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SUPREME COURT
FILED

May 4, 2011

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Frederick K. Ohlrich Clerk
Deputy

Via FedEx overnight delivery

Hon. Chief Justice Tani Cantil–Sakauye and Associate Justices
California Supreme Court
Earl Warren Building
350 McAllister Street
San Francisco, California 94102–4797

Re: *Rebecca Howell v. Hamilton Meats & Provisions, Inc.* — S179115
Appellant Rebecca Howell's Response to the Court's April 20, 2011, Order

Hon. Chief Justice Cantil–Sakauye and Associate Justices:

Appellant Rebecca Howell responds as follows to the two questions in the Court's April 20 order.

QUESTION ONE
WHAT EVIDENCE IS ADMISSIBLE TO ESTABLISH "AMOUNTS PAID" OR "OWING"?

The Court's order states that, for the sake of argument, "only the *amounts that have been paid* or remain owing to medical providers are recoverable as damages for past medical expenses." (Italics added.) Howell's response necessarily depends on what the Court means by "amounts that have been paid." Does it mean only the alternative-rate payment, i.e., partial payment, posted to an insured patient's account by a medical provider who has negotiated a contract with the patient's insurer? Or does "amounts paid" mean all bargained-for consideration under such statutorily authorized "alternate rate contracts" (Bus. & Prof. Code, § 16770, subd. (f); Health & Saf. Code, § 1342.6; Ins. Code, § 10133, subd. (b)), i.e., does "amounts paid" mean the amounts *actually* paid, which include both alternate-rate payments and additional payments in the form of other significant economic benefits negotiated between the plaintiff's healthcare insurer and her medical provider? (Amici Curiae Brief of California Medical Association et al., pp. 30–31 [acknowledging that these negotiated benefits are "concrete benefits" to medical providers].) Howell assumes that the Court's use of the term "amounts paid" means only alternative-rate payments (referred to colloquially as "cash payments") so she will address what evidence is admissible if a plaintiff can recover only the amount of cash payments and amounts still owing.

I. Basing an award of past medical expenses solely on the amount of cash payments and amounts owing is not as simple as it seems.

Howell assumes the Court seeks simplicity in whatever rule it adopts, especially in this time of scant judicial resources. At first blush, defendant's argument that the sole determinant of an award for past medical expenses should be the amount of a plaintiff's insurer's cash payment seems to have the virtue of simplicity: submit evidence of the cash payment; end of story. But that simplicity is illusory. The evidence cannot be limited to the amount of cash payment. And evidence of cash payments will create considerable complexity because such evidence will require several changes in the way personal injury cases are tried.

II. A plaintiff's medical charges and evidence of their reasonableness should remain admissible even if evidence of cash payment is also admissible.

It is bedrock that a plaintiff is entitled to the *reasonable* cost of her medical care. (Answer Brief on the Merits, pp. 16-17; CACI 3903A ["To recover damages for past medical expenses, [*name of plaintiff*] must prove the *reasonable cost* of reasonably necessary medical care that [he/she] has received."], second italics added.) All of defendant's amici curiae agree. (Appellant's Brief in Response to Eight Amici Curiae Briefs, p. 3.) Cash payment cannot be the sole determinant of an award of past medical expenses unless the Court rejects the longstanding reasonable–value (or reasonable–cost) standard and substitutes cash payment as the sole standard. Even the defense bar would reject that approach because, without a requirement of reasonableness, a plaintiff could incur wildly unreasonable charges but recover them simply because they were paid, either by her or her insurer.

A plaintiff's medical charges are admissible because, although they are not dispositive of the amount recoverable, they are at least relevant to the determination. Even courts after *Hanif* have acknowledged this. "In *Greer* [*v. Buzgheia* (2006) 141 Cal.App.4th 1150], we made clear that, notwithstanding the limits they may place on plaintiff's *recovery* of medical expenses, neither *Nishihama* nor *Hanif* 'holds that *evidence* of the reasonable cost of medical care may not be admitted.' . . . [T]hey [the medical charges] reflected on the nature and extent of plaintiffs' injuries and were therefore relevant to their [the jury's] assessment of an overall general damage award." (*Katiuzhinsky v. Perry* (2007) 152 Cal.App.4th 1288, 1295–1296, italics by the court.) Likewise, defendant's healthcare amici curiae explain in detail why medical charges are admissible to determine the reasonable value of services. (Amici Curiae Brief of California Medical Association et al., pp. 30–33.) The reason is that the charges meet the standard of relevancy, i.e., "having *any tendency in reason*" to establish the value of the services. (Evid. Code, § 210, italics added.) Thus, medical charges should remain admissible, as they were in *Hanif* itself. Similarly, as has always been the law, the parties should be allowed to submit other relevant evidence of the charges'

reasonableness, e.g., testimony by the plaintiff's treating providers and expert witnesses' testimony.

III. What evidence of a "cash payment" or the "amount owing" is admissible depends on how the Court defines those terms.

What constitutes "cash payment" or the "amount owing" depends on the plaintiff's type of health insurance and, in some cases, her financial condition. Under fee-for-service or preferred-provider policies, such as the type Howell purchased, the insurer pays the provider based on its treatment of that patient, i.e., the cash payment, together with additional negotiated amounts not attributable to any particular patient's account. The amount of the cash payment can be established by testimony of the plaintiff or her provider, subject to several limitations discussed below.

Another common arrangement is a "health maintenance organization" ("HMO"). How to determine an HMO's cash payment will be problematic because the concept of cash payment does not fit the HMO template. The provider does not receive a fee for service from the health plan but, instead, receives negotiated periodic–payments based on the number of plan members who are expected to be treated by the provider. This results in a "capitation" the plan pays the provider. No amount is paid on behalf of any particular patient, and it does not matter how many patients the provider treats or what treatment any particular patient receives.[1] Thus, a court would have to attribute to the plaintiff an "amount paid" based on how many patients the provider treated during the capitation period. For example, if the capitation was $10,000, and the provider treated 10 patients, it might be said that the amount paid for each patient was $1,000, but if the provider treated 20 patients, the amount was $500. Moreover, does the nature of the treatment matter? Would two HMO patients recover the same amount if one had a broken finger and the other a broken back? A court would seem to need evidence of the contract between the provider and the plan, the number of patients treated in each month the plaintiff received treatment, and expert evidence whether the capitation fee has any relation to the reasonable cost of the service rendered. Presumably, providers will be less than pleased at having to produce such evidence during discovery and at trial. And any disputed question of fact on this issue will have to be decided by a jury.

In many other cases, to determine what has been paid or what remains owing, a court will also have to inquire into a plaintiff's financial condition. Under the statutory Fair Pricing Policies Act, uninsured patients or patients with high medical costs who are at or below 350 percent of the federal poverty level are entitled to discounted hospital charges. (Health & Saf. Code, § 127405, subds.

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[1] The typical HMO arrangement is succinctly explained by one of the major HMOs, Kaiser Permanente. (Kaiser Permanente, *Frequently Asked Questions About Our Medical Care, How Are Kaiser Permanente Physicians Compensated?* at < https://members.kaiserpermanente.org/kpweb/faqmedcare/entrypage.do>.

(a)(1) and (d).) To determine if a patient is entitled to this lower price and, thus, the amount the plaintiff pays or owes, a court will need evidence of the plaintiff's financial condition, insurance status, and total medical costs. And when section 127405 applies, the Court will have to decide whether a defendant should be allowed to bootstrap its way to a lower damage award by injuring a plaintiff and causing her to lose income, thus resulting in lower hospital charges.

IV. If the Court allows evidence of cash payments, the Court will need to promulgate several procedural rules to prevent improper use of that evidence.

A. The Court will need to create a rule to prevent evidence of cash payment from violating the evidentiary prong of the collateral source rule.

Alternate–rate payments, i.e., cash payments, exist only because of the plaintiff's health insurance, but any evidence of the plaintiff's insurance is prohibited by the collateral source rule. As this Court has explained, the collateral source rule is really two "closely linked" principles. (*Lund v. San Joaquin Valley Railroad* (2003) 31 Cal.4th 1, 8.) One is the principle that a plaintiff's recovery should not be diminished by the amount of compensation or indemnity from a collateral source. (*Ibid.*) The other is "the closely related principle that, as a general rule, the jurors should not be told that the plaintiff can recover compensation from a collateral source." (*Id.*, at p. 10; accord, *Gersick v. Shilling* (1950) 97 Cal.App.2d 641, 650; see generally 2 Jefferson's California Evidence Benchbook (Cont.Ed.Bar 2010) § 36.39, pp. 876.6–877.)

So, if the Court chooses to allow defendants to admit evidence of alternate rates paid by a plaintiff's insurer or other collateral source, the Court will have either to abolish the evidentiary prong of the collateral source rule or, more appropriately, to make clear that a defendant is prohibited from submitting any evidence, whether testimony or documents, that could give rise to an inference by the jury that the payments were by plaintiff's insurer. Put in practical terms, the defendant cannot be allowed ask "What did *your insurer* pay?" or "What was paid *on your behalf*?" Nor can the defendant submit evidence that refers in any way to the plaintiff's insurance, e.g., an Explanation of Benefits Form provided by the plaintiff's insurer. The defendant should be allowed to ask a plaintiff nothing more than "How much did *you* pay?" or ask her provider, "How much were you paid?" Without such a rule, the jury would know of the plaintiff's insurance but would be precluded by Evidence Code section 1155 from knowing of the defendant's liability insurance. Alternatively, the Court could hold that the defendant is estopped from asserting Evidence Code section 1155 if any evidence of the plaintiff's medical insurance is submitted to the jury.

B. Evidence of cash payment requires evidence of plaintiff's insurance premiums.

If a defendant is to be given the benefit of a plaintiff having purchased insurance, there is no pretense of fairness unless the plaintiff is given credit for the amount of her insurance premiums. Indeed, in the two instances in which the Legislature has modified the collateral source rule, the Legislature has provided for a credit for premiums. Under Government Code section 985, which applies to public–entity defendants, a court is required to deduct from the collateral–source reduction the amount of premiums paid by the plaintiff or on her behalf. (Gov. Code, § 985, subd. (f)(3)(B).) Similarly, the Medical Injury Compensation Reform Act provides that, if a defendant introduces evidence that the plaintiff had medical insurance, the plaintiff is allowed to introduce evidence of the premiums she paid. (Civ. Code, § 3333.1, subd. (a).) Logic and fairness require that the same rule applies in all cases. A plaintiff should be allowed to introduce evidence of the premiums she paid to obtain the collateral benefit the defendant wants to arrogate to itself. But that creates its own problem because, even if the defendant is prohibited from linking the cash payment to plaintiff's insurance, the plaintiff will be coerced into telling the jury that she has insurance, i.e., she cannot submit evidence of her premiums without disclosing that she has insurance. That result violates the collateral source rule's prohibition, discussed above, against telling a jury that the plaintiff has insurance. The only apparent solution would be to allow a plaintiff to include the amount of her premiums in the "amount paid." For example, if her insurer's cash payment was $25,000, and she paid $10,000 in premiums, when asked, "What did you pay?" she should be allowed to answer, "$35,000." And even though that might seem simple, it will lead to discovery and trial disputes regarding the amount of premiums and how to attribute them to medical expenses incurred because of the tortfeasor's harm.

C. The plaintiff must be allowed to introduce evidence that her insurer's cash payment does not preclude her medical provider from collecting the remainder of its charges.

No one contends a plaintiff cannot recover for charges that remain owing. But standing alone, evidence of cash payments will mislead the jury into laboring under the false premise that the plaintiff is not responsible for any further amounts, i.e., that her insurer's cash payment fully satisfies her legal obligation to her medical providers, i.e., as defendants like to put it, that all other amounts are "written–off." That premise collapses if the plaintiff remains responsible for any or all of the remaining charges. This leads to procedural problems.

As in this case, defendants typically use the expediency of submitting testimony of a medical provider's low-level billing clerk who states that the insurer's cash payment satisfies the plaintiff's debt to the provider. Or the defendant submits a bill with a notation, often cryptic and inconclusive, that the charges have been paid in full or that some amount has been "written off." But

evidence of cash payment, by itself, does not establish what amounts a plaintiff has incurred or still owes. (*Olsen v. Reid* (2008) 164 Cal.App.4th 200, 203.) Absent evidence of those amounts, a court must assume the plaintiff remains liable for the full amount of the charges, and *Hanif's* premise fails, so no reduction is allowed. If the concept of "written off" is to have any meaning, the defendant must establish that the provider will under no circumstance ever seek to recover any further amount from the plaintiff. For example, in *Olsen*, Justice Fybel noted his agreement with *Hanif* in theory, but he joined in reversing a *Hanif* reduction because the record failed to unequivocally establish that the plaintiff's provider could never collect anything more from her. (*Id.*, at pp. 217–218 (conc. opn. of Fybel, J.).) Relevant evidence will include: (i) the medical provider's billing statement to the plaintiff, (ii) the contract between the provider and her health insurer, (iii) the contract between the plaintiff and her provider, (iv) the contract, if any, between the plaintiff and her insurer, and (v) a binding acknowledgment by the plaintiff's providers that she has no further financial responsibility. (*Ibid.*) And this showing must be made for each provider, which creates further complexity. In a typical vehicle–accident such as Howell's, the plaintiff will be treated by many providers, e.g., ambulance personnel, the emergency room, subsequent hospitals, multiple physicians, physical therapists, and pharmacies.

Even if the evidence is conclusive as to what has been paid and what remains owing from the plaintiff, the evidence does not bind the provider because it is not a party to the action. As the *Nishihama* court acknowledged, "[B]ecause CPMC [the provider] is not a party to this action, it is not bound to any ruling concerning its lien rights." (*Nishihama v. City and County of San Francisco* (2001) 93 Cal.App.4th 298, 309.) The same is true of the provider's right to further payment from the plaintiff. The only way to ensure the correctness of the premise that cash payments satisfy the plaintiff's entire debt is to make the provider a party to the action between the plaintiff and her tortfeasor, presumably by filing a third-party cross-complaint for declaratory relief against the provider, by which the plaintiff could obtain a ruling that she owes nothing more than the amount of her insurer's cash payment to the provider. But of course, providers have no interest in being hauled into court for every personal injury action. And presumably, in an era of scant judicial resources, courts do not want that additional level of complexity.

Moreover, as this Court has observed, providers are free to contract to recover the difference between cash payment and the provider's usual and customary charges, i.e., to engage in "balance billing." (*Parnell v. Adventist Health System/West* (2005) 35 Cal.4th 595, 611.) As explained in *Parnell*, Civil Code section 3045.1 grants hospitals a lien "for the amount of the [hospital's] reasonable and necessary charges" against a plaintiff's recovery from a tortfeasor. Regardless of how much a hospital has agreed to accept as "cash payment" from an insurer, the hospital can contract to recover the remainder of its charges by asserting a lien for

the full amount of those charges against the plaintiff's recovery from a tortfeasor. (To the extent the insurer made cash payments to the provider, the contracts between the provider and the insurer will provide that, from its lien recovery, the provider must reimburse the insurer, but the lien against the plaintiff's recovery is for the full charges.) And the lien is asserted against the full judgment, not just the portion that represents past medical expenses. Similarly, for managed–care plans, e.g., HMO capitated-care, Civil Code section 3040 allows a provider with a contractual right of reimbursement to recover an amount equal to "80% of the usual and customary charge" for the same service by providers in the same geographic region who perform the service on a noncapitated basis. (Civ. Code, § 3040, subd. (a)(2).) In short, if a plaintiff's recovery for her medical expenses is limited to her insurer's cash payment, her providers' liens and contractual rights of reimbursement will put her in a worse position than if she had no insurance.

Such result betrays defendant's "concession" that, under the collateral source rule, a plaintiff should be allowed to retain the amount of cash payment by her insurer. In reality, it will not work out that way. Moreover, *Hanif's* cornerstone is that an award for past medical expenses should be limited to the amount of cash payment because otherwise the plaintiff would be overly compensated, i.e., the "windfall" bogeyman. That premise fails if the plaintiff's hospital has a lien or contractual right of reimbursement against a settlement or jury award.

Moreover, any dispute regarding the amount of the hospital's charges and, in turn, its lien will be a question of fact for the jury. Timing will also raise issues. If the hospital asserts its lien before judgment, is the amount of the lien adjudicated during trial, and is that adjudication binding on the hospital, or does it need to be joined as a party to the action? What if the hospital does not assert its lien until after judgment? Does the trial court retain jurisdiction until the period of limitation for asserting the lien has expired? If so, how does the court adjust the judgment to reflect the subsequent lien?

D. A plaintiff must be allowed to submit evidence of her insurer's right to reimbursement from an award based on cash payment.

Allowing evidence of cash payments and limiting the jury's award to that amount assumes the plaintiff will retain the jury's full award. But as with providers' liens, *Hanif's* premise fails if the plaintiff's insurer has a lien or a contractual right of reimbursement against any jury award or settlement. And virtually all health-insurance policies do provide the insurer with a right of reimbursement. (*Helfend v. Southern Calif. Rapid Transit Dist.* (1970) 2 Cal.3d 1, 10–11; *Progressive West Ins. Co. v. Superior Court* (2005) 135 Cal.App.4th 263, 270.) So do government programs. For example, the state agency that implements Medicare (in California, Medi-Cal) is obligated by federal law to seek reimbursement from a plaintiff's settlement or judgment proceeds. (42 U.S.C. § 1396a(a)(25)(B)&(H); *Arkansas Dept. of Health and Human Services v. Ahlborn* (2006) 547 U.S. 268, 275–280.) As another court observed in construing a statute

that permits evidence of "write-offs," except when the plaintiff's insurer has a right of subrogation, "The plaintiff does not receive a windfall payment, however, because the insurer has subrogation rights to recover any expenses it has already paid." (*Jaques v. Manton* (Ohio 2010) 928 N.E.2d 434, 437.)

If cash payments are to be admissible, the rule must be that evidence of any lien or right of reimbursement by the plaintiff's insurer against the plaintiff's recovery will also be admissible. But this would create yet another area of confusion for the jury. It would be presented with evidence of cash payments and would then be told its award is not limited to that amount because plaintiff's insurer has a contractual right of reimbursement. That approach would violate the rule that evidence of a plaintiff's insurance is not admissible. So, the plaintiff must be allowed to present evidence of the amount of an insurer's right or reimbursement without identifying it as a right of her insurer. And the jury must be instructed to include the amount of any right of reimbursement in its award.

E. Evidence of cash payments should be admissible only if juries are properly instructed regarding noneconomic damages.

As every personal injury trial–lawyer (whether for plaintiffs or defendants) knows, juries most commonly calculate noneconomic damages based on the amount of the economic damages. If awards for past medical expenses are based on the amount of cash payment to the plaintiff's medical providers, that will not only lower the award of past medical expenses, it will correspondingly lower the award of noneconomic damages. This Court has recognized the problem:

> "[T]he [collateral source] rule performs entirely necessary functions in the computation of damages. For example, *the cost of medical care often provides both attorneys and juries in tort cases with an important measure for assessing the plaintiff's general damages*. . . . To permit the defendant to tell the jury that the plaintiff has been recompensed by a collateral source for his medical costs might irretrievably upset the complex, delicate, and somewhat indefinable calculations which result in the normal jury verdict." (*Helfend, supra*, 2 Cal.3d 1, 11, italics added; accord, *Katiuzhinsky v. Perry, supra*, 152 Cal.App.4th 1288, 1295–1296.)

To permit evidence of the cash payment will have precisely the same effect, even if the jury is not told the payment was by the plaintiff's insurer. Not only would that result in lower noneconomic damages awards, it would make no sense. The severity and duration of a victim's pain and suffering do not depend on how much her insurer pays for her medical care. Thus, juries should be instructed that the reasonable value of the plaintiff's medical care, but not the amount of cash payment, can be considered in determining an award for noneconomic damages.

F. Evidence of cash payments should be admissible only if juries are properly instructed regarding future medical expenses.

A plaintiff is entitled, not only to an award for past medical expenses, but also for future medical expenses. (*Mendoza v. Rudolf* (1956) 140 Cal.App.2d 633, 637; *Hoffman v. Southern Pacific Co.* (1929) 101 Cal.App.2d 218, 229–230; CACI 3903A [jury instruction for future medical expenses].) And no court has suggested that a plaintiff's recovery of future medical expenses should be based on the amount that her insurer, if she later even has one, *might* pay for her future medical expenses. But to allow evidence of the amounts paid for past medical expenses would have the same effect of reducing an award for future medical expenses. More specifically, evidence of the cash payments for *past* medical expenses will create the likelihood that a jury will be misled into awarding less than it otherwise would award for the plaintiff's *future* medical expenses. That is common sense.

Moreover, that result would be speculative because evidence of the amount paid for past medical expenses says nothing about what amounts the plaintiff or her insurer might pay for future medical expenses—expenses that might be incurred 10 or 15 years after trial. The plaintiff might not even have insurance for future medical expenses. Trying to determine the reasonable value of future medical expenses is hard enough; trying to determine whether the plaintiff will be insured for future medical expenses and, if so, how much her insurer will pay is guesswork.

Thus, if evidence of cash payment is admissible, the Court needs to fashion a jury instruction that a plaintiff's future medical expenses must be determined by the reasonable and necessary charges for those services rather than the amount she or her insurer may have to pay for them.

QUESTION TWO
SHOULD THIS COURT ALLOW A POSTTRIAL "*HANIF* MOTION"?

The short, easy, and emphatic answer is "No." A so–called *Hanif* motion may have the superficial appeal of cutting through the many problems discussed above that would arise if a jury were presented with evidence of the plaintiff's insurer's cash payments. But in reality, the "*Hanif* motion" is no solution because it violates the constitutional and statutory right to a jury trial. Any factual dispute regarding the amount of cash payments or any amounts still owing is a fact question. 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."]; Evid. Code, § 312 subd. (a) ["All questions of fact are to be decided by the jury."].) Defendant's own amici curiae in this case acknowledge that a "*Hanif* motion" violates the right to a jury trial. "If there is a dispute about the amount that

the plaintiff, or another source on her behalf, has paid for medical services, *a posttrial procedure to determine the appropriate damages for a plaintiff's medical expenses violates the right to trial by jury.*" (Amici Curiae Brief of Association of California Insurance Companies and the Personal Insurance Federation of California, filed in the Court of Appeal on July 21, 2009, pp. 15–16, italics added.)

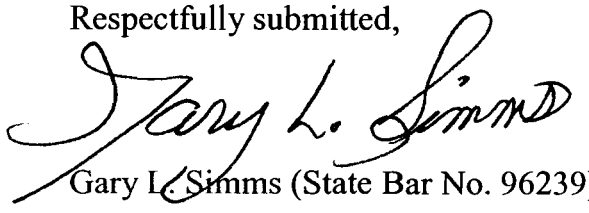
The only way to allow a "*Hanif* motion" when there is a factual dispute would be to nullify Code of Civil Procedure sections 592 and 631 and Evidence Code section 312 and, more boldly, to strike down article 1, section 16 of the California Constitution. But the Court cannot strike down article 1, section 16 simply because the Court might think a so–called *Hanif* motion would be efficient. As the Court recently explained, "*no* decision suggests that . . . [a constitutional provision] may be found unconstitutional on the ground that it conflicts with some *implicit or extraconstitutional* limitation that is to be framed and enforced by the judiciary." (*Strauss v. Horton* (2009) 46 Cal.4th 364, 391, italics by the Court.)

Moreover, the jury-trial problem will not be confined to determining the amount of cash payments. A substantive rule that limits a plaintiff's recovery to the amount of cash payments, together with the admission into evidence of those payments, will raise numerous other fact questions, including, but not limited to, whether the plaintiff owes any further amounts, whether her providers or insurers have a lien or contractual right of reimbursement against her recovery, and the amount of her insurance premiums for which she should be reimbursed by the defendant. Some or all of these questions may be disputed in a particular case. Indeed, even if only one of these many questions is disputed, a posttrial *Hanif* reduction cannot be made by a judge.

CONCLUSION

If recovery of past medical expenses is limited to the amount of a plaintiff's insurer's cash payment and amounts still owing, the Court will need to cut through a thicket of evidentiary and procedural problems. Personal injury actions will become more complex and will consume already thin judicial–resources. Moreover, absent a stipulation by the parties to have all disputed fact–questions decided by a judge, a posttrial "*Hanif* motion" is barred by the statutory and constitutional right to a jury trial. No easy judicial–solution for these problems is apparent. As Justice Moore explained in *Olsen*, *supra*, 164 Cal.App.4th 200, the procedural confusion created by judicial efforts to cobble together a procedure demonstrates why any changes to the collateral source rule should be left to the Legislature. (*Id.*, at pp. 213–214, conc. opn. of Moore, J.).)

Respectfully submitted,



Gary L. Simms (State Bar No. 96239)

♦ **CERTIFICATE OF SERVICE** ♦
Rebecca Howell v. Hamilton Meats & Provisions, Inc.
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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 May 4, 2011, I served true and complete copies of the attached **APPELLANT REBECCA HOWELL'S RESPONSE TO THE COURT'S APRIL 20, 2011, ORDER** 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 postage prepaid, and depositing those sealed envelopes in the United States mail in Ashland, Oregon.

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[one copy]
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Fourth Appellate Dist.—Div. One
Symphony Towers
750 "B" Street — Suite 300
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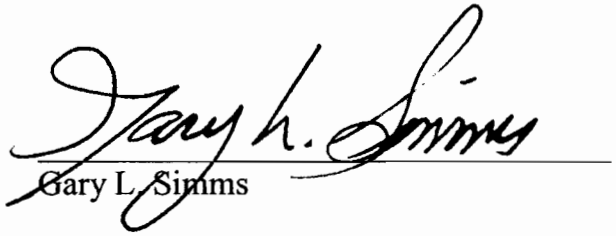
[one copy]
Clerk of the Court
Attn: Hon. Adrienne A. Orfield
San Diego County Superior Court
325 South Melrose
Vista, CA 92081

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 May 4, 2011, in the City of Ashland, County of Jackson, State of Oregon, United States of America.



Gary L. Simms