as economic damages an amount exceeding what his or her private health insurance has paid and the relevant healthcare provider has accepted as full payment for medical services. In other words, should these past expenses subject to neither collection nor pursuit by a plaintiff's healthcare provider (be it hospitals, clinics, doctors, etc.) be considered a recoverable benefit under the collateral source rule? The petition also presents the broader question of whether the collateral source rule should be abolished entirely in the state of California.

This court should grant review and reverse the Court of Appeal's ruling, approving instead the established rule in *Hanif, Nishihama* and their progeny. Alternatively, this court should abolish the collateral source rule in its entirety.

II.

STATEMENT OF THE CASE

A. Underlying Accident

On November 17, 2005, plaintiff/appellant Rebecca Howell was involved in a car accident with a truck operated by an employee of defendant/respondent Hamilton Meats, Inc. on southbound Pacific Coast

Highway in Encinitas, California. The employee, Juan Carlos Saenz, was in the course and scope of his employment with Hamilton Meats at the time.

As a result of the accident, Ms. Howell claimed injuries to her neck, right arm, and right hand. She underwent a series of medical treatments, including two cervical discectomies and fusions.

Ms. Howell had private health insurance through PacifiCare. A portion of her medical bills were never pursued or collected by the hospital and surgeon who provided treatment, pursuant to contractual agreements between PacifiCare and these healthcare providers.

B. Pre-Trial Motion *In Limine* Filed by HAMILTON To Exclude Excess Medical Expenses Is Denied.

HAMILTON filed a motion *in limine* on January 17, 2008 seeking to exclude the introduction of evidence at trial of the excess portions of the medical bills. (1 AA 73-107.) The motion was heard on January 29, 2008 by Judge Adrienne Orfield. (1 RT 64:17-69:6.) Judge Orfield denied the motion. However, the trial court specifically reserved its right to determine *post-trial* whether the medical expenses award would be reduced for the written off amounts. (1 RT 67:13-16.) A court has authority to prioritize and order such evidence. Cal. *Evidence Code* §§ 320, 402

HOWELL's counsel specifically proposed a post-trial procedure be employed to determine the issue, as reflected in the transcript from the *in limine* motion hearing:

> **The Court**: I see this is a post-trial issue. They're [plaintiff] entitled to put their bills in front of the jury, whatever you can actually come up with to meet your burden. We can address that post-trial.
>
> . . .
>
> **[Plaintiff's counsel]**: ...My proposal would be just agree to what the number for past medical bills, **and you guys can raise all the other arguments post trial**, like if the Court inquired.
>
> . . .
>
> **[HAMILTON' counsel]**: So we're clear, I assume, it's the Court's position and ruling that the jury gets to see the entire medical bills and so there's no need for us to argue that they just see the reduced one?
>
> **The Court**: Correct.
>
> **Mr. Tyson**: You handle that at post-trial Hanif motion.
>
> **The Court:** Correct.

(1 RT 67:13-16; 68:10-13, 27-28; 69:1-6 (emphasis added).)

Accordingly, the jury received evidence of the full billed amount of past medical expenses in the amount of $189,978.63. (2 RT 117:15-118:5; 3 RT 195:16-25.) The jury also awarded $200,000.00 to HOWELL for *past* non-economic (general) damages. (1 AA 178, 219.)

C. HAMILTON Filed Its "*Hanif*" Motion With Supporting Evidence of Non-Collected, Excess Medical Bills

HAMILTON filed its motion titled "Post-Trial Motion to Reduce Past Medical Specials Verdict Pursuant to *Hanif v. Housing Authority* (1988) 200 Cal.App.3d 635" (hereafter referred to as "*Hanif* motion") on or about February 15, 2008. The *Hanif* motion included declarations of two personnel qualified to testify as to the amounts billed by their respective companies, the excess amounts never pursued , the zero balance of the accounts, and that HOWELL would not be pursued for the excess amounts in any manner. (1 AA 123-176.) [1] Through the *Hanif* motion, HAMILTON sought a reduction of $130,286.90 from the past medical expenses award, which represented the excess, uncollected amount. (1 AA 123.) The hearing for the *Hanif* motion was initially scheduled for May 2, 2008, the earliest available date provided by the court clerk. (1 AA 192:19-21.)

1. Scripps Memorial Hospital Bills Reduced by $94,894.42

Evidence at trial demonstrated Scripps Memorial Hospital billed $122,841.07 for medical services provided to HOWELL. This information was included in the *Hanif* motion. (1 AA 132-135; 139-146.)

---

[1] For Scripps Memorial Hospital, the declarant was the "Supervisor of Customer Service and Collections from Third Parties" at the hospital. For CORE Orthopedic, the declarant was the knowledgeable employee in the "Accounting Department of CHMB, a medical billing company which provides medical billing services for CORE Orthopedic Medical Center." (1 AA 132-137.)

Of this amount, HOWELL's medical insurer (Pacificare) paid $24,380.39. (1 AA 139-146, entries identified as ""HMO/PPO Payments"; 1 AA 132:25- 133:2, 23-27; 134:20-24.) Additionally, HOWELL paid $3,566.26. (1 AA 139-140 and 145-146, entries identified as "Patient Payment"; 1 AA 132:25- 133:23; 134:20-24.) The balance of the Scripps Memorial bills, amounting to **$94,894.42,** were never collected or pursued by Scripps Memorial. (1 AA 139-146, entries identified as "PPO/HMO/CMS/WC MANUAL"; 1 AA 133:4-7; 134:1-4, 26- 135:2; 135:12-18.) No lien has been asserted for this amount. (1 AA 135:12-18.) According to the declarant for the hospital, supported by the submitted exhibits:

> No outstanding balance remains on Ms. Howell's account and no further collection will be pursued. Accordingly, Ms. Howell's account is considered closed.

(1 AA 135:16-18.)

2. CORE Orthopedic Medical Center Bills Reduced By $35,392.48.

Plaintiff's treating spine surgeon, Dr. Timothy Peppers, is affiliated with CORE Orthopedic Medical Center in Encinitas ("CORE"). The amount billed for Dr. Peppers' treatment of HOWELL related to the accident was $52,915.14 for the period from December 5, 2005 through August 1, 2007. (1 AA 136-137; 148-175.)

Per billing records for CORE for this period, the total amount "adjusted" by CORE, i.e., deemed excess, was **$35,392.48.** (1 AA 137:3-7; 148-175.) This amount was a contractual reduction agreed to between

HOWELL's medical insurer and CORE Orthopedic. (1 AA 137:3-7.) This waived or written off amount will never be sought, or collected, from HOWELL. (1 AA 137:9-12.)

The combined excess amount never to be collected or pursued by Scripps Memorial Hospital (**$94,894.42)** and CORE (**$35,392.48)** is **$130,286.90**. HAMILTON requested the trial court reduce the past medical expenses portion of the judgment by this excess amount. (1 AA 123-130.)

D. HOWELL Requested Continuance of The *Hanif* Motion

The original hearing date for the *Hanif* motion of May 2, 2008 provided HOWELL with more than 10 weeks' notice (76 days). This notice period exceeded the minimum 75-day notice period required for summary judgment motions in California. *C.C.P.* §437c(a).

On April 4, 2008 HOWELL filed an *ex parte* application to continue the *Hanif* motion hearing date and re-open discovery. (1 AA 180-189.) HOWELL claimed a sudden need to pursue discovery from her *own* healthcare providers (Scripps Memorial Hospital and CORE Orthopedic) and her *own* medical insurer (Pacificare), despite the fact she could have sought and obtained such records (as a patient and insured) at any time before or during the litigation. (1 AA 182.) This *ex parte* application marked the first appearance by attorney John Rice for HOWELL, who "associated in on the case principally to handle the post-trial motion on the *Hanif* issue." (5 RT

243:13-15.) HAMILTON filed opposing papers to the *ex parte* application on April 3, 2008. (1 AA 190-210.)

The *ex parte* hearing resulted in the trial court continuing the *Hanif* motion to May 19, 2008. (1 AA 211; 5 RT 253:23-28.) Counsel for HOWELL agreed the court had discretion to conclude the matter at one hearing or, if it wished, could entertain a second hearing. (5 RT 250:10-13.)

On another occasion prior to the *Hanif* motion hearing, counsel for HOWELL again voiced his agreement with the post-trial procedure and propriety of the motion. During an *ex parte* hearing on April 18, 2008, counsel for HOWELL acknowledged:

> And I think we're going to hear the Hanif motion...on the 19th, I'm sorry. On the 19th, and **I think the court has approached this whole issue in a very rational way**, let's deal with the substantive-law issues.

(6 RT 259:25- 260, emphasis added.) Thus, trial counsel agreed the procedure followed by the trial court was not only acceptable, but "rational."

E. HOWELL Filed Her Opposition to the *Hanif* Motion

HOWELL filed her opposition to the *Hanif* motion on April 24, 2008. (2 AA 339-463.) Early in her brief, HOWELL admits her medical bills were satisfied:

> In this case, Plaintiff incurred $189,918.3 in charges the jury found were related to care necessitated by Defendant's negligence. **The bills were submitted to PacifiCare and the debts were satisfied pursuant to the contracts between**

Plaintiff and PacifiCare and between PacifiCare and the treatment providers.

(2 AA 344:28- 345:3, emphasis added.)

Though the parties dispute whether the waived medical bills were ever "incurred" by HOWELL, she plainly admits all medical bills were "satisfied" pursuant to various contracts between the parties. *Id.* HOWELL's admission of satisfaction is in accord with the declarations submitted by HAMILTON in support of the *Hanif* motion, which affirmed HOWELL's medical bills for the subject healthcare providers were satisfied and no outstanding balances (for past medical care) remained to be collected from HOWELL, or from anyone else. (1 AA 132-175.)

HOWELL did not include any evidence with her opposition to the *Hanif* motion to counter the declarations and documentary evidence submitted by HAMILTON. Despite her presumed access and ability to obtain her *own* medical bills and medical insurance information, HOWELL failed to do so for the *Hanif* motion.

F. The *Hanif* Motion Was Heard on May 19, 2008

The *Hanif* motion was heard on May 19, 2008. (8 RT 270-335.) The hearing was lengthy and both sides were afforded extensive oral argument. *Id.* The hearing included a decision on a motion for new trial filed by HAMILTON.

The motion for new trial was denied by the court. (8 RT 272:13-17.) HAMILTON had filed a motion for new trial and a motion to set aside and vacate the judgment, based on the *Hanif* line of cases, in response to the trial court inadvertently entering judgment previously on March 4, 2008. (1 AA 263-338; 2 AA 464-489.) The judgment was mistakenly entered after HAMILTON filed its *Hanif* motion, but prior to its hearing, thus HAMILTON preserved its procedural rights to modify the judgment accordingly. The trial court acknowledged the inadvertent entry when it stated at the *Hanif* motion hearing:

> [The Court] I do understand that what happened in this matter was that the judgment, the proposed judgment, for whatever reason, was not sent to the defense for review before it got sent to the court.
>
> . . .[B]ecause of the way the that business office works, I was unaware that the Hanif motion had been filed at the time I got the judgment.
>
> . . . As I pondered the fact that the judgment was entered and we do have a Hanif motion and try to determine what's the best way to address the judgment itself, I'm thinking that the better procedure would be to leave the judgment in place now.
>
> If the defense is successful on their argument in any fashion then, and it results in a change in the judgment, we can make that change and I can *nunc pro tunc* it to the date that the judgment was initially signed.

(8 RT 271:28- 272:3; 272:7-9, 13-2.)

Counsel for HOWELL specifically agreed with the Court:

That seems like a fair way to do it. If there is an adjustment

> [to the judgment], go back to the date and adjust the interest including the judgment, that makes sense.

(8 RT 273:13-16.)

HOWELL's counsel also affirmed agreement with the Court's stated intent as to the method by which the judgment could be modified pursuant to the *Hanif* motion:

> [The Court]: And does the plaintiff have any objection to proceeding in the manner in which the court has described?
>
> [HOWELL'S counsel]: **We do not, Your Honor. I think that's the proper way to do it.** I think the defendant, having filed their new trial motion and identifying as a single ground for a motion for new trial, what we've been terming "the Hanif issue," I think that sort of wraps it all up.
>
> And the Court certainly does have the power to *nunc pro tunc* to revise the judgment back to the date that the judgment was first entered.

(8 RT 274:2-13, emphasis added.)

The trial court entertained all of HOWELL's arguments on the issue and even accepted a brief counsel HOWELL's had assisted on and filed in connection with the *Olsen v. Reid* case, *infra.* (8 RT 308:10-323:20.) At the conclusion of the lengthy oral argument, the trial court and counsel for HOWELL stated the following:

> [Court]: Gentlemen, I think we have enough on the record unless you feel that something else needs to be in.
>
> [HOWELL's counsel]: I don't think so, Your Honor.
>
> . . .
>
> [Court]: I'll take the matter under submission…
> **If I feel that if I make a decision that warrants another**

> **hearing, then I'll schedule the hearing. If I make a decision that just warrants a reduction of some type, then it will be *nunc pro tunc* to the time the judgment is filed.** [March 4.].
> . . .
> [HOWELL's counsel]: The only caveat is, we only briefed the substantive law issues. **But I think the argument sort of covered most of what would be in the paper anyway.**

(8 RT 334:18- 335:14; emphases **added.)**

The trial court issued its Minute Order dated June 10, 2008 granting HAMILTON's *Hanif* motion in full. (2 AA 553.) As a result, the past medical expenses portion of the verdict was reduced by the amount requested by HAMILTON, *i.e.,* the non-pursued, excess amount of $130,286.90. (1 AA 123.) HAMILTON served and filed a "Notice of Ruling" on or about July 3, 2008, advising of the new judgment amount of $559,691.73 (*nunc pro tunc* as previously stated by the trial court).[2] (2 AA 555-560.)

G. HOWELL Requested a Rehearing of the *Hanif* Motion

HOWELL noticed an *ex parte* hearing for July 11, 2008--one month after the *Hanif* decision was issued--requesting reconsideration of the trial court's decision pursuant to the *Olsen v. Reid* case, *infra*. (3 AA 561-570.) The court denied HOWELL's reconsideration request, noting it had already read the *Olsen* case and concluded it did not affect the decision on the

[2] This amount is exclusive of statutory costs awarded to HOWELL pursuant to *C.C.P.* §1033.5.

Hanif motion. (9 RT 336:11- 337:16.) The court even advised counsel it had read the briefs filed in *Olsen*, along with other authority. (9 RT 344:23-345:8.)

The remainder of the *ex parte* appearance was devoted to HOWELL's request to submit additional "evidence" regarding whether any balances were owed on accounts with the subject healthcare providers Scripps Memorial Hospital and CORE Orthopedic. (8 RT 340:9- 359:22.) HOWELL's counsel admitted at the *ex parte* hearing: "I don't know what CORE [Orthopedic] is going to do" with regard to whether any balance was due and owing on HOWELL's account. (9 RT 351:7-8.) HOWELL had no evidence at that time of any such balance. Apparently in an abundance of caution, the trial court permitted HOWELL to file evidence, if any, on this issue. (9 RT 353:7-27.)

On July 15, 2008 HOWELL filed a Declaration of Michael Vallee (co-counsel for HOWELL), Evidentiary and Procedural Objections, and a "Supplemental Briefing." (3 AA 571-590; 604-617.) According to a Minute Order issued August 14, 2008, the preceding documents were deemed filed as of July 16, 2008. (3 AA 618.) The Minute Order also stated: "Attorney John Rice [for HOWELL] indicates to the Court that a further hearing is not necessary and is requesting that his supplemental be filed and made a part of the record." (3 AA 618.)

H. Court of Appeal Decision

In its opinion filed November 23, 2009, the Court of Appeal (1st District, Division One) reversed the trial court's order granting HAMILTON'S post-verdict motion to reduce the jury's special verdict award for plaintiff's medical expenses. (**Exhibit "1"**.)

III.

LEGAL ARGUMENT

A. This Court Should Grant Review To Resolve The Express Conflict Concerning The Important Issue Of Whether A Plaintiff In A Personal Injury Case May Recover As Economic Damages An Amount Exceeding What His Or Her Private Health Insurance Has Paid And The Relevant Healthcare Provider Has Accepted As Full Payment For Medical Services

This is the quintessential case for Supreme Court review – a case presenting an issue of statewide importance about which the Courts of Appeal are in express disagreement.

The issue is whether a plaintiff in a personal injury case can recover past medical expenses for the amount her healthcare provider is no longer seeking as it is deemed excess and no longer exists. This amount is no longer owed by plaintiff or her health care insurance carrier. The Court of

Appeal here concluded the excess amount of nonexistent medical expenses is a collateral source benefit within the meaning of the collateral source rule. *Howell, supra,* p. 1 (**Exhibit "1," p. 3**). Thus, plaintiff HOWELL is entitled to recover these phantom medical expenses. *Id.*

The Court of Appeal acknowledged its holding is directly at odds with the published decision of another Court of Appeal in *Nishihama, supra,* 93 Cal.App.4th at 307-08, stating "[w]e disagree with this holding in *Nishihama* and the reasoning upon which it is based." *Howell, supra,* p. 11 (**Exhibit "1," p. 24**).

This fiercely contested issue has far-reaching ramifications for personal injury cases throughout California. The Court of Appeal's disregard for precedent and its expansion of the collateral source rule has broad implications in a whole host of cases – driving up the cost of insurance and goods and services for the majority in order to provide undisputed windfalls to plaintiffs and their attorneys.

This Court of Appeal's decision has entirely altered the concept of compensatory damages, which is meant to make plaintiff "whole." Under the Court of Appeal's holding, personal injury plaintiffs will now gain an additional windfall recovery, beyond what the collateral source rule has ever authorized, and allow them to be "reimbursed" for payments that no one has made or will ever make. No principle of California law entitles plaintiff to such a recovery, nor should it.

B. This Court Should Resolve The Conflict In The Court Of Appeal Decisions By Holding That Plaintiffs In Personal Injury Cases Are Not Entitled To Recover Past Medical Expenses Never Pursued Or Collected By Plaintiffs' Healthcare Providers.

The Court of Appeal's creation of a new form of damages called "negotiated rate differential" is a fiction. It is not found in the collateral source rule, and more importantly, it abolishes the basic maxim of California tort law that a plaintiff must be made whole. Rather, this new form of damages is grounded in the dreams of personal injury attorneys throughout California. The holding puts plaintiffs, and their attorneys, in a better position than they would have been if no injury had occurred. Tort injuries are converted into a profit-making scheme.

Plaintiff should never have been allowed to introduce irrelevant evidence of inflated "prices" for medical services that were never paid or charged to her. Plaintiff's evidence of illusory medical charges – charges never paid or to be paid by plaintiff nor anyone on her behalf – should never have been admitted in the first place.

It is a fundamental precept of California law 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 in had the wrongful act not been done. [Citations.]'" *Safeco Ins. Co. v. J & D Painting* (1993) 17 Cal.App.4th 1199, 1202; accord *Metz v. Soares* (2006) 142 Cal.App.4th 1250, 1255; *Valdez v. Taylor*

Automobile Co. (1954) 129 Cal.App.2d 810, 821-22; *Basin Oil Co. v. Baash-Ross Tool Co.* (1954) 125 Cal.App.2d 578, 605. "*The primary object of an award of damages* in a civil action, and the fundamental principle on which it is based, are *just compensation* or indemnity for the loss or injury sustained by the complainant, *and no more* [citations]." *Mozzetti v. City of Brisbane* (1977) 67 Cal.App.3d 565, 576 (original emphasis).

As the Court of Appeal in *Nishihama* correctly held, plaintiff is only entitled to the actually paid amount of medical bills because it represents a "sum certain to have been paid or incurred for past medical care and services." *Id.* at 306. This decision is in alignment with California principles of limiting a plaintiff's recovery to *actual* damages incurred.

Notwithstanding, the Court of Appeal in *Howell* disagreed. It held that the excess, non-pursued medical expenses are a benefit within the meaning of the collateral source rule, and thus recoverable by plaintiff as part of her recovery for economic damages. *Howell, supra,* p. 1 (**Exhibit "1," p. 3-4**). The Court reasoned that plaintiff "did incur detriment in the form of personal financial liability when she executed written agreements in which she agreed to be financially responsible for all charges for the medical services they provided to her." *Howell, supra,* p. 7 (**Exhibit "1," p. 17**).

The court's reasoning is faulty. California *Civil Code* §3333 provides the measure of damages in tort cases is "the amount which will compensate for all the *detriment* proximately caused thereby...." (Emphasis

added.) "Detriment" is defined in *Civil Code* §3282 as "a loss or harm suffered in person or property." Here, plaintiff "suffered" no loss or harm for the non-realized, non-owed portion of medical bills.

Civil Code §3281 further clarifies one must actually "suffer[] detriment" before recovery can be obtained in the form of "money, which is called damages." Finally, *Civil Code* §1431.2(b)(1), which addresses the several liability of tort defendants, defines "economic damages" as "objectively verifiable monetary *losses* including medical expenses," among other *verifiable losses* to the tort claimant. (Emphasis added.) *See also, Emerald Bay Community Ass'n v. Golden Eagle Ins. Corp.* (2005) 130 Cal.App.4th 1078, 1093-94 ("Tort damages are the amount which will compensate for all the detriment proximately caused thereby, whether it could have been anticipated or not.").

Alleged medical expenses that are never pursued or collected by healthcare providers, and therefore non-payable by the plaintiff or her health insurance carrier, do not constitute "detriment." If she is not liable for the excess portions of medical bills, a plaintiff cannot logically claim she "suffered" a "loss or harm" for those amounts. These phantom medical expenses cannot constitute recoverable damages because they do not fall within the definition of "detriment" in *Civil Code* §3282. The lack of any suffering of the excess billings also denies plaintiff the ability to recover "money" for such fictional amounts. *Civil Code* §3281.

Simply put, the Court of Appeal's holding does not create a fair, just, and equitable outcome. Rather, plaintiffs can now recover windfall "compensatory" damages that, in fact, are not compensation for anything that anyone has paid to someone else. That money will come from defendants and their insurers. The result will be that defendants will have to increase the prices they charge to the public at large for goods and services they sell and insurers will have to raise premiums charged to the public at large. Thus, the public at large will ultimately bear the burden of providing windfall profits to a small, select group – tort litigation plaintiffs and their attorneys. That is neither fair, just, nor good public policy.

The rule is and should remain that a plaintiff may not recover more as *compensatory* economic damages than has actually been paid or will be paid on her behalf. Nothing in the traditional collateral source rule suggests otherwise. It should not be radically reformulated to create an unjust result.

C. A Post-Verdict Motion Is Appropriate To Reduce A Plaintiff's Medical Damages By The Amount Never Pursued By, Or Paid To, A Healthcare Provider.

Initially, a plaintiff should never be allowed to present the amount of phantom medical expenses to a jury. However, if allowed to do so, a post-verdict motion is the appropriate procedure for reducing plaintiff's medical damages by that amount. As discussed above, the *Nishihama*, *Greer*,

and *Olsen* cases all support the principle that past medical expenses may be reduced *after* trial by either the trial court or a reviewing court.

D. **The Collateral Source Rule Should Be Abolished in California.**

The Supreme Court of California has the power to abolish the collateral source rule, a doctrine it created and has since "long adhered to." *Helfend v. Southern Cal. Rapid Transit Dist.* (1970) 2 Cal.3d 1, 6.

One of the justifications that the Supreme Court has advanced for retaining the collateral source rule, despite substantial criticism of the rule, is that plaintiffs do not receive a double recovery in the many instances where insurers have rights to subrogation or refund of benefits after a tort recovery by the insured. *Id.* at 11. Yet, even under these circumstances, there is *still* a windfall to the plaintiff. The plaintiff's insurer is only entitled to subrogation for or refund of the amount actually paid by that insurer. The plaintiff gets to keep as a windfall *profit* the difference between an inflated "usual and customary" charge and the amount actually paid by the insurer. Often that difference is several times the amount actually paid.

The absurdity of the result that the Court of Appeal's holding in *Howell* will achieve is particularly great in medical malpractice cases. An integral part of the Medical Injury Compensation Reform Act (MICRA), *Civil Code* §3333.1 was intended to reduce the expense of medical malpractice

actions. It allows a defendant to introduce evidence of amounts paid by collateral sources on the plaintiff's behalf. At the same time, it allows the plaintiff to introduce evidence of amounts that the plaintiff paid in premiums for such insurance as an offset. The collateral source payors are barred from any subrogated or like recovery against the plaintiff.

Under the Court of Appeal's holding issued here, a plaintiff in a medical malpractice case could both offset collateral source payments by insurance premiums paid and receive as a windfall profit the difference between amounts actually paid and an artificial "usual and customary" billed amount. At the same time, plaintiff's medical insurers receive nothing by way of subrogation for the amounts that they paid. The plaintiff thus pockets both premiums and the difference between the amount paid and the never-paid "usual and customary" rate. There is no suggestion that the Legislature – which thought it was eliminating the collateral source rule in medical malpractice actions – contemplated that plaintiffs would receive windfall "collateral source" amounts while health insurers were deprived of their subrogation rights.

In addition, abolition of the collateral source rule would be in conformity with the concept of compensatory damages, which is to make a plaintiff "whole," nothing more. The collateral source rule effectively compensates plaintiff twice for the same injury, resulting in a windfall recovery to the plaintiff.

The collateral source rule is an outdated common law doctrine which no longer suits our modern-day health care system. Elimination of the rule will free up judicial resources, increase the efficiency of the courts, and reduce insurance rates.

IV.

CONCLUSION

For the above reasons, this court should grant review and reverse the Court of Appeal's judgment. Alternatively, the court should abolish the collateral source rule in its entirety.

Dated: December 28, 2009

Respectfully submitted,

TYSON & MENDES, LLP

By:

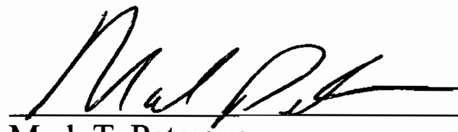
Robert F. Tyson
Mark T. Petersen
Attorneys for Defendant and Respondent
HAMILTON MEATS & PROVISIONS, INC.

CERTIFICATE OF WORD COUNT

(Cal. Rules of Court, rule 8.504(d)(1).)

The text of this Petition consists of 6,651 words as counted by the Microsoft Word software word-processing program used to generate the Petition.

Dated: December 28, 2009



Mark T. Petersen

EXHIBIT “1”

CERTIFIED FOR PUBLICATION

COURT OF APPEAL, FOURTH APPELLATE DISTRICT

DIVISION ONE

STATE OF CALIFORNIA

Court of Appeal Fourth District
FILED
NOV 23 2009
Stephen M. Kelly, Clerk
DEPUTY

REBECCA HOWELL, Plaintiff and Appellant, v. HAMILTON MEATS & PROVISIONS, INC., Defendant and Respondent.	D053620 (Super. Ct. No. GIN053925)

APPEAL from an order of the Superior Court of San Diego County, Adrienne A. Orfield, Judge. Reversed and remanded.

LaFave & Rice, John J. Rice; Basile Law Firm, J. Jude Basile; Law Offices of J. Michael Vallee and J. Michael Vallee for Plaintiff and Appellant.

Hinton, Alfert & Sumner, Scott H.Z. Sumner and Jeremy N. Lateiner for Consumer Attorneys of California as Amicus Curiae on behalf of Plaintiff and Appellant.

Tyson & Mendes and Robert F. Tyson for Defendant and Respondent.

Greines, Martin, Stein & Richland and Robert A. Olson for Association of Southern California Defense Counsel as Amicus Curiae on behalf of Defendant and Respondent.

Horvitz & Levy, David S. Ettinger and H. Thomas Watson for Association of California Insurance Companies and Personal Insurance Federation of California as Amici Curiae on behalf of Defendant and Respondent.

SUMMARY AND HOLDING

In this case, we must decide whether a plaintiff who has private health care insurance in a personal injury case may recover, under the collateral source rule, economic damages for the amount of past medical expenses that her health care providers have billed, but which neither the plaintiff nor her health care insurer is obligated to pay because the providers have agreed, under contracts into which they have entered with the insurer, to accept—as payment in full—payments in an amount that is less than the amount the providers have billed. Stated differently, is the difference (hereafter referred to as the negotiated rate differential)[1] 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

---

1 Amicus curiae Consumer Attorneys of California (CAC) refers to this difference as an "alternative payment rate discount." Amici curiae Association of California Insurance Companies and Personal Insurance Federation of California refer to this difference as "phantom 'expenses' that *no one* paid or ever will pay" and "the price discount." Amicus curiae Association of Southern California Defense Counsel refers to the difference as "the difference between the amount paid and the never-paid 'usual and customary' rate."

medical providers that the providers have agreed to accept as payment in full pursuant to their agreements with the insurer, a benefit within the meaning of the collateral source rule such that the plaintiff is entitled under that rule to recover the amount of the negotiated rate differential as part of her economic damages award?

In this personal injury action, plaintiff Rebecca Howell's private health care insurance policy provided indemnity coverage for medical expenses she incurred for treatment of injuries she sustained in a vehicle accident caused by the negligent driving of an employee of defendant Hamilton Meats & Provisions, Inc. (Hamilton). Howell appeals an order granting Hamilton's posttrial motion to reduce by $130,286.90 the jury's special verdict award for her past injury-related medical expenses from $189,978.63, which was the full amount of her medical bills, to $59,691.73, the amount her medical providers Scripps Memorial Hospital Encinitas (Scripps) and CORE Orthopedic Medical Center (CORE) accepted as payment in full from Howell's health care insurer, PacifiCare PPO (PacifiCare). Howell contends the order should be reversed because (1) the reduction of the jury's award for her past medical expenses violates the collateral source rule, which (as we shall discuss more fully, *post*) generally bars at trial in a personal injury case evidence of compensation the plaintiff has received for her injuries from a source wholly independent of the defendant tortfeasor; and (2) Hamilton's motion was "procedurally improper and lacked sufficient evidence to support the claimed reduction."

We hold that in a personal injury case in which the plaintiff has private health care insurance, the negotiated rate differential is a benefit within the meaning of the collateral source rule, and thus the plaintiff may recover the amount of that differential as part of

her recovery of economic damages for the past medical expenses she incurred for care and treatment of her injuries. Applying this holding to the instant case, we conclude the court erred by granting Hamilton's postverdict motion to reduce the jury's special verdict award for the injury-related medical expenses Howell incurred. Accordingly, we reverse the order.

FACTUAL BACKGROUND

A. *Howell's Private Health Care Insurance*

Howell was seriously injured when the vehicle she was driving was struck by a truck driven by one of Hamilton's employees, who had negligently made an illegal U-turn across the lane in which Howell was traveling.

At the time of the accident, Howell had private health care insurance through PacifiCare. According to Howell, PacifiCare agreed to indemnify her for any medical charges covered by her health plan in exchange for her premium payments, subject to her responsibility for deductibles and copayments; and PacifiCare, as a regular part of its business practice, entered into contractual agreements with hospitals and other health care providers, including Scripps and CORE, to satisfy any bills incurred by PacifiCare plan members who obtained care from those providers.

Howell underwent two fusion spinal surgeries, as well as surgical procedures that took bone from her hip in an attempt to repair her neck and repaired the graft site on her hip.

B. *Howell's Financial Responsibility Agreements with Her Medical Providers*

Before she received treatment from Scripps and CORE, Howell executed written agreements in which she agreed to be financially responsible for all charges for the medical services they provided to her. Specifically, Howell's agreement with Scripps provided that in consideration for all services she received at a Scripps facility, she was "obligated to pay the Facility's usual and customary charges for such services." She expressly acknowledged in that agreement that "she may be asked to execute a separate financial agreement for all amounts deemed to be [her] responsibility and/or not covered under an insurance policy, health care service plan, managed care program or any third party payer not a party to this agreement." An assignment of benefits clause in the agreement provided that Howell "authorize[d] direct payment to the Facility of any insurance or reimbursement from third party payers otherwise payable to or on behalf of the patient for services obtained at the Facility, at a rate not to exceed the Facility's usual and customary charges." Howell also agreed that she "remain[ed] financially responsible for charges due, but not paid, under this assignment of benefits."

Howell's agreement with CORE provided it was "[her] responsibility to pay any co-insurance, or any other balance not paid for by [her] insurance." The agreement contained an assignment of benefits clause, under which she "assign[ed] all medical and/or surgical benefits, to include major medical benefits to which [she was] entitled, including Medi Care, *private insurance*, and other health plans to the provider." (Italics added.)

PROCEDURAL BACKGROUND

A. *Hamilton's Motion In Limine*

Hamilton filed a motion in limine seeking to exclude at trial any evidence of, or reference to, those portions of Howell's medical bills that were not paid either by PacifiCare, or by Howell as a copayment. Hamilton argued that the decision in *Hanif v. Housing Authority* (1988) 200 Cal.App.3d 635 (*Hanif*) "preclude[d] [Howell] from seeking to recover as medical expenses amounts billed, but not ultimately paid by PacifiCare."

Howell opposed the motion, arguing that under the collateral source rule articulated in *Helfend v. Southern California Rapid Transit Dist.* (1970) 2 Cal.3d 1 (*Helfend*), "the gross amount of all medical bills, not any lesser amount, should be presented to the jury."

Following oral argument, the court denied Hamilton's in limine motion, ruling that Howell was entitled to present at trial evidence of the full amount of the medical bills. The court, however, on a defense motion under *Hanif*, *supra*, 200 Cal.App.3d 635, deferred to a posttrial proceeding the determination of whether the jury's award of damages for Howell's past medical expenses should be reduced by any amount her medical providers may have "compromised their billing."

B. *Trial and Special Jury Verdict*

In their joint trial readiness conference report, the parties stipulated that the only issue to be determined at trial was the amount of damages Howell suffered as a result of the accident caused by the admitted negligence of Hamilton's driver. The report and

Howell's trial exhibit list identified as exhibit No. 57 Howell's "Summary of Plaintiff's Past Medical Expenses," which itemized 19 medical expenses and indicated that those expenses totaled $189,978.63. Her trial exhibit list also indicated that copies of the billing records were attached to that exhibit.

During the trial, Dr. Timothy Peppers, who performed Howell's surgeries, testified on her behalf. After Dr. Peppers testified about his qualifications, Howell's injuries, and the medical treatment she received for those injuries, Howell's counsel showed him exhibit No. 57 and the attached billing records. Dr. Peppers testified that to the best of his knowledge the summary and billing records were a fair and reasonable representation of the medical billings.

Howell's husband, James Michael Vallee, also testified on her behalf. He indicated he had been keeping track of her injury-related medical bills, which to date totaled $189,978.63, as shown in exhibit No. 57.

The jury returned a special verdict that awarded to Howell compensatory damages in the total amount of $689,978.63, which included $189,978.63 for "[p]ast economic loss, including medical expenses," $150,000 for "[f]uture economic loss, including medical expenses," $200,000 for "[p]ast *non*economic loss (including physical pain, mental suffering, loss of enjoyment of life, disfigurement, physical impairment, inconvenience, grief, anxiety, humiliation, and emotional distress," and $150,000 for "[f]uture *non*economic loss."

C. *Hamilton's Motion To Reduce the Special Verdict for Past Medical Expenses*

Before the court entered judgment, Hamilton filed a motion under *Hanif, supra*, 200 Cal.App.3d 635 and *Nishihama v. City and County of San Francisco* (2001) 93 Cal.App.4th 298 (*Nishihama*) seeking an order reducing the jury's special verdict for Howell's past medical expenses by $130,286.90 (i.e., from $189,978.63 to $59,691.73).

In its motion papers, Hamilton argued it was entitled to the claimed reduction under *Hanif* and its progeny because the amount was neither incurred nor expended for the medical services that Scripps and CORE provided to Howell in this matter.

In support of its motion, Hamilton submitted the declarations of Mourence Burris, Scripps's supervisor of customer service and collections from third parties, and Betsy Engstrom, who was employed in the accounting department of CHMB, a billing company that provided medical billing services for CORE. In his declaration, Burris indicated that Scripps's billing records showed that Scripps waived or "[wrote] off" the sum of $94,894.42 related to Howell's "surgeries and related treatment as a result of the agreement with PacifiCare," no outstanding balance remained on Howell's account, and no further collection would be pursued. In her declaration, Engstrom indicated that the entries in CORE's bill related to the services CORE provided to Howell showed that CORE had waived or "written off" the sum of $35,392.48 pursuant to its agreement with PacifiCare, and no collection from Howell would be pursued by either CORE or CHMB for the written off amount. The Burris and Engstrom declarations thus showed the total

amount of the negotiated rate differential written off by Scripps and CORE was $130,286.90.[2]

1. *Howell's opposition to Hamilton's motion*

Howell filed written opposition to the motion, contending that (1) as she was not a Medi-Cal beneficiary and she was suing a private defendant, she was permitted under the collateral source rule and the applicable measure of damages to recover the full amount of the reasonable "cost" or "value" of the past medical expenses paid or incurred as a result of her injuries and not just what her private health care insurer paid to her medical providers; and (2) under the collateral source rule, the court should exclude evidence of the benefits PacifiCare "paid" to Howell's health care providers. Howell did not submit any evidence in support of her opposition to Hamilton's motion, nor did she file any evidentiary objections to the Burris and Engstrom declarations filed in support of Hamilton's motion.

D. *Judgment*

The court entered a judgment on the special verdict against Hamilton, awarding Howell economic damages in the amount of $339,978.63, including the sum of $189,978.63 for past medical expenses.

E. *Oral Arguments Regarding Hamilton's Motion*

At the hearing on Hamilton's motion, which the court referred to as the "*Hanif* motion," Howell's counsel argued that unlike the plaintiff in *Nishihama, supra*, 93

---

2 $94,894.42 + $35,392.48 = $130,286.90.

Cal.App.4th 298, Howell disputed the amount that her health care insurer "paid" to the medical providers and objected that Hamilton's presentation of evidence of what Howell's insurer paid to those providers violated the collateral source rule. Counsel also asserted that under *Hanif* and *Nishihama*, Howell was entitled to recover for her past medical expenses the amount paid or incurred; that, under *Parnell v. Adventist Health System/West* (2005) 35 Cal.4th 595 (*Parnell*), the amount incurred is the total amount of debt the patient incurs when she is treated by her medical providers, and, under the contracts between the private health insurer and the medical providers, what the insurer "pays" the medical providers includes both cash payments and any other consideration given in the form of "in-kind benefits."

In support of the motion, Hamilton's attorney argued that *Nishihama* was controlling; Howell's medical bills had been "discounted" and thus she did not owe the full billed amount of about $189,000 charged in the medical bills; she incurred no debt for the negotiated rate differential because her bills were extinguished and her accounts had a zero balance, and she was not entitled under *Nishihama* to recover the amount of the negotiated rate differential because that was the portion of the bills her insurer did not pay to Scripps and CORE; and the collateral source rule did not apply to that unpaid portion of the bills.

In rebuttal, Howell's counsel claimed the declarations submitted by Burris and Engstrom in support of Hamilton's motion were not evidence because "they're hearsay" and stated he doubted they "[had] ever actually seen the contracts" between PacifiCare and Howell's medical providers. Thus, he asserted, there was no competent evidence of

what PacifiCare paid. Counsel repeated his claim that the word "paid" meant more than just the cash payment and included the in-kind benefits the insurer "paid" to the medical providers. Howell's attorney also argued that to determine what the insurer "paid" to the providers would require a finding of fact, and such a finding would violate the collateral source rule, which precludes evidence of the amount paid by a collateral source.

F. *Order and Notice of Ruling*

The court granted Hamilton's motion after taking the matter under submission. The court's minute order stated:

> "The Court grants [Hamilton's] motion to reduce [Howell's] past medical specials to reflect the amount the medical providers accepted as payment in full of the medical bills. Contrary to [Howell's] assertions, reaching this amount does not violate the collateral source doctrine, as evidence of how or why an amount less than the full bill was accepted as payment in full is unnecessary to make this determination. Further, the trier of fact relied on evidence of the gross amount billed to [Howell], and thus had an accurate understanding of the severity of [her] injuries when it rendered its verdict. Thus a post-trial motion to reduce past medical specials to the amount that was actually paid and considered payment in full does not violate the collateral source doctrine; rather it embodies the well-established principle that a plaintiff is entitled to recover an amount that would make her whole, but not overcompensate her. . . ."

Hamilton's counsel served and filed a notice of the court's ruling, which included a copy of the court's minute order, and indicated that the amount of the judgment was reduced by $130,286.90 from $689,978.63 to $559,691.73. Howell thereafter appealed the order.

DISCUSSION

I

THE COURT'S POSTVERDICT REDUCTION OF THE JURY'S ECONOMIC DAMAGES AWARD FOR HOWELL'S PAST MEDICAL EXPENSES VIOLATED THE COLLATERAL SOURCE RULE[3]

Howell argues the order reducing the jury's award of damages for her past medical expenses from the full amount of the medical charges billed by Scripps and CORE ($189,978.63) to the amount of the cash payments her health care insurer, PacifiCare, paid to those medical providers pursuant to its agreements with them ($59,691.73), should be reversed because the reduction violates the collateral source rule. In support of this argument, Howell asserts that when she executed the written financial agreements with Scripps and CORE before she received treatment from them, she became financially liable for, and thus suffered compensable detriment by incurring, the full combined charges these medical providers billed for the services they provided. She also asserts she received *two* collateral source benefits from PacifiCare: (1) the reduced "alternative rate" cash payments in the total amount of $59,691.73 that Pacificare paid to Scripps and

---

3 For discussions of the collateral source rule in medical insurance cases, see Daniel P. Barer's *The Collateral Conundrum: Olsen v. Reid Frames the Hanif/Nishihama Controversy—and Suggests How It Will Turn Out*, and Scott H.Z. Sumner's *Medical Special Damages 'Incurred' Under California Law: The Collateral Source Rule, Law of Contracts, and the Discount Myth*, both of which were recently published in the California State Bar Litigation Section's journal, California Litigation (No. 3 2008) volume 21, at pages 5-11 and 12-18, respectively.

CORE on her behalf;[4] and (2) the negotiated rate differential, which she calls "other contractual consideration," valued at $130,286.90 (i.e., the remaining balance of the combined medical bills) that PacifiCare "paid" to Scripps and CORE on her behalf in the form of "non-cash benefits and services" (such as "preferred provider" listings that are endorsements of, and advertisements for, the medical providers; a guaranteed flow of patients who are members of PacifiCare's health care plan; and timely payments from pooled premiums that reduces the number of collection actions the providers must bring to collect payments from their patients).

Together, she maintains, these two collateral source benefits of her private health insurance resulted in the satisfaction or discharge of the medical services debt she incurred in the full billed amount of $189,978.63; and thus, under the collateral source rule articulated in *Helfend*, *supra*, 2 Cal.3d 1, and the Restatement Second of Torts, section 920A, comment b (discussed, *post*), Hamilton should not have received the benefit of her thrift and foresight in procuring health insurance through the court's postverdict reduction of the damages award for the past medical expenses she incurred as a result of the negligent driving of its employee. Thus, she argues, the court's order reducing the jury's award of damages for her past medical expenses by $130,286.90—the negotiated rate differential that she, Hamilton, and the trial court refer to as the "written-off" balance or portion of her medical bills—violates the collateral source rule.

---

4 Hamilton acknowledges that the collateral source rule applies to PacifiCare's cash payments to Scripps and CORE on Howell's behalf, and that the jury properly awarded her economic damages in the amount of $59,691.73 for this portion of Howell's medical bills.

We conclude the court's order granting Hamilton's postverdict motion to reduce the jury's special verdict award for the injury-related medical expenses that Howell incurred, violated the collateral source rule.

A. *Applicable Legal Principles*

We begin by reviewing applicable California law regarding both the measure of damages in a personal injury case such as this and the collateral source rule.

1. *Measure of damages*

Civil Code[5] section 3333 provides that "[f]or the breach of an obligation not arising from contract, the measure of damages, except where otherwise expressly provided by this code, is the amount which will compensate for all the *detriment* proximately caused thereby, whether it could have been anticipated or not." (Italics added.) Section 3281 provides that "[e]very person who suffers *detriment* from the unlawful act or omission of another, may recover from the person in fault a compensation therefor in money, which is called damages." (Italics added.) Section 3282 defines the term "detriment" as "a loss or harm suffered in person or property." Section 1431.2, subdivision (b)(1) defines the term "economic damages" as "objectively verifiable *monetary losses including medical expenses*, loss of earnings, burial costs, loss of use of property, costs of repair or replacement, costs of obtaining substitute domestic services, loss of employment and loss of business or employment opportunities." (Italics added.)

---

5 All further statutory references are to the Civil Code unless otherwise specified.

In conformity with these statutory provisions, the courts in California have held that the economic damages a plaintiff may recover in a personal injury action for past medical expenses are limited to a reasonable amount that was paid or incurred, whether by the plaintiff or a collateral source (such as the plaintiff's health care insurer), for reasonably required medical care and services that the plaintiff received and were attributable to the defendant's tortious conduct. (*Melone v. Sierra Railway Co.* (1907) 151 Cal. 113, 115 ["the correct measure of damage . . . is . . . the necessary and reasonable value of such services as may have been rendered him[;] [s]uch reasonable sum, in other words, as has been necessarily expended or incurred in treating the injury"]; *Hanif, supra*, 200 Cal.App.3d at p. 640 ["a person injured by another's tortious conduct is entitled to recover the reasonable value of medical care and services reasonably required and attributable to the tort"]; see also *Katiuzhinsky v. Perry* (2007) 152 Cal.App.4th 1288, 1290 ["An injured plaintiff in a tort action cannot recover more than the amount of medical expenses he or she paid or incurred, even if the reasonable value of those services might be a greater sum."]; CACI No. 3903A ["To recover damages for past medical expenses, [plaintiff] must prove the reasonable cost of reasonably necessary medical care that [he/she] has received."]; 6 Witkin, Summary of Cal. Law (10th ed. 2005) Torts, § 1670, p. 1188 ["The plaintiff is entitled to recover the reasonable cost of necessary medical and hospital services . . . ."]; Flavahan et al., Cal. Practice Guide: Personal Injury (The Rutter Group 2009) ¶ 3:34.1, p. 3-61 (rev. #1, 2009) [Plaintiff is entitled to recover the 'reasonable cost' of past medical care and services necessitated by defendant's tortious conduct."].)

2. *The collateral source rule*

California has adopted the collateral source rule. (*Lund v. San Joaquin Valley Railroad* (2003) 31 Cal.4th 1, 9 (*Lund*). The California Supreme Court explained the collateral source rule in *Helfend, supra*, 2 Cal.3d at page 6:

> "[I]f 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."

The *Helfend* court also explained that the collateral source rule "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," and "the tortfeasor should not garner the benefits of his victim's providence." (*Helfend, supra*, 2 Cal.3d at pp. 9-10.)

Similarly, the Restatement Second of Torts, section 920A, comment b, states: "[I]t is the position of the law that a benefit that is directed to the injured party should not be shifted so as to become a windfall for the tortfeasor. If the plaintiff was himself responsible for the benefit, as by maintaining his own insurance or by making advantageous employment arrangements, the law allows him to keep it for himself."

California has also adopted "the closely related principle that, as a general rule, jurors should not be told that the plaintiff can recover compensation from a collateral source." (*Lund, supra*, 31 Cal.4th at p. 10.)

Payments made to, or benefits conferred on, the injured party by a source other than the defendant, someone acting on the defendant's behalf, or someone who is (or

believes he is) subject to the same tort liability, are known as "collateral-source benefits." (Rest.2d Torts, § 920A, com. b.)

B. *Analysis*

Howell's argument that the court's order violates the collateral source rule by limiting her recovery for past medical expenses to the amount she and PacifiCare actually paid through cash payments to her medical providers is premised on her claim (which amicus curiae CAC defends in its brief)[6] that the negotiated rate differential—the so-called "written-off" balance of the medical bills in the amount of $130,286.90 that Howell asserts PacifiCare "paid" to Scripps and CORE in the form of contractually-negotiated "non-cash benefits and services"—is a collateral source benefit that PacifiCare conferred upon her. This claim, in turn, is premised on Howell's (and CAC's) assertion that, as a matter of law, all patients (other than the medically indigent) incur detriment in the form of financial liability for the *full* billed amount of their medical providers' usual and customary charges.

Howell did incur detriment in the form of personal financial liability when she executed written agreements in which she agreed to be financially responsible for all charges for the medical services they provided to her. In her written contract with

---

6 CAC asserts that, "[s]ince hospitals can contract for the right 'to recover the difference between usual and customary charges and the negotiated rate through a lien under the [Hospital Lien Act, §§ 3045.1-3045.6)]' (*Parnell*, *supra*, 35 Cal.4th at [p.] 611), there is no question but that the full usual and customary charge is the debt—the financial detriment—the patient incurs, and that *a health plan's alternate payment rate discount is itself a collateral benefit* indemnifying insureds against the debt they have incurred." (Italics added.)

Scripps, Howell agreed that, in consideration for all services she received at a Scripps facility, she was obligated to pay the facility's "usual and customary charges for such services." In her written contract with CORE, she agreed that it was "[her] responsibility to pay . . . any . . . balance not paid for by [her] insurance."

Howell's personal liability for Scripps's and CORE's usual and customary charges for the medical services they provided was a form of compensable pecuniary detriment or loss within the meaning of sections 3281, 3282, 3333, and 1431.2, subdivision (b)(1). As a result of the admitted negligent driving of Hamilton's employee, she entered into the financial responsibility agreements with Scripps and CORE and became contractually obligated to pay those incurred charges by means of her own cash payments, a collateral source such as her health care insurance, or a combination of the two.

We reject Hamilton's contentions that Howell incurred no liability, and thus no detriment, for what Hamilton calls the "waived portion" of her medical bills. The record shows that the total amount of medical care debt she incurred in this matter was $189,978.63, the combined total of Scripps's and CORE's usual and customary charges for the medical care and services they provided to her. The record also shows that Scripps and CORE agreed to accept from PacifiCare, pursuant to their agreements with PacifiCare, cash payments in the amount of $59,691.73 as payment in full for those medical charges, so that the portion of Howell's liability to those providers that we have called the negotiated rate differential was deemed satisfied and thus not payable by Howell, PacifiCare, or any other payor.

We conclude that the extinguishment of a portion of Howell's debt to Scripps and CORE in the amount of the negotiated rate differential ($130,286.90) was a benefit to Howell because she was no longer personally liable for that portion of the debt she personally incurred in obtaining medical treatment for her injuries.

We also conclude that this benefit to Howell was a collateral source benefit within the meaning of the collateral source rule because it was conferred upon her as a direct result of her own thrift and foresight in procuring private health care insurance through PacifiCare, a source wholly independent of Hamilton as the defendant in this case. Under California's collateral source rule (paraphrasing *Helfend*, *supra*, 2 Cal.3d at pp. 9-10), Howell, as a person who has invested insurance premiums to assure her medical care, should receive the benefits of her thrift; and Hamilton, as the party liable for Howell's injuries, should not garner the benefits of Howell's providence. The law allows Howell to keep this collateral source benefit for herself because (paraphrasing the Restatement Second of Torts) she was responsible for the benefit by maintaining her own insurance. (Rest.2d Torts, § 920A, com. (b).)

Hamilton relies principally on *Hanif, supra*, 200 Cal.App.3d 635, and *Nishihama*, *supra*, 93 Cal.App.4th 298, as support for its contention that the court did not violate the collateral source rule by reducing the jury's award of damages for Howell's past medical expenses to the negotiated combined amount of cash payments ($59,691.73) that Scripps and CORE agreed to accept from PacifiCare. Hamilton's reliance on *Hanif* and *Nishihama* is misplaced.

In *Hanif*, a personal injury action brought on behalf of a minor who was struck by an automobile on the defendant public housing authority's property, the trial court awarded as special damages to the minor, who was a Medi-Cal beneficiary, the reasonable value of the past medical services he received in the amount of $31,618 that the medical providers billed to Medi-Cal, even though that award exceeded the amount Medi-Cal actually paid for those services. (*Hanif*, *supra*, 200 Cal.App.3d at pp. 639, 643-644.) The defendant appealed, arguing the trial court should have limited the minor's recovery for past medical services to the amount Medi-Cal "actually paid" ($19,317). (*Id.* at p. 639.) The Court of Appeal preliminarily noted it was undisputed the minor was entitled under the collateral source rule to recover from the defendant, as special damages, the sum of $19,317 that Medi-Cal paid. (*Id.* at pp. 639-640.) Noting that there was no evidence the minor was or would become liable for the difference between the undisputed reasonable value of the medical services and the amount Medi-Cal paid, and noting also that the hospital had "written off" the balance between the amount billed to Medi-Cal and the amount Medi-Cal paid, the *Hanif* court nevertheless concluded that the minor was "*deemed* to have personally paid or incurred liability" (italics added) for those services, and thus was "entitled to recompense accordingly," which it found was reasonable and fair "in light of Medi-Cal's subrogation and judgment lien rights." (*Id.* at p. 640.)

After reviewing California law pertaining to the measure of damages in personal injury actions, the *Hanif* court stated that, "when the evidence shows a sum certain to have been *paid or incurred* for past medical care and services, whether by the plaintiff or

by an independent source, that sum certain is the most the plaintiff may recover for that care despite the fact it may have been less than the prevailing market rate." (*Hanif, supra*, 200 Cal.App.3d. at p. 641, italics added.) Thus, it concluded, "a plaintiff is entitled to recover *up to, and no more than*, the actual amount *expended or incurred* for past medical services so long as that amount is reasonable." (*Id.* at p. 643, second italics added.) Applying this measure of damages, the *Hanif* court held that the trial court erred in awarding to the minor plaintiff, as special damages for past medical services, the reasonable value of those services in the amount of $31,618, rather than $19,317, the "actual amount [Medi-Cal] paid." (*Id.* at pp. 643-644.) Apparently referring to the difference between the reasonable value of the medical services rendered and the amount Medi-Cal paid for those services, the *Hanif* court stated that "the collateral source rule . . . is not an issue in this case." (*Hanif, supra*, 200 Cal.App.3d at p. 641.)

Hamilton's reliance on *Hanif* is unavailing because that case is inapposite. As already discussed, Howell, who was privately insured, incurred personal liability for her medical providers' usual and customary charges. Unlike Howell, the minor in *Hanif* did not have private health care insurance, and he incurred no personal liability for the medical charges billed to Medi-Cal—and thus suffered no compensable pecuniary detriment or loss beyond his judicially "deemed" liability for the medical services he received in the amount that Medi-Cal actually paid to the medical providers—because he was a Medi-Cal beneficiary, and (as a minor) he also lacked the capacity to enter into financial responsibility agreements with his medical providers. As the *Hanif* plaintiff neither paid, nor incurred personal liability, for the amount of the medical charges his

health care providers billed to Medi-Cal, the *Hanif* court had no occasion to address the issue presented here of whether a plaintiff in a personal injury action who has *private* health care insurance may recover, under the collateral source rule, economic damages for the amount of reasonable charges her health care providers have billed, but which neither she nor her health care insurer is obligated to pay because the providers, under contracts into which they have entered with that insurer, have agreed to accept as payment in full payments from the plaintiff and her health care insurer in an amount that is less than the amount the providers have billed.[7]

Hamilton's reliance on *Nishihama* is also unavailing. In that case, the plaintiff (Nishihama) was injured when she tripped and fell in a pothole in a crosswalk maintained by the defendant city. (*Nishihama, supra*, 93 Cal.App.4th at p. 301.) The jury's award of damages for Nishihama's past medical care expenses included the sum of $17,168 for care she received from California Pacific Medical Center (CPMC). (*Id.* at p. 306.) That amount was based on CPMC's normal rates. (*Ibid.*) Under an agreement between CPMC and Nishihama's health care insurer (Blue Cross), CPMC agreed that Blue Cross would pay reduced rates for specified services that CPMC rendered to Blue Cross's members, and CPMC would accept those reduced payments as payment in full for its services. (*Ibid.*) Under the terms of that agreement, CPMC accepted from Blue Cross the sum of

7 In *Parnell, supra*, 35 Cal.4th 595, a 2005 decision that involved a hospital's lien rights under California's Hospital Lien Act (HLA) (§§ 3045.1-3045.6), the California Supreme Court stated in a footnote that "we do not reach, and express no opinion on," the issue of whether *Hanif, supra*, 200 Cal.App.3d 635, "appl[ies] outside the Medicaid context and limit[s] a patient's tort recovery for medical expenses to the amount actually paid by the patient notwithstanding the collateral source rule." (*Parnell* at p. 611, fn. 16.)

$3,600 as payment in full for the services CPMC rendered to Nishihama. (*Id.* at pp. 306-307.)

The defendant city appealed, complaining that the jury's award for CPMC's services was based on CPMC's normal rates, rather than on the sum CPMC accepted under its agreement with Blue Cross. (*Nishihama, supra,* 93 Cal.App.4th at p. 307.) Nishihama responded by claiming that because CPMC had filed a lien against her recovery under the HLA, she should not be placed in the position of having to accept the lesser amount that Blue Cross paid while risking the possibility that she would have to pay the greater billed amount to CPMC because of its lien. (*Nishihama, supra,* at p. 307.)

Addressing Nishihama's concerns first, the Court of Appeal concluded that CPMC's lien rights under the HLA did not extend beyond the amount it agreed to receive from Blue Cross as payment in full for the services CPMC provided to Nishihama. (*Nishihama*, *supra*, 93 Cal.App.4th at p. 307.) Noting that the HLA provides for third party liability to a lienholding health care provider "for the amount of its lien claimed in the notice which the hospital was *entitled to receive* as payment for the medical care and services rendered to the injured person" (§ 3045.4, italics added), the Court of Appeal stated that "[t]he amount that a hospital is entitled to receive as payment necessarily turns on any agreement it has with the injured person or the injured person's insurer." (*Id.* at p. 308.) The *Nishihama* court concluded that CPMC had no lien rights against Nishihama because it had received $3,600, which was the amount it was "entitled to receive" as payment for the medical care and services it rendered to Nishihama, as that was the

payment amount it had agreed to receive from Blue Cross as payment in full for the medical services it provided to Nishihama. (*Id.* at pp. 307-308.)

The *Nishihama* court then addressed the defendant city's contention that the trial court erred by permitting the jury to award Nishihama damages for medical expenses based on CPMC's normal rates, rather than on the negotiated sum CPMC actually accepted from Blue Cross ($3,600). Citing *Mercy Hospital & Medical Center v. Farmers Ins. Group of Companies* (1997) 15 Cal.4th 213 for the proposition that a hospital's lien rights under the HLA derive from the rights of the injured person, *Nishihama* held that because CPMC had no lien rights under the HLA against Nishihama's recovery as it had been paid $3,600 as payment in full for the medical services it provided to her, the trial court "erred in permitting the jury to award [her] an amount in excess of $3,600 for the services provided by CPMC." (*Nishihama, supra*, 93 Cal.App.4th at pp. 307-308.)

We disagree with this holding in *Nishihama* and the reasoning upon which it is based. In our view, the issue of whether Nishihama was entitled to recover damages for past medical expenses based on her medical provider's (CPMC's) normal (i.e., usual and customary) rates or based on the negotiated rates CPMC agreed to accept from her private health care insurer (Blue Cross) as payment in full for the medical services CPMC rendered to her should have been resolved based on an analysis of Nishihama's rights under the collateral source rule, rather than on an analysis of CPMC's lien rights under the HLA. Nishihama was an injured plaintiff whose medical care expenses were covered under private health care insurance she had procured, and her common law compensatory rights under the collateral source rule were independent of, and unrelated

to, CPMC's statutory lien rights under the HLA. Thus, the fact that CPMC had no lien rights against Nishihama's recovery against the defendant city because CPMC had received from Blue Cross the reduced negotiated payment of $3,600 it was entitled to receive under its agreement with Blue Cross, was not pertinent to the issue of whether Nishihama was entitled under the collateral source rule to recover economic damages in the amount of $17,168 based on CPMC's usual and customary rates. Resolution of that issue required an analysis under the collateral source rule of whether Nishihama, before she received medical care from CPMC, entered into a financial responsibility agreement with that medical provider, and thus whether she incurred pecuniary detriment or loss in the form of personal liability for the medical expenses she would later incur at CPMC's normal rates. Because the holding in *Nishihama* is not based on such an analysis under California's collateral source rule, Hamilton's reliance on that case is misplaced.

We agree with the observations of Associate Justice Eileen C. Moore in her concurring opinion in *Olsen v. Reid* (2008) 164 Cal.App.4th 200, 204 (*Olsen*) that, "[w]ithout statutory authority or the Supreme Court's blessing, the *Hanif/Nishihama* line of cases divorced the collateral source rule from the complicated area of medical insurance," and, "[a]bsent such approval, *Hanif/Nishihama* simply goes too far."

We also agree with Justice Moore's view that changes to the collateral source rule should be made by the Legislature. (*Olsen*, *supra*, 164 Cal.App.4th at pp. 213-214 (conc. opn. of Moore, J.).) The collateral source rule has twice been abrogated or modified by statute. "The Medical Injury Compensation Reform Act (MICRA) abrogates the rule in actions for professional negligence against health care providers." (6 Witkin, Summary

of Cal. Law, *supra*, Torts, § 1631, p. 1145, citing § 3333.1 subd. (a).) Government Code section 985 modifies the collateral source rule by "establish[ing] a special procedure by post-trial motion for the reduction of a judgment against a state or local public entity in an action for personal injuries or wrongful death." (6 Witkin, Summary of Cal. Law, *supra*, Torts, § 1637, p. 1152.) Under that section, a public entity defendant may, by noticed motion, seek a posttrial reduction of a judgment entered against it that includes damages "for which payment from a collateral source" above a specified amount "has already been paid or is obligated to be paid for services or benefits that were provided prior to the commencement of trial." (Gov. Code, § 985, subd. (b); see also 6 Witkin, Summary of Cal. Law, *supra*, Torts, § 1638, p. 1153.)

We conclude that any further abrogation of the collateral source rule, particularly in the complex context of medical insurance presented here, is best left to legislative enactment rather than piecemeal common law development. (See *Helfend*, *supra*, 2 Cal.3d at p. 13 [the collateral source rule, "at least with respect to medical insurance benefits has become so integrated with our present [tort] system that its precipitous judicial nullification would work hardship"; and any proposed changes, "if desirable, would be more effectively accomplished through legislative reform"]; see also *Smock v. State of California* (2006) 138 Cal.App.4th 883, 888 ["If other modifications or limitations to this long-established rule are warranted, their creation is best left to the Legislature."].)

In sum, the court's order reducing the jury's special verdict for Howell's past medical expenses by $130,286.90 (from $189,978.63 to $59,691.73) must be reversed because it violates the collateral source rule.

II

POSTVERDICT MOTION PROCEDURE

Howell next contends that Hamilton's postverdict motion was procedurally improper. Specifically, she contends the postverdict motion procedure the court used in this case was not authorized because "[t]he only authority for a 'post-verdict reduction hearing' concerning the role of collateral source payments in recovery of damage awards" is Government Code section 985, subdivision (b),[8] and "that procedure is exclusively reserved to public entity defendants." Howell also contends that because she did not "waive her right to have all questions of fact determined by the jury" and "the issue of what was paid to satisfy the charges incurred by [Howell] to her past healthcare providers is a question of fact," the court "erred in invading the province of the jury and acting as trier of fact on the issue of what was 'paid.'"

---

8 Government Code section 985, subdivision (b) (discussed, *ante*) provides in part: "Any collateral source payment paid or owed to or on behalf of a plaintiff shall be inadmissible in any action for personal injuries or wrongful death where a public entity is a defendant. However, *after a verdict has been returned against a public entity that includes damages for which payment from a collateral source . . . has already been paid or is obligated to be paid* for services or benefits that were provided prior to the commencement of trial, . . . *the defendant public entity may, by a motion . . . request a posttrial hearing for a reduction of the judgment against the defendant public entity for collateral source payments* paid or obligated to be paid for services or benefits that were provided prior to the commencement of trial." (Italics added.)

A. *Authority To Hear and Decide Hamilton's Postverdict Motion*

In response to Howell's contention that the postverdict motion procedure the court used in this case was not authorized, Hamilton relies on *Greer v. Buzgheia* (2006) 141 Cal.App.4th 1150 (*Greer*) and Justice Richard D. Fybel's concurring opinion in *Olsen*, *supra*, 164 Cal.App.4th at pages 214-218, for the proposition that this posttrial procedure for reducing the past medical expenses portion of a jury verdict under what Hamilton calls the "*Hanif/Nishihama* rule" is specifically authorized in California. Hamilton's reliance on *Greer* and Justice Fybel's concurring opinion in *Olsen* is unavailing.

In *Greer*, the trial court denied the defendant's motion in limine to exclude evidence of the amount of medical expenses billed to the plaintiff that exceeded the amount paid on the plaintiff's behalf to his medical providers. (*Greer*, *supra*, 141 Cal.App.4th at p. 1154.) The Court of Appeal noted that in denying the defendant's motion in limine, "the trial court informed defense counsel that, while a postverdict reduction of the jury's award of medical expenses might be justified, defendant could not prevent the jury from hearing evidence regarding reasonable medical costs for plaintiff's care in the first instance." (*Id*. at p. 1157.) Noting also that the trial court "made it clear that if the jury rendered an award that was excessive under *Hanif/Nishihama*, it would consider a posttrial motion to reduce the recovery," the *Greer* court concluded that "the trial court did not abuse its discretion in allowing evidence of the reasonable cost of plaintiff's care *while reserving the propriety of a Hanif/Nishihama reduction until after the verdict*." (*Ibid*., italics added.) Despite Howell's claim to the contrary, *Greer* thus

supports the proposition that a trial court is authorized to use the postverdict motion procedure to reduce under *Hanif* and *Nishihama* a jury's award for past medical expenses.

In his *Olsen* concurring opinion, however, Justice Fybel gave only conditional support for this proposition, indicating that such a posttrial motion procedure would "not be necessary or appropriate" if the proper application of the collateral source rule does *not* include the reduction of a verdict to the amount actually paid or incurred by the plaintiff or a collateral source such as a health plan:

> "If the proper application of the collateral source rule includes reducing a verdict to the amount actually paid or incurred by the plaintiff or a collateral source such as a health plan, a hearing is necessary and appropriate to determine the correct amount. *If a reduction is not proper under the collateral source rule, a hearing would not be necessary or appropriate*. Therefore, whether such a hearing should be held is dependent on whether a reduction to the total amount actually paid by any source or incurred by the plaintiff is proper under the collateral source rule. The propriety of such a hearing is not a separate issue. If such a hearing is to be held, the trial court has the statutory authority under Evidence Code sections 320 (order of proof) and 402 (procedure for determining evidentiary matters) to hold the hearing." (*Olsen*, *supra*, 164 Cal.App.4th at pp. 217-218 (conc. opn. of Fybel, J.), italics added.)

We disagree with *Greer* to the extent it holds that a trial court in a personal injury action is authorized to hear and grant a defendant's posttrial motion to reduce under *Hanif* and *Nishihama* a privately insured plaintiff's recovery of economic damages for past medical expenses. As discussed, *ante*, we have concluded that the negotiated rate differential is a collateral source benefit within the meaning of the collateral source rule, and thus the trial court erred in granting Hamilton's motion for an order reducing the

jury's award for Howell's past medical expenses in the amount of that differential ($130,286.90).

Paraphrasing Justice Fybel's concurring opinion in *Olsen*, we conclude that, because the proper application of the collateral source rule does not include reducing a verdict to the amount actually paid or incurred by the plaintiff or a collateral source such as a health plan, a defendant's posttrial motion to reduce a privately insured plaintiff's recovery of economic damages for past medical expenses by the amount of the negotiated rate differential is not necessary or appropriate and is thus unauthorized. (*Olsen*, *supra*, 164 Cal.App.4th at pp. 217-218 (conc. opn. of Fybel, J.).)

B. *Claim of Improper Posttrial Fact Finding*

In light of our conclusions that the court erred in reducing the jury's award for Howell's past medical expenses by the amount of the negotiated rate differential and that the posttrial motion procedure the court used was unauthorized, we need not reach Howell's claim that the court violated her right to a jury trial.

III

SUFFICIENCY OF THE EVIDENCE

Last, Howell contends that Hamilton's motion to reduce the jury's verdict "lacked sufficient evidence to support the claimed reduction." Specifically, Howell's principal contention is that "there is no evidence in the trial record to support a finding of fact as to what was 'paid' by [her] private health insurer to satisfy her past medical debts to Scripps and/or CORE and thus an insufficient record to support the court's reduction of the verdict for past medical specials." This contention appears to be based on a claim that

Hamilton, as the moving party, failed to present evidence of what PacifiCare "paid" to her medical providers in the form of "in-kind benefits," as shown by Howell's assertion that "she incurred and is entitled to recover the full value of the past medical expenses incurred as awarded by the jury, without regard to how those incurred charges were discharged on her behalf by PacifiCare."

As discussed, *ante*, we conclude that Howell is entitled under the collateral source rule to recover the full reasonable amount of past medical expenses she incurred in this matter ($189,978.63), as awarded by the jury. Accordingly, we conclude her claim that the evidence is insufficient to support the court's posttrial reduction in the jury's award of such damages is moot.

DISPOSITION

The order is reversed, and the matter is remanded with directions to reinstate the jury's award of economic damages for Howell's past medical expenses in the amount of $189,978.63 and to enter judgment accordingly. Howell shall recover her costs on appeal.

NARES, J.

WE CONCUR:

BENKE, Acting P. J.

McINTYRE, J.

Rebecca Howell v. Hamilton Meats & Provisions, Inc., et al.
SDSC Case Number: GIN053925
Division One, Case Number: D053620

PROOF OF SERVICE

I, the undersigned, declare that I am over the age of 18 years and not a party to the within action or proceeding. I am employed in and am a resident of San Diego County where the mailing occurs; and my business address is 5661 La Jolla Blvd, La Jolla, CA 92037.

On December ~~28~~ 29, 2009, I caused to be served the following document(s):

PETITION FOR REVIEW

on the interested parties in this action by:

__X__ BY MAIL: I further declare that I am readily familiar with the firm's business practice of collection and processing of correspondence for mailing with the United States Postal Service, and that the correspondence shall be deposited with the United States Postal Service this same day in the ordinary course of business pursuant to Code of Civil Procedure section 1013(a). I then sealed each envelope and, with postage thereon fully prepaid, placed each for deposit in the United States Postal Service, this same day, at my business address shown above, following ordinary business practices.

____ BY FACSIMILE SERVICE: I transmitted the document(s) described above to the person(s) and facsimile number(s) identified below pursuant to California Rules of Court, Rule 2006. The facsimile machine I used complied with California Rules of Court, Rule 2003 and no error was reported by machine.

____ BY PERSONAL SERVICE: I placed a copy in a separate envelope addressed to each addressee as indicated below, and delivered to the person(s) identified below for personal service.

SEE ATTACHED SERVICE LIST

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed on December 29, 2009, at La Jolla, California.

Claudia Gonzalez

SERVICE LIST
Howell v. Hamilton Meats & Provisions, Inc., et al.
Case No: GIN053925
Division One, Case No: D053620

J. Jude Basile, Esq.
BASILE LAW FIRM
755 Santa Rosa Street, Suite 310
San Luis Obispo, CA 92401
Tel: (805) 781-8600
Fax: (805) 781-8611
Counsel for Plaintiff Rebecca Howel
(1 copy)

Michael Vallee
LAW OFFICES OF MICHAEL VALLEE
603 N. Highway 101, Suite G
Solana Beach, CA 92075
Tel: (858) 755-6477
Fax: (858) 755-0785
Co-Counsel for Plaintiff Rebecca Howell
(1 copy)

John J. Rice
LaFave & Rice
2333 First Ave., Ste. 201
San Diego, CA 92101
Tel: (619) 525-3918
Fax: (619) 233-5089
Associated counsel for Plaintiff Rebecca Howell
(1 copy)

Hon. Adrienne A. Orfield
San Diego Superior Court
325 South Melrose, Dept. N-28
Vista, CA 92081
(1 copy)

California Supreme Court
350 McAllister Street
San Francisco, CA 94102
(Original plus 13 copies)

Fourth District Court of Appeal/Division One
Symphony Towers
750 B Street, Suite 300
San Diego, California 92101
(1 copy)