S179115

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 Court of Appeal, Fourth Appellate District, Division One,
Reversing a Post-Verdict Order In A Civil Action,
County of San Diego, Hon. Adrienne Orfield, Judge Presiding
[SDSC Case No. GIN 053925]
Fourth Appellate District Case No. D053620

AMICI CURIAE BRIEF IN SUPPORT OF DEFENDANT AND RESPONDENT

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INTRODUCTION

The trial court permitted plaintiff to present evidence of the full billed amount of medical charges to the jury. Since neither plaintiff nor her insurer ever incurred or paid that amount, plaintiff should not collect that amount as economic damages. Rather, plaintiff should be limited in economic damages to the amount the medical provider accepts as payment. That is why the trial court did not err when it reduced the jury's award of damages to the negotiated rate – the rate that was in fact paid.

The Court of Appeal was wrong when it reversed the trial court, particularly when the Court of Appeal reasoned that the "negotiated rate differential" is a benefit within the meaning of the collateral source rule. That was wrong in many ways, but primarily because the Court of Appeal's approach will unnecessarily burden society with more cost than is necessary to achieve the goals of compensation and deterrence.

This Court should uphold the post-trial procedure that the appellate courts have developed for reduction of judgments in *Hanif v. Housing Authority* (1988) 200 Cal.App.3d 635 and *Nishihama v. City and County of San Francisco* (2001) 93 Cal.App.4th 298 (collectively "*Hanif/Nishihama*"). The *Hanif/Nishihama* procedure achieves the fundamental purpose of awards for past medical expenses: ensuring that the plaintiff is compensated for those expenses that have been paid or incurred as a result of a defendant's tort – no more, and no less.

SUMMARY OF REASONS WHY THE JUDGMENT SHOULD BE REDUCED BY THE AMOUNT OF THE "NEGOTIATED RATE DIFFERENTIAL"

As the Court of Appeal acknowledged, the collateral source rule provides that, "[i]f 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." (*Howell,* Slip Opn., p. 16, quoting *Helfend v. Southern Cal. Rapid Transit Dist., supra,* 2 Cal.3d at 6. Emphasis in bold added.) Consistent with that goal, when a California jury awards such a payment to the plaintiff, the trial court often is asked to fashion a judgment that redistributes such payment from the plaintiff to the "source" of the payment. That is, the court enforces rights of either subrogation or indemnification and, thereby, achieves reimbursement of the insurer or the governmental entity that is the "collateral source" of the payment. In doing so, the trial court simultaneously addresses the controversial "double recovery" that occurs as a result of the collateral source rule.

This appeal is about the procedure by which the trial courts of California have been routinely reducing awards for past medical expenses by the amount of money that is **not** paid or incurred by or on behalf of the plaintiff patient. It is in that way that the courts have been able to avoid not only that controversial "double recovery" of collateral benefits, but the even more controversial awards of past medical expenses for which plaintiff never incurred liability. The procedure was developed by the lower courts more than twenty years

ago. It is a procedure for medical expense reconciliation. It is commonly known as the "*Hanif-Nishihama* reduction," referring to a reduction of the jury's award for past medical expenses.

The Court of Appeal in this case characterized the procedure as "a defendant's post-trial motion to reduce under *Hanif* and *Nishihama* a privately insured plaintiff's recovery of economic damages for past medical expenses." (Slip Opn., p. 29.) The court also characterized it as an "abrogation of the collateral source rule." (Slip Opn., p. 26.) Even though the procedure has been routinely applied by the judiciary for many years, the court reasoned, any such change to the collateral source rule should be accomplished by statute, rather than by "piecemeal common law development." (*Ibid*.)

That was wrong. It was the judicial branch of government, after all, not the legislative branch, that conceived the collateral source rule in the first place, and it has been the judicial branch that has refined the rule ever since. The courts developed, refined, and regularly applied the post-trial procedure known as the "*Hanif/Nishihama* reduction" for awards for past medical expenses. The courts did so to deal with one of the most widely acknowledged and, heretofore, intractable problems of the collateral source rule, overcompensation.

The Court of Appeal cited two statutes which relate to the collateral source rule, Civil Code section 3333.1 and Government Code section 985 (Slip Opn., pp. 25-26), but the court never said that statutory changes are the *only* way to address problems with the collateral source rule. Nor did the court analyze the legislative histories of those two statutes, both of which were enacted in response

to specific problems that arose in specific litigation contexts. The court ignored the Legislature's willingness to leave overall responsibility for evolution of the collateral source rule, *i.e.,* the development, refinement and application of the rule in all other contexts, to the judiciary. The court failed to appreciate that this post-trial procedure for reduction of judgments, the "*Hanif-Nishihama* reduction," is the next, logical step in the evolution of the collateral source rule.

The Court of Appeal's use of the negative term "abrogation" suggests that the court perceived not only the "*Hanif-Nishihama* reduction" but also those two statutes as negative developments in the law. That too was wrong. The "*Hanif-Nishihama* reduction" was created after those two statutes were enacted and is consistent with both. It is consistent with Civil Code section 3333.1, which demonstrated in subsections (a) and (b) that there are two legal doctrines to consider, the collateral source rule and the right of subrogation, not just the collateral source rule. It is consistent with Government Code section 985, which demonstrated in subsection (b) how a reduction can be accomplished after the verdict, before judgment is entered, to remove the unfortunate overcompensation that is the inevitable consequence of the collateral source rule. The timing arguably suggests that the "*Hanif-Nishihama* reduction" was inspired by Government Code section 985.

Regardless, it is to the **credit** of the judicial branch that California now has that procedure. This Court should endorse that procedure, precisely because it is the logical next step in the evolution of the law as it relates to the collateral source rule. This Court then

should endorse reduction of the judgment in this and all other cases by the amount of the "negotiated rate differential."

STATEMENT OF THE INTERESTS OF *AMICI* IN THE ISSUE OF THE "NEGOTIATED RATE DIFFERENTIAL"

Amici and Their Affiliated Organizations Reflect Many of the Competing Interests in the Issue

The California Medical Association ("CMA") is a non-profit, incorporated, professional association of more than 33,000 member physicians practicing in the State of California, in all specialties. The California Dental Association ("CDA") represents almost 24,000 California dentists, over 70 percent of the dentists practicing in the state. CMA's and CDA's membership includes most of the physicians and dentists engaged in the private practice of medicine and dentistry in California. California Hospital Association ("CHA") is the statewide leader representing the interests of nearly 450 hospitals and health systems in California. CMA, CDA, and CHA are active in California's courts in cases involving issues of concern to the health care industry.

CMA, CHA, and CDA have been active before this Court in scores of cases involving all aspects of litigation which affect California health care providers. Those cases have included *Fein v. Permanente Medical Group* (1985) 38 Cal.3d 137, *Central Pathology Service Medical Clinic, Inc. v. Superior Court* (1992) 3 Cal.4th 181, *Western Steamship Lines, Inc. v. San Pedro Peninsula Hospital* (1994) 8 Cal.4th 100, *Barris v. County of Los Angeles* (1999) 20 Cal.4th 101, *Bird v. Saenz* (2002) 28 Cal.4th 910, *Covenant Care, Inc. v. Superior Court* (2004) 32 Cal.4th 771, *Fox v. Ethicon Endo-*

Surgery, Inc. (2005) 35 Cal.4th 797, and *Reigelsperger v. Siller* (2007) 40 Cal.4th 574. Most recently, CMA and CHA filed briefs in *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group* (2009) 45 Cal.4th 497, and *Mileikowsky v. West Hills Hosp. and Medical Center* (2009) 45 Cal.4th 1259.

Some funding for this brief was provided by organizations and entities that share *Amici*'s interests, including physician-owned and other medical and dental professional liability organizations and non-profit and governmental entities engaging physicians for the provision of medical services, specifically the Cooperative of American Physicians, Inc., Kaiser Foundation Health Plan, Inc., MedAmerica Mutual, Medical Insurance Exchange of California, NORCAL Mutual Insurance Company, The Dentists Insurance Company, The Doctors Company, and the Regents of the University of California.

Because all of those organizations are contributing to this *amicus* brief, this brief reflects many interests that will be affected by this Court's ruling in this case. That includes the interests of

- **Health care providers:** After all, health care providers provide the medical care that is the whole point of the two questions that are presented in this case. The interests of health care providers in that regard are directly represented by CMA, CDA, and CHA.
- **Defendants in personal injury litigation:** Occasionally, health care providers are **defendants** in professional liability litigation. That interest of health care providers, and the corresponding interests of their insurers, is directly represented by insurance companies such as The

Dentists Insurance Company, MedAmerica Mutual, Medical Insurance Company of California, The Doctors Company, NORCAL Mutual Insurance Company, and other organizations such as the Cooperative of American Physicians, which defend and indemnify their physician and dentist insureds/members.

- **Sources of collateral benefits:** Many health care providers are employees of the health care organizations or governmental entities that are potential "sources" of collateral benefits in question in this case. That interest is directly represented by Kaiser Foundation Health Plan, Inc., and indirectly by the Regents of the University of California. In addition, some health care providers provide charitable care, and a few health care providers contract directly with patients for reimbursement from patient recovery in litigation. As such, they too are potential "sources" of collateral benefits. That interest is directly represented by CMA, CDA, and CHA.

This brief was not authored, either in whole or in part, by any party to this litigation or by any counsel for a party to this litigation. No party to this litigation or counsel for a party made a monetary contribution intended to fund the preparation or submission of this brief.

The Collateral Source Rule Impacts California Health Care Providers, And It Does So In Several Ways

Amici always have been concerned about the adverse impact of the collateral source rule, which concern was one of the things that led to the Medical Injury Compensation Reform Act ("MICRA"). In particular, Civil Code section 3333.1, subdivision (a), suspends the collateral source rule in professional liability litigation against health care providers. Unfortunately, there are major exceptions to Section 3333.1, as explained further at pages 11 and 12 of this brief.

Now, *Amici* have even more reason for concern. The Court of Appeal decision in this case, if followed by this Court, will further erode the impact of Section 3333.1. That may occur, for example, because the "negotiated rate differential" is not specifically identified in the statute as a collateral source, which is one technique by which plaintiffs avoid application of Section 3333.1, subdivision (a). Health care provider defendants in professional negligence litigation will be adversely affected.

The most obvious effect of the Court of Appeal decision in this case is to increase the amount which defendants must pay plaintiffs. Health care provider defendants and their insurers already have seen larger judgments in trials of professional liability cases. In the future, at least in the short term, insurers will be required to recalculate insurance "reserves" for pending litigation. In the longer term, there will have to be an increase in the amount of insurance premiums that defendants will have to pay. This will apply to all tort cases involving medical expenses.

For the physician-owned insurance companies who will indemnify the physician-defendants in professional liability cases, there is another consequence: unpredictability. Critical to the evaluation of medical malpractice claims is the analysis of potential liability exposure for past medical costs. Many times, the plaintiffs' past medical costs were paid through health care insurance, whereby the medical providers accept a reduced amount from a health care insurance company as payment in full – the remaining amounts were written off. Other times, payments were made by MediCal, Medicare, or some other governmental assistance program. The common factor is that *Amici* need to evaluate the potential damage recoveries with some degree of certainty. The previous certainty provided by the *Hanif/Nishihama* rule was lost with the *Howell* decision.

In addition, since the Court of Appeal decision allows plaintiffs to recover money damages for the "negotiated rate differential," the health care providers, health insurers, governmental entities, and others who are sources of the benefits naturally will reconsider whether they are willing to allow the "negotiated rate differential" to continue. In the short term, there will be confusion regarding agreements between health insurers, health care providers, patients, and the employers and governmental entities that are paying the bills. In the longer term, there will be renegotiation of those agreements, to share the proceeds attributable to the patients' recovery of the "negotiated rate differential." Some will react by recalculating the "differential." Others will withdraw altogether from the arrangements that result in the "differential," opting instead for other arrangements

that properly capture the economies of scale that are the reason why there is a "differential" in the first place.

In summary, there will be economic effects, both direct and indirect, from the Court of Appeal's approach to the issue. That is because the decision of the Court of Appeal, that defendants in personal injury litigation pay the "negotiated rate differential" to plaintiffs, is fundamentally an economic decision.

The Court Of Appeal's Approach Will Result In Health Care Provider Defendants Paying Plaintiffs More Than Health Care Providers Receive For The Medical Care In Question

For those health care providers who are defendants in personal injury litigation, there is a disturbing if not appalling irony: the decision to allow plaintiffs to recover the "negotiated rate differential" in the past medical expenses award means that plaintiffs will receive more for the medical care than the health care providers who rendered the care to plaintiffs. That is particularly appalling in the context of professional liability claims.

Thirty-five years ago, when MICRA was enacted, *Amici* assumed that Civil Code section 3333.1 would address the problems that the collateral source rule created in professional liability litigation against health care providers. That legislative solution turned out to be largely illusory, due to the *exceptions* for benefits from MediCal, Medicare, employer-funded health plans, *etc*., the first of which appeared soon after MICRA was enacted. (*Brown v. Stewart* (1982) 129 Cal.App.3d 331.) The point was and still is that Civil Code

section 3333.1 provides far less relief to *Amici* than the Legislature intended.

There is a very dramatic illustration of this that is currently pending in the Court of Appeal, Second Appellate District, in a case entitled *Yee v. Tse* (B222570). Dr. Kam Y. Tse is a physician who was sued by a former patient, Linda Yee, in Los Angeles Superior Court ("LASC"), for medical malpractice. (LASC case no. GC 037350.) Because Ms. Yee was allegedly a Medicare patient, the trial court applied an exception to Civil Code section 3333.1, such that the collateral source rule applied to the case. The jury awarded her millions of dollars in damages to compensate her for medical expenses, most of which she never incurred liability for or paid, and far exceeding the amount that her health care providers received as payment in full for their services. Awarding that amount as damages ignores that plaintiff received care in exchange for a reduced rate of compensation to the health care providers. Then, as the trial court itself noted, "[s]ubsequent to the jury verdict and prior to the *Howell* decision, the [trial] court conducted extensive evidentiary hearings on the payments actually made for plaintiff's past medical expenses with a view towards a *Hanif/Nishihama* reduction." (LASC case no. GC 037350, Order on Motions to Reduce Verdict, dated Dec. 1, 2009, p. 2.) Based solely on *Howell v. Hamilton Meats & Provisions, Inc.,* the trial court changed its mind and denied "[d]efendant's motion for a reduction in the jury's award for past economic damages." (*Id.* at p. 1.)

The case of *Yee v. Tse* is so dramatic because of the staggering amount of the windfall that plaintiff will receive, and the way in

which that windfall was achieved. The jury awarded $3,591,755.00 for past medical care and treatment, even though the total amount that actually was paid was far less, $653,428.89. That was because Ms. Yee's care was funded by HealthNet, a private insurer that administered her Medicare benefits. The actual amount paid to or owing to the health care providers was less than one fifth the amount that the jury awarded. The $2,938,326.20 difference was due entirely to the applicability of the collateral source rule, which in turn was due to the inapplicability of Civil Code section 3333.1, which in turn was due to the fact that Ms. Yee claimed to be a Medicare recipient. Although the trial court was poised to ameliorate the problem, by applying the *Hanif /Nishihama* reduction, the Court of Appeal rendered its decision in *Howell v. Hamilton Meats & Provisions, Inc.,* and, based solely on the *Howell* decision, the trial judge in *Yee v. Tse* chose not to apply the *Hanif/Nishihama* reduction.[1]

In summary, *Amici* and their affiliated organizations are very interested in the issue which this case presents. It is for that reason that they offer the following insights regarding the issue and suggestions regarding its resolution.

[1] The trial court in *Yee v. Tse* applied *Howell* even though the *Howell* court explicitly stated that its holding did not apply to cases involving government benefits.

LEGAL DISCUSSION

I. THE "*HANIF / NISHIHAMA* REDUCTION" IS THE BEST WAY FOR THE PARTIES, THE TRIAL JUDGE, AND THE JURY TO WORK TOGETHER TO ACHIEVE THE BEST DECISION REGARDING DAMAGES

A. The Procedure For Reduction Of An Award For Past Medical Expenses Is Consistent With Statutes Relating To Damages And With The Collateral Source Rule

1. Originally, the Legislature directed the courts to consider the question of damages in broad terms: "detriment," "loss," and "harm"

The applicable California statutes were identified by the court in *Hanif v. Housing Authority, supra*, 200 Cal.App.3d 635, 640-641, as well as by Justice Fybel in his concurring opinion to the court's decision in *Olsen v. Reid* (2008) 164 Cal.App.4th 200, 214-216, and by the Court of Appeal in its decision in this case (Slip Opn., p. 14):

- Civil Code section 3333: "For the breach of an obligation not arising from contract, the measure of damages, except where otherwise expressly provided by this code, is the amount which will compensate for all the detriment proximately caused thereby, whether it could have been anticipated or not."
- Civil Code section 3281: "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 Code section 3282: "Detriment is a loss or harm suffered in person or property."

These three statutes all were enacted in 1872, as part of the Field Act.

In these statutes, the Legislature explained the substantive rules for determination of damages in tort litigation, and it did so in very broad terms, "detriment," "loss," and "harm." The Legislature also explained that the purpose of such was "compensation." Beyond that, the Legislature left the parties, the trial judge, and the jury substantial freedom to decide how to evaluate, how to measure, how to prove, and how to decide the question of "damages."

The Legislature did not say that one of the purposes of that category of damages was to "reward" the plaintiff for purchasing insurance in anticipation of such "detriment," "loss," and "harm." Nor did the Legislature say that, in addition to "compensation," a purpose of such is "punishment" of the defendant. Finally, the Legislature did not say that one of the purposes of such is to pay the plaintiff's attorney's fees and costs.

Although the Legislature codified the notion that evidence of insurance will not be admitted at trial for the purpose of proving or disproving *negligence* (Evid. Code, § 1155), the Legislature said nothing with regard to the proof of damages.

2. Then, the Legislature and the Voters used more precise language, referring to different types of damages: "economic," "noneconomic," "past," and "future"

In 1975, with regard to damages in medical malpractice litigation, the Legislature enacted the Medical Injury Compensation Reform Act ("MICRA"), which included three damages provisions:

- Civil Code section 3333.2(a): "In any action for injury against a health care provider based on professional negligence, the injured plaintiff shall be entitled to recover noneconomic losses to compensate for pain, suffering, inconvenience, physical impairment, disfigurement and other nonpecuniary damage."
- Code of Civil Procedure section 667.7(a): "In any action for injury or damages against a provider of health care services, a superior court shall, at the request of either party, enter a judgment ordering that money damages or its equivalent for future damages of the judgment creditor be paid in whole or in part by periodic payments rather than by a lump-sum payment if the award equals or exceeds fifty thousand dollars ($50,000) in future damages."
- Code of Civil Procedure section 667.7(e)(1): "As used in this section: [¶] (1) 'Future damages' includes damages for future medical treatment, care or custody, loss of

future earnings, loss of bodily function, or future pain and suffering of the judgment creditor."

It was in MICRA, in Civil Code section 3333.1(b), that the Legislature first specifically referred in a statute to the concept of collateral source, by use of the phrase "the source of collateral benefits." Again, that was just five years after this Court's decision in *Helfend v. Southern Cal. Rapid Transit Dist.* (1970) 2 Cal.3d 1.

It also was in MICRA that the Legislature delineated different ways in which damages should be evaluated,

- in terms of their "economic" and "noneconomic" nature,
- in terms of their "past" and "future" components, and
- in terms of the type of harm, whether it be "medical," "earnings," "bodily function," or "pain and suffering."

The Legislature made it clear, at least in medical malpractice litigation, that lawyers, judges, and juries should evaluate, measure, prove, and decide damages in terms of the new dimensions, economic versus noneconomic / past versus future. In other words, lawyers, judges, and juries were required to think about damages in new, more sophisticated ways, rather than simply deciding upon a single dollar number.

In 1986, the Voters enacted Proposition 51, which modified the doctrine of joint and several liability in all personal injury litigation. Proposition 51 followed the lead of the Legislature in MICRA, by distinguishing between economic and noneconomic loss, but then Proposition 51 went on to distinguish between different types of economic and noneconomic damages:

- Civil Code section 1431.2(b)(1): "For purposes of this section, the term 'economic damages' means objectively verifiable monetary losses including medical expenses, loss of earnings, burial costs, loss of use of property, costs of repair or replacement, costs of obtaining substitute domestic services, loss of employment and loss of business or employment opportunities."
- Civil Code section 1431.2(b)(2): "For purposes of this section, the term 'noneconomic damages' means subjective, non-monetary losses including, but not limited to, pain, suffering, inconvenience, mental suffering, emotional distress, loss of society and companionship, loss of consortium, injury to reputation and humiliation."

One significant feature of these statutes was that the courts were required to approach damages differently than they had before. For example, not only were economic damages to be distinguished from noneconomic damages, but economic damages were to be analyzed in terms of separate economic components, as opposed to a simple single number that reflected the jury's overall sense of the injury. This was true in all personal injury litigation, not just professional negligence claims against health care providers, as had been the case since the enactment of MICRA. For another example, both future economic and noneconomic damages were to be evaluated, measured, proved and decided in monetary terms, so that they could be paid in periodic payments, pursuant to Code of Civil Procedure section 667.7.

By implication, "pecuniary" damages should be considered in light of other "pecuniary" evidence, such as collateral benefits.

3. Next, the Legislature directed the courts to address the adverse effect of the collateral source rule in personal injury litigation against governmental entities

In 1987, the year following Proposition 51 and the Voters enactment of Civil Code section 1431.2, the Legislature enacted

- **Government Code section 985(b)**: "Any collateral source payment paid or owed to or on behalf of a plaintiff shall be inadmissible in any action for personal injuries . . . where a public entity is a defendant. However, after a verdict has been returned against a public entity that includes damages for which payment from a collateral source . . . has already been paid or is obligated to be paid for services or benefits that were provided prior to the commencement of trial, . . . the defendant public entity may, by a motion . . . , request a posttrial hearing for a reduction of the judgment against the defendant public entity for collateral source payments paid or obligated to be paid for services or benefits that were provided prior to the commencement of trial."

Although Section 985 addressed only the substantive issue of damages in tort litigation against governmental entities, it outlined a new procedure for dealing with one of the problems of the collateral source rule. Specifically, Section 985 required a post-verdict

procedure wherein the trial court adjusted the plaintiff's damages recovery, to reflect the actual amounts paid as opposed to the jury's determination of what would be reasonable.

The Legislature showed the courts the way, although in the limited context of claims against governmental entities. More importantly, it was the most obvious way to deal with the problem of overcompensation due to the collateral source rule, while at the same time assuring that the sources of the collateral benefits are reimbursed. Most importantly, the Legislature left it possible for the collateral source rule to function as a rule of evidence.

Government Code section 985 demonstrated a logical way in which to simultaneously maximize the advantages of the collateral source rule and minimize the disadvantages. At the same time, the courts could satisfy other goals of other legal doctrines. Even though juries would remain ignorant of insurance and governmental benefits, as a result of which jury awards would overcompensate plaintiffs, because juries would not know that they were awarding damages that the plaintiff never paid, the trial judge was in a position to remedy the problem, by "reduction of the judgment." (Gov. Code, § 985, subd. (b).) In the same way, even though the jury award was to the plaintiff rather than the source of the collateral benefit, the trial judge was in a position to remedy that problem, as well, by "reimbursement from the judgment." (Gov. Code, § 985, subd. (f).)

4. The "*Hanif/Nishihama* reduction" is consistent with these statutes and, more importantly, with the collateral source rule

In 1988, the year after the Legislature enacted Government Code section 985, the Court of Appeal decided a case against a governmental entity, *Hanif v. Housing Authority, supra,* 200 Cal.App.3d 635. The court referred to but did not rely upon Section 985, however, because the accident in question occurred in 1979, before the effective date of Section 985. The court did so in the context of MediCal benefits.

In 2001, in *Nishihama v. City and County of San Francisco, supra,* 93 Cal.App.4th 298, the Court of Appeal went one step further by applying the logic of the *Hanif v. Housing Authority* decision in the context of private insurance.[2] In addition, the Court defined the specific procedure for doing so.

During the years that followed, the court in *Greer v. Buzgheia* (2006) 141 Cal.App.4th 1150, 1154, specifically described the procedure as the "*Hanif/Nishihama* reduction" (at p. 1154); the court in *Katiuzhinsky v. Perry* (2007) 152 Cal.App.4th 1288 described it as "a *Nishihama*-type reduction" (at p. 1296); and the court in *Olsen v. Reid, supra*, 164 Cal.App.4th 200, called it "the purported *Hanif/Nishihama* rule" (at p. 257, fn. 2). The court in *Howell v. Hamilton Meats & Provisions, supra*, called it "a defendant's post-

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[2] In addressing the "Award of Plaintiff's Medical Expenses," the court in *Nishihama v. City and County of San Francisco, supra,* also considered the statutory scheme known as the Hospital Lien Act, Civil Code sections 3045.1 through 3045.6. (93 Cal.App.4th at 307-309.)

trial motion to reduce under *Hanif* and *Nishihama* a privately insured plaintiff's recovery of economic damages for past medical expenses." (Slip Opn., p. 29.)

In summary, the courts found a way to continue to apply the collateral source rule as a rule of evidence, while at the same time balancing the interests of all of the relevant parties. By following the lead of the Legislature, the courts found a way to decide damages issues in the face of

- the determination of plaintiffs, to duplicate recovery of collateral benefits,
- the concerns of defendants, to avoid "double recovery," and
- the rights of the sources of those collateral benefits, to be reimbursed.

And, best of all, the courts did so in a way that followed the other damages provisions of the Civil Code, sections 3281, 3282, 3333, and 1431.2.

B. The *Hanif /Nishihama* Reduction Allows Plaintiffs And Defendants To Prove Damages As They Wish, In The Form Of Documentary Evidence Of What Was Charged, Opinion Evidence Of What Is Reasonable, Or Any Other Kind Of Damages Evidence

Under the collateral source rule, the introduction of evidence regarding damages does not follow a specific formula. The courts recognize that each case is unique, that the damages sought in each case will vary, and that the proof of damages will vary. For example, one plaintiff may choose to present documentation of payment of

medical bills as proof. Another may choose not to do so but, rather, introduce the medical bills themselves. Another plaintiff may choose not to present any such evidence but, rather, the testimony of an expert witness as to what reasonable care would cost for the injuries. Yet another plaintiff might choose to present no evidence whatsoever of health care costs, under the assumption that it could have the effect of diminishing the jury's perception of the severity of injury. These are choices which should be left to the plaintiffs, based upon their own perceptions of what is best for their own cases.

The *Hanif /Nishihama* reduction procedure assumes that there will be such variation, and it allows the trial judge to fashion a judgment according to the evidence at trial and any additional evidence that the parties present to the judge after the verdict.

This approach is consistent with the approach of the Restatement Second of Torts. As noted in comment h to section 911:

> 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. A person can recover even for an exorbitant amount that he was reasonable in paying in order to avert further harm. (See § 919).

Importantly, the *Hanif/Nishihama* approach achieves the primary purpose of awards for past medical expenses: ensuring that a

plaintiff receives enough to cover his or her actual medical expenses – no more, and no less. As the *Hanif* court noted, "[i]n tort actions, medical expenses fall generally into the category of economic damages, representing actual pecuniary loss caused by the defendant's wrong. . . . Applying [fundamental] principles [of tort law], it follows that an award of damages for past medical expenses in excess of what the medical care and services actually cost constitutes overcompensation." (*Hanif, supra,* 200 Cal.App.3d at 641.) Implicit in the California authorities, *Hanif* concluded, was the principle that a "a plaintiff is entitled to recover *up to, and no more than*, the actual amount expended or incurred for past medical services so long as that amount is reasonable." (*Id.* at 643.) This rule is rooted in fundamental principles of tort compensation, and is in harmony with similar fundamental rules, such as the rule requiring discounting of future damages to present value, the rule against double recovery, against imaginary damages, the rule that when damages may be calculated by either of two alternative measures the plaintiff may recover only the lesser, the rule that damages must be mitigated where reasonably possible. (*Id.* at 643.)

Thus, it was not error for the trial court to permit the plaintiff to present the full billed amount of medical charges to the jury. The trial court illustrated the wisdom of the *Hanif/Nishihama* approach in this case, by avoiding running afoul of the collateral source rule during trial, and taking evidence as to what was actually paid to plaintiff's medical providers post-trial, and adjusting the award for past medical expenses accordingly.

C. The *Hanif/Nishihama* Reduction Reconciles The Competing Legal Doctrines, Of The Collateral Source Rule On The One Hand And Of The Right Of Restitution On The Other

As UCLA Law Professor Richard Maxwell noted in the introduction to his seminal article (Maxwell, *The Collateral Source Rule and the American Law of Damages* (1962) 46 Minn.L.Rev. 669) there is conflict between the doctrine of avoidable consequences and the collateral source rule. And, as Boalt Law Professor John Fleming then noted in his article, there is a conflict between the collateral source rule and the right to subrogation. Fleming characterized

> [t]he collateral source problem [as], **that prickly game of three-cornered catch** that occurs when an injured person has received compensation from a source independent of the injurer, **remains one of the most troublesome in the modern law of damages**.

(Fleming, *The Collateral Source Rule and Contract Damages* (1982) 71 Cal.L.Rev. 56, emphasis added.) As noted by University of Arizona Law Professor Dan Dobbs, there are the interests of the plaintiff in achieving full compensation, of the defendant in avoiding overcompensation, and of the collateral sources themselves in achieving reimbursement. (See generally, Dobbs, The Law of Remedies (1993 Student Ed.), pp. 266-269; 404-406.)

That is, there are three goals. Court should **simultaneously**

- maintain the advantages of the collateral source rule that favor plaintiff, but
- not overcompensate the plaintiff, and yet also

- protect the interests of those who seek restitution and reimbursement.

The second goal is best achieved by the *Hanif/Nishihama* reduction procedure, which arguably is modeled on Government Code section 985. That is only possible if

- defendants are prohibited from introducing evidence of collateral benefits to the jury, but
- defendants are allowed to introduce evidence of collateral benefits to the judge, after trial, before judgment is entered.

And that is how and why the reduction accomplished in the *Hanif/Nishihma* procedure is consistent with the collateral source rule.

As the Court of Appeal noted, the collateral source rule simply states that "[i]f 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." (*Howell,* Slip Opn., p. 16, quoting *Helfend v. Southern Cal. Rapid Transit Dist., supra,* 2 Cal.3d at 6, italics added.) Consistently, *Hanif/Nishihama* does *not* call for the deduction from damages for any compensation paid to or on behalf of a plaintiff by a third party, *i.e.*, the health care insurer.

Hanif/Nishihama states that a plaintiff shall receive the full amount paid by the third party, *i.e.*, the health care insurer. *Hanif/Nishihama* and the collateral source rule are in fact two sides of the same coin: both rules call for the plaintiff to receive *the full amount of what a third party paid on her behalf*. The

Hanif/Nishihama rule in no way contravenes, abrogates, or otherwise weakens the collateral source rule.

In fact, the *Hanif/Nishihama* rule *reflects and supports* the collateral source rule. Under the *Hanif/Nishihama* rule, the plaintiff is *guaranteed* to receive all amounts her health care insurer pays – she does not have her recovery reduced by the amount her health care insurer pays. To argue that *Hanif/Nishihama* undermines the collateral source rule is to misunderstand both *Hanif/Nishihama* and the collateral source rule.

To illustrate this point, assume that a plaintiff received treatment from a hospital for injuries, and her bills were $100, and her insurer paid $60 to the hospital to satisfy plaintiff's bill. The collateral source rule would hold that the $60 insurance payment *could not be deducted* from plaintiff's damages. The *Hanif/Nishihama* rule would state that plaintiff was *entitled to receive* the $60 in damages. The collateral source rule and the *Hanif/Nishihama* rule co-exist in harmony. This is why the collateral source rule is not implicated, abrogated, or in any way undermined by the application of *Hanif/Nishihama* in this case. And this is why the *Howell* decision fails to articulate how the collateral source rule is abrogated by *Hanif/Nishihama* – because there is no such abrogation.

There is an added advantage to the *Hanif/Nishihma* reduction. It allows the courts to respond to changes, in insurance and in governmental benefits, which are inevitable. That is particularly significant in light of the recent, national legislation regarding health care insurance.

Thus, in all situations, *Hanif/Nishihama* fulfills the purpose of past medical expenses awards: it ensures that plaintiffs' actual expenses for past medical treatment are covered. Where a plaintiff has insurance, and his insurer pays at a negotiated rate of 50% of the medical provider's bill, the plaintiff will recover that 50% amount. Where a plaintiff does not have insurance and must pay or is liable for 100% of the medical provider's bill, the plaintiff will recover 100% of the medical provider's bill. And as to gratuitous medical care provided to a plaintiff, as Hamilton Meats notes at pages 18-19 of its Opening Brief on the Merits, the law has set out a special policy to address that occasional circumstance. (Citing *Rodriguez v. McDonnell Douglas Corp.* (1978) 87 Cal.App.3d 626, 662 and *Arambula v. Wells* (1999) 72 Cal.App.4th 1006.)

In summary, the collateral source rule evolved with the *Hanif/Nishihama* reduction. It allowed the courts to continue to apply the collateral source rule to the introduction of evidence at trial and then to enter judgments after trial that awarded restitution to collateral sources and avoided double recovery to plaintiffs. The courts were able to do so by separating the role of the trier of fact, in assessing damages, from the role of the judge, in fashioning the remedy. In that way, the courts were able to reconcile the collateral source rule with the right of subrogation.

II. THE COLLATERAL SOURCE RULE SHOULD BE ANALYZED IN TERMS OF ECONOMIC DAMAGES, NOT IN TERMS OF NONECONOMIC DAMAGES

Plaintiff ignores the evolution of California law as it relates to damages. In particular, plaintiff conflates discussion of economic and noneconomic damages. For example, plaintiff argues that her medical bills were relevant not only to determining her "medical expenses" but also to determining her "other damages." (Answer Brief, p. 56.) For another example, plaintiff argues that "[a]llowing evidence of collateral benefits can 'irretrievably upset the complex, delicate, and somewhat indefinable calculations which result in the normal jury verdict.'" (*Id.* at 20, citing *Helfend v. Southern Cal. Rapid Transit Dist., supra,* 2 Cal.3d at 11.) In effect, plaintiff urges this Court to ignore those changes in the law of damages and focus only on the collateral source rule. (See, *e.g.,* Answer Brief, pp. 19-21 ["First Principles Set Forth In *Helfend* Are As Persuasive Now As They Were Then"].)

Plaintiff never explains how her approach to damages can be reconciled with those changes in the law that now require judges, juries, lawyers, and witnesses to speak in terms of economic and noneconomic damages. To the contrary, she simply characterizes the law as "complex, delicate, and somewhat indefinable," using words that this Court used forty years ago. In doing so, she essentially acknowledges that her approach is outdated.

Setting aside that plaintiff's approach ignores changes in the law, she confuses the issue by making it even more complex. She

expands the discussion from monetary concepts such as "compensation," "payment," and "benefit," to include nonmonetary concepts such as "pain" and "suffering." That is, she conflates the concepts of pecuniary and nonpecuniary damages.

Any discussion of the collateral source rule becomes complex and confusing when the analysis is extended from economic to noneconomic damages. Proper analysis, if not common sense, suggests that discussion of the collateral source rule should be limited to economic damages. It should not be analyzed in terms of damages that are noneconomic in nature.

III. THE TRIAL COURT DID NOT ERR IN THIS CASE WHEN IT PERMITTED PLAINTIFF TO PRESENT THE FULL BILLED AMOUNT OF MEDICAL CHARGES TO THE JURY AND THEN REDUCED THE JURY'S AWARD OF DAMAGES BY THE NEGOTIATED RATE DIFFERENTIAL

A. The Trial Court Did Not Err When It Permitted Plaintiff To Present Evidence Of The Full Billed Amount

Defendant Hamilton Meats and Provisions suggests in the Opening Brief on the Merits that "the full billed amount of medical charges" is not the "reasonable value" of the medical care. (OBM, pp. 49-50.) Nevertheless, defendant agrees that "gross medical bills" may be submitted to the jury. (OBM, p. 52.) Essentially, defendant disparages health care providers' usual, customary and reasonable ("UCR") bills to patients. This is both inaccurate and misleading. First, and most obviously, the reasonableness of the gross medical bill

was not an issue, either at trial or on appeal of *Howell v. Hamilton Meats & Provisions, Inc.* Second, health care providers are entitled to, and do collect, their full UCR bills.

During the trial of the *Howell* case, defendant sought to exclude evidence of the amounts "written off" the medical bills, on the grounds that those amounts were not paid by the plaintiff, and those amounts should not be recovered by plaintiff. (OBM, p. 6, citing 1 AA 73-107.) The trail court denied that request. As a result, "the jury received evidence of the *gross* amount of medical expenses as reflected on the medical bills." (OBM, p. 7, citing 2 RT 117:15-118:5; 3 RT 195:16-25.) The evidentiary issue was handled simply by having plaintiff present *to the jury* the gross amount, and then defendant presented *to the trial court* the reduced amount. (OBM, pp. 6-10.) It was in this fashion that plaintiff was allowed to present evidence of the full billed amount of the medical services for purposes of trying to shape the juries' assessment of damages, but then, defendant was allowed to present evidence to the court that allowed the court to conform the award of damages to the legal principles that govern a proper determination of damages.

It is true that many health care providers contractually agree to offer discounts on their UCR rates on specified services rendered to specific health insurance subscribers, as well as beneficiaries of government health care programs. Such discounts are business decisions that providers make in exchange for concrete benefits of participating in a private or government health care network. (See Frances H. Miller, "Vertical Restraints And Powerful Health Insurers: Exclusionary Conduct Masquerading As Managed Care?" (1988) 51

Law & Contemp. Probs. 195 ["These participating providers in effect pay for the competitive advantage of securing patient referrals from the HMOs by agreeing to accept lower reimbursement and controls on their clinical autonomy"].)

Numerous courts have recognized the rationale and economic factors that underlie this business decision. For example, the court in *HCA Health Servs. v. Employers Health Ins. Co.* (2001) 240 F.3d 982, 999, fn. 33, noted that "[g]iven what is usual and customary in the managed care industry, we cannot imagine that even a poorly represented [provider] entity would promise to discount its fees in return for nothing." For another example, the court in *California Physicians' Service v. Aoki Diabetes Research Institute* (2008) 163 Cal.App.4th 1506, 1511, stated that a health plan "is able to obtain medical services at lower rates due to its ability to direct volume and control costs."

Courts have rejected the argument that providers' UCR bills are unreasonable or inflated because providers often collect discounted rates in managed care arrangements. The court in *Banner Health v. Medical Sav. Ins. Co.* (2007) 216 Ariz. 146, 151-152, held the fact that hospitals routinely accept reduced payments on behalf of many patients does not mean that the hospitals' published and billed rates are unreasonable. Similarly, the court in *Geddes v. United Staffing Alliance Employer Medical Plan* (2006) 469 F.3d 919, 929, observed that, "it would be unreasonable to interpret the 'usual and customary' fee charged by an out-of-network provider to be equivalent to the fees charged by in-network providers, with whom the Plan negotiates discounted rates." Finally, in *Huntington Hosp. v. Abrandt* (2004)

779 N.Y.S.2d 891, 892, the court held, "[t]he fact that lesser amounts for the same services may be accepted from commercial insurers or government programs as payment in full does not indicate that the [UCR bill] amounts charged to defendant were not reasonable."

In addition, regulations promulgated to the Health Care Providers Bill of Rights, Stats. 2000, Ch. 827 (AB 1455), established that non-contracted providers are entitled to "the reasonable and customary value for the health care services rendered" to a health plan's enrollee. This value is determined by, among other things, "the fees usually charged by the provider," and "prevailing provider rates charged in the general geographic area in which the services were rendered." (28 Cal. Code Regs., § 1300.71(a)(3).) Furthermore, when providers grant indigent or uninsured patients a discount for necessary medical care, the law expressly states that "any discounted fee granted . . . shall not be deemed to be the health care provider's usual, customary or reasonable fee for any purposes, including but not limited to, any health care service plan or insurance contract." (Health & Saf. Code, § 1371.22.)

These are just some of the reasons why the trial court did not err in permitting plaintiff to present the full billed amount.

B. The Trial Court Did Not Err When It Applied The *Hanif/Nishihama* Procedure, Which Generally Followed The Procedural Guidelines Set Out In Government Code Section 985

Trial courts have been following *Hanif/Nishihama* for years, and those courts have developed procedures to handle the process of establishing the reduction. The most obvious analogy was the

procedure that the Legislature set out in Government Code section 985. Following that statutory procedure, the *Hanif/Nishihama* reduction was akin to a motion for new trial, or a motion to conform a verdict to MICRA. As with a Section 985 reduction, the *Hanif/Nishihama* hearing did not occur "until after the determination of any motions for a new trial, for [JNOV], for remitter, [or for] additur . . . ." (Govt. Code, § 985, subd. (b).) The trial court thus had the time and flexibility to take evidence relevant to the *Hanif/Nishihama* motion.

That is to say, the procedure does not entail an entirely new trial. Rather, the procedure is accomplished by way of a post-trial motion. That also means that there are few if any changes in existing trial procedure. For example, in cases where a *Hanif/Nishihama* reduction is applicable, the instruction to the jury could be modified from Government Code section 985, subsection (j).[3] (See also BAJI No. 1460.5; CACI No. 3923.) The same is true of procedure before

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[3] Government Code Section 985, subsection (j) provides as follows:

> In all actions affected by this section, the court shall instruct the jury with the following language:
>
> You shall award damages in an amount that fully compensates plaintiff for damages in accordance with instructions from the court. You shall not speculate or consider any other possible sources of benefit the plaintiff may have received. After you have returned your verdict the court will make whatever adjustments are necessary in this regard.

trial, because there is a model for discovery in Section 985. That model allows for a flexible approach, requiring the plaintiff, upon demand by defendant, to disclose the names and addresses of any collateral sources. (Govt. Code, § 985, subds. (c)-(d).)

Following the general outline of Section 985 as a template for the *Hanif/Nishihama* reduction, the trial court has the structure and the flexibility necessary to ensure that the equitable goals of the *Hanif/Nishihama* reduction are met. That also is consistent with the powers that trial courts already have to ensure that the proper parties are indemnified and achieve subrogation. (See, *e.g.*, *Fireman's Fund Ins. Co. v. Maryland Casualty Co.* (1998) 65 Cal.App.4th 1279, 1291; *Amerigas Propane, LP v. Landstar Ranger, Inc.* (2010) 184 Cal.App.4th 981.)

The key is that the *Hanif/Nishihama* reduction, like indemnification and subrogation, is accomplished in equity.

C. The Court Could Allow Plaintiffs To Recover The Amounts They Have Paid In Insurance Premiums

Plaintiff in this case repeatedly argues that the *Hanif/Nishihama* reduction unfairly denies plaintiffs a recovery of the amount plaintiffs paid in insurance premiums. (See, *e.g.*, Answer Brief at 13 ["offset for Howell's investment, *i.e.*, her premium payments to her insurer"].) If this is a concern, the obvious remedy is to allow plaintiffs to recover the amounts they have in insurance premiums for the insurance policy that covered the plaintiffs' medical bills at a reduced negotiated rate. The amount a plaintiff has paid for insurance premiums is easily ascertainable and quantifiable.

IV. THE COURT OF APPEAL'S APPROACH WILL AGGRAVATE THE TENDENCY OF THE COLLATERAL SOURCE RULE TO RESULT IN OVERCOMPENSATION

The obvious consequence of the collateral source rule is that people who receive the collateral benefits achieve double recovery. In other words, the rule is overcompensatory. (See Dan B. Dobbs, Law of Remedies, *supra*, p. 266.) Just as obviously, that feature of the rule will be aggravated if plaintiffs are allowed to recover still more, such as by way of the "negotiated rate differential."

If this Court endorses the approach of the Court of Appeal in this case and characterizes the "negotiated rate differential" as a collateral benefit, this Court will increase that overcompensation.

CONCLUSION

Given the direction the collateral source rule has evolved in California, the *Hanif /Nishihama* procedure was almost inevitable. The procedure has been and continues to be critical to the viability of the collateral source rule, in that it recognizes and accounts for the multiple interests involved and limits the problem of overcompensation.

Amici urge this Court to endorse the *Hanif/Nishihama* procedure.

DATED: July 16, 2010

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CERTIFICATION

Appellate counsel certifies that this brief contains 8,478 words. Counsel relies on the word count of the computer program used to prepare the brief.

DATED: July 16, 2010

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PROOF OF SERVICE
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I am employed by Cole Pedroza LLP, in the County of Los Angeles, State of California. I am over the age of 18 and not a party to the within action. My business address is 200 S. Los Robles Avenue, Suite 300, Pasadena, California 91101.

On the date stated below, I served in the manner indicated below, the foregoing document described as: ***AMICI CURIAE*** **BRIEF IN SUPPORT OF DEFENDANT AND RESPONDENT** on the parties indicated below by placing a true copy thereof, enclosed in a sealed envelope addressed as follows:

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I declare under the penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed this 16th day of July, 2010.

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Kathleen Eastham

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