D053620

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

FOURTH APPELLATE DISTRICT, DIVISION ONE

REBECCA HOWELL,
Plaintiff and Appellant,

v.

HAMILTON MEATS & PROVISIONS CO.,
Defendant and Respondent.

APPEAL FROM SAN DIEGO COUNTY SUPERIOR COURT
ADRIENNE ORFIELD, JUDGE • CASE NO. GIN053925

APPLICATION FOR LEAVE TO FILE AMICI CURIAE BRIEF; AMICI BRIEF OF ASSOCIATION OF CALIFORNIA INSURANCE COMPANIES AND PERSONAL INSURANCE FEDERATION OF CALIFORNIA IN SUPPORT OF RESPONDENT

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IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

FOURTH APPELLATE DISTRICT, DIVISION ONE

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Plaintiff and Appellant,

v.

HAMILTON MEATS & PROVISIONS CO.,
Defendant and Respondent.

APPLICATION FOR LEAVE TO FILE AMICI CURIAE BRIEF

Under California Rules of Court, rule 8.200(c), the Personal Insurance Federation of California (PIFC) and the Association of California Insurance Companies (ACIC), request permission to file the attached amici curiae brief in support of respondent Hamilton Meats & Provisions, Inc.

PIFC is a California-based trade association that represents insurers selling approximately 40 percent of the personal lines insurance sold in California. PIFC represents the interests of its members on issues affecting homeowners, earthquake, and automobile insurance before government bodies, including the California Legislature, the California Department of Insurance, and the California courts. PIFC's membership includes mutual and stock insurance companies.

ACIC is an affiliate of the Property Casualty Insurers Association of America (PCI) and represents more than 300 property/casualty insurance companies doing business in California. ACIC member companies write 40.5 percent of the property/casualty insurance in California, including personal automobile insurance, commercial automobile insurance, homeowners insurance, commercial multi-peril insurance, and workers compensation insurance. ACIC members include all sizes and types of insurance companies -- stocks, mutuals, reciprocals, Lloyds-plan affiliates, as well as excess and surplus line insurers.

As counsel for PIFC and ACIC, we have reviewed the briefs filed in this case and believe this court will benefit from additional briefing concerning the proper measure of damages for a personal injury plaintiff's medical expenses when a healthcare provider has agreed to accept as payment in full for the plaintiff's medical services an amount negotiated with the plaintiff's insurance company. This issue is of great interest to PIFC and ACIC since it directly affects the amount of money liability insurers may have to pay for medical expense damages caused by their insureds. The attached amici curiae brief supplements, but does not duplicate, the parties' briefs.

This application is timely. It is being submitted well within the amicus curiae briefing period provided by rule 8.200(c)(1): "Within 14 days after the last appellant's reply brief is filed or could have been filed . . . , whichever is earlier."

Under rule 8.200(c)(3), PIFC and ACIC state that no party or counsel for a party authored the proposed amici brief in whole or in

part and that no one (including a party or counsel for a party), other than amici and their members, has made a monetary contribution to fund the preparation or submission of the proposed amici brief.

Accordingly, amici request that this court accept and file the attached amici curiae brief.

July 15, 2009

Respectfully submitted,

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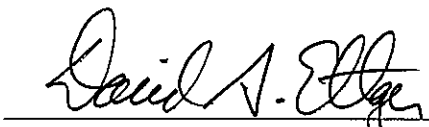
By: 
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AMICI CURIAE BRIEF

INTRODUCTION

In this personal injury action, plaintiff invokes the collateral source rule to argue that the trial court unfairly reduced the damages she is to recover as compensation for her medical expenses. The collateral source rule allows a plaintiff to recover as damages the amounts paid for her medical expenses even if the plaintiff's insurance company made the payment. The trial court ruled plaintiff could recover all that her insurance company paid for her medical expenses, but rejected her attempts to also recover higher amounts that her healthcare providers had stated in their bills. It did not allow recovery of the higher amounts because no one had paid or ever will pay them; the healthcare providers agreed to accept the lower amounts negotiated with plaintiff's health insurance company as payment in full for plaintiff's medical services.

The trial court's decision followed the common-sense rule stated in *Hanif v. Housing Authority* (1998) 200 Cal.App.3d 635 that "a sum certain . . . paid or incurred . . . , whether by the plaintiff or by an independent source, . . . is the most the plaintiff may recover for [medical] care despite the fact it may have been less than the prevailing market rate." (*Id.* at p. 641.) Plaintiff challenges the *Hanif* rule, at least when it comes to payments by private insurers. She claims the *Hanif* rule is an improper exception to the collateral source rule.

Contrary to plaintiff's assertions, the *Hanif* rule is not an exception to the collateral source rule, but a corollary to it. *Hanif* does not alter the prohibition against reducing a damage award because of payments made by someone else on a plaintiff's behalf. Rather it protects against windfalls and overcompensation by not allowing a plaintiff to be "reimbursed" for payments that no one has made or ever will make.

Significantly, this court recently accepted the *Hanif* rule. In the analogous context of providing full reimbursement to a crime victim, this court rejected the argument that the victim should receive the amount billed by his medical providers rather than the lower amount paid by his insurance company. (*People v. Millard* (June 22, 2009) __ Cal.App.4th __ [2009 WL 1743623, at p. *23].) That holding fully supports the trial court's ruling here.

We also explain in this brief that the procedure commonly used for implementing the *Hanif* rule — in this case and in others — is defective. Courts have allowed juries to hear evidence of the amount *billed* by healthcare providers and to base their damage verdicts on that amount, deferring to a posttrial proceeding (on motion of the defendant) a possible reduction of the damage award to the lesser amount accepted by the healthcare providers as full payment of the plaintiffs' medical expenses. If there is a dispute about the amount actually paid to the healthcare providers, a posttrial proceeding violates the constitutional right to a jury trial on the issue, unless the parties stipulate to such a proceeding. Also, by requiring the defendant to move for a reduction of the jury's

inflated award, the court improperly shifts to the defendant the burden of proof on that element of the plaintiff's damages.

LEGAL DISCUSSION

I. THE LAW STATED IN *HANIF V. HOUSING AUTHORITY* IS COMPLEMENTARY TO, NOT A VIOLATION OF, THE COLLATERAL SOURCE RULE.

A successful personal injury plaintiff is entitled to recover her medical expenses as damages. The defendant is liable for those expenses even if all or some of them were paid not by the plaintiff herself, but by her insurer. That is the result of the collateral source rule, which, as stated by the Supreme Court, provides, "if an injured party receives some compensation for his injuries from a source wholly independent of the tortfeasor, such payment should not be deducted from the damages which the plaintiff would otherwise collect from the tortfeasor." (*Helfend v. Southern Cal. Rapid Transit Dist.* (1970) 2 Cal.3d 1, 6 (*Helfend*); see also *Lund v. San Joaquin Valley Railroad* (2003) 31 Cal.4th 1, 8, 9-10.)

The issue in this case is whether the defendant is liable not only for medical expenses that the plaintiff or her insurer has paid, but for phantom "expenses" that *no one* paid or ever will pay. Those unpaid medical expenses are not really "expenses" at all because no one is obligated to pay them — they are the difference between what a healthcare provider agreed to accept as full payment for

medical services and the larger amount that the healthcare provider quotes as the price of the services.

In *Hanif v. Housing Authority* (1998) 200 Cal.App.3d 635 (*Hanif*), the court concluded a defendant is *not* liable for unpaid medical expenses: "a sum certain . . . paid or incurred . . . , whether by the plaintiff or by an independent source, . . . is the most the plaintiff may recover for [medical] care despite the fact it may have been less than the prevailing market rate." (*Id.* at p. 641.) Plaintiff here claims that applying *Hanif* in this case would contravene the collateral source rule. Plaintiff is wrong.

The very statement of the collateral source rule by the Supreme Court illustrates why that rule does not conflict with *Hanif*. As seen, the collateral source rule applies to "*compensation*" that "an injured party *receives* . . . for his injuries from a source wholly independent of the tortfeasor." (*Helfend, supra*, 2 Cal.3d at p. 6, emphases added.) The *Hanif* court itself recognized, there is "no question" that payment under Medi-Cal insurance "for all injury-related medical care and services does not preclude plaintiff's recovery from defendant, as special damages, of the amount paid" because "plaintiff is deemed to have personally paid or incurred liability for these services and is entitled to recompense accordingly." (*Hanif, supra*, 200 Cal.App.3d at pp. 639-640.) But an amount over and above what was actually paid, or will ever be paid, to a healthcare provider — and accepted as payment in full for those services — cannot be considered "compensation" that the injured party "receives."

Hanif is a common-sense application of basic remedies principles. The court noted the rules that "'damages are normally awarded for the purpose of *compensating* the plaintiff for injury suffered,'" that the object of damages is "'*just compensation . . . and no more*,'" and that a plaintiff, "'in being awarded damages, [is not] to be placed in a better position than he would have been had the wrong not been done.'" (*Hanif, supra*, 200 Cal.App.3d at pp. 640-641, original emphases.) The court concluded, "it follows that an award of damages for past medical expenses in excess of what the medical care and services actually cost constitutes over-compensation." (*Ibid.*)

The *Hanif* court also found its rule "in harmony with other rules and practices" governing compensatory damages in tort, "such as the practice of discounting future damages to present value [citation], the bar against double recovery [citations], the rule that damages not be imaginary [citation], the rule that when damages may be calculated by either of two alternative measures the plaintiff may recover only the lesser [citations], and the rule that damages be mitigated where reasonably possible [citations]." (*Hanif, supra*, 200 Cal.App.3d at p. 643.)

Both the collateral source rule and the law stated in *Hanif* serve the same purpose — to insure that a personal injury plaintiff is properly compensated for her medical expenses. Under both, the defendant is liable for whatever the plaintiff or her insurer pays to a healthcare provider for medical services. *Hanif* simply adds the qualification that the defendant is *not* liable for *more* than what plaintiff or her insurer pays. Thus, *Hanif* is not, as plaintiff

contends, an "exception" to the collateral source rule (AOB 20-22), but a corollary to it.

II. THE *HANIF* RULE HAS BEEN APPLIED AND APPROVED BY NUMEROUS COURTS, INCLUDING THIS ONE.

The *Hanif* rule has been applied not only in the Third District Court of Appeal (*Hanif, supra,* 200 Cal.App.3d 635; see also *Katiuzhinsky v. Perry* (2007) 152 Cal.App.4th 1288, 1290; *Greer v. Buzgheia* (2006) 141 Cal.App.4th 1150, 1157 (*Greer*)), but also in the First District (*Nishihama v. City and County of San Francisco* (2001) 93 Cal.App.4th 298, 306 (*Nishihama*)). Moreover, the Supreme Court has relied on the rule at least in situations where Medicaid pays a plaintiff's medical expenses. (*Olszewski v. Scripps Health* (2003) 30 Cal.4th 798, 809; see *Parnell v. Adventist Health System/West* (2005) 35 Cal.4th 595, 611, fn. 16 (*Parnell*).) The only dissenting voice is one justice's opinion in a case in Division Three of this district. (*Olsen v. Reid* (2008) 164 Cal.App.4th 200, 204 (conc. opn. of Moore, J.); but see *id.* at pp. 214-216 (conc. opn. of Fybel, J.) (*Olsen*) [defending the *Hanif* rule; "The collateral source rule was followed because the plaintiffs in those cases [*Hanif* and *Nishihama*] recovered all medical costs actually incurred, even though the costs were paid by others"].)

Significantly, this court and another have, in a related context, also approved the *Hanif* rule.

In *People v. Millard* (June 22, 2009) __ Cal.App.4th __ [2009 WL 1743623] (*Millard*), this court determined the amount of restitution necessary to, as required by statute, "'fully reimburse [a crime] victim'" for the victim's medical expenses. (*Id.* at p. *23.) The People argued there that the victim should be reimbursed for the amount billed by his medical providers rather than the amount paid by his insurance company. (*Ibid.*) This court disagreed: "To 'fully reimburse' the victim for medical expenses means to reimburse him or her for all out-of-pocket expenses actually paid by the victim or others on the victim's behalf (e.g., the victim's insurance company). The concept of 'reimbursement' of medical expenses generally does not support inclusion of amounts of medical bills in excess of those amounts accepted by medical providers as payment in full." (*Ibid.*)

In ruling as it did, this court agreed with and adopted the reasoning of the Second District's opinion in *People v. Bergin* (2008) 167 Cal.App.4th 1166 (*Bergin*). (*Millard, supra*, __ Cal.App.4th __ [2009 WL 1743623, at p. *23].) Like in *Millard*, the People in *Bergin* contended that "the restitution amount should have been . . . the amount billed by [the victim's] medical providers[ ] rather than . . . the amount the medical providers accepted from [the victim's] insurer as full payment for their services, plus the deductible paid by [the victim])." (*Bergin, supra*, at p. 1168.) The court concluded, however, that it was the lesser amount that "fully complied with the [applicable] statute's mandate to 'order full restitution.'" (*Id.* at p. 1169.) Because "[n]either [the victim] nor her insurers incurred any economic loss beyond the amount

identified in the trial court's restitution order," the court said, "we find it impossible to see any basis for concluding that [the victim] has not been '100 percent compensated.'" (*Id.* at p. 1172; see also *In re Anthony M.* (2007) 156 Cal.App.4th 1010, 1018 [applying *Hanif* rule in juvenile restitution case]; *id.* at p. 1017 [restitution "order is not . . . intended to provide the victim with a windfall"].)

The *Bergin* court specifically relied on *Hanif* for its holding, stating that "there is no reason why the *Hanif* principle — that 'an award of damages for past medical expenses in excess of what the medical care and services actually cost constitutes overcompensation' [citation] — should not be applied in a criminal restitution case." (*Bergin, supra,* 167 Cal.App.4th at pp. 1171-1172.) And, in adopting *Bergin,* this court in *Millard* noted *Bergin*'s citation of *Hanif.* (*Millard, supra,* __ Cal.App.4th __ [2009 WL 1743623, at p. *23].)

This court thus can and should affirm here based on its own precedent, as well as the precedent of other Courts of Appeal.

III. THE *HANIF* RULE IS AS RELEVANT WHEN A PRIVATE INSURER PAYS A PLAINTIFF'S MEDICAL EXPENSES AS WHEN THE GOVERNMENT DOES.

Plaintiff attempts to distinguish *Hanif* because in that case the plaintiff's medical expenses were paid by the government (under the Medi-Cal insurance program), while the payment in this case was made by a private insurance company. This is a distinction without a difference. The dispositive point is that the payments on

the plaintiff's behalf were accepted by the healthcare providers as payment in full. It is legally irrelevant whether it was a governmental or a private insurer that fully paid the plaintiff's medical expenses.

Of course, courts — including this court — have already applied the *Hanif* rule in cases where the medical expenses were paid by private insurers. (*Millard, supra*, __ Cal.App.4th __ [2009 WL 1743623, at p. *23] [payment by medical insurance company]; *Bergin, supra*, 167 Cal.App.4th at p. 1170 [payment by Blue Cross]; *Nishihama, supra*, 93 Cal.App.4th at pp. 306-307 [same].) And one of those courts specifically rejected a distinction between Medi-Cal and private insurance payments. (*Bergin, supra*, at p. 1172, fn. 4.) The results in those cases make sense.

Plaintiff's argument to the contrary focuses on the contract between her healthcare provider and her insurance company, under which the healthcare provider agrees to accept the insurer's payment as full satisfaction of her medical expenses. She claims that the negotiated price is a benefit paid for by her insurance premiums and that only by taking the provider-insurer contractual relationship into account will she be allowed to "recover the full amount of the debts she incurred with the providers." (AOB 31.)

The contract between plaintiff's insurance company and her healthcare providers did not cause plaintiff to "incur" any additional debt with the providers, however. Quite the opposite, the contract *limited* the debt she incurred *to* the amount her insurance company paid on her behalf. When a hospital accepts a payment as payment in full of a patient's medical expenses, the patient's "entire debt to

the hospital has . . . been extinguished." (*Parnell, supra,* 35 Cal.4th at p. 609.)

As the *Bergin* court pointed out in rejecting an argument similar to plaintiff's here, "'incur' means 'to become liable or subject to' [citation], and there is no suggestion in the record that [the crime victim there] was at any time liable for the amounts billed by her medical providers." (*Bergin, supra,* 167 Cal.App.4th at p. 1170, fn. 2.) Similarly, in holding that a lawyer representing himself could not recover attorney fees "'which are incurred to enforce [a] contract,'" the Supreme Court reasoned, "To 'incur' a fee, of course, is to 'become liable' for it [citation], i.e., to become obligated to *pay* it. It follows that an attorney litigating in propria persona cannot be said to 'incur' compensation for his time and his lost business opportunities." (*Trope v. Katz* (1995) 11 Cal.4th 274, 280; see also *Musaelian v. Adams* (2009) 45 Cal.4th 512, 516-517.)

An agreement between a medical insurer and a healthcare provider to provide healthcare services at lower costs for an insured plaintiff does not increase the debt that the plaintiff incurs to the provider above those lower costs. This common-sense conclusion is illustrated in *Whiteside v. Tenet Healthcare Corp.* (2002) 101 Cal.App.4th 693 (*Whiteside*).

In *Whiteside,* a patient sued his healthcare provider for allegedly breaching its agreement with his insurance company by first accepting a discounted amount from the insurance company and then accepting an additional payment from another insurer with which he was also insured (under a group policy). The patient asserted that the healthcare provider had violated the agreement's

term that prohibited collecting from the patient any payment above the discounted amount. The Court of Appeal concluded, however, that accepting the second insurance payment was not equivalent to collecting money from the patient himself. It held that "the insurance proceeds were not an asset legally equivalent to money in a bank account or a life insurance policy owned by [the patient]." (*Whiteside, supra,* 101 Cal.App.4th at p. 703.) The court explained that "[t]he basic obligation of the medical insurers is to pay the medical providers directly for their services and to insulate the insured from any monetary obligation for such medical care. [The insured] is entitled to no more than that under the terms of his coverage." (*Id.* at p. 705.)

In any event, the price "discount" that plaintiff stresses is largely illusory because payment of the so-called "full" price is the exception, not the rule.

The Ninth Circuit has recognized the reality that, "in a world in which patients are covered by Medicare and various other kinds of medical insurance schemes that negotiate rates with providers, providers' supposed ordinary or standard rates may be paid by a small minority of patients." (*Vencor Inc. v. National States Ins. Co.* (9th Cir. 2002) 303 F.3d 1024, 1029, fn. 9; see Nation, *Obscene Contracts: The Doctrine of Unconscionability and Hospital Billing of the Uninsured* (2005-2006) 94 Ky. L.J. 101, 104 [Labeling hospital charges as "'regular,' 'full,' or 'list,' [is] misleading, because in fact they are actually paid by less than five percent of patients nationally"].)

Moreover, it is becoming increasingly unlikely that even those patients *not* covered by public or private health insurance will ever be billed for "full" charges. Because of lawsuits and state statutes, hospitals are billing uninsured patients at the same "discounted" rates that they agree to accept for insured patients. (See, e.g., *In re Sutter Health Uninsured Pricing Cases* (2009) 171 Cal.App.4th 495, 499-500 [reporting settlements in other cases, and approving a settlement in the case before the court, under which uninsured patients would not be charged more than insured patients]; Goldstein, *Exerting Their Patients* (May 2009) ABA Journal 19 [noting similar settlements nationwide]; Health & Saf. Code, § 127405, subd. (d) ["A hospital shall limit expected payment for services it provides to a patient at or below 350 percent of the federal poverty level . . . eligible under its discount payment policy to the amount of payment the hospital would expect, in good faith, to receive for providing services from Medicare, Medi-Cal, Healthy Families, or another government-sponsored health program of health benefits in which the hospital participates, whichever is greater. If the hospital provides a service for which there is no established payment by Medicare or any other government-sponsored program of health benefits in which the hospital participates, the hospital shall establish an appropriate discounted payment"].)

The hypothetical "full" charge that plaintiff wants to recover as damages in this case thus bears little relation to reality. That is reflected in this court's *Millard* case, where the amount billed by the victim's medical providers ($418,081) was over three times the

amount paid by his insurance company ($133,256). (*Millard, supra,* __ Cal.App.4th __ [2009 WL 1743623, at p. *23].)

"[A] hospital's price list doesn't reflect what hospitals expect to recoup for a given service. Instead the prices are the hospital's initial bargaining position from which insurers negotiate down." (Goldstein, *Exerting Their Patients, supra,* ABA Journal at p. 19.) As such, the "full" price is a particularly unreliable measure of damages in a personal injury action where the plaintiff is not to be put in a better position than she would have been had she not been harmed. (See *Coalition for Quality Health Care v. New Jersey Dept. of Banking and Ins.* (N.J.Super.Ct.App.Div. 2003) 358 N.J. Super. 123, 127 [817 A.2d 347, 350] ["if . . . providers routinely accept significantly less than . . . they purport to charge, then paid fees are a realistically more accurate measure of reasonable and prevailing fees than billed fees"].)

IV. REQUIRING A POSTTRIAL PROCEDURE TO CALCULATE ACTUAL MEDICAL EXPENSE DAMAGES VIOLATES THE CONSTITUTIONAL RIGHT TO JURY TRIAL AND IMPROPERLY SHIFTS THE BURDEN OF PROOF ON THAT ISSUE.

Hanif was a bench trial. (*Hanif, supra,* 200 Cal.App.3d at p. 637.) In subsequent cases involving jury trials, the courts have developed a rule that, as happened in this case, the plaintiff is allowed to introduce evidence of her healthcare provider's "full" price and the court after trial will reduce the medical expense

damages to reflect the lower amount the healthcare provider accepted from the plaintiff's insurance company as full payment for the plaintiff's medical expenses.

The courts backed into this posttrial method of handling medical expense damages. It started with one court holding that introducing the "full" price into evidence was not prejudicial error requiring a new trial. (*Nishihama, supra,* 93 Cal.App.4th at p. 309.) From there, another court concluded a trial court had not "abuse[d] its discretion in allowing evidence of the reasonable cost of plaintiff's care while reserving the propriety of a . . . reduction until after the verdict." (*Greer, supra,* 141 Cal.App.4th at p. 1157.) That procedure has now apparently become ingrained. (See *Olsen, supra,* 164 Cal.App.4th at p. 202 [trial court denied defense motion to admit evidence of amount actually paid for medical treatment, "stating that any reduction in the amount of medical expenses would be handled after the trial"].)

The posttrial-reduction procedure is based on the premise that the "full" price is relevant evidence. As explained, however, damages should be calculated according to the amount actually paid, not the "full" price that no one pays. Indeed, the "full" price evidence should be inadmissible because it does not accurately reflect the cost of medical services for *any* purpose, and is therefore irrelevant to any issue before the jury. [1] Moreover, the courts have

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[1] Some courts have reasoned that the "full" price is admissible evidence because it "gives the jury a more complete picture of the extent of a plaintiff's injuries." (*Greer, supra,* 141 Cal.App.4th at p. 1157.) If, however, the "full" price is paid by almost no one, "full" (continued...)

not considered the constitutional implications of this posttrial procedure.

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. Whether or not the court admits evidence of the "full" price, the jury should hear evidence of the amount that the plaintiff or her insurer actually paid, and it should be instructed that the latter amount is the most it can award as damages.

The California Constitution provides that "[t]rial by jury is an inviolate right and shall be secured to all." (Cal. Const., art. 1, § 16; see also Code Civ. Proc., §§ 592, 631, subd. (a).) "[W]hen the state Constitution or a statute provides a right to a jury trial, a trial court's invalid denial or curtailment of that right is considered an act *in excess of jurisdiction* and reversible error." (*Corder v. Corder* (2007) 41 Cal.4th 644, 652.)

"The guarantee of jury trial in the California Constitution operates at the time of trial to require submission of certain issues to the jury." (*Jehl v. Southern Pac. Co.* (1967) 66 Cal.2d 821, 829.) Determining damages in a personal injury action is clearly one of those issues. (See *Salgado v. County of Los Angeles* (1998)

(...continued)
price evidence gives the jury a distorted view, not a "more complete picture," especially if evidence of the actual amount accepted by healthcare providers as payment in full for their services is kept from the jury.

19 Cal.4th 629, 649-650; *Hrimnak v. Watkins* (1995) 38 Cal.App.4th 964, 978-979.)

In *Brandt v. Superior Court* (1985) 37 Cal.3d 813, the Supreme Court held that if attorney fees are recoverable as tort damages in an insurance bad faith case, the jury must determine the amount of those damages unless the parties stipulate to a posttrial award by the trial court. (*Id.* at pp. 819-820.) The same is true with medical expenses in a personal injury lawsuit — absent an agreement by the parties that in effect waives their constitutional right to a jury trial on the issue, the amount of damages to be awarded for a plaintiff's medical expenses must be decided by a jury.

A posttrial procedure to reduce the jury's award is objectionable for another reason. The procedure not only deprives defendants of their right to a jury trial on the issue of the amount of plaintiffs' medical expense damages, but it also improperly shifts to defendants the burden of proof on that issue.

Plaintiffs have the burden of proof on damages. (*Linthicum v. Butterfield* (June 24, 2009) __ Cal.App.4th __ [2009 WL 1782954, at p. *5]; *Dumas v. Stocker* (1989) 213 Cal.App.3d 1262, 1269 ["In the compensatory damages arena, it is well established that plaintiff has the burden to prove the amount to which he is entitled with reasonable certainty"].) Yet, when the jury has based its verdict on a "full" price (because that's the only evidence on the issue the jury has heard) and the defendant then moves posttrial to reduce the jury's award, the burden is likely to fall on the defendant as the moving party to establish the actual price paid.

Indeed, one court reversed a posttrial reduction because the *defendant* did not produce sufficient evidence of what the *plaintiff* (or another on her behalf) had actually paid for medical services. (*Olsen, supra,* 164 Cal.App.4th at p. 203; see also *id.* at pp. 216-217 (conc. opn. of Fybel, J.).) In another case, the court refused to reduce the jury's award because the defendant had failed to request a special verdict form that would have specified plaintiff's medical expenses. (*Greer, supra,* 141 Cal.App.4th at pp. 1157-1159.)

It should not be the defendant's burden to produce evidence of the amount actually paid to satisfy the plaintiff's obligation to her healthcare providers. Nor should the defendant be penalized if the jury awards medical expense damages based on "full" price evidence but the verdict does not disclose the exact amount of those damages. Such results improperly relieve the plaintiff of the burden of proof on that element of damages.

If a largely hypothetical "full" price quoted by a healthcare provider is at all relevant to any issue in a personal injury action, the admission of that price into evidence should not eviscerate fundamental procedural principles. It should still be the plaintiff who is required to prove the amount of her medical expense damages, which can be no more than the actual amount paid for that expense, and she should have to carry that burden of proof before a jury.

CONCLUSION

For the reasons stated, this court should affirm the judgment and hold that plaintiff had the burden of proving to the jury the amount actually paid for her medical care.

July 15, 2009

Respectfully submitted,

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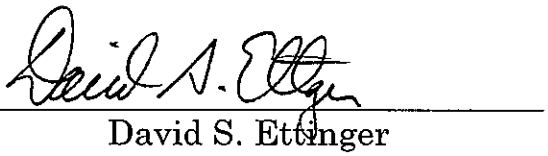
By: 
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CERTIFICATE OF WORD COUNT
(Cal. Rules of Court, rule 8.204(c)(1).)

The text of this brief consists of 4,377 words as counted by the Microsoft Word version 2007 word processing program used to generate the brief.

Dated: July 15, 2009

David S. Ettinger

PROOF OF SERVICE

STATE OF CALIFORNIA, COUNTY OF LOS ANGELES

At the time of service, I was over 18 years of age and not a party to this action. I am employed in the County of Los Angeles, State of California. My business address is 15760 Ventura Boulevard, 18th Floor, Encino, California 91436-3000.

On July 15, 2009, I served true copies of the following document(s) described as **APPLICATION FOR LEAVE TO FILE AMICI CURIAE BRIEF; AMICI BRIEF OF ASSOCIATION OF CALIFORNIA INSURANCE COMPANIES AND PERSONAL INSURANCE FEDERATION OF CALIFORNIA IN SUPPORT OF RESPONDENT** on the interested parties in this action as follows:

SEE ATTACHED SERVICE LIST

BY MAIL: I enclosed the document(s) in a sealed envelope or package addressed to the persons at the addresses listed in the Service List and placed the envelope for collection and mailing, following our ordinary business practices. I am readily familiar with Horvitz & Levy LLP's practice for collecting and processing correspondence for mailing. On the same day that the correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the United States Postal Service, in a sealed envelope with postage fully prepaid.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct and that I am employed in the office of a member of the bar of this Court at whose direction the service was made.

Executed on July 15, 2009, at Encino, California.

Victoria Beebe

Victoria Beebe

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Howell v. Hamilton Meats
D053620

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