Case No. **S179115**

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IN THE SUPREME COURT OF THE STATE OF CALIFORNIA

REBECCA HOWELL,
Plaintiff and Appellant,

vs.

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

AFTER A DECISION BY THE CALIFORNIA COURT OF APPEAL,
FOURTH APPELLATE DISTRICT, DIVISION ONE, NO. D053620.
SAN DIEGO COUNTY SUPERIOR COURT, HON. ADRIENNE ORFIELD, GIN053925.

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

FRED J. HIESTAND
Fhiestand@aol.com
State Bar No. 44241
1121 L Street, Suite 404
Sacramento, CA 95814
Tel.: (916) 448-5100
Fax.: (916) 442-8644

Counsel for *Amicus Curiae*

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INTRODUCTION: IMPORTANCE OF ISSUE AND INTEREST OF AMICUS

This case presents an issue of critical importance to the administration of justice and the interests of the Civil Justice Association of California (CJAC) – *viz.*, whether a plaintiff in a personal injury action is entitled to recover an amount for medical expenses *greater* than what her private health insurance paid on her behalf and what the healthcare providers who treated her for her injuries accepted as full payment for their services.[1]

The answer to this question initially appears to turn on the answer to a related underlying one: Why should *any* plaintiff receive *more* for medical care damages than what was actually paid to and accepted by health care providers as full reimbursement for their treatment of plaintiff? One can readily understand why plaintiffs and their lawyers, who typically get a "piece" of plaintiff's action should they settle or prevail,

[1] By separate application accompanying this lodged brief, CJAC asks the Court to accept it for filing.

like to reach for the sky when it comes to compensatory damages, the more the merrier and the bigger the better. But given that all resources – including money – are limited, explaining why plaintiffs should get more than what it actually costs for their medical treatment seems dicey. If *more* is to be awarded by way of compensable medical expenses than what was actually paid for medical services, how much more and how is that amount to be determined?

The opinion here, in contrast to other appellate decisions, concluded the amounts billed for plaintiff's medical care, and not the amount actually paid by plaintiff's medical insurance to fully satisfy all her financial obligations for that care, was the correct measure of medical damage because to hold otherwise "violates the collateral source rule." (*Howell v. Hamilton Meats & Provisions, Inc.* (2010) 101 Cal.Rptr.3d 805, 819.) Whether that conclusion is legally correct is, of course, the principal point of contention in this case and the subject of our brief. But before we get into the meat of the matter, the consequences of a ruling that affirms the appellate opinion should be understood: an increase in the size of settlements, verdicts, the number of lawsuits filed, and the cost of health care and insurance to cover that care.

In this case alone, the difference between the two amounts in dispute – what plaintiff's medical treatment actually cost (*i.e.*, what her health insurance paid for health care providers to treat her ($60,000)[2]) and what those providers would charge as market rates but for their agreement with the health insurers to accept less with no right to any further reimbursement from plaintiff or her insurers (roughly $190,000

[2] For convenience and because it does not alter the essential facts or principals at stake, these numbers are evenly rounded-off throughout this brief to the nearest one thousand dollars.

or three times the agreed upon and paid amount) – comes to $130,000. This difference, which the appellate court calls the "negotiated rate differential"[3], is not only a significant amount in this case, but when extrapolated to the many other personal injury cases where these very disputes about the proper measure of damages regularly occur, amounts to "hundreds of millions of dollars over several years." (Evan George, *Appeal Panel Ruling of Real Value of Injuries is a Big Win for Plaintiffs*, *DAILY JOURNAL*, Nov. 25, 2009.)

CJAC is a nonprofit organization of businesses, professional associations and local government groups dedicated to educating the public about ways to make our civil liability laws more fair, economical and certain. Toward these ends, we regularly petition the courts for redress over who pays, how much, and to whom when wrongful conduct is alleged to occasion injury to others. Affirming the appellate court's reasoning and decision here would indisputably impose additional financial obligations upon defendants, further raising the cost of medical insurance and providing an incentive for the filing of ever more personal injury actions. In a state already smarting from a large population of medically uninsured due to the high cost of health care, this is neither sound public policy nor the meting out of justice.

SUMMARY OF SALIENT FACTS[4]

Rebecca Howell was seriously injured when the car she was driving was struck by a truck driven by one of Hamilton's employees, who had negligently made an

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[3] *Id.* at 689.

[4] These facts are excerpted from the appellate opinion and set forth because they inform and provide the context for a better understanding of the legal questions addressed.

illegal U-turn across the lane in which Howell was traveling.

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

Despite Howell's agreements with her medical providers to pay them their usual and customary charges for services she received from them, she in fact had to pay nothing beyond the deductibles and co-payments because of agreements her medical providers had entered into with PacifiCare that they would accept the amounts agreed upon as full payment for their services.

Hamilton filed a motion *in limine* seeking to exclude at trial any evidence of, or reference to, those portions of Howell's medical bills that were not paid either by PacifiCare, or by Howell, as a co-payment. Hamilton argued that the decision in *Hanif v. Housing Authority* (1988) 200 Cal.App.3d 635 (*Hanif*) "preclude[d] [Howell] from seeking to recover as medical expenses amounts billed, but not ultimately paid by PacifiCare." (*Howell, supra*, 101 Cal.Rptr.3d at 809.)

Howell opposed the motion, arguing that under the collateral source rule as articulated in *Helfend v. Southern California Rapid Transit Dist.* (1970) 2 Cal.3d 1 (*Helfend*) "the gross amount of all medical bills, not any lesser amount, should be presented to the jury." (*Howell, supra*, 101 Cal.Rptr.3d at 809.)

Following oral argument, the court denied Hamilton's *in limine* motion, ruling that Howell was entitled at trial to present evidence of the full amount of the medical bills. The court, however, on a defense motion pursuant to *Hanif, supra,* 200 Cal.App.3d 635 deferred to a post-trial proceeding the determination of whether the jury's award of damages for Howell's past medical expenses should be reduced by any amount her medical providers may have "compromised their billing." (*Howell, supra*, 101 Cal.Rptr.3d at 809.)

The jury returned a special verdict awarding Howell compensatory damages in the total amount of $689,978.63, which included about $190,000 for "[p]ast economic loss, including medical expenses, $150,000 for "[f]uture economic loss, including medical expenses," $200,000 for "[p]ast *non* economic loss (including physical pain, mental suffering, loss of enjoyment of life, disfigurement, physical impairment, inconvenience, grief, anxiety, humiliation, and emotional distress)," and $150,000 for "[f]uture *non* economic loss." (*Howell, supra*, 101 Cal.Rptr.3d at 809.) Before the court entered judgment, Hamilton moved under *Hanif, supra,* 200 Cal.App.3d 635 and *Nishihama v. City and County of San Francisco* (2001) 93 Cal.App.4th 298 (*Nishihama*)to reduce the jury's special verdict for Howell's past medical expenses by $130,000 (i.e., from $190,000 to $60,000). In support of its motion, Hamilton presented evidence that the difference between the amounts charged by Howell's health care providers for her medical treatment and what they received from PacifiCare for that treatment ($130,000) had been "written-off" and "no collection from Howell would be pursued by [them.]" The court granted defendant's motion, explaining:

The Court grants defendant's motion to reduce plaintiff's

> past medical specials to reflect the amount the medical providers accepted as payment in full of the medical bills. Contrary to plaintiff's assertions, reaching this amount does not violate the collateral source doctrine, as evidence of how or why an amount less than the full bill was accepted as payment in full is unnecessary to make this determination. Further, the trier of fact relied on evidence of the gross amount billed to plaintiff, and thus had an accurate understanding of the severity of [her] injuries when it rendered its verdict. Thus a post-trial motion to reduce past medical specials to the amount that was actually paid and considered payment in full does not violate the collateral source doctrine; rather it embodies the well-established principle that a plaintiff is entitled to recover an amount that would make her whole, but not overcompensate her . . ..[5]

Howell appealed.

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[5] *Howell, supra*, 101 Cal.Rptr.3d at 811.

THE APPELLATE OPINION

The Court of Appeal reversed the trial court. In its opinion, the Court concluded that the "extinguishment of a portion of Howell's debt to [its health care providers] in the amount of the negotiated rate differential – $130,000 – was a benefit to Howell because she was no longer personally "liable for that portion of the debt she . . . incurred in obtaining medical treatment for her injuries." (*Howell, supra*, 101 Cal.Rptr.3d at 815.) "This benefit to Howell," the appellate opinion also concluded,

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

> the benefit by maintaining her own insurance. (Rest.2d Torts, § 920A, com. (b).)[6]

Recognizing that its conclusion appears to run counter to *Hanif* and *Nishihama*, the opinion sought to distinguish these opinions from the facts animating this one by claiming defendant's "reliance on [them] is misplaced." It dismissed guidance from *Hanif* by calling the opinion "unavailing" because it is allegedly "inapposite" to the facts presented here. The supposed factual distinction between this case and *Hanif* is that here the cost of plaintiff's medical treatment was indemnified by *private* health insurance, while in *Hanif* the plaintiff was a minor so medical treatment was paid for by Medi-Cal, a *publicly* funded program.

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

[6] *Howell, supra*, 101 Cal.Rptr.3d at 815.

> care insurer in an amount that is less than the amount the providers have billed.[7]

The opinion also found defendant's "reliance on *Nishihama* . . . unavailing." That conclusion, the court stated, was based on *Nishihama's* holding that the plaintiff was not entitled to recover damages based on his health care provider's normal and customary rates, but on the sum it accepted under its agreement with plaintiff's health insurer for services rendered. The appellate opinion here felt *Nishihama* "should have been resolved based on an analysis of [plaintiff's] rights under the collateral source rule," not on "an analysis of [the health care provider's] lien rights under the Hospital Liability Act." (*Id.* at 818.) "Because the holding in *Nishihama* is not based on . . . an analysis under California's collateral source rule, [plaintiff's] reliance on that case is misplaced." (*Id.* at 819.)

SUMMARY OF ARGUMENT

The intersection of the law of damages with the collateral source rule should entitle a personal injury plaintiff to recover from defendant the discounted amount actually paid out of pocket by her and her health insurers and accepted by her medical providers as payment in full, but not the larger "sticker price" amount billed by her providers for her medical care. A damage award for past medical expenses in an amount greater than the actual cost of covering those expenses constitutes overcompensation.

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[7] *Id.* at 816.

Fairness and common sense compel the conclusion that a plaintiff in a tort action should not normally be compensated for loss or harm the plaintiff did not suffer. To hold otherwise would compensate plaintiffs for detriment they, in fact, never suffered, and invite extrapolation to the stars as to the reasonable value of those medical services once they are untethered to the amount actually paid for them.

A determination of the *reasonable cost* of medical services ultimately should rest with the two parties with the most sophistication and knowledge in the matter: the health care provider and the health care insurer. Allowing a plaintiff to obtain medical expense damages based on the amounts billed by his or her health care provider rather than the actual amount paid to cover the full cost of those services will necessarily increase the size of settlements and judgments, the number of lawsuits filed and the cost of health care and medical insurance. It would solely and unfairly benefit plaintiffs and their lawyers to the detriment of the public and the administration of justice.

LEGAL ANALYSIS

I. THE PURPOSE OF THE LAW OF DAMAGES AND THE COLLATERAL SOURCE RULE IS TO FAIRLY COMPENSATE AN INJURED PLAINTIFF FOR DETRIMENT ACTUALLY SUFFERED, NOT TO UNJUSTLY ENRICH THE PLAINTIFF FOR VIRTUAL OR PHANTOM LOSS.

Damages in a personal injury action and their measure are defined by statute. Thus, Civil Code section 3281 provides: "Every person who suffers detriment from the unlawful act or omission of another, may recover from the person in fault a compensation therefor in money, which is called damages." Civil C. section 3333 states: "For the breach of an obligation not arising from contract, the measure of

damages . . . is the amount which will compensate for all the detriment proximately caused thereby. . .." "Detriment" is statutorily defined as "a loss or harm suffered in person or property." (Civil C. § 3282.) Economic damages suffered by an injured person include the *reasonable cost* of medical care. (Civ. Code, § 1431.2, subd. (b)(1); *Dimmick v. Alvarez* (1961) 196 Cal.App.2d 211 (emphasis added); see CACI No. 3903A.)

Juxtaposed to these statutory definitions of compensable "damage" is the common law "collateral source rule," which provides that damages recoverable by an injured person should not be reduced by the amount of payments for his or her loss from a source wholly independent of the wrongdoer. (See, *e.g.*, *Helfend v. Southern California Rapid Transit Dist.*, *supra*, 2 Cal.3d at 6; *Acosta v. Southern Cal. Rapid Transit Dist.* (1970) 2 Cal.3d 19, 25.) While the Legislature has modified or abrogated the collateral source rule in two situations not applicable here – medical malpractice actions[8] and lawsuits against government[9] – and the rule has come under severe scholarly criticism,[10] it still applies to this and all other personal injury claims. Its purpose is to further California's public policy of encouraging "prudent investment in insurance" and ensuring that personal injury plaintiffs are "made whole." (*Lund v.*

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[8] Civ. C. § 3333.1.

[9] Gov. C. § 985.

[10] See, *e.g.*, 2 Harper & James, *THE LAW OF TORTS* (1968 Supp.) § 25.22, at p. 152; see, *e.g.*, Fleming, *The Collateral Source Rule and Loss Allocation in Tort Law* (1966) 54 *CAL.L.REV.* 1478; James, *Social Insurance and Tort Liability: The Problem of Alternative Remedies* (1952) 27 *N.Y.U.L.REV.* 537; Schwartz, *The Collateral Source Rule* (1961) 41 *B.U.L.REV.* 348; West, *The Collateral Source Rule Sans Subrogation: A Plaintiff's Windfall* (1963) 16 *OKLA.L.REV.* 395; Note, *Unreason in the Law of Damages: The Collateral Source Rule* (1964) 77 *HARV.L.REV.* 741.

San Joaquin Valley R.R. (2003) 31 Cal.4th 1, 9-10; *Helfend*, *supra*, 2 Cal.3d at 10.)

There is no dispute in this case that the collateral source rule applies to and entitles Howell to recover the actual amounts paid by her and her insurers to her health care providers for injuries caused by Hamilton's negligence ($60,000). This is the substantive result of the collateral source rule. It benefits plaintiff by compensating her for her actual cost of medical care expenses and provides her a "windfall" to the extent her noneconomic damage component is a multiple of her medical damages, which here is $350,000 or six times the amount of the actual cost to pay for her medical care.[11]

There is also no dispute that the fact Howell had insurance coverage for medical costs she incurred as a result of the accident was inadmissible under *Hrnjak*, the evidentiary effect of the collateral source rule. The primary question raised here is whether the collateral source rule entitles Howell to recover the full amount billed by her providers for her medical care ($190,000) or only the discounted amount actually paid out of pocket by her and her insurers, and accepted by her medical providers as payment in full ($60,000).

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[11] In *Seffert v. Los Angeles Transit Lines* (1961) 56 Cal.2d 498, 512, Justice Roger Traynor observed then in a dissenting opinion that "[a] review of reported cases involving serious injuries and large pecuniary losses reveals that ordinarily the part of the verdict attributable to pain and suffering [non economic damage] does not exceed the part attributable to pecuniary losses." While Traynor felt strongly that to continue to award non economic damages without limitation was "anomalous" given the popular trend toward "loss spreading" under tort law, he attributed to them the purpose of "ease[ing] plaintiffs' discomfort and . . . pay[ing] for attorney fees for which plaintiffs are not otherwise compensated." (*Id.* at 511.) Significantly, this same rationale, to provide a fund for the payment of plaintiff attorney's fees, was advanced nine years later for the collateral source rule. *Helfend, supra*, 2 Cal.3d at 11-12.

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

A. The "Reasonable Value" of the Medical Services Rendered a Plaintiff for Detriment Suffered is the "Actual Cost" of those Services, not the Prevailing Market Rate Billed but Never Paid and Indisputably Uncollectible from Plaintiff.

In *Hanif*, the trial judge in a bench trial awarded plaintiff the "reasonable value" of medical services rendered, despite the fact that the hospital that billed for the expenses accepted a reduced amount from plaintiff's Medi-Cal insurance. (*Hanif, supra,* 200 Cal.App.3d at 639.) Based on "[f]undamental principles underlying recovery of compensatory damages in tort actions" (*id.* at 640), the court held that a damage award for past medical expenses in an amount greater than its actual cost "constitutes overcompensation" (*id.* at 641). The court directed a reduction of the award, declaring that the maximum amount a plaintiff can recover for medical services is the amount "expended or incurred for past medical services," even if that amount "may have been less than the prevailing market rate" (*id.* at p. 641; see also *id.* at 643-644).

Hanif rests on the common sense notion that a plaintiff in a tort action should not normally be compensated for loss or harm the plaintiff did not suffer. To hold otherwise and allow compensation for the reasonable value of medical services based on what health care providers bill regardless of the amount actually paid, presents serious difficulties. First, it compensates the plaintiff for detriment that she, in fact, never suffered. Second, determining the *reasonable value* of medical services invites extrapolation to the stars once they are untethered to the amount actually paid for them. As the Indiana Supreme Court astutely remarked in *Stanley v. Walker* (2009) 906 N.E.2d 852, 857:

> The complexities of health care pricing structures make it difficult to determine whether the amount paid, the

amount billed, or an amount in between represents the reasonable value of medical services. One authority reports that hospitals historically billed insured and uninsured patients similarly. Mark A. Hall & Carl E. Schneider, *Patients As Consumers: Courts, Contracts, and the New Medical Marketplace* (2008) 106 *MICH. L. REV.* 643, 663). With the advent of managed care, some insurers began demanding deep discounts, and hospitals shifted costs to less influential patients. *Id.* This authority reports that insurers generally pay about forty cents per dollar of billed charges and that hospitals accept such amounts in full satisfaction of the billed charges. *Id.*

* * *

As more medical providers are paid under fixed payment arrangements, another authority reports, hospital charge structures have become less correlated to hospital operations and actual payments. The Lewin Group, *A Study of Hospital Charge Setting Practices* I (2005). Currently, the relationship between charges and costs is "tenuous at best." *Id.* at 7. In fact, hospital executives reportedly admit that most charges have "no relation to anything, and

certainly not to cost." Hall, *supra*, *Patients As Consumers* at 665.[12]

Amounts billed by health care providers as opposed to amounts actually paid for services rendered by them are analogous to the manufacturer's suggested retail price on automobiles. Hospital retail charges are inflated prices that don't reflect what they are actually paid. In fact, the differential is even greater for hospitals than for automobiles. Medicare and private insurers pay only a fraction of hospital charges. (See Jones, *Managed Care and the Tort System: Are We Paying Unnecessary Billions?* (Jan. 1, 1996) 63 *DEFENSE COUNSEL J.* 74, 75 ["[R]esearch discloses that, depending on the geographical area, as many as 80 percent of providers are estimated to be rendering health care under managed plans of one type or another" and "[a]t least half of all health care in the United States now is provided under some type of managed care plan. [¶] . . . The difference between the managed care fixed rate and the provider's billed charges is often as much as 600 to 800 percent."].)

Given the aforementioned reality, it takes powers of divination unique to soothsayers to find compensable "detriment" from bills she does not have to pay. While the appellate opinion herein found "detriment" in the mere fact of the original billing and plaintiff's initial, theoretical obligation to pay these bills, this "detriment" is, at best, evanescent here and extinguished for others by the formulas and agreements between the health care providers and the health insurance carrier. A determination

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[12] Cited and quoted in *King v. Willmet* (2010) WL 3096258 (Cal.App. 3 Dist.), Hull, J. dissenting. Accord: *Vencor Inc. v. National States Ins. Co.* (9th Cir. 2002) 303 F.3d 1024, 1029, fn. 9 ("[I]n a world in which patients are covered by Medicare and various other kinds of medical insurance schemes that negotiate rates with providers, provider's supposed ordinary or standard rates may be paid by a small minority of patients.").

of the *reasonable cost* of medical services ultimately should rest with the two parties with the most sophistication and knowledge in the matter – the health care provider and the health care insurer. To award plaintiff $190,000 for medical damages that were fully satisfied by a payment of $60,000 is to confer upon her "phantom damages." This is an over-broad application of the collateral source rule, an unwarranted extension of a much criticized concept. To award this amount as "damages" is to disregard the fundamental principle that tort damages are intended to compensate for real, objectively measurable loss or harm, not imaginary "pie-in-the-sky" loss.

B. There is No Sound Policy Reason to Distinguish Between How the Collateral Source Rule is Applied Based on Whether the Amounts Actually Paid for Plaintiff's Medical Care are from Public as Opposed to Private Health Insurance.

The appellate opinion in this case and those supporting it seek to dismiss *Hanif* and *Nishihama* on the grounds that *Hanif* was limited to collateral sources from Medi-Cal, not private, health insurance; and *Nishihama* did not address whether *Hanif* should apply outside the context of Medi-Cal. This, however, is a specious distinction because it makes no sense from a public policy standpoint.

The discounts or "write-offs" of private insurance have their counterpart in Medi-Cal. Doctors treat Medi-Cal patients and receive reimbursement under a predetermined rate schedule. That amount is generally less than what that provider would usually charge for that service in the open market. States have broad discretion in setting the rates. (Earl Dirk Hoffman, Jr. et al., Office of the Actuary, Centers for Medicare & Medicaid Services, Dep't of Health and Human Services, *Brief Summaries of Medicare & Medicaid* 21 (2006).) The rates must only be sufficient to "enlist enough providers so that covered services are available at least to the extent that comparable

care and services are available to the general population." (*Id.*) Providers are required to accept the reimbursement amount as payment in full for the plaintiff's obligations. (*Id.*) The difference between the amount the provider would generally charge for the service and the reimbursement amount from the government is "written off" by the medical provider. "This 'written off' amount presents a dilemma similar to the discounts under private insurance." (Rebecca F. Anderson, *The Collateral Source Rule and Medicaid Plaintiffs: Eliminating Windfalls and Double Recovery* (2007) 30 *T. JEFFERSON L. REV.* 223, 232.)

Why, then, distinguish between public and private health insurance when it comes to interpreting and applying the collateral source rule? *Helfend* does not, after all, distinguish between the public and private sector when it comes to applying the collateral source rule, but holds that it applies to governmental entities in the same manner that it applies to *all* other tortfeasors. (*Helfend, supra,* 2 Cal.3d at 14 (disapproving contrary statements in *City of Salinas v. Souza & McCue Contruction Co.* (1967) 66 Cal.2d 217).) *Greer v. Buzgheia* (2006) 141 Cal.App.4th 1150, which involves the intersection of private health insurance benefits and the collateral source rule, implicitly accepts *Nishihama's* premise that "it is error for the plaintiff [in a tort action] to recover medical expenses in excess of the amount paid or incurred" and makes no distinction between public and private health insurance. Moreover, judgments against public entities may be reduced under Government Code section 985 based on services or benefits the plaintiff has received from certain publicly funded sources *and* private insurance.

In *People v. Millard* (2009) 175 Cal.App.4th 7, defendant was convicted of driving under the influence causing bodily injury to another person, and was ordered to pay restitution for the victim's medical expenses. (*Id.* at 13.) The People appealed the trial court's restitution order, arguing that the trial court erred by valuing the victim's medical expenses based on the amount paid by his insurance company rather than the amount billed by his medical providers. (*Ibid.*) The appellate court upheld the trial court's methodology, following *People v. Bergin* (2008) 167 Cal.App.4th 1166, a previous restitution case that relied on *Hanif*. *Millard* found that limiting restitution to the amount actually paid by the insurer had a rational basis and was not legally erroneous. (*Id.* at 26, 28-29.) The court observed that a restitution order was not intended to provide the crime victim with a "windfall," but only to reimburse the victim for the actual economic loss incurred, even if the amount of the loss is paid by a collateral source such as Medi-Cal *or* private insurance. (*Id.* at 28.)

Finally, the approach of the aforementioned opinions to the evaluation of the reasonable value of medical services in the context of the collateral source rule is in accord with the *Restatement (Second) of Torts*, § 911 comment h (1977), which without distinguishing between public and private health insurance benefits, states: "When the plaintiff seeks to recover for expenditures made or liability incurred to third persons for services rendered, normally the amount recovered is the reasonable value of the services rather than the amount paid or charged. 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." It also is consistent with the approach taken in other jurisdictions. See, e.g., *Bates v. Hogg* (Kan. Ct. App.) 921 P.2d

249, rev. den., 260 Kan. 991 (1996) (plaintiff properly prohibited from admitting evidence of market value of medical services; because of medical provider's contractual agreement, the amount allowed by Medicaid represented the customary charge under the circumstances).

Rather than sanction distinctions between public and private health insurance that conflict with common sense when it comes to application of the collateral source rule, the Court should provide uniformity when it comes to the treatment of both. This is an appropriate role for the Court given that provisions of the Civil Code defining damages and their measurement are based on the common law.

> The provisions of this Code, so far as they are substantially the same as existing statutes or the common law, must be construed as *continuations* thereof, and not as new enactments. (Civ. C. (1872) § 5; italics added.) The effect of these sections was early expressed by us in *In re Jessup* (1889) 81 Cal. 408, 419 in the following terms: "[E]ven as to the code, 'liberal construction' does not mean enlargement or restriction of a plain provision of a written law. If a provision of the code is plain and unambiguous, it is the duty of the court to enforce it as it is written. If it is ambiguous or doubtful, or susceptible of different constructions or interpretations, then such liberality of construction is to be indulged in as, within the fair interpretation of its language, will effect its apparent object

and promote justice."[13]

CONCLUSION

For all the aforementioned reasons, amicus urges the Court to reverse the opinion of the Court of Appeal and reinstate the trial court order.

Dated: September 1, 2010

Respectfully submitted,

/s/
Fred J. Hiestand, General Counsel
The Civil Justice Association of California

[13] *Li v. Yellow Cab Co.* (1975) 13 Cal.3d 804, 815 (interpreting a more than 100-year-old statute that had consistently been read to provide for the all-or-nothing defense of contributory negligence as instead establishing pure comparative negligence).

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Date: September 1, 2010

/s/
Fred J. Hiestand

PROOF OF SERVICE

I, David Cooper, am employed in the city of Sacramento, Sacramento County, State of California. I am over the age of 18 years and not a party to the within action. My business address is The Senator Office Building, 1121 L Street, Suite 404, Sacramento, CA 95814.

On September 1, 2010, I served the foregoing document(s) described as: *Amicus Curiae* Brief of the Civil Justice Association of California in Support of Defendant and Respondent in *Howell v. Hamilton Meats & Provisions, Inc.*, S179115 on all interested parties in this action by placing a true copy thereof in a sealed envelope(s) addressed as follows:

Robert F. Tyson, Esq.
Mark T. Petersen, Esq.
Kristi Deans, Esq.
Tyson & Mendes, LLP
5661 La Jolla Blvd.
La Jolla, CA 92037
Attorneys for Defendant/Respondent

John J. Rice, Esq.
LaFave & Rice
2333 First Avenue, Suite 201
San Diego, CA 92101
Attorney for Plaintiff/Appellant

Gary L. Simms, Esq.
Law Office of Gary L. Simms
2050 Lyndell Terrace, Suite 240
Davis, CA 95616
Attorney for Plaintiff/Appellant

J. Jude Basile, Esq.
Basile Law Firm
1334 Chorro Street
San Luis Obispo, CA 93401
Attorney for Plaintiff/Appellant

Clerk, Court of Appeal
Fourth Appellate District, Div. 1
750 B Street, #300
San Diego, CA 92101
Appellate Court

Hon. Adrienne Orfield
San Diego County Superior Court
North County
325 S. Melrose Drive
Vista, CA 92081
Trial Court

[X](BY MAIL) I am readily familiar with the practice of the Senator Office Building for the collection and processing of correspondence for mailing with the United States Postal Service and such envelope(s) was placed for collection and mailing on the above date according to the ordinary practice of the law firm of Fred J. Hiestand, A.P.C.

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

Executed this 1st day of September 2010 at Sacramento, California.

/s/
David Cooper