IN THE

SUPREME COURT OF CALIFORNIA

CASE NO.: S179115

REBECCA HOWELL,
Plaintiff and Appellant,

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

After a Decision by the Court of Appeal
Fourth Appellate District, Division One
Case Number D053620
(San Diego Superior Court Case Number GIN053925)
(The Hon. Adrienne Orfield, Judge)

APPELLANT'S ANSWER TO PETITION FOR REVIEW

LAFAVE & RICE
John J. Rice, Esq. (Bar No. 162968)
2333 First Avenue, Suite 201
San Diego, CA 92101
(619) 525-3918

Attorney for Plaintiff and Appellant,
REBECCA HOWELL

IN THE

SUPREME COURT OF CALIFORNIA

CASE NO.: S179115

REBECCA HOWELL,
Plaintiff and Appellant,

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

After a Decision by the Court of Appeal
Fourth Appellate District, Division One
Case Number D053620
(San Diego Superior Court Case Number GIN053925)
(The Hon. Adrienne Orfield, Judge)

APPELLANT'S ANSWER TO PETITION FOR REVIEW

LAFAVE & RICE
John J. Rice, Esq. (Bar No. 162968)
2333 First Avenue, Suite 201
San Diego, CA 92101
(619) 525-3918

Attorney for Plaintiff and Appellant,
REBECCA HOWELL

TABLE OF CONTENTS

TABLE OF CONTENTS (CONTINUED)

TABLE OF AUTHORITIES

Cases Page

TABLE OF AUTHORITIES (CONTINUED)

Cases Page

TABLE OF AUTHORITIES (CONTINUED)

Cases Page

TABLE OF AUTHORITIES (CONTINUED)

Cases Page

Codes & Statutes **Page**

California Business and Professions Code

California Civil Code

California Health and Safety Code

California Insurance Code

TABLE OF AUTHORITIES (CONTINUED)

Codes Page

California Rule of Court

Government Code

Torts

Restatement of Torts, Second

TABLE OF AUTHORITIES (CONTINUED)

Codes Page

Welfare & Institutions Code

Secondary Authority

I.

INTRODUCTION

This is a personal injury action. The jury awarded Rebecca Howell $189,978.63 in past medical special damages. This amount represents the undisputed reasonable value of the charges she incurred to her health care providers.

Well before she was injured, Mrs. Howell's private health insurer, Pacific Care, negotiated alternative rate contracts with the health care providers to satisfy the insurer's duty to indemnify Mrs. Howell for the charges incurred to the health care providers for necessary health care services (subject only to co-pays and deductibles). Those contracts called for the providers to accept cash payment amounts less than the full charges incurred. In exchange, Pacific Care agreed to also provide the health care providers with other contract benefits of value - such as quick payments, pre-approvals, captive patient bases, marketing and advertising. These alternative rate contracts are standard and favored in California, allowing both parties to leverage the economies of scale presented by large number of insureds and patients.

Petitioner brought a post verdict motion to reduce the award of past medical damages to the amount of the cash payments, $59,691.73,

contending that this amount represented the only charges incurred. The trial court granted the motion and the judgment was reduced by $130,286.90. (2AA 553). Plaintiff appealed.

In a unanimous decision, the Court of Appeal (Fourth District, Division One) reversed the Trial Court, holding that Howell had indeed incurred the full charges of $189,978.63. The Court of Appeal further held that the entirety of the contract benefits negotiated and exchanged by Pacific Care with Howell's health care providers, not just the cash portions, were collateral benefits within the meaning of the collateral source rule. The Court of Appeal ordered remand and the Judgment for full past medical special reinstated. *Howell v. Hamilton Meats & Provisions, Inc.*, (2009) 179 Cal. App. 4th 686; 101 Cal. Rptr. 3d 805.

Petitioner seeks review of the Court of Appeal's ruling.

II.

ISSUES PRESENTED

Petitioner's grievance centers upon one thing: the difference between a contracting medical provider's usual and customary charges and the schedule of cash payments under its agreement with a health plan. Petitioner calls those amounts "phantom or excess medical expenses". Petition for Review at 4 (PFR). The unanimous Court of Appeal's opinion

calls this difference the "negotiated rate differential" (*Howell*, supra, at 806) and this nomenclature is adopted herein.

Petitioner's argument can be summarized as follows: if Rebecca Howell did not incur the usual and customary charges of her treating medical providers, she "cannot logically claim she 'suffered' a 'loss or harm' for those amounts." (PFR) 26:16-18.

As Howell did before the Court of Appeal, we agree. Importantly, the converse is equally true and not disputed by Petitioner. If Plaintiff Rebecca Howell ***did*** incur the usual and customary charges of her treating medical providers, Petitioner "cannot logically claim" she did not suffer compensable detriment.

The determinative issues can be stated as follows:

Issue No. 1: It is established that a medical patient incurs the usual and customary charges of their providers.

Issue No. 2: It is established that negotiated rate differentials negotiated between health plans and contracting medical providers are a collateral source benefit to insureds within the meaning of the collateral source rule.

Petitioner insists "there is an express split of authority in the published Court of Appeal decisions." (PFR) 1. Were that true, *and* were it

also true that this Court had not itself addressed and resolved that very issue, review would indeed be appropriate. As discussed below, neither of those things are true.

Petitioner's contentions concerning the propriety of a trial court hearing a post-verdict motion to reduce a plaintiff's past medical expenses award on the basis of rate differentials negotiated between health plans and contracting medical providers is inseparable from and determined by Issues 1 and 2.

III.

WHY REVIEW IS UNNECESSARY

A. The *Howell* Decision Does Not Present Any Unresolved Issue of Law for the Court to Consider and Decide

Review of *Howell*, *supra*, is unnecessary because this Court has already determined that a medical patient incurs the usual and customary charges of their medical providers, and that negotiated rate differentials benefit insureds who select those providers. *Parnell v. Adventist Health System/West*, (2005) 35 Cal. 4th 595.

Parnell reaffirmed this Court's decisions in both *City and County of San Francisco v. Sweet*, (1995) 12 Cal.4th 105, 117 and *Mercy Hospital and Medical Center v. Farmers Insurance Group of Companies*, (1997) 15

Cal. 4th 215 , confirming that a hospital and a patient have "a creditor-debtor relationship" (*Parnell*, *supra* 35 Cal. 4th at 601-609) for the usual and customary charges for medical services furnished to a patient. When patients obtain health care services, they incur a debt to the health care provider:

- "We begin by determining whether a lien asserted under the HLA requires the existence of an underlying debt owed by the patient to the hospital." *Id.* at 601;

- "We … hold that a lien under the HLA requires the existence of an underlying debt owed by the patient to the hospital." *Id*, at 609;

- "[T]he difference between" the "hospital's usual and customary charges" and "the amount owed under the insurance contract" was a "discount received for using a" contracting facility, and was "written off," and the patient therefore "no longer owes a debt to the hospital for its services." *Id*, at 609; and

- "If hospitals wish to preserve their right to recover the difference between usual and customary charges and the negotiated rate through a lien under the HLA, they are free to contract for this right. Our decision today does not preclude hospitals from doing so." *Id*, at 611.

- There is simply no unresolved issue for this court to address concerning whether Howell incurred the entire charges for past medical care that was awarded by the jury. This settled point of law, this creditor-debtor relationship, is firmly grounded in basic principles of contract law.

Accepting Petitioner's position calls for the Court to reject the reasoning and reverse the holdings in *Parnell*, *supra*; *City and County of San Francisco v. Sweet*, *supra* and *Mercy Hospital and Medical Center v. Farmers Insurance Group of Companies*, *supra*.

The established creditor-debtor relationship is the foundation upon which the statutory framework governing medical providers and health plans in California has been developed. Petitioner would require this Court to disregard the statutory schemes detailed in Insurance Code sections 10123.12, 10133, 10133.2, 10133.3, 10133.5, 10133.55, 10133.6, 10133.65, 10180; Health & Safety Code sections 1342.6, 1373.18, 1373.9, 1395.6; and Bus. & Prof. Code § 16770, several of which this Court analyzed and applied in both *Parnell* and *Prospect Medical Group, Inc. v. Northridge Medical Group*, (2009) 45 Cal. 4th 497.

In addition to rejecting this Court's holdings in *Sweet*, *Mercy Hospital* and *Parnell*, Petitioner also rejects, and would require this Court to overrule, a number of appellate court decisions, all of which are premised on the established creditor-debtor relationship at issue herein:

- *Reichle v. Hazie*, (1937) 22 Cal. App. 2d 543, 547 (where a patient is "admitted to a hospital without an express contract to pay for his care and treatment," the law implies an obligation of indebtedness for the hospital's charges for services rendered);

- *Appleman v. National-Ben Franklin Ins. Co. of Illinois*, (1978) 84 Cal. App. 3d 1012 (Hospital charges were actually incurred by Medicare recipient, despite terms of contract between Medicare and hospital)

- *Lindsey v. County of Los Angeles*, (1980) 109 Cal. App. 3d 933, 938 (unpaid county hospital is a creditor of plaintiff for its full charges for medical care rendered);

- *Holmes v. CSAA,* (1982) 135 Cal. App. 3d 635, 638-639 (Medicare patient "expressly undertook personal liability" for the full charges of their hospitalization, as conditioned by the application of the agreement between the hospital and Medicare); and

- *Bell v. Blue Cross of California*, (2005) 131 Cal. App. 4th 211 (health plans must reimburse their plan members' non-contracting emergency providers the reasonable value of their services, not the same rates the plan negotiated to pay the contracting physicians).

From the trial court proceedings forward, Petitioner states again and again that the difference between the charges incurred and the cash portion of the contract payments made by private health insurers to medical care providers are "phantom" or a "nonexistent medical expense". The lack of authority to support their position is telling, as is their turning a blind eye to the established precedents in both case law and statutes. But repeating the statement again and again does not make it true. Ignoring the controlling precedents of this court does not create an unresolved issue of law justifying this court accepting the Petition for Review.

B. *Howell* Is Not in Conflict with the Decisions Cited by Petitioner: There Is No Split of Authority for the Court to Resolve

Petitioner's insistence that "there is an express split of authority in the published Court of Appeal decisions" depends upon a conscious disregard for the rules of precedence and a misconstruction of the appellate decisions themselves.

Petitioner posits that *Howell* is in conflict with the appellate decisions of *Hanif v. Housing Authority*, (1988) 200 Cal. App. 3d 635 and *Nishihama v. City and County of San Francisco*, (2001) 93 Cal. App. 4th 298. For that to be true, those cases would had to have addressed the

creditor-debtor relationship between medical providers and patients, and analyzed the treatment of negotiated contract rate differentials under the collateral source rule. A plain reading of these cases shows clearly that neither the *Hanif* nor *Nishihama* courts were presented with those issues, did not address them and do not rely on any analysis related to these issues.

1. *Howell* Presents No Conflict with *Hanif v. Housing Authority*, (1988) 200 Cal. App. 3d 635

Hanif, supra, concerned unearned public Medi-Cal benefits, governed by a distinct statutory framework with specific provisions dictating the measure and right to recovery of damages for medical services from third parties sued in tort. W&I Code §§ 14124.70 *et. seq.*

That Medi-Cal benefits require analysis distinct from private health insurance plans is not merely a function of the nature of the benefits – earned benefits versus unearned welfare. Distinct analysis is compelled by the fact that these two forms of benefits are governed by entirely separate statutory schemes.

With regard to Medi-Cal benefits and third party liability for injuries, *as a matter of both federal and state law*, the right to recover "payment for [past] medical care from any third party" is not retained by

the patient-litigant. Rather, that right of recovery is assigned to the Department of Health Care Services (DHCS, formerly Department of Health Services):

> "'[T]he State is considered to have acquired the rights of such individual [a Medicaid beneficiary] to payment by any other party for such health care items or services,' [42 U.S.C.] § 1396a(a)(25)(H)." *Arkansas Dept. of Health and Human Services v. Ahlborn*, (2006) 547 U.S. 268, 268. Federal Medicaid law requires participating States: to provide that, as a condition of [Medicaid law requires participating States: "to provide that , as a condition of [Medicaid] eligibility. . . , the individual is required . . .(A) to assign the State any rights . . . to payment for medical care from any third party; . . . (B) to cooperate with the State. . . in obtaining [such] payments . . . and . . . (C) . . . in identifying, and providing information to assist the State in pursuing any third party who may be liable, § 1396k(a)(1)."

Id. at 268 (brackets and ellipses in original).

Welfare & Institutions Code § 14124.71(a) fulfills that requirement in California:

> When benefits are provided . . . to a beneficiary . . . because of an injury for which another person is liable, or for which a carrier is liable in accordance with the provisions of any policy of insurance . . . the director [of DHCS] shall have a right to recover from such person or carrier the reasonable value of benefits so provided.

The nature and extent of DHCS' right to recovery of past medical damages is also proscribed by statute: "the 'reasonable value of benefits' means the Medi-Cal rate of payment." Welf. & Inst. Code § 14124.70 (c)(1).

Thus, as observed by this Court in *Olszewski v. Scripps Health*, (2003) 30 Cal. 4th 798, 827, as a matter of law "in a tort action," where Medi-Cal has provided services, "a Medicaid beneficiary may only recover the amount payable under the state Medicaid plan as medical expenses. Consistent with DHCS' assigned statutory rights, "based upon "Medi-Cal's subrogation and judgment lien rights (W&I § 14124.70 et. seq.)" the tort plaintiff "is deemed to have personally paid or incurred liability" in the amount of Medi-Cal's rate of payment as to services paid by Medi-Cal, "and is entitled to recompense accordingly." *Hanif, supra,* 200 Cal. App. 3d at 640.

This result is not inconsistent with, and does not affect, either the provider-patient creditor-debtor relationship, or application of the collateral source rule to negotiated contract rate differentials- the issues analyzed in the *Howell* opinion and upon which the opinion rests.

2. *Howell* Presents No Conflict with *Nishihama v. City and County of San Francisco*, (2001) 93 Cal. App. 4th 298

Nishihama involved a patient insured with Blue Cross, who obtained medical care from California Pacific Medical Center (CPMC). CPMC was a contracting provider with Blue Cross. Nishihama brought suit against

the City and County of San Francisco. And CPMC made a claim under the Hospital Lien Act (Civ. Code § 4045.1, et. seq.) to recover the difference between its usual and customary charges for medical services rendered to the patient, and the contract rates it had *negotiated* under its contract with Blue Cross. *Nishihama, supra* at 307.

So while *Nishihama* did at least involve a contracting provider's negotiated rate differential with Blue Cross, *Nishihama* did not analyze, consider or discuss (1) the patient's liability under the creditor-debtor relationship with their providers, or (2) whether that negotiated rate differential is a benefit to the health plans' insureds who select those contracting providers and subject to the collateral source rule. *see*, Ins. Code § 10133 (discussing alternative rates of payment contracts, and identifying the alternate rates as a benefit to insureds who select contracting providers).

Since neither *Hanif* nor *Nishihama* analyzed or discussed those issues, they are not proper authority for Petitioner's proposition that patients do not incur their providers' usual and customary charges and that negotiated contract rate differentials do not benefit insureds who choose to use contracting providers. "Cases are not authority for propositions not

considered." *People v. Banks*, (1959) 53 Cal. 2d 370, 389; *Peterson v. Lamb Rubber Co.*, (1960) 54 Cal. 2d 339, 343 (a decision has no value as precedent as to an undisputed, unchallenged proposition). In short, neither decision stands for the proposition that private health coverage negotiated rate differentials are not a collateral benefit.

Petitioner will correctly point out that *Nishihama* cited *Hanif* and found "that the jury improperly awarded plaintiff certain medical costs that she did not incur." *Nishihama*, supra, 93 Cal. App. 4th at 301. It is on the basis of *that* finding that Petitioner makes the claim of a conflict between *Howell* and *Nishihama* – if she did not incur CPMC's normal rates, she "cannot logically claim she 'suffered' a 'loss or harm' for those amounts." (PFR 26: 16-18.)

However, Petitioner's reliance is misplaced. Four years after *Nishihama*, in *Parnell*, this Court reviewed the HLA. *Parnell*, *supra*. Like *Nishihama* before it, *Parnell* invalidated a hospital's claim under the HLA where that hospital's contract with the patient's health plan contained a negotiated schedule of payments through which the health plan could extinguish its plan members' debts for medical services. *Parnell, supra* at 609.

Unlike *Nishihama*, *Parnell* examined the creditor-debtor relationship between the medical provider and patient. *Parnell* found that the creditor-debtor relationship of provider and patient is for the provider's *usual and customary charges*, not the negotiated health plan rate. *Id.* at 611. To be fair to the *Nishihama* Court, the provider-patient creditor-debtor relationship was not disputed or contested by the parties before the Court – "Plaintiff did not and does not contest" the City and County of San Francisco's "assertion that CPMC accepted $3,600 as payment in full for the services provided." *Nishihama, supra* at 307.

Parnell held that a contracting hospital could not pursue an HLA claim against its patients where the patient's "entire debt" for their providers' usual and customary charges is "extinguished" through the negotiated terms and payments between the hospital and those patients' health plans. *Parnell, supra* at 609. That holding is consistent with the statutory intent of Insurance Code Section 10133 (b), which describes alternate rates as a benefit to insureds: "an insurer may negotiate and enter into contracts for alternative rates of payment with institutional providers, and offer the benefit of these alternative rates to insureds who select those providers."

The *Nishihama* Court's bare statement that "the jury improperly awarded plaintiff certain medical costs that she did not incur" (*Nishihama*, *supra*, 93 Cal. App. 4th at 301) directly conflicted with numerous prior authorities where disputed issues of medical debt *were* directly analyzed and discussed, as well as with existing statutory authority:

- *Reichle v. Hazie*, (1937) 22 Cal. App. 2d 543, 547 (where a patient is "admitted to a hospital without an express contract to pay for his care and treatment," the law implies an obligation for the charges of a hospital for services rendered);

- *Appleman v. National-Ben Franklin Ins. Co. of Illinois*, (1978) 84 Cal. App. 3d 1012 (Hospital charges were actually incurred by Medicare recipient despite terms of contract between Medicare and hospital)

- *Lindsey v. County of Los Angeles*, (1980) 109 Cal. App. 3d 933, 938 (unpaid County hospital is a creditor of plaintiff for its full charges for medical care rendered);

- *Holmes v. CSAA*, (1982) 135 Cal. App. 3d 635, 638-639 (Medicare patient "expressly undertook personal liability" for the full charges of their hospitalization, as condition to application of the agreement between the hospital and Medicare);

- Insurance Code § 10133 (1982 Amendments) (payment of health insurance benefits requires that plan member first incur expenses for hospitalization or medical aid);

- Health & Safety Code § 1339.51(b)(1) (Added by Stats. 2003, Former § 1339.51, added by Stats. 1984) ("'Charge description master' means a uniform schedule of charges represented by the hospital as its gross billed charge for a given service or item, regardless of payer type");

- *City and County of San Francisco v. Sweet*, (1995) 12 Cal. 4th 105, 117 (patient is a debtor to county hospital for hospital's billed charges, "regardless of the outcome of" patient's third party tort action); and

- *Mercy Hospital and Medical Center v. Farmers Insurance Group of Companies*, (1997) 15 Cal. 4th 215 (a hospital is a creditor of the patient and has a "pre-existing right" to "recover sums due from any after-acquired assets of the patient . . . regardless of the source of those assets," a right that is reduced, but not extinguished by, payment of an HLA claim).

///

Subsequent to *Parnell*, in *Prospect Medical Group, Inc. v. Northridge Medical Group*, (2009) 45 Cal. 4th 497, 510, this Court returned to review aspects of the statutory scheme governing medical provider and health plan relations, set forth in the Insurance and Health & Safety Codes. *Prospect* observes that California's statutory scheme "requires emergency care patients to agree to pay for the services *or* to supply insurance information," that a health plan has a "duty to pay a reasonable and customary amount for the services rendered" for non-contracting providers' emergency treatment of plan members, and that absent a contract, neither the patient nor the health plan can impose alternate rates of payments on medical providers.

To the doubtful extent *Nishihama* should ever have served as precedent for Petitioner's proposition, *Nishihama* is no longer valid authority. The *Nishihama* court's statements concerning amounts not incurred, on which Petitioner relies, are supplanted by this Court's holding to the contrary in *Parnell*. An injured plaintiff's "common law compensatory rights under the collateral source rule" are "independent of, and unrelated to" a hospital's "statutory lien rights under the HLA." *Howell, supra*, 101 Cal. Rptr. 3d at 818.

In this light, the *Howell* court's statement "We disagree with this holding in *Nishihama* and the reasoning upon which it is based", *(Howell, supra* at 818) does not reflect a conflict with regard to the issues presented. Rather, the *Howell* Court's opinion recognizes the controlling precedent of *Parnell* and *Helfend. (Id.* at 815-816). Since the decision in *Nishihama* rested on application of the HLA and not the collateral source rule, *Howell's*, application of the collateral source rule does not create a split of authority to warrant this court granting the Petition for Review.

3. No Case Creates or Endorses a Post-Verdict Reduction Procedure with Regard to Health Insurance Benefits

Petitioner next asserts that *Nishihama*, *supra*, 93 Cal. App. 4th 298, *Greer v. Buzgheia*, (2006) 141 Cal. App. 4th 1150, and *Olsen v. Reid*, (2008) 164 Cal. App. 4th 200 establish a procedure whereby "past medical expenses may be reduced after trial," offsetting damages by virtue of the negotiated rate differential accepted by contracting medical providers from a plaintiff's health plan. (PFR 7-90, heading B; 27-28, heading C.)

Petitioner seeks to bootstrap this language concerning procedure and evidentiary issues into holdings on the substantive law issue, of whether a Plaintiff can only recover the cash portion of the consideration paid by

private health insureds to health care providers to satisfy a Plaintiff's incurred debts for past medical specials, while ignoring the value of the negotiated rate differential. This effort is pure sophistry.

Petitioner's claim that *Greer v. Buzgheia*, *supra*, and *Olsen v. Reid*, *supra*, stand for the proposition that a post-verdict hearing is appropriate is at odds with the express statements of those courts to the contrary.

Greer discussed post-trial modifications under the sub-heading "*Post-verdict Hanif/Nishihama issues*":

> Defendant next claims the trial court erred in not ordering a Hanif/*Nishihama* reduction after the verdict was returned . . . [¶] We **need not address these claims** individually, for we find they have all been forfeited by defendant's failure to request a verdict form containing a separate entry for plaintiff's past medical expenses. [emphasis added]

Greer, *supra*, 141 Cal. App. 4th at 1157-1158 (emphasis added)

The Greer court never reached the substantive law issue, dispensing with the case based on the lesser grounds of procedural and evidentiary insufficiency. Defendant had not preserved the issue by separating the past medical specials from other special damages on the special verdict form. As such, there was no finding on the amount of past medical specials - a necessary starting point in deciding the motion. *Greer* at 1158.

///

Petitioner's assertion that *Olsen v. Reid* "confirms a post-trial hearing in the trial court is proper," (PFR) 8, is flat-out false. The majority opinion does briefly address the question of whether a post-trial hearing is proper – it states "we do not decide that Reid was entitled to such a hearing." *Olsen, supra,* 164 Cal. App. 4th at 204.

Thereafter, Petitioner's citation to *Olsen* in support of their claim is not to the majority opinion, as would be necessary for their claim to be true. Instead, Petitioner cites to Justice Fybel's concurrence. Yet here, Petitioner continues to misconstrue the plain language of the concurrence. Petitioner's excerpt from Justice Fybel's concurrence is a qualified "if" from the outset: "If the proper application of the collateral source rule includes reducing a verdict..." *Id.*, at 217. Revealingly, Petitioner's quotation from Fybel's concurrence omits two sentences in the middle of the paragraph they cite. These two sentences are:

> 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.

Id., at 218 (conc. opn. of Fybel, J.).

///

///

The omitted portion of the passage demonstrates that Justice Fybel recognized not that a post-verdict hearing was proper, but rather that the propriety of such a hearing was entirely inseparable from determining whether reduction is appropriate at all under the collateral source rule – an issue that the *Howell* decision resolved in the manner compelled by this Court's holding in *Parnell* and *Helfend.*

C. Petitioner's Request to Overturn the Collateral Source Rule Should Be Rejected Outright.

Petitioner does not stop at its refusal to accept the eighty years of jurisprudence from *Reichle* (1937) through *Prospect Medical* and *Howell* (2009), which establish that a medical patient is contractually obligated for their medical providers' usual and customary charges. Petitioner proceeds to ask this Court for something it did not request from the Trial Court, and did not request of the appellate court. Petitioner wants to abolish the collateral source rule, which would literally require this Court to overrule dozens of its own decisions, and dozens, if not hundreds, of appellate cases, all spanning some 150 years of jurisprudence.

California follows the majority of States in observing the collateral source rule, and the holding in *Howell* follows and applies the collateral

source rule as set forth in both State decisional law and The Restatement of Torts, Second, which California follows. *Helfend v. Southern California Rapid Transit Dist., (1970)* 2 Cal.3d 1, *Lund v. San Joaquin Valley Railroad*, (2003) 31 Cal. 4th 1, 9; *Howell, supra*, at 16.

Adoption of Petitioner's position would also render null the Legislature's creation of two statutory exceptions to the collateral source rule: Civil Code Section 3333.1 (MICRA), and Government Code Section 985, and reverse this Court's commitment that changes to the collateral source rule, "if desirable, would be more effectively accomplished through legislative reform" and that "the judicial repeal of the collateral source rule" would not be "the place to begin." *Helfend, supra,* 2 Cal. 3d at 13.

Petitioner is correct to observe that the allocation of millions of California citizens' dollars rests on this issue. (PFR 9:19-20.) It is not money belonging to defendants and liability insurers at stake, however, it pooled the health insurance premiums of all of California's citizens.

The issue is whether a tortfeasor and their liability insurers should be entitled to an unearned "windfall from the thrift and foresight of persons who have actually or constructively secured insurance, pension or disability benefits to provide for themselves and their families." *Arambula*

v. Wells, (1999) 72 Cal. App. 4th 1006, 1009. That is not a new or novel question. The answer to that question in California is and has been "no" for over one hundred years. Compensation or indemnity for a financial loss or detriment, from a source independent of a tortfeasor – regardless of the form it takes – is the definition of a collateral benefit. *Helfend, supra*, 2 Cal. 3d at 11-12; *Peri, supra*, 22 Cal. 2d at 131; Rest. 2d of Torts, § 920A (2).

> [T]he real issue is not whether a windfall is to be conferred upon either party, but rather which party shall receive the benefit of a windfall which presumably already exists. As between the insured plaintiff and the tortfeasor, it would seem that justice compels the conclusion the former's claim is the better. [*citing Helfend*, supra, 2 Cal. 3d at 11-12] In any event, it is clear the possibility of a double recovery in favor of respondent will not impose a double burden on appellant; appellant, as tortfeasor, bears responsibility only for the single burden of his wrong.

Philip Chang, supra, 177 Cal. App. 3d at 170.

The holding in *Howell* simply follows over one hundred years of California precedent, including from this Court.

///

///

This all boils down to the fact that Petitioner and California's liability insurers just don't want to have to bear responsibility for all of the detriment they and their insureds cause. As history demonstrates, when its not their investment and benefits at stake, defendants just don't like the collateral source rule and keep trying to find a way to get around it or do away with it, in whole or in part. That is not a proper ground for review.

IV.

HEALTH INSURANCE *BENEFITS*, NOT JUST CASH PAYMENTS, ARE PROTECTED BY THE COLLATERAL SOURCE RULE.

In *Helfend*[1], this Court confronted a challenge to application of the collateral source rule to health insurance benefits. *Helfend* unanimously affirmed that, "if an injured party receives some compensation for his injuries from a source wholly independent of the tortfeasor, such payment should not be deducted from the damages which the plaintiff would otherwise collect from the tortfeasor." *Helfend*, *supra*, 2 Cal. 3d at 6, *citing Peri v. Los Angeles Junction Ry. Co.*, (1943) 22 Cal. 2d 111, 131

("'Damages recoverable for a wrong are not diminished by the fact that the party injured has been wholly or partly indemnified for his loss by insurance effected by him, and to the procurement of which the wrongdoer did not contribute . . . . '").

/ / /

---

[1] And in that same session, *Acosta v. Southern California Rapid Transit Dist.*, (1970) 2 Cal. 3d 19.

Just as the Court recognized in *Peri*, consistent with the Restatement of Torts 2d, and the rule in the majority of States in the U.S., the *Howell* Court recognized that collateral source benefits are not limited to cash payments, but encompass any "benefits conferred on the injured party by a source other than the defendant." Rest. 2d Torts, § 920A; com. b. California follows the Restatement of Torts 920A. *Lund v. San Joaquin Valley Railroad*, (2003) 31 Cal. 4th 1, 9.

As much as Petitioner refuses to acknowledge it, insurance benefits are not restricted to cash payments. Relief from debt – indemnity – is a "benefit conferred on the injured party" by collateral health coverage. *Howell, supra*, 101 Cal. Rptr. 3d 805.

> **insurance**. 1. A contract by which one party (the insurer) undertakes to indemnify another party (the insured) against ... liability arising from the occurrence of some specified contingency.

(Black's Law Dictionary, West, 2004)

V.

THE LEGISLATURE INTENDED "NEGOTIATED RATE DIFFERENTIALS" TO BENEFIT MEMBERS OF A HEALTH PLAN WHO CHOOSE CONTRACTING MEDICAL PROVIDERS.

What the *Howell* court describes as a "negotiated rate differential" is not a creation of the *Howell* court. Rather, it is a creation of the California Legislature.

In the 1980s, the California Legislature enacted amendments to various sections of the Health & Safety and Insurance Codes "authorizing various types of contracts to be entered into between public or private payers of health care coverage, and institutional or professional providers of health care services." H&S Code § 1342.6; Ins. Code § 10133.6.

In both Health & Safety Code § 1342.6 and Insurance Code § 10133.6, the Legislature explained its intent "to ensure that the citizens of this State receive high-quality health care coverage in the most efficient and cost-effective manner possible," and stated that it had demonstrated its intent through its enactment of amendments in 1982. Insurance Code § 10133.6 expressly finds and declares "that the public interest in ensuring that citizens of this State receive high-quality health care coverage in the most efficient and cost-effective manner possible is furthered by permitting negotiations for alternative rate contracts between purchasers and payers and both institutional and professional providers."

In exchange for contractual exclusivity and other contractual benefits, these negotiated "alternative rate contracts" permitted health plans to indemnify their members' incurred liability for their providers' gross billed charges (H&S Code § 1339.51(b)(1)) at negotiated discount rates. The difference between a contracting medical provider's usual and

customary charges and the schedule of cash payments under their agreement with a health plan pursuant to "alternative rate contracts" are the "negotiated rate differentials" described in *Howell.*

Alternative rate contracts set the terms and manner in which health plans fulfill their indemnity obligations to their members, but only when their members choose to obtain services through medical providers contracting with their health plan. Ins. Code §§ 10123.12, 10133, 10133.2, 10133.3, 10133.5, 10133.55, 10133.6, 10133.65, 10180; H & S Code §§ 1342.6, 1373.18, 1373.9, 1395.6; and Bus. & Prof. Code § 16770.

The statutes both encourage health plans to negotiate and enter into the alternative rate contracts and provide that their purpose is to "offer the benefit of these alternative rates to insureds who select those providers." Ins. Code § 10133(b).

These negotiated agreements intended to benefit health plans' insureds are what the *Mercy Hospital* and *Parnell* courts analyzed. But for the negotiated contract between a health plan and a medical provider, even an insured patient owes their provider the full charges for services received. *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group*, (2009) 45 Cal. 4th 497, 510:

> HMO members are not required to go to doctors who have contracted with their HMO. In a non-emergency situation, members may, if they choose, seek professional services from anyone. If they obtain services from a non-contracting provider, the HMO might not be obligated to pay all or even part of that provider's bill, depending on the exact terms of the health care plan. If the HMO is not obligated to pay the non-contracting provider, obviously, the member would be liable to pay for the services.

By choosing to direct the benefit of negotiated rate differentials to patients who maintain health insurance and choose contracted providers, the statutes dictate that negotiated rate differentials are a collateral benefit. "[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." Rest.2d Torts, § 920A, com. B (emphasis added); *see Howell, supra*, 101 Cal. Rptr. 3d at 814.

It does not matter whether the benefit takes the form of cash payments, as Petitioner insists, or another form of compensation or indemnity. "The law does not differentiate between the nature of the benefits, so long as they do not come from the defendant or a person acting for him . . . it is the tortfeasor's responsibility to compensate for all harm that he causes, not confined to the net loss that the injured party receives." Rest.2d Torts, § 920A, com. b.

VI.

EARNED INVESTMENT BENEFITS ARE NOT AN IMPROPER WINDFALL, AND DO NOT IMPOSE A DOUBLE BURDEN ON TORTFEASORS

A Plaintiff who is allowed to receive the benefit of their bargain with a collateral source is not "in a better position than she would had she not been injured at all," i.e., that she is making a "double recovery" and receiving a "windfall."

Health insurance "is an investment contract, giving the owner or beneficiary an absolute right, independent of the right against any third person responsible for the injury covered by the policy." *Helfend, supra*, 2 Cal. 3d at 12.

The law allows plaintiffs to keep the benefit of the bargain of their investment even though the defendant paying the total amount "may be a double compensation for a part of the plaintiff's injury." Rest. 2d of Torts, § 920A, comment b.

///

///

The citation generally given by the defense to suggest a double recovery is improper, is from *Hanif*: "The rule we express is consistent with fundamental principles underlying recovery in tort of compensatory damages, and it is in harmony with other rules and practices flowing from those principles, such as . . . the bar against double recovery." *Hanif, supra*, 200 Cal. App. 3d at 643, *citing Mozzetti v. City of Brisbane*, (1977) 67 Cal. App. 3d 565, 576, and 4 Witkin, Summary of Cal. Law (8th Ed. 1974) Torts § 844, p. 3139.

However, the bar against double recovery is not what Petitioner suggests. *Mozzetti* involved an owner of a motel and trailer park suing the City of Brisbane for flood damage. A jury instruction in the case improperly allowed cumulative recovery from the defendant on two measures of the same damages – the cost of repair and the diminution in value of the property. *Id.* at 576. As the *Mozzetti* court explained:

> [I]n a case involving damage to plaintiff's property due to defendant's negligence, the general rule is that if the cost of repairing the injury and restoring the premises to their original condition amounts to less than the diminution in value of the property, such cost is the proper measure of damages; and if the cost of restoration will exceed such diminution in value, then the diminution in value of the property is the proper measure.

(*Id.*)

Mozzetti was not concerned with an injured party recovering both their own indemnity insurance and damages from a tortfeasor; rather, *Mozzetti* was concerned with preventing the injured party recovering twice from the tortfeasor for a single injury. The Witkin provision which the *Hanif* decision also cites similarly deals with the permissibility of only "one complete satisfaction" in tort for the same wrong:

> The general theory of compensatory damages bars double recovery for the same wrong. The principal situation is where joint or concurrent tortfeasors are jointly and severally liable for the same wrong. Only one complete satisfaction is permissible, and if partial satisfaction is received from one, the liability of others will be correspondingly reduced.

(6 Witkin, Summary of Cal. Law (10th Ed. 2005) Torts § 1550, pp. 1023-24 (which succeeded the section relied on in *Hanif*: 4 Witkin, Summary of Cal. Law (8th Ed. 1974) Torts, § 844, p. 3139).

Stated simply, there is no prohibition against "double compensation" to a plaintiff with collateral insurance, only a double recovery from the tortfeasor(s) is prohibited. An injured plaintiff who has invested in collateral insurance may legally claim and recover both contractual benefits from their collateral insurance and damages from the tortfeasor(s). Although this might be a "windfall," and could certainly be double compensation for a financial loss, it is not a prohibited "double recovery"

since the plaintiff is not recovering the same damages twice from a defendant or from multiple defendants for a single wrong.

The prohibition against a double recovery "is nothing more than a reference to the usual rule of law existent in negligence actions generally that a partial satisfaction of the liability by *a joint or concurrent tortfeasor* will result in a pro tanto reduction of the liability of the other tortfeasors." *De Cruz v. Reid*, (1968) 69 Cal. 2d 217, 225-26 (emphasis in original). Where the collateral source is independent of defendant, "[t]he wrongdoer is not permitted to obtain a windfall by reason of the principle that an injured person should be compensated only once." *Dodds v. Bucknum*, (1963) 214 Cal. App. 2d 206, 213.

VII.

NEW EXCEPTIONS TO THE COLLATERAL SOURCE RULE SHOULD COME FROM THE LEGISLATURE NOT THE JUDICIARY

"The collateral source rule operates both as a substantive rule of damages and as a rule of evidence." *Arambula*, *supra*, 72 Cal. App. 4th at 1015.

/ / /

In Government Code § 985, the Legislature expressly created a substantive offset procedure like that sought by defendants,[2] and in Civil Code § 3333.1 (MICRA), the Legislature created an evidentiary exception for health insurance benefits, but limited each of those exceptions to discreet classes of defendants.

Howell agreed with this Court's sentiment in *Helfend*, "any further abrogation of the collateral source rule, particularly in the complex context of medical insurance presented here, is best left to legislative enactment." *Howell*, *supra*, 101 Cal. Rptr. 3d 805 at 819, *citing Helfend*, *supra*, 2 Cal. 3d at p. 13 (proposed changes to the rule, "if desirable, would be more effectively accomplished through legislative reform"). Justice Moore voiced the same sentiment concurring in *Olsen*, *supra*, 164 Cal. App. 4th at 213-14 (conc. opn. of Moore, J.) (changes to the rule "should be promulgated by the Legislature"); as did the Court in *Smock v. State,* 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").

Similarly, in *Olszewski v. Scripps Health*, (2003) 30 Cal. 4th 798, 827, this court called for *Legislative* action to remedy the windfall

---

[2] While counter-balancing any such reduction with enumerated offsets, including offsets for plaintiff's investment of premiums, attorney's fees, costs, out-of-pocket costs, and comparative fault. Gov. Code § 985(f)(3).

tortfeasors receive at the expense of medical providers under the Medicaid statutes – where the right of recovery for past medical services provided through Medi-Cal does not belong to the injured plaintiff, but is statutorily assigned to the State (*Arkansas Department of Health and Human Services v. Ahlborn*, (2006) 547 U.S. 268; W&I Code § 14124.71(a)) and in California, limited to the Medi-Cal rate of payment (W&I Code §14124.72(d)).

Advocating for a further exception to the collateral source rule to benefit third party liability insurers should be directed to the Legislature, not this Court through the instant Petition for Review.

IX.

CONCLUSION

Respondent has shown that Petitioner has sought to create a false conflict in a settled area of law, citing cases as authority for propositions not considered, or as precedent for a proposition that was undisputed or unchallenged. In doing so, they have throughly disregarded the rules of precedent. *People v. Banks*, *supra*, 53 Cal. 2d 370; *Peterson*, *supra*, 54 Cal. 2d 339.

Howell is not inconsistent with the authorities cited by Petitioner. *Howell* is inconsistent only with Petitioner's desired outcome – one premised on a frank rejection of settled Supreme Court authority and uniform decisional support and application of the collateral source rule in California.

Howell accurately observes that it has always been the case that "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 <u>*incurred*</u>." *Id., citing Melone v. Sierra Railway Co.* (1907) 151 Cal. 113, 115, *Hanif, supra*, 200 Cal. App. 3d at p. 640, *Katiuzhinsky v. Perry* (2007) 152 Cal. App. 4th 1288, 1290.

Parnell provides that patients *incur* the usual and customary charges of their medical providers, and that the terms negotiated between contracted providers and health plans extinguish that entire debt. *Parnell, supra*, 35 Cal. 4th at 609.

Parnell is the key to denial of review in this case. *Parnell* disposes of the premise of Petitioner's claims that a medical patient does not incur the usual and customary charges of their medical providers. *Howell* resolved the issue in the only manner permissible pursuant to *Parnell.*

Since – as a settled legal principle – a medical patient incurs the usual and customary charges of their medical providers (*Parnell*, supra, 35 Cal. 4th at 609), in the absence of a statutory assignment of the right of recovery away from the patient and to the State (as per Medi-Cal/Medicaid), indemnity against that entire debt from a source independent of the defendant is a collateral source benefit for which an insured plaintiff may recover.

It is not the Supreme Court's job to review every important or significant published appellate decision. The basic grounds for Supreme Court review of an appellate decision are "to secure uniformity of decision or to settle an important question of law." C.R.C., Rule 8.500(b)(1). If, as here, a question of law *is* settled, if there is *already* uniformity of decision, review is not necessary.

Dated: January 20, 2010

Respectfully submitted,

By: _____

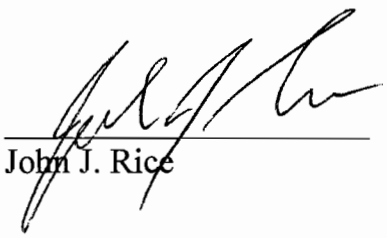
John J. Rice
Attorney for
Appellant/Plaintiff
REBECCA HOWELL

CERTIFICATE OF COMPLIANCE PURSUANT TO THE

CALIFORNIA RULES OF COURT, RULE 8.204(c)

Pursuant to the California Rule of Court, Rule 8.204(c), I certify that the foregoing brief is proportionally spaced, has a typeface of 13 points, is double-line space, and based upon the word count feature contained in the world processing program used to produce that brief (Word Perfect version 12), contains 7119 words.

Dated: January 20, 2010



John J. Rice

Rebecca Howell v. Hamilton Meats & Provisions, Inc., et al.

SUPREME COURT OF CALIFORNIA
CASE NO.: S179115

Court of Appeal of the State of California, Fourth Appellate District, Division One
Case No.: D053620

San Diego Superior Court Case No: GIN053925

PROOF OF SERVICE

STATE OF CALIFORNIA, COUNTY OF SAN DIEGO

I, Kathy Aragon, am employed in the County of San Diego, State of California. I am over the age of 18 and not a party to the within action; my business address is 2333 First Avenue, Suite 201, San Diego, California 92101. On January 20, 2009, I served the foregoing document(s) described as:

APPELLANT'S ANSWER TO PETITION FOR REVIEW

SERVED UPON:

SEE ATTACHED SERVICE LIST

__X__) BY EXPRESS MAIL. (FED EX express mail carrier). I deposited in a box or other like facility regularly maintained by an express carrier service, or delivered to an authorized courier or driver authorized by the express service to carrier to receive documents, a copy of each document served in an envelope or package designated by the express carrier with delivery fees paid or provided for, each envelope being addressed to each person served in accordance with Code of Civil Procedure § 1013(c).

__X__ (STATE) I declare under the penalty of perjury under the laws of the State of California that the above is true and correct.

Executed on January 20, 2010, at San Diego, California.

Kathy Aragon

Rebecca Howell v. Hamilton Meats & Provisions, Inc., et al.

SUPREME COURT OF CALIFORNIA
CASE NO.: S179115

Court of Appeal of the State of California, Fourth Appellate District, Division One
Case No.: D053620

San Diego Superior Court Case No: GIN053925

SERVICE LIST

Robert F. Tyson
Mark T. Peterson
TYSON & MENDES LLP
5661 La Jolla Boulevard
La Jolla, CA 92037
T: (858) 459-4400
F: (858) 459-3864

(Counsel for Defendant/ Respondent HMPI)

(1 copy)

Court of Appeal
Fourth Appellate District
Division One
Symphony Towers
750 B Street, Suite 300
San Diego, California 92101

(1 copy)

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

Courtroom
T.: 760-201-8007

Case No.: GIN53925

(1 copy)