ORIGINAL

S179115

IN THE SUPREME COURT OF CALIFORNIA

REBECCA HOWELL

Plaintiff and Appellant,

v.

HAMILTON MEATS & PROVISIONS, INC.,

Defendant and Respondent.

On Review of a Published Decision by the Fourth Dist. Ct. of Appeal—Div. One
Case Number D053620 — Filed November 23, 2009
On Appeal From a Judgment After Jury Verdict and Postjudgment Order
San Diego County Superior Court — Hon. Adrienne Orfield — GIN053925

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♦ TABLE OF CONTENTS ♦

♦ TABLE OF CONTENTS ♦

♦ TABLE OF CONTENTS ♦

♦ TABLE OF CONTENTS ♦

♦♦♦♦♦

♦ TABLE OF AUTHORITIES ♦

CASES

♦ TABLE OF AUTHORITIES ♦

CASES

♦ TABLE OF AUTHORITIES ♦

CASES

♦ TABLE OF AUTHORITIES ♦

CASES

♦ TABLE OF AUTHORITIES ♦

CASES

♦ TABLE OF AUTHORITIES ♦

CASES

♦ TABLE OF AUTHORITIES ♦

CASES

♦ TABLE OF AUTHORITIES ♦

CASES

CONSTITUTION

CALIFORNIA CONSTITUTION

♦ TABLE OF AUTHORITIES ♦

STATUTES

CALIFORNIA CODES AND STATUTES

♦ TABLE OF AUTHORITIES ♦

STATUTES

CALIFORNIA CODES AND STATUTES

FEDERAL STATUTES

♦ TABLE OF AUTHORITIES ♦

ADMINISTRATIVE REGULATIONS

JURY INSTRUCTIONS

TREATISES, LAW REVIEWS, AND DICTIONARIES

♦ TABLE OF AUTHORITIES ♦

TREATISES, LAW REVIEWS, AND DICTIONARIES (CONTINUED)

MISCELLANEOUS

♦♦♦♦♦

INTRODUCTION

- "The collateral source rule should be abolished in California." (Petition for Review, p. 28.)

- "The long–standing collateral source rule must be protected. The collateral source rule should not be abolished or weakened, but rather it should be enforced and strengthened." (Opening Brief on the Merits, p. 1.)

Defendant's seemingly epiphanic embrace of the collateral source rule calls to mind not so much "Who's on First," but rather Marc Antony's hollow paen, "Brutus is an honorable man."[1] Indeed, defendant's claim that it seeks to stengthen the collateral source rule is preposterous. To permit tortfeasors to reduce their liability for harm they have inflicted by taking advantage of contractual terms that a victim's healthcare insurer has negotiated to indemnify its insureds against medical debt is to "bury" the collateral source rule. (*Olsen v. Reid* (2008) 164 Cal.App.4th 200, 204 ("*Olsen*") (conc. opn. of Moore, J.).)

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[1] Abbott & Costello, *Who's on First?*, March 1938, reprinted in Einstein, Fireside Book of Baseball (1956) pp. 347–348; Shakespeare, Julius Caesar, act 3, scene 2, lines 90, 95 & 102.)

Moreover, as defendant's amici curiae observe, the issues in this appeal arise "in *thousands* of California cases *every year*."[2] Indeed, because virtually all personal–injury plaintiffs seek to recover for the medical debt they incur, this is almost certainly the most important personal–injury case to come before the Court since *Li v. Yellow Cab Co.* (1975) 13 Cal.3d 804. Likewise, this case presents one of the most important personal–injury issues since this Court's adoption of the collateral source rule more than 150 years ago and its modern reaffirmation in *Helfend v. Southern Cal. Rapid Transit Dist.* (1970) 2 Cal.3d 1 ("*Helfend*"). (*Smock v. State of California* (2006) 138 Cal.App.4th 883, 885 ["Though oft-maligned, a form of the rule has been a part of our jurisprudence since California's earliest days in the union."] citing *White v. Steam–Tug Mary Ann* (1856) 6 Cal. 462, 470-471.)

Tortfeasors seek to gut this longstanding rule whenever insured victims have obtained medical care from providers that have contracted with the victims' health plans. But the existence and use of such healthcare insurance embody public policy as expressed by the Legislature when it enacted statutes to encourage contractual bargaining between healthcare

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[2] January 22, 2010, letter (p. 1) by Horvitz & Levy, submitted on behalf of liability insurers, original italics. As the many amici curiae letters seeking review show, defendant Hamilton Meats & Provisions, Inc. ("Hamilton") is, in practical effect, a proxy for all personal–injury defendants. Plaintiff Rebecca Howell will thus use the plural term "defendants" to refer to personal–injury defendants in general. References to "defendant" in the singular are to Hamilton.

insurers and medical providers. (See, e.g., Ins. Code, § 10133, subd. (b).) These negotiated payments (cash remittances and contractual indemnity) are designed to benefit insureds who use such providers, i.e., participating providers who have contracted with the victim's insurer. Tortfeasors seek that benefit for themselves without paying for it. They do not pay insurance premiums. Nor do they incur an insurer's costs of administering its health plan. Nor do they incur the costs of a provider in rendering services. In short, insureds, insurers, and providers bring something—including contractual allowances against the patient's debt—to the table to make the system work. But tortfeasors want the benefit of the system, including such allowances, without having contributed anything. That is the windfall at issue.

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STATEMENT OF THE CASE

FACTS

I. HAMILTON'S NEGLIGENT DRIVER CRASHED INTO HOWELL.

Juan Saenz was driving a Hamilton truck on Highway 101 when he made an illegal U–turn across the lane in which Rebecca Howell's vehicle was traveling. (1 A.A. 53:26–28 & 54:11–13.) Saenz crashed into Howell. (1 A.A. 53:28.) Saenz was negligent and was in the course and scope of his employment for Hamilton when he crashed into Howell. (1 A.A. 54:18–20.) Saenz's negligence caused Howell's injuries. (1 A.A. 54:23; 4 R.T. 213:24–25.)[3]

II. HOWELL WAS SEVERELY INJURED.

Howell suffered severe spinal injuries that required two separate surgeries: a frontal fusion and then a rear fusion involving three vertebrae in her neck. (1 A.A. 2:1–2.) She underwent a third surgery in which bone was taken from her hip to repair her neck. (1 A.A. 2:2–4.) She had further surgery to repair the bone-graft site on her hip. (1 A.A. 2:4–5.)

III. HOWELL INCURRED MEDICAL EXPENSES.

Howell received medical care from Scripps Memorial Hospital Encinitas ("Scripps") and CORE Orthopedic Medical Center ("CORE").

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[3] Hamilton stipulated to liability. (1 A.A. 53–63; 4 R.T. 213:24–25.) Hamilton disputed only the amount of damages. (1 A.A. 54:25; 4 R.T. 214:5–6.)

Before receiving treatment, Howell was required by Scripps and CORE to sign agreements to be responsible for Scripps' and CORE's charges and to acknowledge that she would be responsible for any amounts not paid by her insurer. (2 A.A. 368–370.)

Scripps billed Howell $122,841.07. (1 A.A. 132:25–26; 133:23–25; 134:20–21.) CORE billed $52,915.14. (1 A.A. 136:24–25 & 1 A.A. 148–175.) The parties stipulated that the amount of medical expenses billed to Howell was $189,824.68. (1 A.A. 131:17–20.)

IV. HOWELL'S HEALTHCARE INSURER PAID HER MEDICAL BILLS WITH CASH AND NONCASH PAYMENTS.

Howell had private healthcare insurance provided by PacifiCare. PacifiCare made cash payments to Scripps totaling $24,380.39 ($6,651.26, $14,719.13, and $3,010.00). (1 A.A. 132:26–27; 133:25–26 & 134:21–22.) Pursuant to its contract with PacifiCare, Scripps posted credits totaling $98,894.42 against Howell's debt ($33,572.71, $49,919.32, and $11,402.39). (1 A.A. 133:4–7; 134:1–4, & 134:26 to 134:2.) PacifiCare made cash payments to CORE totaling $9,665.32. (1 A.A. 136:24–27.) Pursuant to its contract with PacifiCare, CORE posted credits totaling $35,392.48 against Howell's debt. (1 A.A. 137:3–7.)

PROCEDURAL HISTORY

I. THE COURT DENIED HAMILTON'S MOTION IN LIMINE REGARDING HOWELL'S MEDICAL EXPENSES.

Hamilton moved in limine to exclude at trial any evidence of, or reference to, any portions of Howell's medical expenses that were not paid in cash by PacifiCare or by Howell as a copayment. (1 A.A. 73–107.) Howell opposed the motion on the ground that, under the collateral source rule as set forth in *Helfend*, *supra*, 2 Cal.3d 1, the amount of billed medical expenses should be presented to the jury. (1 A.A. 108–110.)

After hearing, the court denied Hamilton's motion, ruling that "I see this as a post trial issue. They're [Howell] entitled to put up their bills in front of the jury. Whatever you [Hamilton] can actually come up with to meet your burden. We can address that post trial." (1 R.T. 67:13–16.)

The court deferred ruling on the substantive question of how to deal with payments by Howell's insurer. (1 A.A. 111 [minute order stating that defendant's motion "to exclude evidence of medical bills and expenses not paid by plaintiff's insurance: Deferred."].)

II. HAMILTON SUBMITTED NO EVIDENCE TO DISPUTE HOWELL'S MEDICAL EXPENSES; THE JURY AWARDED THE AMOUNTS CHARGED BY HER PROVIDERS.

Howell's surgeon was shown a summary of Howell's past medical expenses with the supporting medical bills. (Trial Exhibit 57, at 1 A.A. 116.1–116.2.) He testified that Howell's bills totaled $189,978.63

and that the charged amounts were customary and reasonable. (2 R.T. 117:15–118:8.) Howell's husband, who kept track of her medical bills, confirmed that they totaled $189,978.63. (3 R.T. 195:12–25.) And Hamilton's counsel told the jury:

> "I'm just going to write down the same number that [Howell's] counsel just told you. *We don't dispute it.* $189,978.63." (4 R.T. 214:15-16, italics added.)

The jury awarded Howell as damages for past medical expenses the undisputed amount of $189,978.63. (1 A.A. 118:23–24 [Special Verdict].)

III. HAMILTON MOVED AFTER VERDICT TO REDUCE THE AWARD OF PAST MEDICAL EXPENSES.

After verdict but before judgment, Hamilton moved pursuant to *Hanif v. Housing Authority of Yolo County* (1988) 200 Cal.App.3d 635, to reduce the $189,978.63 award of past medical expenses to the amount paid in cash by Howell's insurers, i.e., $59,537.78—a reduction of $130,286.90. (1 A.A. 120–176 & 1 A.A. 130:7–15.)

A. HAMILTON'S TWO DECLARATIONS IN SUPPORT OF ITS REDUCTION MOTION.

Hamilton relied on the declarations of a Scripps customer service supervisor and a CORE accounting employee. (1 A.A. 132–137.) Scripps' representative asserted that the total of charges billed for Howell's three surgeries was $122,841.07 ($42,500.23, $64,638.45, and $15,702.39). (1 A.A. 132:25–26, 133:23–25 & 134:20–21.) She further asserted that, of that total, $94,894.42 had been subsequently credited by Scripps pursuant

to its agreement with Howell's insurer. (1 A.A. 133:4–5; 134:1–2; 134:26–27.) Howell objected on numerous grounds to Scripps' clerk's declaration. (3 A.A. 606-607; see, pp. 10-11, *post*.)

CORE's accounting clerk asserted that CORE had billed Howell $52,915.14. (2 A.A. 136:24–25.) She further asserted that CORE had subsequently credited $35,392.48 of those charges against Howell's debt, pursuant to CORE's agreement with Howell's insurer. (2 A.A. 137:3–7.) Howell objected on numerous grounds to CORE's clerk's declaration. (3 A.A. 606-607; see, pp. 10-11, *post*.)

B. THE PROCEDURE USED FOR HAMILTON'S REDUCTION MOTION.

The motion was set for hearing on May 2. (1 A.A. 120:15–16.) (All dates in this posttrial history were in 2008.) Before May 2 and before Howell filed her opposition to that motion, the court entered judgment on the jury verdict for the full amount of the verdict, i.e., without the reduction requested by Hamilton. (1 A.A. 177–179.) The court, though, did not vacate the May 2 hearing date for defendant's reduction motion.

Howell appeared ex parte on April 4 to raise scheduling and procedural matters and to request discovery relevant to Hamilton's reduction motion. (5 R.T. 246–256; 1 A.A. 180–189.) At the ex parte hearing, the court re–scheduled the May 2 hearing to May 19 and ruled that the court would at that time rule only on the substantive issue of whether a

reduction was proper. (5 R.T. 249:17 to 250:14 & 253:26–28.) The court further explained that, if it ruled that the reduction was not substantively permissible, the procedural and evidentiary issues would be moot. (5 R.T. 248:17 to 250:15.) Alternatively, the court assured Howell that, if the court were to later rule that the requested reduction was substantively permissible, the court would allow Howell to brief and argue the procedural and evidentiary issues. (5 R.T. 249:17 to 250:14.)

Then, on April 21, Hamilton moved to vacate the judgment, reasserting the same arguments made in Hamilton's reduction motion (1 A.A. 263–264 & 2 A.A. 265–274.) And on April 29, Hamilton also moved for a new trial, again reasserting the same arguments. (2 A.A. 470–484.) At a hearing on May 2 to determine the scheduling and hearing of Hamilton's motions, the court clarified that: "It sounds like, as you both have been saying, it's all the same issues. It's just procedurally the best way we get there." (7 R.T. 267:23–25.) Hamilton's counsel agreed: "Correct." (7 R.T. 267:26.)

Howell timely filed her opposition to Hamilton's reduction–motion. (2 A.A. 339–463.) Pursuant to the court's prior direction, Howell dealt only with substantive issues regarding the reduction–motion and did not address procedural issues, or make any objections to Hamilton's evidence in support of the motion, or present Howell's own evidence, or discuss factual issues. Howell did likewise in her opposition to defendant's motion

for new trial. (2 A.A. 464–489.)

On May 19, the court heard defendant's reduction–motion, the motion to vacate, and the motion for new trial. The court ruled that defendant's motion for new trial was "deemed moot by the Hanif motion." (2 A.A. 551.) The court deferred ruling on the motion to vacate. (*Ibid.*) And the court took Hamilton's reduction–motion under submission. (8 R.T. 331:28 to 332:8.)

On June 10, the court issued its order granting Hamilton's reduction–motion in full. (2 A.A. 553.) Contrary to its prior statements that it would limit its ruling after the May 19 hearing to the substantive question—i.e., whether such reductions are even permissible under California law—and defer all procedural, evidentiary, and factual questions, the court granted Hamilton's reduction–motion outright and in its entirety without reference to any further proceedings. (2 A.A. 553.) The order does not set forth any amount that the court determined had been paid by Howell's insurer or accepted as full payment by her providers. And the order does not direct that the judgment be amended nunc pro tunc or otherwise to reflect the unstated amount of the reduction. (2 A.A. 553.)

Howell sought reconsideration and an order setting further hearings to deal with the procedural and evidentiary issues, as the court had previously stated it would do. (3 A.A. 561–568.) The court denied reconsideration and the request for the previously promised further

hearings. (3 A.A. 570.) The court acknowledged the prior arrangement. (8 R.T. 337:28 to 338:4.) But the court stated that it had decided not to proceed as agreed. "I've made my ruling, I'm not going to set the additional evidentiary hearings and get into these additional subjects . . . ." (8 R.T. 338:6–8.) And the court repeatedly stated it would not consider any evidence submitted by Howell or any evidentiary objections to Hamilton's evidence. (8 R.T. 338–359.) The court, though, granted Howell permission to file her evidence and her evidentiary objections for the appellate record. (3 A.A. 570.) Howell did so. (3 A.A. 571–617.)

The court did not rule on Hamilton's motion to vacate. No amended judgment was filed. Hamilton did not appeal from the judgment entered on March 4, 2008. Howell appealed from the June 10, 2008, order that granted Hamilton's reduction motion. (3 A.A. 619–620.)

ARGUMENT

Before entering the thicket created by defendants' and liability insurers' attempt to abrogate the collateral source rule and to invalidate healthcare providers' pricing models, some threshold context is in order.

First, defendants' real argument is with healthcare providers' billing rates and practices. Defendants seek to punish plaintiffs for pricing models over which plaintiffs have no control. Moreover, this Court cannot solve the societal problem of high healthcare costs by providing tortfeasors an unearned windfall from benefits negotiated on plaintiffs' behalf by their

healthcare insurers. The proper forum in which to challenge the legitimacy of high healthcare costs is, if not the Legislature, in suits directly against healthcare providers.

Second, this Court is the wrong forum in another respect. Every defendant is, and always has been, entitled to dispute the reasonable value of a plaintiff's medical expenses. But defendant Hamilton tactically declined to do so. Rather than dispute to the jury the reasonable value of Howell's medical care and have that factual dispute resolved in the normal course by a jury, Hamilton (and liability insurers as an industry) want to impose an immutable rule that only cash payments matter, a rule that rewards tortfeasors whenever their victims have healthcare insurance and, pursuant to their insurance plans, obtain care from providers that have contracted with the victim's insurer.

Third, with the metronomic regularity of a Hindu mantra, defendants contend Howell and all plaintiffs are seeking a "windfall." But defendants ignore that the alleged "windfall" is an *earned* benefit, i.e., a benefit of a plaintiff's indemnity (healthcare) insurance for which *she* paid. Conversely, defendants ignore that *they* seek a true windfall, i.e., an *unearned* benefit, by parasitizing themselves onto a plaintiff's insurance benefits. (*Philip Chang & Sons Assocs. v. La Casa Novato* (1986) 177 Cal.App.3d 159, 170 [noting that the real question is who obtains the windfall].) "The choice is an easy. One party is innocent; the other at

fault." (McDowell, *The Collateral Source Rule: The American Medical Association and Tort Reform* (1985) 24 Washburn L.J. 205, 208.) "The tortfeasor should not garner the benefits of his victim's providence." (*Helfend, supra*, 2 Cal.3d at p. 10.)

Defendant, though, seeks for itself the unearned benefit of Howell's insurance premiums. That is bad enough. But defendant wants more. It wants that benefit without any offset for Howell's investment, i.e., her premium payments to her insurer. Even in the two instances in which the collateral source rule has been limited—for public entity and MICRA defendants—the plaintiff's premiums are taken into account as an offset. (Gov. Code, § 985, subd. (f)(2)(B); Civ. Code, § 3333.1, subd. (a).) The apt metaphor for defendant's argument is thus is not "windfall." It is "free ride." And it is specifically what the collateral source rule is intended to prevent: "[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, p. 514.)

Fourth, defendant has an unduly lawyerly view of what constitutes a "windfall" to a real person. Does anyone really believe that a person such as Howell, who had her spine shattered and underwent multiple surgeries, has received a windfall in any real sense? As one court observed, "Not many people would sell an arm for the average or even the maximum amount that juries award for loss of an arm." (*Hudson v. Lazarus* (D.C.

Cir. 1954) 217 F.2d 344, 346; *Rayfield v. Lawrence* (4th Cir. 1958) 253 F.2d 209, 214 [same].)

Fifth, defendant's entire premise is that only cash transactions are protected by the collateral source rule. But that is never what the rule has said or how it has been applied. Rather, it governs "payments made *or benefits* conferred." (Rest.2d Torts, § 920A, com. b, p. 514, italics added.) By purchasing healthcare insurance, when the insured later receives medical treatment, she receives, not just cash payments on her behalf by her insurer, but the benefit of negotiated contractual–credits that indemnify and extinguish her "entire debt." (*Parnell v. Adventist Health System/West* (2005) 35 Cal.4th 595, 609.) In the real world, that is an enormous benefit. Defendants make the point. They say that healthcare charges are extremely high. Yes, they are. Thus, avoiding those charges is the reason why a person buys healthcare insurance in the first instance. But defendant says not having to pay these charges is no benefit at all. That argument does not fly in the real world.

Sixth, a myth needs dispelling. There is no "*Hanif* rule" or "*Hanif*/*Nishihama*" rule, as defendants and liability insurers adulate it. Even the trial judge in this case acknowledged that the judges in her court differ over *Hanif*. "It [*Hanif*] was a big concern of mine because there were inconsistencies within the court itself. . . . [A]s I started to look at what was happening within the court, I discovered there really wasn't a single frame

of mind." (9 R.T. 343:11–20.) That was understatement. *Hanif* has spawned more than two decades of confusion, battles, and commentary. (See, e.g., *Olsen*, *supra*, 164 Cal.App.4th 200, 203, fn. 2 [referring to the "***purported*** *Hanif/Nishihama* rule"] emphasis added.)

Seventh, defendants' linchpin is that a plaintiff should not recover for healthcare charges unless those charges were incurred. But the undisputed evidence *in this case* is that the full charges were incurred. Defendant simply failed to meet its burden of proof. Indeed, defendant submitted no evidence whatsoever that Howell's full charges were not actually incurred. (Pp. 57–60, *post*.)

Eighth, this appeal poses a substantive issue and procedural issues. If the Court holds that reductions are substantively improper, the Court will have no occasion to address the procedural issues. But to permit reductions will create a procedural quagmire that will entangle the Courts of Appeal and this Court for the foreseeable future.

SUBSTANTIVE ISSUE

I. HOWELL IS ENTITLED TO RECOVER THE REASONABLE VALUE OF HER MEDICAL CARE.

Defendant's linchpin is that healthcare providers' charges are too high to serve as a measure of damages. Defendant's foe is thus not plaintiffs or the collateral source rule but healthcare providers.

Also obscured in the defense thicket is the jurisprudential bedrock that a plaintiff is entitled to the reasonable value of her medical care. (*Helfend*, *supra*, 2 Cal.3d 1, 6.) "The correct measure of damage is the necessary and reasonable value of the services rendered, rather than the amount which may have been paid for such services . . . ." (*Townsend v. Keith* (1917) 34 Cal.App. 564, 565.) "It has long been the rule that the cost alone of medical treatment and hospitalization does not govern the recovery of such expenses." (*Gimbel v. Laramie* (1960) 181 Cal.App.2d 77, 81.) Even *Hanif* restated the premise that reasonable value governs. (200 Cal.App.3d at p. 640.) And it is the basis of the standard jury instruction. "To recover damages for past medical expenses, [name of plaintiff] must prove the reasonable costs of reasonably necessary medical care that he/she has received." (CACI No. 3903A.) That seems sufficiently straightforward.

Under defendant's view, though, there is no consistent measure of value for any particular medical treatment. Rather, says defendant, the

reasonable value of any treatment will depend on the bargaining power of the plaintiff's healthcare insurer, such that a tortfeasor's liability for damages will be the least when a plaintiff is a member of the largest health plan with the greatest bargaining power. Conversely, a tortfeasor's liability for damages will be the greatest when the opposite is true, i.e. when the plaintiff is covered by an insurer with the least bargaining power.

For example, the 2007 chargemaster for Scripps Memorial Hospital–Encinitas, which treated Howell, states that the charge for heart failure and shock is $31,267.[4] But under defendant's view, if three insurers have negotiated three different rates of cash payment for that procedure, e.g., $15,000, $20,000, and $25,000, there is no such thing as reasonable value; or put differently, the reasonable value depends not on the hospital's determination of the value of its services, or even the marketplace's determination, but on each insurer's negotiating power. No authority supports defendant's view that the reasonable value of medical care depends on the luck of the draw in terms of plaintiff's insurance coverage.

Moreover, defendant's argument is really much ado about nothing. Defendants have always been entitled to dispute the reasonable value of a plaintiff's medical care. (*Gimbel v. Laramie*, *supra*, 181 Cal.App.2d 77, 81

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[4] <www.ohspd.ca.gov/HID/Products/PatDischargeDate/Pivot Tables BenchmarkDRG/2007TopDRG_Benchmark.pdf.> A chargemaster is a statutorily required posting of a hospital's usual and customary charges. (Pp. 40-41, *post*.)

[affirming trial court's refusal to award plaintiff's hospital expenses because he failed to submit evidence of reasonable value]; *Harris v. Los Angeles Transit Lines* (1952) 111 Cal.App.2d 593, 598 [awarding less than claimed amount].) Hamilton could have done so. If a defendant believes a provider's charges are unrealistic and thus not the reasonable value of the care, the defendant can submit its evidence and have the trier of fact decide the question. (*Ibid.*) That is how the system works. It is why we have trials. But rather than do its work, Hamilton asks this Court to relieve it and other defendants of that responsibility by creating a rule that damages are determined solely by the bargain negotiated by a plaintiff's healthcare insurer on behalf of its insureds.

Defendant's insistence that only the cash portion of the negotiated exchange between providers and insurers should be recoverable as damages is also off the mark because it fails to account for future medical expenses. " 'The cost of anticipated medical care reasonably certain to be required in the future has long been held to be a proper item of recoverable damages.' " (*Potter v. Firestone Tire & Rubber Co.* (1993) 6 Cal.4th 965, 1005, quoting *Miranda v. Shell Co.* (1993) 17 Cal.App.4th 1651, 1656; *Hoffman v. Southern Pacific Co.* (1929) 101 Cal.App. 218, 229–230; CACI No. 3903A.) By definition, future medical services have not yet been performed, and charges have thus not been incurred or paid, and it is entirely speculative what type of insurance coverage, if any, the plaintiff

will have when future services are rendered. How would such a plaintiff's future medical care be valued? One can only guess. Defendant's view leads to needless speculation and uncertainty.

II. FIRST PRINCIPLES SET FORTH IN *HELFEND* ARE AS PERSUASIVE NOW AS THEY WERE THEN.

"The Supreme Court of California has long adhered to the collateral source rule, i.e., 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 1, 6.) This Court has never backed away even an inch from the collateral source rule despite the defense bar's repeated assaults on it. (*Hrnjak v. Graymar, Inc.* (1971) 4 Cal.3d 725, 732–733; *Lund v. San Joaquin Valley Railroad* (2003) 31 Cal.4th 1, 9–11.)

In particular, a tortfeasor is not entitled to a reduction of damages based on benefits provided by his victim's insurer. This 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. The tortfeasor should not garner the benefits of his victim's providence." (*Helfend*, *supra*, 2 Cal.3d at pp. 9–10.)

Defendant's argument for a reduction in damages whenever a plaintiff has healthcare insurance—no matter how defendant tries to

disguise the argument—is an attack on *Helfend*, which rejected these same arguments. Resurrected, these arguments are no more persuasive now than when *Helfend* interred them. *Helfend* speaks for itself. But its key points merit brief reiteration.

- The defendant should not get a free ride on his victim's providence in having "invested years of insurance premiums." (*Helfend*, *supra*, 2 Cal.3d at pp. 9-10.)
- "If we were to permit a tortfeasor to mitigate damages with payments from a plaintiff's insurance, plaintiff would be in a position inferior to that of having bought no insurance, because his payment of premiums would have earned no benefit." (*Id.*, at p. 10.)
- "Defendant should not be able to avoid payment of full compensation for the injury inflicted merely because the victim has had the foresight to provide himself with insurance." (*Id.*, at p. 10.)
- Allowing evidence of collateral benefits can "irretrievably upset the complex, delicate, and somewhat indefinable calculations which result in the normal jury verdict." (*Id.*, at p. 11.)
- The alleged double recovery by a plaintiff is largely illusory. Her insurer will almost universally have a right of reimbursement from any damage award against the tortfeasor. (*Id.*, at p. 10.)

- The tortfeasor is not being required to pay doubly for his wrong.

(*Id.*, at p. 11.)

Every reason that led the *Helfend* court to reaffirm the collateral source rule equally leads to the rejection of defendant's renewed attack on the rule. And the last–noted *Helfend* reason—that the tortfeasor is not required to pay doubly—merits emphasis because defendants are so enamored of the notion that plaintiffs seek a double recovery under the collateral source rule. Howell seeks no such thing from Hamilton, and that is not the rule's effect. A tortfeasor pays only once. The rule does "not impose a double burden on [the tortfeasor who] bears responsibility only for the single burden of his wrong." (*Bush v. Superior Court* (1992) 10 Cal.App.4th 1374, 1387, quoting *Philip Chang & Sons Assocs. v. La Casa Novato*, *supra*, 177 Cal.App.3d at p. 170.)

III. HAMILTON'S DESIRED OBJECTIVE IS BEST LEFT TO THE LEGISLATURE.

A. *HELFEND'S* DEFERENCE TO THE LEGISLATURE IS EVEN MORE APPROPRIATE NOW THAN WHEN *HELFEND* WAS DECIDED 40 YEARS AGO.

This Court has observed, as long ago as *Helfend*, *supra*, 2 Cal.3d 1, that healthcare insurance is a complex field. Healthcare economics and healthcare insurance are enormously more complex now than when *Helfend* was decided 40 years ago—a labyrinth of statutes, regulations, accounting practices, and agreements between insurers and providers. (*Olsen*, *supra*,

164 Cal.App.4th at p. 204 (conc. opn. of Moore, J.) [rejecting *Hanif's* application to the "complicated area of medical insurance."].)[5] Faced with this complexity, it makes no sense to jettison or gut the collateral source rule without the benefit of empirical evidence and analysis that are entirely absent from a personal–injury action between an injured victim and her tortfeasor. Rather, the issue calls for the investigation and empirical analysis that only the Legislature can accommodate, e.g., evidence, testimony, studies, and hearings, and the social engineering that is best left to the Legislature. Any change to one part of the system will affect other parts. As one healthcare commentator has observed,

> "When a legislative body acts to allocate healthcare costs, it simultaneously amends a society–wide, interwoven web of regulation and incentives that is steeped in decades of tradition." (Caldie, *Medigap: Should Private Insurers Pay Public Rates and Who Should Make the Decision?* (2004) 30 Amer. J. Law & Medicine 69.)

The defense bar should be addressing its desired "reforms" to the Legislature, not to this Court. "It is more appropriate to seek repeal [of the collateral source rule] by statute." (McDowell, *supra*, 24 Washburn L.J. 205; Hubbard, *The Nature and Impact of the "Tort Reform" Movement* (2006) 35 Hofstra L.Rev. 437, 486–488 [discussing legislative modifications to the rule].) For example, in declining to abrogate the

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[5] In light of recent sweeping federal healthcare legislation, the complexity is sure to increase. (Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (March 23, 2010) 124 Stat. 119.)

collateral source rule, the *Helfend* court explained: "The reforms which many academicians propose cannot be easily achieved through piecemeal common law development; the proposed changes, if desirable, would be more effectively accomplished through legislative reform." (*Helfend*, *supra*, 2 Cal.3d at p. 13.) The Legislature did just that in response to *Helfend*, enacting Government Code section 985 for public entity defendants. Likewise, the Legislature enacted Civil Code section 3333.1, which permits a MICRA defendant to introduce evidence of a plaintiff's collateral benefits. And in *Olszewski v. Scripps Health* (2003) 30 Cal.4th 798, the Court stated its concern that tortfeasors were profiting from Medi–Cal windfalls. "*We therefore urge the Legislature* to remedy this anomaly in a manner consistent with federal law." (*Id.*, at p. 827, italics added.) Deference to the Legislature should be the result here as well.

That deference is warranted for another reason. Defendant's cornerstone is that healthcare charges are so inflated that they are phantom and bogus. If the Court adopts that premise, the Court must expect a spate of class actions against virtually all California healthcare providers. Any investigation and findings regarding healthcare costs—and providers' liability for allegedly inflated charges—can properly be accomplished only by the Legislature.

B. HAMILTON SEEKS EVEN MORE THAN THE LEGISLATURE HAS PROVIDED WHEN IT HAS LIMITED THE COLLATERAL SOURCE RULE.

As noted above, the Legislature has limited the collateral source rule in two situations: public–entity defendants (Gov. Code, § 985) and medical–malpractice defendants (Civ. Code, § 3333.1). Hamilton and its many amici seek an advantage those statutes do not provide. Indeed, if Hamilton's view were adopted, public–entity and medical–malpractice defendants could, and would, forego those statutes and enjoy an even greater free-ride.

More specifically, under Government Code section 985 ("section 985"), the trial court has total discretion whether to grant any reduction based on a collateral benefit. (§ 985, subd. (f).) If the court makes such a reduction, section 985 *requires* the court to deduct from the reduction the amount of the plaintiff's insurance premiums. (§ 985, subd. (f)(3)(B).) The plaintiff is also entitled to credit for attorney's fees and costs. (§ 985, subd. (f)(3)(C).) And the deduction is limited to 50 percent of the plaintiff's net recovery. (§ 985, subd. (g).) Similarly, Civil Code section 3333.1 ("section 3333.1") permits a MICRA defendant to introduce evidence of collateral benefits, but any deduction is discretionary with the jury. And if the defendant introduces such evidence, the plaintiff is entitled to introduce evidence of the amount of her insurance premiums. (§ 3333.1, subd. (a).)

Defendants seek a judicial rule without any such limitations. Worse, what defendants actually seek is judicial negation of these statutory limitations. Under defendants' proposed rule—a mandatory rather than discretionary deduction in all cases—every public entity defendant and medical malpractice defendant would forego the authorized procedures under section 985 and section 3333.1, relegating those statutes to the judicial dustbin.

IV. TO EXTEND *HANIF* BEYOND MEDI-CAL PAYMENTS IS TO ABROGATE THE COLLATERAL SOURCE RULE.

The genesis of the debate is *Hanif, supra*, 200 Cal.App.3d 635. The *Hanif* court properly decided solely the narrow issue before it: whether a Medi-Cal beneficiary could recover damages for medical care provided through Medi-Cal and for which Medi-Cal had subrogation and lien rights limited to the amount of Medi-Cal's payment. (200 Cal.App.3d at pp. 639–640; Welf. & Inst. Code, § 14124.70.) Further narrowing *Hanif's* scope, the defendant was a public entity and, as the *Hanif* court noted, while *Hanif* was pending, the Legislature in 1987 enacted section 985, which provides an exception to the collateral source rule for public entities. (*Hanif, supra*, 200 Cal.App.3d at p. 640, citing Gov. Code, § 985.)

Thus, *Hanif* lay virtually ignored for more than a decade, being cited only for its holding that a plaintiff can recover the reasonable value of personal services rendered for her benefit. (*Arambula v. Wells* (1999)

72 Cal.App.4th 1006, 1008.) It was not until 2001 in *Nishihama v. City and County of San Francisco* (2001) 93 Cal.App.4th 298, that *Hanif* was even cited for the issue now in dispute. But *Nishihama* was the match to *Hanif's* tinder, and *Hanif* has flared into an argument made by defendants in virtually every personal injury action: that, in all contexts, a victim may recover only the amount of her insurer's cash payments to her healthcare providers.

This argument for *Hanif's* expansion outside the Medi–Cal context fails for two reasons. *First*, *Hanif's* analysis was driven by the Medi–Cal statutes, which do not apply to private insurance or Medicare. *Second*, *Hanif* lacked any statutory or case authority that required such reductions outside the Medi–Cal context, if even in that limited context. Rather, *Hanif* relied on an inapplicable section of the Restatement of Torts Second. *Hanif* cannot be extended beyond Medi–Cal to private insurance or Medicare without abrogating the collateral source rule and without creating numerous substantive and procedural problems.

This Court can affirm the Court of Appeal decision on the narrower of two bases, i.e., that *Hanif* does not apply outside its limited (Medi–Cal) context, by reaffirming this Court's observation that a provider who treats a Medi–Cal beneficiary is statutorily precluded from recovering from the beneficiary any amount exceeding Medi–Cal's payment to the provider. (*Olszewski v. Scripps Health*, *supra*, 30 Cal.4th 798, 824–825, citing

42 U.S.C. § 1396(a)(25)(C) and 42 C.F.R. § 447.20 (2002).)

Alternatively, the Court can disapprove *Hanif* in its entirety. Although Howell recommends that course to the Court, in deference to judicial parsimony, Howell will first address the narrower ground, i.e., why *Hanif* should not be extended beyond its limited context. Howell emphasizes, though, that by first addressing the narrower ground, she is not, and should not be seen as, conceding that *Hanif* was correct.

A. NEGOTIATED NONCASH INDEMNITY IS AS MUCH A PURCHASED BENEFIT TO A PLAINTIFF AS IS CASH INDEMNITY.

A bit of economic common–sense is useful at the outset. As any purchaser of medical insurance understands, the reason she purchases the insurance is twofold. *First*, as a matter of physical well–being, she wants to be able to obtain healthcare. *Second*, as a matter of economic security, she wants to have the debt for her healthcare eliminated. That is what her healthcare insurance does for her. It indemnifies her against medical debt. Thus, although healthcare insurance may not be referred to in lay parlance as indemnity insurance, that is its purpose and function. Put simply, it takes

care of the bills.[6]

As modern healthcare and healthcare insurance have evolved, and as allowed and even encouraged by the Legislature, healthcare insurers negotiate contracts with providers to establish networks of providers for the insurer's policyholders. Pursuant to these negotiated contracts, insurance takes care of medical debt two ways: (1) negotiated contractual allowances and (2) concomitantly reduced cash payments. And based on these negotiated contracts, which, like all contracts, are necessarily based on an exchange of consideration, a contracting provider agrees to recognize the contract's value as an allowance, thus providing the insurer with a credit against the insured's medical debt, and permitting the insurer to fulfill its indemnity obligation to its insureds through a combination of cash payments and contractual allowances.

From the insured's perspective, the result is the same for both forms of debt extinguishment. She does not have to pay the debt. By purchasing insurance, she has provided for indemnity against her liability for medical

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[6] Insurance Code section 22 defines insurance as "a contract whereby one undertakes to indemnify another against loss, damage, or liability arising from a contingent or unknown event." Similarly, Civil Code section 2772 states, "Indemnity is a contract by which one engages to save another from a legal consequence of the conduct of one of the parties, or of some other person." (See, Black's Law Dict. (West 8th ed. 2004), p. 814, col. 2 ["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."].)

care. That is a benefit to any insured. To argue to the contrary is to ignore pocketbook common–sense.

Regardless of the label attached to it, any amount the patient does not have to pay because of her healthcare insurance fits the definition of a collateral benefit purchased by a tortfeasor's victim. The classic formulation is set forth in Restatement section 920A, the section that specifically adopts the collateral source rule:

> "Payments made to *or benefits conferred on* the injured party from other sources are not credited against the tortfeasor's liability, although they cover all or a part of the harm for which the tortfeasor is liable." (Rest.2d Torts, § 920A, p. 513, italics added.)

If not having to pay tens of thousands of dollars in healthcare charges is not a benefit, what is? Defendant, though, contends this combined indemnity–benefit should be disregarded and that contractually negotiated allowances (noncash indemnity), sometimes called "negotiated rate differentials," should be treated differently from contractually negotiated and concomitantly reduced cash payments (cash indemnity). That is the sum and substance of defendant's position—the argument that negotiated contractual allowances are never incurred. The argument fails three ways.

First, defendant's purposed distinction between cash payments and noncash indemnity (i.e., contractual allowances) is not the law. "The law does not differentiate between the nature of the benefits, so long as they did

not come from the defendant or a person acting for him." (Rest.2d Torts, § 920A, com. b., p. 514; Marshall & Fitzgerald, *The Collateral Source Rule and Its Abolition: An Economic Perspective* (2006) 15 Kan. J. L. & Pub. Policy 57, 58 ["The collateral source rule does not differentiate between the nature of the benefits."].) Likewise, " 'Payment' is not a talismanic word. It may have many meanings depending on the sense and context in which it is used." (*United States v. Consolidated Edison Co. of New York, Inc.* (1961) 366 U.S. 380, 391; 81 S.Ct. 1326; 6 L.Ed.2d 356.)

The point is well made by *Goble v. Frohman* (Fla. 2005) 901 So.2d 830, in which the court was faced with a Florida statute that abrogated the collateral source rule. The question was whether the difference between a provider's charges and the amount of cash payment to the provider was a collateral benefit and thus subject to the statute. (*Id.*, at pp. 831–832.) The court held the difference was a collateral benefit and thus had to be set–off against the award of damages. (*Id.*, at p. 833.) Of course, that statutorily mandated result is not the result Howell seeks. But the court's reasoning is spot on. It refutes defendant's argument that cash payments are a benefit but that noncash indemnity ("write offs" in defendant's parlance) are not a benefit. As another court observed, the argument against allowing a plaintiff to recover the full amount of her medical expenses, including noncash payments, is analytically the same as the argument against allowing her to recover the amount of her insurer's cash payment—the

same argument "in different dress." (*White v. Jubitz Corp.* (Or. 2009) 219 P.3d 566, 578.)

Likewise here, the contractual allowances negotiated by Howell's insurer were a form of payment. Only in combination with the concomitantly reduced cash–payments under her insurer's contract with her providers, were Howell's debts to her providers discharged. The contractual allowances were thus as much a benefit to Howell as were the cash payments to her providers.[7]

Second, as discussed below (pp. 38–45), defendant is wrong that a patient does not incur liability for charges beyond the amount of cash payment. The common defense–characterization of the issue makes the point. Defendant refers to amounts not paid in cash as "write offs." An amount cannot be written–off if it was never incurred in the first instance.

Third, aside from common sense, the evidence in this case refutes defendant's point. Howell's financial responsibility contracts with her providers explicitly provided that Howell "is obligated to pay the Facility's usual and customary charges for such services." (2 A.A. 368.) "It is your responsibility to pay any . . . balance not paid for by your insurance." (2 A.A. 370.) Howell avoided ultimately having to personally pay her providers' full charges only because she had purchased insurance. In turn,

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[7] In addition to the common-sense obviousness of this benefit, Howell was prepared to submit expert evidence on this point but was precluded from doing so. (Pp. 8–11, *ante*, & 66-71, *post*; 3 A.A. 591–595.)

the contractual allowances against her debt were possible only because of her insurer's contracts with her providers. In real economic terms, those "write offs" as defendant likes to call them, are a collateral benefit indistinguishable from cash payments. And the collateral source rule protects collateral benefits, not just collateral cash–payments.

B. HAMILTON SEEKS TO USURP NOT ONLY HOWELL'S COLLATERAL BENEFIT BUT ALSO TO DEPRIVE HER OF OTHER ASSETS WITHOUT PAYING FOR THEM.

Defendant contends that to allow a plaintiff's damage award to include all indemnity benefits provided by her healthcare insurance, including cash payments and negotiated rate differentials, would be akin to the plaintiff winning the lottery. Not so, but the lottery example, though a defense trope, is useful. At least a person who has purchased a winning lottery ticket has paid for it. But a thief who takes it from the purchaser or even a passerby who finds it lying on the sidewalk has in every sense received a windfall. Defendant is in that role. Defendant seeks to limit its damage based entirely on the fortuity of having injured someone who purchased insurance from an insurer who had the negotiating leverage to obtain a healthcare provider's agreement to accept noncash as well as cash payments to discharge the patient's debt. *That* is winning the lottery—without even buying a ticket.

Defendant's lottery analogy is useful in another respect. As the United States Supreme Court long ago made clear in applying the collateral

source rule, "The contract with the insurer is in the nature of a wager between third parties, with which the trespasser has no concern." (*The Propeller Monticello v. Mollison* (1854) 58 U.S. (17 How.) 152, 155; 15 L.Ed. 68.) So too here, defendant has no concern with the agreement between the plaintiff and her insurer.

Moreover, a patient covered by either private insurance or Medicare has paid for her coverage. Defendant, though, does not include in its formulation any allowance for the plaintiff's premiums. Assume, for example, that the negotiated rate differential is $50,000. But also assume the plaintiff has paid five years of insurance premiums totaling $30,000. Defendant contends the full $50,000 should be deducted from the plaintiff's damages award. But this ignores the $30,000 she paid for the insurance that made the negotiated rate differential possible. Thus, defendant wants a plaintiff's collateral benefit—for free. And that is a tortfeasor windfall the Legislature has declined to provide even when the Legislature has limited the collateral source rule. (Gov. Code, § 985, subd. (f)(2)(B) ["The court shall deduct from the reimbursement or reduction the amount of premiums the court determines were paid by or on behalf of the plaintiff to the provider of a collateral source payment."]; Civ. Code, § 3333.1, subd. (a) ["[T]he plaintiff may introduce evidence of any amount which the plaintiff had paid or contributed to secure his right to any insurance benefits . . . ."].)

Likewise, a typical healthcare–insurance policy limits coverage to a specified number of days of hospitalization. Thus, for example, if a tortfeasor's negligence causes a plaintiff to be hospitalized for 30 days under a policy that pays for 365 lifetime days of care, she will have 30 days less coverage for future hospitalization. Defendant does not propose to compensate the plaintiff for her loss of this coverage—for which she paid.

Defendant also ignores annual and lifetime dollar–limits typically found in healthcare policies. Under defendant's view, a plaintiff can recover only the amount of her insurer's cash payment, which the insurer then takes from her under its contractual right of reimbursement. But the plaintiff has nonetheless depleted the dollar amount of her coverage. Defendants do not propose to compensate her for this.

Defendant also proposes to deprive insured plaintiffs of the opportunity cost of their premiums. An insured may pay tens of thousands of dollars in premiums. That is money the insured could have used or invested for other purposes. (Marshall, *supra*, 15 Kan. J. L. & Pub. Policy at p. 64 [explaining opportunity costs under the collateral source rule].) Too bad, says defendant.[8]

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[8] According to a 2009 study, the average annual family–premium in the individual market in California was $6,567. (America's Health Insurance Plans Center for Policy and Research, A Comprehensive Survey of Premiums, Availability, and Benefits (Oct. 2009) Table 3, p. 6, at <www.ahipresearch.org/pdfs/2009IndividualMarketSurveyFinalReport.pdf.>.)

Similarly, defendant's approach would put insured patients in a worse position than if they received charity medical–care. The collateral source rule fully applies to gratuitous payments, i.e., charity. (*Arambula v. Wells*, *supra*, 72 Cal.App.4th 1006, 1008; Rest.2d Torts, § 920A, com. c(3), p. 515; Maxwell, *The Collateral Source Rule in the American Law of Damages* (1962) 46 Minn. L.Rev. 669, 687–689.) But even if the rule did not apply to gratuitous payment, at least the plaintiff would not be deprived of the benefit of her bargain in having bought insurance.

C. HEALTHCARE PROVIDERS DO NOT GRATUITOUSLY EXTINGUISH THEIR CHARGES; RATHER, THEY DISCOUNT THEM IN EXCHANGE FOR COMPENSATION.

Defendant ignores not only the benefit from the patient's perspective, but also from her provider's perspective. Defendant asks the Court to indulge the fantasy that healthcare providers accept as full payment whatever an insurer is willing to pay and simply forego the balance of a patient's debt without obtaining *anything* of value in exchange.

That is not the way business works. A negotiated rate differential is not a gift, but a negotiated exchange, the result of the bilateral agreement between the provider and the insurer. As with any contract, consideration is exchanged. (Otherwise, there is no contract.) The insurer obtains the provider's agreement to accept a cash payment of less than the full debt. In exchange, the provider obtains consideration in addition to cash payments by the insurer. Most obviously, the provider obtains patients because,

under the typical healthcare policy, insureds are encouraged with financial incentives to use participating providers. The provider also obtains guaranteed and reasonably prompt payments by the insurer, thus resulting in a reliable revenue–stream. Howell documented with expert testimony the many types of consideration received by providers under their contracts with insurers. (3 A.A. 593:7–594:23 & 3 A.A. 602.) Defendant submitted no contrary evidence.

These noncash benefits to the provider are valid contractual consideration. "The amount of *consideration* . . . is not necessarily the amount of *money* paid." (*Franklin Mint Co. v. Superior Court* (2005) 130 Cal.App.4th 1550, 1557, original italics.) Defendant knows this. In a press release touting this Court's grant of review, defendant's counsel explained that hospitals discount their bills "in exchange for prompt payment and/or a guaranteed volume of business." (Tyson & Mendes, News Release: *California Supreme Court to Hear Significant Victim's Compensation Case*, at <www.tysonmendes.com> as of May 19, 2010.)

As the Restatement aptly explains it, "In most commercial bargains there is a rough equivalence between the value promised and the value received as consideration." (Rest.2d Contracts, § 71, com. c, p. 174.) That principle squarely applies to the negotiated rate differentials that providers grant healthcare insurers to secure a contract with the insurers. This Court must presume that a provider has received from the insurer a rough

equivalence in exchange for the discount. In simple terms, if a contracting provider bills $1,000, accepts cash payment of $500, and discounts the remaining $500, one must presume the provider—at least to its satisfaction—received consideration equivalent to the $500 discount. Otherwise, in defendant's world, the Court is asked to presume healthcare providers are Forrest Gumps—kind souls with no business acumen.

Defendant's view also ignores the "elementary rule that a court of law will not inquire into the adequacy of consideration for a contract (see *Taylor* v. *Taylor*, [1944] 66 Cal.App.2d 390, 398; *Gerson* v. *Kelsey*, [1935] 4 Cal.App.2d 158, 162; Rest., Contracts, § 81)." (*Grant v. Aerodraulics Co.* (1949) 91 Cal.App.2d 68, 76 (bracketed dates added); *Foley v. Interactive Data Co.* (1988) 47 Cal.3d 654, 679; Rest.2d Contracts, § 71, com. c, p. 174.)

Moreover, a written instrument, e.g., the contracts between insurers and providers, are presumptive evidence that the provider received consideration for the negotiated discounts. (Civ. Code, § 1614 ["A written instrument is presumptive evidence of consideration."].) And "the burden of showing a want of consideration . . . lies with the party seeking to invalidate or avoid it." (Civ. Code, § 1615.) Defendant has not even attempted to meet that burden.

Lastly, defendant's premise that a provider receives nothing of value from an insurer except the insurer's cash payment cannot be accepted

at face value. Rather, defendant's premise requires empirical investigation and analysis of healthcare accounting procedures and procedures. As explained above, a garden variety tort–action between one plaintiff and one tortfeasor is not the proper forum to conduct such inquiry. That task is best left to the Legislature. At a minimum, the issue should be decided in a dispute between healthcare insurers and healthcare providers.

D. HOWELL IS ENTITLED TO RECOVER PAYMENTS MADE OR CHARGES INCURRED.

Again, the correct measure of damages is simply the medical care's reasonable value. Defendant's "paid or incurred" argument is a strategic distraction. Moreover, even on its own terms, defendant's "paid *or incurred*" argument fails because defendant fails to acknowledge "incurred" charges.

By arguing so vigorously that providers' charges paid with negotiated contractual allowances are not incurred, defendant necessarily acknowledges that its argument fails if the charges are incurred. Indeed, *Hanif* itself and all subsequent cases on which defendant relies make clear that a plaintiff is entitled to recover the amount of charges "he paid *or for which he incurred* liability." (*Hanif, supra*, 200 Cal.App.3d at p. 640, italics added; *Nishihama, supra*, 93 Cal.App.4th at p. 306 ["paid or incurred"]; *Greer v. Buzgheia* (2006) 141 Cal.App.4th 1150, 1154

["expenses actually paid or incurred"].) The rule that a plaintiff can recover for charges incurred as well as for charges paid is bedrock.

E. HOWELL INCURRED LIABILITY FOR ALL CHARGES BILLED BY HER HEALTHCARE PROVIDERS.

The law is clear that a patient incurs liability for her healthcare provider's charges. Before turning to the authorities, though, a further bit of common sense may be useful. As anyone who obtains healthcare knows, he or she must first agree to pay the provider's charges. The typical contract is titled something such as "Financial Responsibility Agreement" or "Conditions of Admission." Just try to get past the provider's reception desk without signing such an agreement. Indeed, like any patient, Howell had to sign such contracts with her providers before they treated her. (2 A.A. 368–370.) And even when a patient is treated by a hospital without such an express agreement, the law implies an agreement to pay for the services. (*Mathes v. Aggeler & Musser Seed Co.* (1919) 179 Cal. 697, 700 ["The law, of course, in the absence of evidence to show gratuitous service, would imply an agreement by her [plaintiff] to pay the reasonable value."]; *Reichle v. Hazie* (1937) 22 Cal.App.2d 543, 547 [same].)

More fundamentally, as explained above, healthcare insurance provides indemnity against medical debt. But insurance cannot indemnify against debt that is never incurred. Defendant ignores this fundamental

point by arguing that Howell never incurred debt for any amount of her insurer's negotiated contractual allowances.

Defendant's claim that a provider's customary charges are never even incurred is also refuted by the governing statutes. California has a Payers' Bill of Rights. (Health & Saf. Code, § 1339.50 et seq.) It requires hospitals to make publicly available a copy of the hospital's "charge description master." (Health & Saf. Code, § 1339.51.) As the Statewide Office of Healthwide Planning and Development explains, "A hospital charge description master, also known as a chargemaster or CDM, contains the prices of all services, goods, and procedures for which a separate charge exists. *It is used to generate a patient's bill.*"[9]

More technically, Health and Safety Code section 1339.51, states that " 'Charge description master' means a uniform schedule of charges represented by the hospital as its gross billed charges for a given service or item, regardless of payer type." (Health & Saf. Code, § 1339.51, subd. (b)(1); Cal. Code Regs., tit. 22, § 96000, subd. (a) [same].) Put simply, hospitals are statutorily required to state the charges that patients *incur*, regardless of who will pay them, i.e., the patient or her insurer. Indeed, section 1339.51 specifically does not allow hospitals to report the amount they accept from insurers as payment. To the contrary, the statute

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[9] <www.oshpd.ca.gov/HID/Products/Hospitals/Chrgmstr/index.html>, italics added.)

says the charges must be listed "regardless of payer type." But if the billed charges are never even incurred, as claimed by defendant, every California hospital is violating the law. Providers are thus exposed to enforcement actions and fines by federal and state regulatory agencies and to class actions by patients these providers have been defrauding.

Defendant's view that billed charges are never incurred is also refuted by numerous decisions, including this Court's decisions. In *City and County of San Francisco v. Sweet* (1995) 12 Cal.4th 105, the question was whether a hospital's lien for charges should be reduced by any amount of attorney's fees incurred by a patient in obtaining recovery from the third–party tortfeasor, a recovery the patient characterized as a common fund. The Court held no deduction for fees was allowed. The Court's cornerstone was that the common–fund doctrine did not apply because the plaintiff owed the hospital the amount of its charges. "The fact remains that defendant Sweet [the patient] received services from the county for which payment was due. He was a debtor whose assets the county had a preexisting right to pursue regardless of the source of those assets." (*Id.*, at p. 117.) This conclusion is inconsistent with defendant's notion that providers' charges are not incurred when billed.

Similarly, in *Appleman v. National–Ben Franklin Ins. Co. of Illinois* (1978) 84 Cal.App.3d 1012, the court held that a provider's charges are incurred when the service is rendered even if third–party payment (in that

case, Medicare) subsequently discharges the patient's obligation to pay. "Expenses were actually incurred." (*Id.*, at p. 1014; accord *Holmes v. California State Auto. Assn.* (1982) 135 Cal.App.3d 635, 637–638 [expenses incurred even though paid by Medicare].)

Likewise, in *Mercy Hospital & Medical Center v. Farmers Ins. Group of Cos.* (1997) 15 Cal.4th 213, the Court was asked to decide the proper amount of a hospital's lien for care to a patient injured by a third party. In discussing the hospital's lien rights against the third party (or its insurer), the Court made plain that, regardless of the proper lien amount, "the hospital may still proceed directly against the patient for any unpaid balance." (*Id.*, at p. 217.) Moreover, three justices dissented, concluding that the hospital should have been allowed a greater recovery in that case. But on the issue central to the present case, they agreed that, "Apart from the statutes at issue here, *the hospital may proceed at law directly against the patient for the entire amount of its reasonable and customary charges*." (*Id.*, at p. 227, dis. opn. of Baxter, J., joined by Kennard, J. and Werdegar, J.). In short, although disagreeing as to the result in *Mercy Hospital*, all seven justices agreed that a patient incurs liability for reasonable and customary charges billed by a healthcare provider.

The Court's subsequent decision in *Parnell v. Adventist Health System/West*, *supra*, 35 Cal.4th 595, did not reach the question now before the Court. "[W]e do not reach, and express no opinion on . . . whether

[*Olszewski* and *Hanif*] apply outside the Medicaid context and limit a patient's tort recovery for medical expenses to the amounts actually paid by the patient notwithstanding the collateral source rule." (*Id.*, at p. 611, fn. 16.) But *Parnell* did answer the question of whether a patient incurs her providers' full charges and confirmed that a healthcare provider's charges are incurred, not illusory. The patient had been injured in an automobile accident. The hospital received payment from his insurer in the amount specified in the hospital's agreement with the insurer and, also pursuant to that agreement, agreed to accept this amount as full payment of the charges. The patient later sued the third–party tortfeasor. The hospital asserted a lien for the difference between the full charge for its services and the amount it had agreed to accept as payment. The Court held the hospital could not do so because the patient's entire debt to the hospital had been extinguished.

In reaching that decision, the *Parnell* court concluded that the patient was a debtor to the creditor hospital for the full amount of the charges, which were subsequently extinguished by the cash payment and by the provider's agreement to accept the cash payment as full payment. Of course, there can be no extinguishment of a debt without a debt. As the Court explained, "Because Parnell *no longer owes at debt* to the hospital for its services, we conclude the hospital may not assert a lien under the

HLA [Hospital Lien Act] against Parnell's recovery from the third party tortfeasor." (*Id.*, at p. 609, italics added.)

By explaining that, until the charges were extinguished, they were a debt owed by the patient, *Parnell* makes clear that the charges were incurred. If they had not been incurred, there would have been no debt. The Court further emphasized that the charges had been incurred and were a debt.

> "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 p. 611.)

But of course, a hospital would not be free to collect this difference if the charges had never been incurred. Again, as in prior cases, the Court's premise was that the charges had been incurred and a debt created.

Parnell's premise is codified in Insurance Code section 10133, which makes clear that health insurance benefits are contingent on the patient incurring expenses for medical care:

> "[A]ny disability insurer shall pay group insurance benefits *contingent upon, or for expenses incurred* on account of, hospitalization or medical or surgical aid to the person or persons furnishing the hospitalization or medical or surgical aid . . . ." (Ins. Code, § 10133, subd. (a).)[10]

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[10] Healthcare insurance is statutorily defined as a form of disability insurance. (Ins. Code, § 106, subd. (b).)

So too, in *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group* (2009) 45 Cal.4th 497, the Court held that "doctors may not bill a patient for emergency services that an HMO is obligated to pay. Balance billing is not permitted." (*Id.*, at p. 507.) But the court made clear that, for nonemergency services, "If the HMO is not obligated to pay the noncontracting provider, obviously, the member *would* be liable to pay for the services." (*Id.*, at p. 508, italics by the Court.)

In plain language, a healthcare insurer's obligation to pay does not arise until charges have been incurred. The two–step sequence is: (1) charges are incurred; (2) payments and other extinguishments are made. It does not matter what the other extinguishments are labeled: write offs, noncash indemnity, negotiated rate differentials, or alternative rates of payment. Whatever the label, they do not come into play until there is a debt.

In short, this Court has repeatedly recognized that a patient incurs liability for her healthcare provider's customary and reasonable charges. That liability may ultimately be extinguished by cash payment or by other means, but it was incurred at the outset.

F. CRIMINAL–RESTITUTION CASES DO NOT SUPPORT WINDFALLS TO TORTFEASORS.

Defendant contends "convicted criminals who rape, murder, and maim . . . .¶ enjoy the *Hanif/Nishihama* rule when it comes to paying

restitution to their victims" and that civil tortfeasors should be entitled to the same windfall. (Opening Brief, pp. 38 & 41.)

Let us first be clear about the repugnancy of defendant's argument. In 1978, Lawrence Singleton picked up 15–year–old Mary V. while she was hitchhiking. He beat her. He raped her—twice. He sodomized her. He took a hatchet, and he chopped off her left hand, then her right. He threw her into a culvert, and he drove away, "abandoning the bleeding, armless child in a wilderness" to die. (*People v. Singleton* (1980) 112 Cal.App.3d 418, 421–422 & 433.) Under defendant's view, Singleton would have to pay Mary restitution only in the amount of cash payments by her insurers.

Fortunately, that is not the law. Penal Code section 1202.4, subdivision (f)(2) states that "determination of the amount of restitution ordered pursuant to this subdivision shall not be affected by the indemnification or subrogation rights of any party." And in *People v. Birkett* (1999) 21 Cal.4th 226, this Court made clear that California's criminal–restitution statutes give crime victims "a right to restitution based on the *full amount* of their losses, without regard to full or partial recoupment from other sources except the Restitution Fund." (*Id.*, at p. 229, italics by the Court.) The victim is entitled to restitution "regardless

of that victim's reimbursement from other sources." (*Id.*, at p. 246.)[11] And as further support for its conclusion, the Court specifically relied on the collateral source rule and on *Helfend*, *supra*, 2 Cal.3d 1, 9-10. (*Birkett*, *supra*, 21 Cal.4th at p. 247, fn. 19.) But now, defendant asks this Court to use *Birkett* to eviscerate *Helfend* even though *Birkett* relied on *Helfend*.

Defendant cites three Court of Appeal decisions. (*In re Anthony M.* (2007) 156 Cal.App.4th 1010 [shooter]; *People v. Bergin* (2009) 167 Cal.App.4th 1166 [drunk driver]; *People v. Millard* (2009) 175 Cal.App.4th 7 [drunk driver].) In those decisions, the courts interpreted the criminal-restitution statute as requiring a windfall to criminals. Even if that interpretation were correct—it was not—this Court should reject that result for civil cases, which are not subject to the statute. Moreover, the restitution statutes makes clear, "there is no requirement the restitution order . . . reflect the amount of damages that might be recoverable in a civil action." (*People v. Carbajal* (1995) 10 Cal. 4th 1114, 1121; *In re Brian S.* (1982) 130 Cal. App. 3d 523, 528–532.) And under the penal statute, a court has broad discretion in setting restitution. (*People v. Baker* (2005) 126 Cal. App. 4th 463, 470; *People v. Ortiz* (1997) 53 Cal. App. 4th 791, 800; Pen. Code §1202.4.) But in defendant's view, the broad

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[11] When *Birkett* was decided, the criminal–restitution statute was Penal Code section 1203.04. (*Birkett*, *supra*, 26 Cal.4th at p. 231.) The present statute is Penal Code section 1202.4.

discretion granted trial courts in ordering restitution should not be allowed in civil cases.[12]

V. *HANIF* WAS QUESTIONABLE AT BEST IN ITS OWN LIMITED CONTEXT AND WRONG OUTSIDE THAT CONTEXT.

The Court need not disapprove *Hanif* to reject defendant's proposed expansion of *Hanif* beyond its Medi–Cal context. But an analysis of *Hanif* is useful because *Hanif* is defendant's sine qua non.

Hanif was decided "without statutory authority." (*Olsen*, *supra*, 164 Cal.App.4th at p. 204 (conc. opn. of Moore, J.).) Unlike the statutory exceptions for public entity and medical malpractice defendants (Gov. Code, § 985 & Civ. Code, § 3333.1), no California statute purports to allow collateral-source reductions in other contexts.

Nor was *Hanif* supported by case authority. *Hanif* relied on four decisions from 1907 to 1954. (*Melone v. Sierra Railway Co.* (1907) 151 Cal. 113; *Townsend v. Keith*, *supra*, 34 Cal.App. 564; *Castro v. Giacomazzi Bros.* (1949) 92 Cal.App.2d 39; *Guerra v. Balestrieri* (1954) 127 Cal.App.2d 511.) Not one of those decisions dealt with insurance or government payments of a personal–injury victim's medical expenses, or with a reduction of medical expenses, or with so-called "write–offs" of

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[12] Moreover, *Anthony M.* is distinguishable for the same reason as *Hanif*. The victim's medical expenses were paid by Medi–Cal, not private insurance or Medicare. (*Anthony M.*, *supra*, 156 Cal.App.4th at p. 1018.)

medical charges. "Cases are not authority for propositions not considered." (*Little v. Auto Stiegler, Inc.* (2003) 29 Cal.4th 1064, 1080, fn. 3.)

Faced with a lack of primary authority, the *Hanif* court tried to ground its result on the Restatement Second of Torts section 911, comment h. (200 Cal.App.3d at p. 643.) That was dead wrong. Section 911, comment h has nothing to do with the issue. Worse, *Hanif's* holding is directly contradicted by the Restatement sections that *are* on point: sections 920A and 924.

Hanif first ignored Restatement section 920A, the section that specifically addresses "benefits from collateral sources." (Rest.2d Torts, § 920A, com. b., p. 514.) Section 920A states:

> "Payments made to *or benefits conferred* on the injured party from other sources are not credited against the tortfeasor's liability, although they cover all or part of the harm for which the tortfeasor is liable." (Rest.2d Torts, § 920A, p. 513, italics added.)

Restatement section 924, which *Hanif* also ignored, refutes *Hanif.* Section 924 is titled "Harm to the Person." (Rest.2d Torts, § 924, p. 523.) And comment f specially deals with medical expenses:

> "The value of medical services made necessary by the tort can ordinarily be recovered *even though they have created no liability or expense to the injured person*, as when a physician donates his services." (Rest.2d Torts, § 924, com. f, pp. 526–527, italics added.)

Hanif squarely conflicts with Restatement section 924 as well as section 920A. *Hanif's* misunderstanding of the Restatement has been pointed out by other courts that have rejected *Hanif.* (*Bynum v. Magno*

(Haw. 2004) 101 P.3d 1149, 1159–1160, & fn. 19; *Wills v. Foster* (Ill. 2008) 892 N.E.2d 1018, 1027–1029.)

Ignoring sections 920A and 924, the relevant Restatement sections, *Hanif* relied on a snippet from comment h to section 911. (*Hanif, supra*, 200 Cal.App.3d at p. 643.) That snippet states:

> "If, however, the injured person paid less than the exchange rate, he can recover no more than the amount paid, except when the low rate was intended as a gift to him." (Rest.2d Torts, § 911, com. h, pp. 476–477.)

Section 911's text, which *Hanif* ignored, makes plain that section 911 does not deal with personal–injury damages. It deals with property damages and wrongful taking of services. Likewise, the three cases cited in the Reporters Notes for section 911's comment h further illustrate its inapplicability to medical expenses. Two dealt with fraudulent employment-practices. (*Hanlon v. MacFadden Publications, Inc.* (N.Y. 1951) 99 N.E.2d 546; *Alder v. Crosier* (Utah 1917) 168 P. 83.) The third dealt with the replacement value of a dead dog. (*Demeo v. Manville* (Ill. Ct. App. 1979) 386 N.E.2d 917.)

VI. POST–*HANIF* DECISIONS DO NOT SUPPORT ITS EXPANSION TO OTHER CONTEXTS.

A. *HANIF* HAS BEEN OVERWHELMINGLY REJECTED IN OTHER JURISDICTIONS.

When virtually all other states have rejected an approach, "we should question the advisability of continued allegiance to our minority

approach." (*Moradi–Shalal v. Fireman's Fund Ins. Cos.* (1988) 46 Cal.3d 287, 298; *Freeman & Mills v. Belcher Oil Co.* (1995) 11 Cal.4th 85, 98–99 [same]; *City and County of San Francisco v. Sweet*, *supra*, 12 Cal.4th 105, 118 [same].) And *Hanif* is only a Court of Appeal decision.

Hanif has been soundly and repeatedly rejected outside California. "[T]hose cases [*Hanif and Nishihama*] represent *a distinct minority view* and have not been followed by other courts." (*Lopez v. Safeway Stores, Inc.* (Ariz. Ct. App. 2006) 129 P.3d 487, 494–496 italics added; *Leitinger v. DBart, Inc.* (Wis. 2007) 736 N.W.2d 1, 9, fn. 28 [noting that *Hanif* is a minority view].) Rather, "the vast majority of courts to employ a reasonable–value approach hold that the plaintiff may seek to recover the amount originally billed by the medical provider." (*Wills v. Foster*, *supra*, 892 N.E.2d 1018, 1027–1031; *White v. Jubitz Corp.*, *supra*, 219 P.3d 566, 580.) Indeed, *Hanif* has been rejected by numerous states, the District of

Columbia, and at least five federal courts.[13]

B. POST–*HANIF* CALIFORNIA DECISIONS DO NOT SUPPORT ITS CONTINUED APPLICATION, MUCH LESS EXPANSION.

The most oft–cited decision for applying *Hanif* is *Nishihama v. City and County of San Francisco*, *supra*, 93 Cal.App.4th 298, the case that resurrected *Hanif* from the judicial boneyard. But *Nishihama* did not improve on *Hanif* or even analyze it. Rather, the primary question was whether California's Hospital Lien Act (Civ. Code, § 3045.1, et seq.) allowed the plaintiff's hospital a lien in an amount greater than the amount the hospital had agreed to accept from her insurer pursuant to the contract between her insurer and the hospital. Without analyzing either the collateral source rule or the creditor–debtor relationship between the

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[13] See, e.g., *Lopez*, *supra*, 129 P.3d 487, 495; *Bynum*, *supra*, 101 P.3d at pp. 1160–1162; *Wills*, *supra*, 892 N.E.2d 1018, 1027; *White*, *supra*, 219 P.3d 566, 580; *Leitinger*, *supra*, 736 N.W.2d 1, 9; *Hardi v. Mezzanotte* (D.C. 2003) 818 A.2d 974, 985; *Mitchell v. Haldar* (Del. 2005) 883 A.2d 32, 40; *Olariu v. Marrero* (Ga.Ct.App. 2001) 549 S.E.2d 121, 123; *Baptist Healthcare Systems, Inc. v. Miller* (Ky. 2005) 177 S.W.3d 676, 682–684; *Bozeman v. Louisiana* (La. 2004) 879 So.2d 692, 705–706; *Walmart Stores, Inc. v. Frierson* (Miss. 2002) 818 So.2d 1135, 1139–1140; *Brown v. Van Noy* (Mo.App. 1994) 879 S.W.2d 667, 676; *Haselden v. Davis* (S.C. 2003) 579 S.E.2d 293, 295; *Papke v. Harbert* (S.D. 2007) 738 N.W.2d 510, 535–536; *Texarkana Memorial Hospital, Inc. v. Murdock* (Tex.Civ.App. 1995) 903 S.W.2d 868, 874, reversed on other grounds at 946 S.W.2d 836, 841 (1997); *Acuar v. Letourneau* (Va. 2000) 531 S.E.2d 316, 322; *McMullin v. United States* (E.D.Ark. 2007) 515 F.Supp.2d 904, 908; *Calva–Cerqueira v. United States* (D.D.C. 2003) 281 F.Supp.2d 279, 295–296; *Reed v. Nat'l. Council of the Boy Scouts of America* (D.N.H. 2010) 2010 U.S. Dist LEXIS 9236; *Pipkins v. TA Operating Corp.* (D.N.M. 2006) 466 F.Supp.2d 1255, 1261–1262; *Lindholm v. Hassan* (D.S.D. 2005) 369 F.Supp.2d 1104, 1110.

hospital and its patient, the *Nishihama* court cited *Hanif* to justify limiting the hospital's lien to the amount it had been paid in cash by the plaintiff's insurer, and in doing so, the court concluded that the plaintiff had never incurred the full charges and thus that the jury's award had to be reduced.

What gets overlooked about *Nishihama* is that the plaintiff did not contend the negotiated rate differential was a collateral benefit; indeed, she did not contest that the cash payment was all that had been paid or that she incurred any debt beyond that amount. (*Nishihama*, *supra*, 93 Cal.App.4th at p. 307.) Nor she did not even dispute *Hanif*. She argued only that the hospital might later seek to recover from her more than the amount of her insurer's cash payment. (*Ibid.*) But of course, these matters are very much in dispute in the present case and virtually all others now that defendants routinely seek to apply *Hanif* beyond its context. And *Nishihama's* statement that the jury erred in awarding any damages other than the amount of contractual cash payments conflicts with this Court's holdings in *City and County of San Francisco v. Sweet*, *supra*, 12 Cal.App.4th 105; *Mercy Hospital*, *supra*, 15 Cal.4th 213; and *Parnell*, *supra*, 35 Cal.4th 595.[14]

Nor was *Hanif* advanced by *Greer v. Buzgheia*, *supra*, 141 Cal.App.4th 1150. The defendant contended the trial court had erred in

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[14] Moreover, the *Nishihama* defendant was a public entity and was thus statutorily entitled to a collateral–source reduction under Government Code section 985.

refusing to make a *Hanif* reduction. The court rejected that argument and affirmed the full judgment because the defendant had not properly raised *Hanif* at trial. (*Id.*, at pp. 1157–1159.) The *Greer* court thus did not need to decide whether it agreed with *Hanif* and *Nishihama*.

More recently, the same court that decided *Hanif* was faced with a related issue. (*Katiuzhinsky v. Perry* (2007) 152 Cal.App.4th 1288.) Some of the plaintiffs' healthcare providers had sold plaintiffs' bills to a financial services company (MedFin) at a discount. The providers "wrote off" the balances, but the plaintiffs remained liable to MedFin for the full amount of the charges. (*Id.*, at p. 1290.) The trial court precluded the plaintiffs from recovering any amount beyond the discounted rate. (*Ibid.*) The Court of Appeal held this was error and reversed the judgment. Because the plaintiff still owed a debt for her medical care, the payor (MedFin) had not provided full indemnity. Thus, as in *Greer*, the *Katiuzhinsky* court did not need to and did not purport to analyze whether contractually negotiated indemnity benefits are protected under the collateral source rule.

Hanif was again dealt with in *Olsen, supra*, 164 Cal.App.4th 200, in which the trial court had reduced a jury's award of past medical expenses. The three appellate justices unanimously agreed the defendant's evidence was not sufficient to permit the reduction. The court thus reversed the order and directed the trial court to reinstate the full amount of the jury's award. (*Id.*, at p. 203.) That same opinion also specifically declined to

embrace *Hanif*. "We do not decide that Reid [the defendant] was entitled to such a [*Hanif*] hearing." (*Id.*, at p. 204.) Justice Moore, though, filed a detailed concurring opinion in which she analyzed and rejected *Hanif*. "[T]he *Hanif/Nishihama* line of cases divorced the collateral source rule from the complicated area of medical insurance." (*Olsen*, *supra*, 164 Cal.App.4th at p. 204 (conc. opn. of Moore, J.).)

Moreover, in *Olszewski*, *supra*, 30 Cal.4th 798, the Court held that federal law preempts California's hospital–lien law and precludes a healthcare provider from recovering from a tortfeasor any more than charges allowed by Medicaid. (*Id.*, at pp. 805–806.) But the Court stated that "we do so reluctantly" in light of *Hanif* because "we give the third party tortfeasor a windfall at the expense of the innocent healthcare provider." (*Id.*, at pp. 826–827.) *Olszewski* was not an appeal from a judgment against a tortfeasor for which the trial court had either allowed or refused a *Hanif* reduction. *Olszewski* was a declaratory relief action against a provider based on its lien against its patient's recovery from a tortfeasor. *Olszewski* thus did not provide the Court with an opportunity to squarely decide whether *Hanif* was correct even in its limit context—Medi–Cal. And the Court did not analyze *Hanif*, instead merely referring to it. But the Court's stated reluctance to provide tortfeasors a windfall of *unearned* collateral–benefits under the federal and state statutory framework for Medi–Cal recipients further shows why a windfall should not be handed to

tortfeasors for *earned* collateral benefits such as those purchased by Howell.

In short, no path in logic, reason, or statute leads from *Hanif* to the expansive rule now sought by defendants.

VII. HOWELL'S MEDICAL BILLS WERE RELEVANT TO DETERMINING HER MEDICAL EXPENSES AND OTHER DAMAGES.

Hamilton has equivocated on whether providers' bills should be allowed into evidence. In seeking review, Hamilton argued that "***a plaintiff should never be allowed to present the amount of phantom [gross] medical expenses to a jury.***" (Petition, p. 27, Hamilton's emphasis.) In its Opening Brief, Hamilton backpedals: "[G]ross medical bills may be submitted to the jury for review . . . ." (Opening Brief, p. 52.) Moreover, at trial, Howell's providers' full charges were submitted to the jury, and Hamilton did not object; indeed, Hamilton stipulated to that amount. (4 R.T. 214:15–16.) And in the Court of Appeal, Hamilton argued that the introduction of Howell's medical bills was a ground for *affirming* the reduction. (Court of Appeal Respondent's Brief, pp. 43–44.) In short, Howell's medical bills were introduced, and Hamilton has acceded to that evidence. Thus, the question of whether a plaintiff's medical bills should be allowed into evidence is moot in this case. But if Hamilton's amici curiae raise the issue, Howell will show in her response to those amici briefs why a plaintiff's medical bills are relevant and admissible.

VII. THE REDUCTION WAS IMPROPER BECAUSE HAMILTON FAILED TO SUBMIT EVIDENCE THAT HOWELL'S PROVIDERS' FULL CHARGES WERE NOT INCURRED AND PAID.

This Court, of course, granted review to resolve a substantive issue of importance to all personal–injury actions. But regardless how the Court resolves the broad issue, the reduction in this case was error on procedural and evidentiary grounds. Howell will first address the evidentiary shortcoming.

Defendant's premise is that Howell should not be able to recover for charges she never incurred in the first instance. But that premise is missing in this case because defendant failed to present any evidence that Howell did not incur the full amount of her healthcare providers' charges.

Before Howell received treatment, she was required by her providers, Scripps and CORE, to sign written agreements to be responsible for Scripps' and CORE's *full charges*. (2 A.A. 368–370.)

The "Agreement for Services at a Scripps Facility" stated:

> "**6. <u>Financial Arrangements</u>**. . . . *[T]he undersigned is obligated to pay the Facility's usual and customary charges for such services*." (2 A.A. 368, boldface and underlining in original, italics added.)

Likewise, Howell's agreement with CORE stated:

> "Please remember than *insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. . . . It is your responsibility to pay* any co-insurance, or other balance not paid for by your insurance." (2 A.A. 370, italics added.)

Howell was contractually bound from the very outset to pay her providers' full charges. That is what the contract said. And undisputed expert testimony confirmed that, "Pursuant to such a contract, the patient is personally financially responsible for all of the medical providers' charges." (3 A.A. 593:2–3.) And there is no mention in her financial–responsibility agreements of any negotiated price-differentials, write-offs, noncash indemnities—or whatever defendant wants to call them. What defendant asks the Court to do is this to rewrite those contracts to indulge the fiction that they do not mean what they say, which is that Howell incurred a debt for the full charges. Defendant was not a party to those contracts, but even if it were, the Court would not rewrite them. Courts "do not have the power to create for the parties a contract which they did not make and cannot insert language which one party now wishes were there." (*ML Direct, Inc. v. TIG Specialty Ins. Co.* (2000) 79 Cal.App.4th 137, 142; *Safeco Ins. Co. v. Robert S.* (2001) 26 Cal.4th 758, 764 ["[C]ourts are not to insert what has been omitted."]; Code Civ. Proc., § 1858 [same].) And healthcare providers, no doubt, would be chagrined if this Court were to rewrite their contracts to eliminate a patient's agreed debt.

Defendant submitted no evidence to refute Howell's contractual duty to pay her providers' full charges. To the contrary, at trial, defendant stipulated that Howell's medical expenses totaled $189,978.63. "We don't dispute it." (4 R.T. 214:15-16.) And in its posttrial reduction motion,

defendant submitted no evidence that the negotiated contractual allowances (noncash payments) were not provided as agreed consideration under the providers' contracts with Howell's insurer. (Indeed, defendant did not submit the written agreements between Howell's insurer and her providers or any evidence relating to those agreements.)

Defendant's only evidence was two posttrial declarations by hospital billing personnel. (1 A.A. 132–137.) Both declarations were hearsay, to which Howell objected. (3 A.A. 605:18.) Moreover, neither clerk purported to claim that Howell's contracts with the providers were a sham. And neither claimed that the full charges had not been incurred in the first instance. All they said was that the difference between the full, incurred charges and the cash payments by Howell's insurers had been "written off." (1 A.A. 133:9–13, 134:6–10, 135:4–8, & 137:9–12.) By stating that the difference had been written off, the clerks thus confirmed that it had been incurred in the first instance—precisely as Howell's financial–responsibility contracts provided.[15]

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[15] Defendant claims, barely in passing, that Howell's providers had "previously agreed—prior to Howell's admission for services—to only recover a certain amount for service rendered." (Opening Brief, p. 19.) That misrepresents the record. *First*, defendant cites no evidence, rather, only to a trial court brief by Howell's counsel. (2 A.A. 345:1–3.) "[S]tatements of counsel are not evidence." (*People v. Redd* (2010) 48 Cal.4th 691, 727 & 743, fn. 25.) *Second*, Howell's counsel acknowledged only that her medical debts had been satisfied. He said nothing about when the debts were incurred or how they were satisfied.

Could defendant have presented evidence that the full charges were never incurred? Doubtful. But what matters for this case is that defendant failed to do so, reflecting its assumption that a *Hanif* reduction was to be had for the mere asking. Defendant thus failed to meet its burden of producing evidence and burden of proof. (Evid. Code, §§ 500 [proof] & 550 [production].)

Thus, whatever the rule may be in other cases, in this case, the Court of Appeal's *disposition* was correct even if this Court rejects its reasoning and extends *Hanif*. (*Brown v. Kelly Broadcasting Co.* (1989) 48 Cal.3d 711, 720 [affirming Court of Appeal decision on different grounds than used by the Court of Appeal]; *People v. Brookfield* (2009) 47 Cal.4th 583, 586 [same].)

PROCEDURAL ISSUES

If the Court holds that reductions based on negotiated price differentials, i.e., noncash indemnity–payments, are improper as a matter of substantive law, the Court will not need to address procedural issues. But if the Court permits such reductions, the Court will be required to promulgate a nonstatutory procedure for reduction requests because, as explained below, posttrial reduction–motions are not statutorily authorized. And regardless of what procedure the Court creates for future cases, the nonstatutory procedure used in this case was particularly improper and unfair and would require reversal of the reduction.

IX. THE REDUCTION WAS PROCEDURALLY IMPROPER.

Hanif has proved to be a Petri dish of "procedural confusion." (*Olsen*, *supra*, 164 Cal.App.4th at p. 213, fn. 3 [conc. opn. of Moore, J.].) Defendant's own amicus curiae characterize the situation as a "procedural mess." (Association of Southern California Defense Counsel, Jan. 20, 2010, Amicus Letter in Support of Review, p. 4.)

Most fundamentally, the posttrial reduction now sought by defendants in virtually all cases is a perversion of the trial process. Parties are not permitted to withhold evidence and then, after an unfavorable verdict, try to obtain a different result by submitting new evidence. But that is precisely what defendant did in this case. That is not the way trials are conducted. You try your case, you put on your evidence, and that is it. There are no mulligans.

Posttrial reduction-motions are improper in two other fundamental respects. *First*, they are not authorized by statute or decision. *Second*, they violate a plaintiff's constitutional right to a jury trial. Howell will first address the lack of statutory or case authority and then the constitutional problem.

A. POSTTRIAL REDUCTION–MOTIONS ARE NOT AUTHORIZED BY STATUTE.

Defendant points to no authority for a postjudgment *Hanif* motion untethered to any recognized statutory procedure. That such nonstatutory

motions are not generally allowed is further demonstrated by the one situation in which they *are* allowed—for public entity defendants under Government Code section 985, subdivision (b). That the Legislature chose to provide such a hearing only for public–entity defendants shows the Legislature did not intend such a hearing for private defendants. Moreover, if existing statutory procedures do not fit the relief that defendants seek, the solution lies with the Legislature. (That is one more reason why the Court should defer to the Legislature.)

B. CODE OF CIVIL PROCEDURE SECTIONS 657 AND 658 PROHIBIT DEFENDANTS FROM INTRODUCING POSTTRIAL EVIDENCE TO REDUCE DAMAGES.

Not only is there no statutory authority for so–called "*Hanif* motions," they are improper under the two statutory procedures that do exist for relief from a verdict or judgment: a motion for new trial and a motion to vacate.

A "*Hanif* motion" is a motion to reduce damages. The statutory procedure for seeking a damages reduction is a motion for new trial. But such a motion is not a permissible vehicle for seeking a so–called *Hanif* reduction. Code of Civil Procedure section 657 ("section 657") specifies seven grounds for a motion for new trial. A claim of "excessive damages" is the fifth ground; a claim that the verdict is against the law, e.g., legally improper damages, is the sixth ground.

Code of Civil Procedure section 658 ("section 658"), in turn, provides that "When the application [for a new trial] is made for a cause mentioned in the first, second, third, and fourth subdivisions of Section 657, it must be made upon affidavits; *otherwise it must be made on the minutes of the court.*" (Italics added.) Thus, when a motion for new trial is made on the grounds of excessive damages (fifth ground) or improper damages (sixth ground), the motion must be decided only on the minutes of the court. No new evidence is permitted. That is what section 658 says; that is what it means. "[M]otions relying on the remaining three grounds [i.e., subdivisions 5, 6, and 7 of section 657] 'must be made on the minutes of the court.' (§ 658.)." (*Wall Street Network Ltd. v. New York Times Co.* (2008) 164 Cal.App.4th 1171, 1192.) By definition, a so–called posttrial *Hanif* motion, as in the present case, is not made on the minutes of the trial but is based on new, posttrial evidence. Thus, a motion for new trial cannot serve as a vehicle for a posttrial *Hanif* reduction.

C. CODE OF CIVIL PROCEDURE SECTION 663 DOES NOT PERMIT A POST–VERDICT REDUCTION.

The other postjudgment statutory procedure is a motion to vacate the judgment under Code of Civil Procedure section 663. Defendant made such a motion. (1 A.A. 255–256.) The trial court never ruled on that motion, and defendant does not now rely on section 663. But in any event, section 663 is not a vehicle for a posttrial damages reduction.

Section 663 has two distinct provisions. In numbered paragraph 1, section 663 deals with a decision *by the court* and sets forth the grounds for vacating a *court* decision. In numbered paragraph 2, section 663 addresses the second situation—a *jury's* verdict.

For the paragraph dealing with verdicts, the only authorized basis for granting a motion to vacate is that the judgment is "not consistent with or supported by the special verdict." Defendant did not, and could not, contend the judgment was inconsistent with the jury verdict. They were identical—to the penny. (1 A.A. 118–119 [verdict]; 1 A.A. 177–178 [judgment].) Rather, defendant did not like the verdict because it reflected the full debt that Howell had incurred. But disappointment with the result is not an inconsistency under section 663. A motion to vacate is thus not a proper vehicle for seeking a reduction.

D. NO PRECEDENT PERMITS POSTTRIAL REDUCTION MOTIONS.

Defendant claims, "Of course, *Hanif* laid the foundation for a post–trial reduction (by an appellate court) of a medical specials award . . . ." (Opening Brief, p. 52.) Not even close. *Hanif* was a ***bench*** trial. The reduction was dealt with *at trial*. There was no posttrial hearing. *Hanif* said nothing about such a hearing, and any such statement would have been dictum.

Defendant also contends a posttrial reduction is permitted by *Greer*, *supra*, 141 Cal.App.4th 1150. Quite the contrary. The *Greer* court specifically declined to address the propriety of a postjudgment motion because the defendant had failed to preserve that issue. (*Id.*, at p. 1158.)

Equally unavailing for the notion of a posttrial procedure is *Olsen*, *supra*, 164 Cal.App.4th 200. Indeed, defendant's distortion of *Olsen* is egregious. Defendant quotes this passage: "If the proper application of the collateral source rule includes reducing a verdict to the amount actually paid or incurred . . . a hearing is necessary and appropriate to determine the correct amount." (*Id.*, at p. 218.) This quote fails to support defendant.

First, and worse, the *Olsen* court said no such thing. Rather, the language is in a separate concurring opinion of Justice Fybel in which the other two justices declined to join. (*Olsen*, *supra*, 164 Cal.App.4th at pp. 214–218 [conc. opn. of Fybel, J.].)

Second, the *Olsen* court *reversed* a posttrial reduction. (*Olsen*, *supra*, 164 Cal.App.4th at p. 203.) They also made clear they were *not* endorsing a posttrial procedure. "The question of what form a motion to reduce the judgment under the purported *Hanif/Nishihama* rule should take is unclear, but need not be decided here." (*Id.*, at p. 203, fn. 2.)

Moreover, even *Nishihama*, *supra*, 93 Cal.App.4th 298, so often viewed as *Hanif's* sibling, did not purport to approve or create a posttrial

procedure, even though one would have been proper under Government Code section 985 because the defendant was a public entity.

In short, there is no authority, either statutory or decisional, for a postjudgment reduction except under Government Code section 985 for public–entity defendants.

E. THE REDUCTION VIOLATED HOWELL'S RIGHT TO A JURY TRIAL.

The amounts incurred and paid for Howell's past medical expenses were disputed fact–questions. (*Choate v. County of Orange* (2000) 86 Cal.App.4th 312, 321 ["What constitutes fair and reasonable compensation in a particular case is a question of fact."]; *Torres v. City of Los Angeles* (1962) 58 Cal.2d 35, 53.) The special verdict form directed the jury to determine the amount of damages, including past medical expenses, and the jury did so. (1 A.A. 118 [special verdict].) Plaintiffs are constitutionally and statutorily entitled to have all disputed fact questions, including damages, decided by a jury. (Cal. Const., art. I, § 16 ["Trial by jury is an inviolate right and shall be secured to all . . . ."]; Code Civ. Proc., § 631, subd. (a) ["The right to a trial by jury as declared by Section 16 of Article I of the California Constitution shall be preserved to the parties inviolate."]; Code Civ. Proc., § 592 ["[A]n issue of fact must be tried by a jury, unless a jury is waived."].)

Indeed, defendant's insurance–industry amici argue forcefully in this case that a posttrial *Hanif* reduction violates the right to a jury trial:

> "[A] posttrial procedure to determine the appropriate damages for a plaintiff's medical expenses violates the right to trial by jury." (Personal Insurance Federation of California, Court of Appeal amicus brief, pp. 15–16.)

The Court of Appeal in this case correctly declined to address the jury issue because the court rejected the reduction on substantive grounds. But a remand to the Court of Appeal for further consideration of this issue would serve no purpose because the deprivation of the right to a jury trial is one of the few remaining civil–trial errors that is reversible per se. (*Soule v. General Motors Corp.* (1994) 8 Cal.4th 548, 576–578 [A denial of the right to jury trial is a "structural" trial error that is not subject to the traditional analysis of whether an error was prejudicial.]; *Golden West Baseball Co. v. City of Anaheim* (1994) 25 Cal.App.4th 11, 50 [Wrongful denial of jury trial is reversible per se.].)

F. HOWELL WAS DEPRIVED OF HER RIGHT TO PRESENT EVIDENCE OR TO OBJECT TO HAMILTON'S EVIDENCE.

As set forth more fully in her Court of Appeal briefs, Howell challenged the reduction on numerous procedural and evidentiary grounds specific to this case. Because the Court of Appeal rejected *Hanif* as a matter of substantive law, the Court of Appeal did not deal with any of the case–specific issues. Thus, there is no Court of Appeal decision on those

issues for this Court to review. Nor does defendant raise any of them in its Opening Brief in this Court. Howell will thus not burden this Court with an extensive discussion of those issues. Very briefly stated, though, these issues are as follows.

First, as set forth above, defendant failed to submit any evidence that Howell did not incur the full amount of her providers' charges. (Pp. 57–60, *ante*.)

Second, Howell was denied the opportunity to conduct discovery to rebut defendant's posttrial evidence or even to object to defendant's evidence before the court's decision. As set forth above (pp. 8–11), the court denied Howell's discovery request, explaining that the court would rule only on the substantive issue of whether a *Hanif* reduction was proper. (5 R.T. 249:17 to 250:15 & 253:26–28.) The court assured Howell that, if the court were to later rule that the requested reduction was substantively permissible, the court would allow Howell to brief and argue the procedural and evidentiary issues in further proceedings. (5 R.T. 249:17 to 250:15.)

Howell timely filed her opposition to Hamilton's reduction motion. (2 A.A. 339–463.) Pursuant to the court's prior direction, Howell dealt only with substantive issues regarding the reduction motion and did not address procedural issues, or object to Hamilton's evidence in support of the motion, or present Howell's own evidence, or discuss factual issues. Howell did likewise in her opposition to defendant's motion for new trial.

(2 A.A. 464–489.)

The court then heard defendant's motion. (8 R.T. 270–335; 2 A.A. 551.) The court took the motion under submission. (8 R.T. 331:28 to 332:8.) The court subsequently issued its order granting defendant's motion in full. (2 A.A. 553.) Contrary to its prior statements that it would limit its ruling to the substantive question—i.e., whether reductions are permissible—and defer for a later hearing and ruling all procedural, evidentiary, and factual questions, the court granted Hamilton's motion outright and in its entirety without reference to any further proceedings. (2 A.A. 553.)

Howell sought reconsideration and an order setting further hearings to deal with the procedural and evidentiary issues, as the court had previously stated it would do. (3 A.A. 561–568.) The court denied reconsideration and the request for the previously promised further hearings. (3 A.A. 570.) The court acknowledged the prior arrangement. (8 R.T. 337:28 to 338:4.) But the court stated that it had decided not to proceed as agreed. "I've made my ruling, I'm not going to set the additional evidentiary hearings and get into these additional subjects . . . ." (8 R.T. 338:6–8.) And the court repeatedly stated it would not consider any evidence submitted by Howell or any evidentiary objections to Hamilton's evidence. (8 R.T. 338–359.) The court, though, granted Howell permission to file for the appellate record her evidence and her evidentiary

and procedural objections, even though the court refused to consider her evidence or objections. (3 A.A. 570.) Howell did so. (3 A.A. 571–603 [evidence] & 604–606 [objections].)[16]

Defendant contends none of these problems matter because Howell somehow consented to the posttrial procedure used. That is off the mark two ways.

First, Howell was faced with a Morton's Fork. The court made clear it would deal with a *Hanif* reduction—period. (1 R.T. 67:13–69:6.) Howell thus could agree to let defendant submit evidence of her insurance coverage to the jury. That would have imposed an unfair burden on her. Alternatively, she could agree the *Hanif* issue could be dealt with after trial.

At most, Howell consented, under duress, to *some* type of posttrial procedure. (1 R.T. 67:13–69:6.) But she did not agree the matter could be decided after trial without regard to statutory procedures and restrictions. And she most certainly did not consent to a procedure that precluded her from submitting evidence or objections to defendant's evidence. (See pp. 8-11, *ante.*) The trial court promised Howell that opportunity, but then changed its mind and disallowed Howell the right to present any evidence,

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[16] Howell's evidentiary objections included: (1) The two clerks on whose declarations defendant relied had not been identified in defendant's Trial Witness List or in any of defendant's discovery responses, and Howell was thus deprived of the opportunity to obtain discovery regarding their testimony. (2) The declarations state impermissible expert opinions. (3 A.A. 605:1–24 [evidentiary objections].)

to question defendant's witnesses, or to object to defendant's evidence. (*Ibid.*) There was not even a pretense of fairness.

Howell respectfully submits that, if these case–specific issues are relevant to the ultimate disposition of this case, this Court should remand the action to the Court of Appeal to consider these issues in the first instance. Alternatively, this Court can request supplemental briefing on these issues if it wishes to address them.

CONCLUSION

Defendants and liability insurers ask this Court to abrogate the collateral source rule with regard to indemnity benefits in any form other than direct cash–payments. To do so would be a radical departure from more than a century of law. In light of the complexity of healthcare economics and healthcare insurance, that departure is best left to the Legislature.

Equally importantly, defendants seek a free ride on the backs of working men and women who often make enormous sacrifices to pay for healthcare insurance. The only reason the so–called "write offs" of which tortfeasors are so enamored even arise is because of the insurance that personal-injury victims purchase and the resulting bargaining-power their

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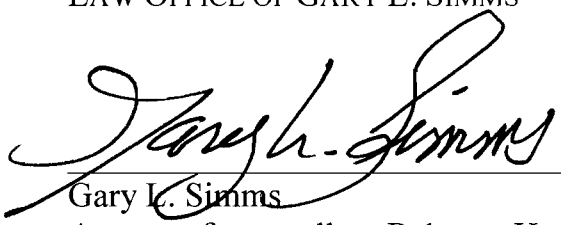
premiums provide their insurers. It is simply unfair to give defendants a free ride on the backs of their victims.

The Court of Appeal decision was correct. It should be affirmed.

DATED: June 4, 2010.

Respectfully submitted,
LAW OFFICE OF GARY L. SIMMS



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CERTIFICATE OF WORD COUNT
RULE 8.204(C)(1)

I am counsel of record in this appeal for plaintiff and appellant Rebecca Howell. Pursuant to California Rule of Court 8.204(c)(1), I hereby certify that the text of the foregoing Answer Brief on the Merits, including section headings, and footnotes, is 16,549 words, as calculated by the Microsoft Word™ computer program with which this brief was created, and I hereby certify that the text, headings, and footnotes are in proportionately spaced Times New Roman 13–point font.

Dated: June 4, 2010.

Gary L. Simms (S.B.N. 96239)
Attorney for appellant Rebecca Howell

♦ **CERTIFICATE OF SERVICE** ♦

Rebecca Howell v. Hamilton Meats & Provisions, Inc.

S179115

I, the undersigned, declare as follows:

I am employed in the County Yolo, State of California by The Law Office of Gary L. Simms. I am more than 18 years of age. I am not a party to this action. My business address is 2050 Lyndell Terrace—Suite 240; Davis, California 95616.

On June 5, 2010, I served true and complete copies of the attached **ANSWER BRIEF ON THE MERITS** on the following attorneys of record and courts by placing true and complete copies of that document in sealed envelopes addressed as follows, with United States Postal Service Priority Postage prepaid, and depositing those envelopes in the United States mail in Georgetown, Texas.

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I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct and that I signed the original of this Certificate of Service on June 5, 2010, in Georgetown, Texas.

Gary L. Simms