Case Nos. **A143440 and A144041**

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

FIRST APPELLATE DISTRICT, DIV. ONE

B.C.,

Plaintiff and Respondent,

vs.

CONTRA COSTA COUNTY,

Defendant and Appellant.

ON APPEAL FROM THE SUPERIOR COURT OF CONTRA COSTA COUNTY,
HON. STEVEN K. AUSTIN, CASE NO. MSC09-01786.

AMICUS CURIAE BRIEF OF THE CIVIL JUSTICE ASSOCIATION OF CALIFORNIA IN SUPPORT OF DEFENDANT AND APPELLANT

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IN THE COURT OF APPEAL
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INTRODUCTION: IMPORTANCE OF ISSUES AND INTEREST OF AMICUS

The Civil Justice Association of California ("CJAC" or "amicus")[1] welcomes the opportunity to address two issues this case presents: (1) Does the Medical Injury Compensation Reform Act's (MICRA's) repeal in Civil Code section 3333.1 of the common law collateral source rule for medical malpractice actions allow the defendant to introduce evidence of *future* benefits the plaintiff is entitled to receive for his injuries, including insurance proceeds under the federal Affordable Care Act (ACA); and (2) Did the trial court commit reversible error in refusing to instruct the jury that future medical damages must be limited to amounts that will with reasonable certainty be paid and accepted by health care providers for treatment they render plaintiff, as opposed to just the plaintiff's evidence of the sticker-price amounts likely to be "billed" for that care?

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[1] By separate application accompanying the lodging of this brief, CJAC requests the Court to accept and file it.

These purely legal questions are of utmost interest to the public and of immense importance to CJAC's members, which include health care organizations, businesses, professional associations and financial institutions. Amicus's principal purpose as a more than 37-year-old non-profit corporation is to educate the public about ways to make California state and federal liability laws more fair, economical, clear and certain. Toward this end, CJAC regularly petitions co-equal and co-ordinate branches of our government for redress in determining who gets paid, how much, and from whom when certain conduct is alleged to occasion harm to others. Our participation in the principal MICRA cases over the years, as well as recent opinions on the use of actual discounted amounts instead of inflated "billed" amounts for ascertaining medical damages, informs our perspective in this case.[2]

That the issues raised by this case directly impact these concerns is shown by the difference between what the plaintiff here was permitted to present to the jury about his future care damages – $285 million, with a present value of $29 million – and what the defendant's expert would have testified to had the court allowed the jury to hear that evidence – $3,341,037 in present value. As it turns out, the jury returned a "compromise" verdict based on slanted, incomplete evidence for $9,577,000 in present

[2] See, *e.g.*, *American Bank & Trust Co. v. Community Hosp. Of Los Gatos-Saratoga, Inc.* (1984) 36 Cal.3d 359; *Fein v. Permanente Medical Group* (1985) 38 Cal.3d 137 (*Fein*); *Roa v. Lodi Medical Group, Inc.* (1985) 37 Cal.3d 920; *College Hospital Inc. v. Superior Court* (1994) 8 Cal.4th 704; *Bird v. Saenz* (2002) 28 Cal.4th 910; *Rashidi v. Moser* (2014) 60 Cal.4th 718; *Winn v. Pioneer Medical Group, Inc.* (2016) 63 Cal.4th 148; *Haworth v. Superior Court* (2010) 50 Cal.4th 372; *Howell v. Hamilton Meats & Provisions, Inc.* (2011) 52 Cal.4th 541 (*Howell*); *Ruiz v. Podolsky* (2010) 50 Cal.4th 838; *Stinnett v. Tam* (2011) 198 Cal.App.4th 1412; *Chan v. Curran* (2015) 237 Cal.App.4th 601; and *Corenbaum v. Lampkin* (2013) 215 Cal.App.4th 1308 (*Corenbaum*).

value, nearly three times more than what defendant expert's excluded testimony shows the actual cost of that care to be. Something looks wrong.

SUMMARY OF ARGUMENT

Evidence of future medical benefits a plaintiff is entitled to receive for his injuries is admissible under California's repeal of the collateral source rule for medical malpractice lawsuits. (Civil Code § 3333.1.) This includes benefits conferred on a plaintiff by the federal Affordable Care Act (ACA). Abrogation of the common law collateral source rule by section 3333.1 expressly permits a defendant to introduce evidence of "any amount payable" to a plaintiff for his injuries from a variety of sources, including the ACA. The trier-of-fact is not required to, but may consider that evidence and reduce the amount of plaintiff's recoverable damages. In this way "double payments" to the plainitff are eliminated, the cost of medical liability insurance is reduced and the availability of that insurance is increased.

A number of courts to have considered the issue agree that future health insurance benefits are encompassed by MICRA's repeal of the common law collateral source rule. These judicial rulings recognize that the plain language, purpose and logic of section 3333.1 do not countenance a distinction between past and future medical care benefits when it comes to evidence a jury can hear and consider in deciding the amount of damages to which a medical malpractice plainitff is entitled.

That the ACA is controversial for some people and the target of a succession of failed repeal efforts, does not detract from its usefulness as a measure of plaintiff's damages in a medical malpractice case. The trial court's refusal to allow the jury to hear

testimony and consider evidence of these benefits payable to plaintiff violates the plain language of section 3333.1.

Neither is it lawful for the court to preclude, as it did here, the jury from hearing and considering evidence of the actual discounted amounts a plaintiff paid or will pay for his medical care needs, past and future. Despite the collateral source rule, California courts have ruled that the actual amounts paid or to be paid, and not billed, are the only ones relevant to determining the loss or damage to the plaintiff. When, as here, the collateral source rule is repealed and the defendant expressly allowed by statute to introduce evidence of benefits to which the plaintiff is entitled, it is axiomatic that the actual discounted cost for medical care, and not the "billed" sticker price, is the proper yardstick for measuring the damage incurred.

ANALYSIS

I. EVIDENCE OF FUTURE MEDICAL AND HEALTH INSURANCE BENEFITS IS ADMISSIBLE IN MEDICAL MALPRACTICE ACTIONS PURSUANT TO CIVIL CODE SECTION 3333.1.

A. The Plain Meaning of the Word "Payable" in Section 3333.1, Combined with the Statute's Purpose, Underscores that Evidence of Future Benefits or Payments a Plaintiff is Entitled to Receive for his Injuries Should be Heard and Considered by the Jury in Assessing the Amount of Plaintiff's Recovery.

MICRA's abolition of the traditional collateral source rule for medical malpractice lawsuits was enacted in 1975 as Civil Code § 3333.1. The *general purpose* of this provision, along with other changes to conventional legal rules for determining liability and damages in medical malpractice actions, is to reduce the cost of medical malpractice insurance. (*Fein, supra,* 38 Cal.3d at 159.) This goal is furthered by the section's *specific purpose* to eliminate the "double recovery" obtained by plaintiffs who

have their medical expenses paid by their own health insurance and still obtain damages for such expenses from defendant tortfeasors. (See Keene, *California's Medical Malpractice Crisis* in *A LEGISLATOR'S GUIDE TO THE MEDICAL MALPRACTICE ISSUE* (1976) 27, 31; *Cf. Helfend v. Southern Cal. Rapid Transit Dist.* (1970) 2 Cal.3d 1 [explaining the rationale underlying the traditional "collateral source" rule excluding evidence of such collateral source benefits].)

The intended effect of section 3333.1, then, is "to reduce a defendant health care provider's overall liability by allowing for a potential reduction in damages (subd. (a)) and by prohibiting third party subrogation of such damages (subd. (b)) . . .." (*Miller v. Sciaroni* (1985) 172 Cal.App.3d 306, 313.) "[T]he Legislature's assumption [in enacting § 3333.1] was that the trier of fact would take the plaintiff's receipt of such benefits into account by reducing damages." (*Barme v. Wood* (1984) 37 Cal.3d 174, 179.) A reduction in medical liability insurance premiums is thus achieved by "a shifting of . . . liability for a plaintiff's medical-care costs from a defendant health-care provider to the plaintiff's health-insurance company."[3]

As the Court explained when upholding the collateral source and other MICRA tort reforms against constitutional attack based on guarantees to equal protection and due process:

> Under section 3333.1, subdivision (a), a medical malpractice defendant is permitted to introduce evidence of such collateral source benefits *received by or payable* to the plaintiff; when a

[3] Fagel, *The Collateral Source Rule Under the Affordable Care Act*, 1 *PLAINTIFF MAG.* 1 (Jan. 2014), http://plaintiffmagazine.com/Jan14/Fagel_The-Collateral-Source-Rule-under-the-Affordable-Care-Act_Plaintiff-article.pdf, accessed June 1, 2016.

> defendant chooses to introduce such evidence, the plaintiff may introduce evidence of the amounts he has paid – in insurance premiums, for example – to secure the benefits. Although section 3333.1, subdivision (a) – as ultimately adopted – does not specify how the jury should use such evidence, the Legislature apparently assumed that in most cases the jury would set plaintiff's damages at a lower level because of its awareness of plaintiff's "net" collateral source benefits.

(*Fein, supra,* 38 Cal.3d at 164; italics added.)

Fein's use of the phrase "received or payable" evinces an understanding gleaned from the plain language of section 3333.1 specifying that collateral sources include *both* payments already made by a collateral source – *i.e.*, "*received*" – and those not yet made but "*payable*" to the plaintiff in the future, what are known as "future benefits" to be considered by the jury in its calculus of "future damages":

> (a) In the event the defendant so elects, in an action for personal injury against a health care provider based upon professional negligence, he may introduce *evidence of any amount payable* as a benefit to the plaintiff as a result of the personal injury pursuant to the United States Social Security Act, any state or federal income disability or worker's compensation act, *any health*, sickness or income-disability *insurance*, accident insurance that provides health benefits or income-disability coverage, and *any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or other health care services.* Where the defendant elects to introduce such evidence, the plaintiff may introduce evidence of any amount which the plaintiff has paid or contributed to secure his right to

> any insurance benefits concerning which the defendant has introduced evidence.

(Civil C. § 3333.1, subd. (a); italics added.)

Unless otherwise defined in the statute itself, which is not the case with section 3333.1, use of the word "payable" in the statute is to be given its ordinary dictionary definition. "When attempting to ascertain the ordinary, usual meaning of a word, courts appropriately refer to the dictionary definition of that word." (*Wasatch Property Management v. Degrate* (2005) 35 Cal.4th 1111, 1121-1122.) The dictionary definition of "payable" is "capable of being or liable to be paid," an obvious reference to an event that has not yet happened but will or should occur. (*WEBSTER'S ENCYCLOPEDIC UNABRIDGED DICTIONARY OF THE ENGLISH LANGUAGE* (1989 ed.) 1059.) "Payable may . . . signify an obligation to pay at a future time . . .." (*BLACK'S LAW DICTIONARY* (5th ed. 1979) 1016.) In other words, addition of the suffix "able," meaning "capable of," to the stem word "pay" yields the adjective "payable," which denotes a future occurrence.[4]

That the word "payable" in section 3333.1 includes "future" benefits or damages a plaintiff is entitled to receive from various collateral sources for his injuries, is further evinced by the Legislative Counsel's Digest to Assembly Bill 1 – the MICRA legislation – which describes section 3333.1 as allowing the defendant "to introduce evidence of specified benefits to which the plaintiff is *entitled* by reason of the loss." (Legis. Counsel's Digest., Assem. Bill 1 (1975-76 2d. Ex. Sess) as enrolled Sept. 23, 1975, § 1; italics added.) This digest description does not refer solely to "specified benefits"

[4] http://www.dictionary.com/browse/-able, accessed June 1, 2016.

already "paid," but to "benefits to which the plaintiff is *entitled*," which logically includes those to which one has a future right to claim but which have not yet been received. "We look to the Legislative Counsel's digest and other summaries and reports indicating the Legislature's intent. Although the . . . digests are not binding, they are entitled to great weight." (*Mt. Hawley Insurance Company v. Lopez* (2013) 215 Cal.App.4th 1385, 1401.)

Finally, MICRA's provisions are to be construed "broadly" so as to effectuate the purpose of its liability insurance cost savings provisions like section 3333.1's collateral source reform. (See, *e.g.*, *Preferred Risk Mutual Ins. Co. v. Reiswig* (1999) 21 Cal.4th 208, 215; *Canister v. Emergency Ambulance Service* (2008) 160 Cal.App.4th 388, 406 ("[C]ourts have broadly construed 'professional negligence' to mean negligence occurring during the rendering of services for which the health care provider is licensed.").) After all, "if a statute is to make sense, it must be read in the light of some assumed *purpose*. A statute merely declaring a rule, with no purpose or objective, is nonsense." (Llewellyn, *Remarks on the Theory of Appellate Decision and the Rules or Canons About How Statutes Are to Be Construed* (1950) 3 *VAND.L.REV*. 395, 400, emphasis added, reprinted in Singer, *Statutes and Statutory Construction* (6th ed. 2000) § 48A:08, p. 639.) The contingency fee bar knows this, which is why its members and plaintiff's counsel here "argue for the narrowest construction of MICRA['s section 3333.1] possible because courts have generally construed it broadly, relying on the stated legislative purpose of lowering medical malpractice insurance premiums." (Sigelman, *Unhappy Birthday: California's Med-mal Cap Turns 40* (2015) 51-*MAY TRIAL* 48, 49.)

To construe the scope and application of the phrase in section 3333.1 of "*any amount payable* as a benefit to the plaintiff" as confined to just past, and not future, entitlements, defies common sense. If accepted it would, since future damages are often the largest component of the total damage award, defeat the cost savings purpose of the statute by rending its plain meaning a nullity.

B. Other Courts Have Ruled that Admissible Collateral Source Evidence under Section 3333.1 Includes a Plaintiff's Entitlement to Future Health Care Benefits.

Despite the organized plaintiff bar's attempt to persuade courts that future health insurance benefits are not encompassed by MICRA's repeal of the common law collateral source rule,[5] a number of courts recently addressing the issue have held just the opposite. *Brewington v. United States*,[6] for instance, was presented with the same legal issue this case presents: May the defendant in a medical malpractice lawsuit "introduce evidence [pursuant to section 3333.1] of Affordable Care Act (ACA) coverage as a collateral source of future medical care expenses"? Remarking that "[o]ther district courts have taken future insurance benefits into consideration [citations omitted], the court found "it appropriate to take insurance benefits available under the ACA into consideration in calculating [plaintiff's] reasonable future life care plan needs." (*Id.* at p. *6 [nonpub. opn.].)

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[5] "California appellate courts have not yet addressed the applicability of MICRA's collateral source exceptions to future damages. MICRA allows defendants to introduce certain collateral sources that include 'any amount *payable* as a benefit to the plaintiff.' The plaintiff may then introduce evidence of the premiums 'paid or contributed' to secure those benefits. Because the statute does not expressly allow the defendant to introduce evidence of amounts 'paid or contributed' in the future, 'payable' should refer only to past benefits." Sigelman, *supra* at 49.

[6] C.D. Cal., July 24, 2015, No. CV 13-07672-DMG (CWx); 2015 WL 4511296.

Similarly, in parsing the pertinent statutory language, *S.H. ex rel. Holt v. U.S.*[7] opined (assuming but not deciding) that "pursuant to section 3333.1 a trier of fact can consider future collateral source benefits and reduce a damages award accordingly." (*Id.* at pp. *3-4 [nonpub. opn.].) *Accord*: *Silong v. United States*[8] ("section 3333.1(a) . . . allows this Court, as trier of fact, to determine how to apply future [health insurance] benefits to damages calculation. [Health insurance] coverage for [plaintiff's] future medical expenses does not vitiate plaintiffs' claims for recoverable damages; [but health insurance] coverage is a factor for this Court to consider." (*Id.* at p. *17 [nonpub. opn.].); *Veasley ex rel. Veasley v. United States*[9] ("Plaintiffs' motion . . . to preclude defendant from introducing evidence or arguing that any portion of plaintiffs' future damages should be reduced by payments that might be made in the future by any collateral source is denied . . .") (*Id.* at p. *2.).

C. Evidence of Benefits Available to a Medical Malpractice Plaintiff under the Affordable Care Act Should be Admissible Pursuant to Section 3333.1.

As previously mentioned, Section 3333.1 expressly provides that a defendant in a medical malpractice action can introduce evidence of "any amounts payable as a benefit to the plaintiff as a result of the personal injury pursuant to . . . any state or federal . . . *health insurance* . . . that provides health benefits . . . and *any contract or agreement of any group . . . or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental,*

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[7] E.D. Cal., Oct. 30, 2014, No. 2:11-cv-1963-MCE-DAD; 2014 WL 5501005.

[8] E.D. Cal., Sept. 5, 2007, No. CV F 06-0474 LJO DLB; 2007 WL 2580543; 69 Fed.R.Serv.3d 648.

[9] S.D. Cal., Oct. 15, 2015, No. 12-CV-3053-WGH-WVG; 2015 WL 6033563.

or other health care services." (Italics added.) This language plainly includes health insurance plans under the ACA.

The ACA is a federally mandated health insurance law enacted in 2010 that "will result in almost all Americans being insured. Section 1501 [of the ACA], the individual mandate, requires that most Americans maintain 'qualified' health insurance coverage." (Comment, *The Fate of the Collateral Source Rule after Healthcare Reform* (2013) 60 *UCLA L. REV*. 736, 760.) By "qualified" the ACA requires a health insurance plan to include, at a minimum, "essential health benefits." (26 U.S.C. § 5000A(f); Supp. V 2011.) Essential health benefits must include "ambulatory patient services, emergency room services, hospitalization, maternity and newborn care, mental health and substance abuse, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services." (ACA § 1302(b), 124 Stat. at 163-65 (codified at 42 U.S.C. § 18022 (Supp. V 2011).) The individual mandate "will minimize adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums." (42 U.S.C. § 18091.)

The ACA further limits the amount a patient pays out of pocket for care to the current Health Savings Account (HSA) limits.[10] Other ACA provisions that limit the variability between insurance plans include prohibiting lifetime limits on coverage,[11] prohibiting insurers from rescinding coverage except in fraud cases, (*id.*) prohibiting

[10] *Id.* at 6, showing that the 2010 HSA limits are $5,950 for an individual and $11,900 for a family.

[11] ACA § 1001, 124 Stat. at 130-37.

preexisting-condition exclusions,[12] requiring guarantee issue and renewability of health insurance plans,[13] and limiting rating variations based only on age, premium rating area, family composition, and tobacco use.[14] These limitations will create insurance contracts that are more standardized from patient to patient regardless of which insurance plan a patient holds.

California has, pursuant to the ACA, implemented a state-run health benefit exchange, an organized marketplace where residents can buy coverage from health insurers. The ACA, after setting the minimal essential coverage standards, establishes four levels of coverage – bronze, silver, gold and platinum – for plans sold on the state exchange. Plaintiff is now on Medi-Cal, California's name for Medicaid, but because of his injuries is able to retain those benefits through a "special needs trust" (42 U.S.C. 1396a(a)(25)) and use it to purchase private health insurance under the ACA.

All the aforementioned legal facts were, according to appellant, presented as an offer of proof to the court, but it barred the jury from hearing or considering them by granting plaintiff's motion in limine to preclude them. (Appellant's Reply Brief, pp. 26-32.) A major reason given by the trial court for preventing the jury from hearing and considering evidence of benefits the plaintiff is entitled to be paid pursuant to the ACA is the court's view that the ACA is susceptible to repeal and that there is insufficient certainty plaintiff will be able to reap continued benefits from his ACA plan. Under that speculative reasoning, however, there could never be a circumstance that would permit

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[12] *Id.* § 1201, 124 Stat. at 154-61.

[13] *Id.* § 1001, 124 Stat. at 130-37.

[14] *Id.* § 1201, 124 Stat. at 154-61.

a jury to hear and take into consideration future benefits to which a plaintiff is entitled as measure of his future damage. The ACA has been with us now for six years, has withstood numerous repeal efforts and survived to date two Supreme Court challenges. (See *National Federation of Independent Businesses v. Sebilius* (2012) 567 U.S. __ [132 S.Ct. 2566]; *King v Burwell* (2015) 576 U.S. __ [135 S.Ct. 2480].) Courts must take the law as it is, and not assume that becasue it may be controversial to some and frequently challenged, it cannot figure into the calculation of damages consistent with section 3333.1.

The court's ruling barring evidence of ACA benefits to which the plaintiff is "entitled" and "reasonably likely to obtain" runs afoul of section 3333.1; it requires reversal and remand for a new trial where the jury can hear evidence of ACA benefits "payable" to plaintiff.

II. APPELLANT IS ENTITLED TO AN INSTRUCTION THAT PLAINTIFF'S FUTURE MEDICAL DAMAGES MUST BE LIMITED TO AMOUNTS THAT WERE OR WILL BE PAID AS OPPOSED TO "BILLED"; AND TO PRESENT EVIDENCE TO THE JURY AS TO THOSE AMOUNTS.

Howell, supra, 52 Cal. 4th 541 holds that the collateral source rule does not entitle a plaintiff to recover economic damages which the plaintiff never incurred or were never actually paid to the providers. Instead, the plaintiff in *Howell* was limited to obtaining as medical damages "no more than the amounts [he] paid . . . or his or her insurer [paid] for the medical services received . . .." (*Id.* at 566.) The court explained that, "[t]o be recoverable, a medical expense must be . . . incurred." (*Id.* at 555.) "[I]f the plaintiff negotiates a discount and thereby receives services for less than might reasonably be charged, the plaintiff has not suffered a pecuniary loss or other detriment

in the greater amount and therefore cannot recover damages for that amount." (*Id.*)

Howell was not a medical malpractice case. The *Howell* opinion declined to modify or abrogate the common law collateral source rule, whereas here section 3333.1's repeal of the collateral source rule is in effect. Similarly, *Corenbaum, supra,* 215 Cal.App.4th 1308 holds that a plaintiff can recover for *future* medical care only the amounts likely to be paid for that care. (*Id.* at 1331.) "Because the full amount billed for past medical services provided to plaintiffs is not relevant to the value of those services . . . the full amount billed for those past medical services can provide no reasonable basis for an expert opinion on the value of future medical services." (*Ibid.*)

To be sure, under the common law collateral source rule, "medical damages are calculated using billed charges, regardless of whether the medical provider accepts a lower negotiated rate from the plaintiff's insurance company as payment in full." (Comment, *supra*, 60 *UCLA L. Rev.* at 763.) After the ACA mandate, "almost everyone will now carry some form of health insurance, and although a medical provider's billed charge might not change, the amount ultimately received as payment will almost always be a reduced negotiated rate." (*Id.*) Since California has already provided through *Howell* and *Corenbaum* that the actual amount paid, not the billed amount, is the proper basis for calculating medical damages despite the common law collateral source rule, abrogation of the rule in medical malpractice claims makes that transition even smoother.

Since the collateral source rule has been repealed by section 3333.1 for medical malpractice actions such as this, two obvious ways to ascertain plaintiff's actual detriment here are by (1) reducing the amount of medical damages incurred by the

amount plaintiff's insurance company actually paid for them, or (2) reducing medical damages by the amount the plaintiff's insurance company paid, but offsetting this amount by premium payments the plaintiff made. An anomaly to these two approaches occurs if the plaintiff is uninsured because the negligent defendant who injures an insured person whose costs are reimbursed will incur less liability (and therefore be "better off") than one who injures an uninsured person. But as previously discussed, that incongruity is not present here because the plaintiff is covered by Medi-Cal and can, from a special needs trust, obtain mandated insurance under the ACA.

Accordingly, it is fitting and proper that the court permit the jury to hear testimony about the actual cost or detriment suffered by plaintiff for his past and future medical care so the jury can decide whether to take that evidence into consideration in calculating plaintiff's recoverable compensation. A new trial on remand with directions to allow evidence to be presented about plaintiff's actual, as opposed to "billed" loss, is the correct cure for this malady.

CONCLUSION

For all the aforementioned reasons, CJAC respectfully asks this court to reverse the judgment and remand the case for a new trial.

Dated: June 16, 2016

Respectfully submitted,

/s/_____

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CERTIFICATE OF WORD COUNT

I certify that the WordPerfect® software program used to compose and print this document contains, exclusive of the caption, tables, certificate and proof of service, approximately 4,300 words.

Date: June 16, 2016

Respectfully submitted,

/s/

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PROOF OF SERVICE

I, David Cooper, am employed in the city and county of Sacramento, State of California. I am over the age of 18 years and not a party to the within action. My business address is 3418 Third Avenue, Suite 1, Sacramento, CA 95817.

On June 16, 2016, I served the foregoing document(s) described as: *Amicus Curiae* Brief of the Civil Justice Association of California in Support of Defendant and Appellant in *B.C. v. Contra Costa County*, A143440 & A144041 on all interested parties in this action as follows:

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/s/
David Cooper