S179115

IN THE

SUPREME COURT OF CALIFORNIA

REBECCA HOWELL,

Plaintiff and Respondent,

v.

HAMILTON MEATS & PROVISIONS, INC.,

Defendant and Petitioner

APPLICATION FOR PERMISSION TO FILE AMICUS CURIAE BRIEF AND AMICUS CURIAE BRIEF OF THE LEAGUE OF CALIFORNIA CITIES

After a Decision By the Court of Appeal,
Fourth Appellate District
Case No. D053620

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APPLICATION FOR PERMISSION TO FILE AN AMICUS CURIAE BRIEF

TO: THE HONORABLE CHIEF JUSTICE OF THE CALIFORNIA SUPREME COURT:

Under Rule 8.520(f) of the California Rules of Court, the League of California Cities respectfully requests permission to file the accompanying amicus curiae brief in support of neither party.

I. INTEREST OF AMICUS

Founded in 1898, the League of California Cities is an association of 474 California cities dedicated to protecting and restoring local control to provide for the public health, safety, and welfare of their residents, and to enhance the quality of life for all Californians. The League is advised by its Legal Advocacy Committee, which is comprised of 24 city attorneys from all regions of the State. The Committee monitors litigation of concern to municipalities, and identifies those cases that are of statewide – or nationwide – significance. The Committee has identified this case as being of such significance.

California cities have a substantial interest in the case because they receive tens of thousands of personal injury claims and lawsuits each year. Questions concerning civil litigation procedures and tort liability are of vital interest to the League's members.

The League's members provide public services to millions of California residents in every county, from city centers to suburbs to rural areas of the State. These cities operate a wide array of operations, including international airports, sea ports, public utilities, police and fire departments, public health agencies, public transportation, public works, cultural and recreational facilities (including museums, libraries, parks,

theaters, and convention centers). As a result of these varied operations, California cities receive thousands of personal injury claims a year and pay out substantial dollar amounts in settlements and judgments annually. California cities have extensive experience with tort litigation and risk management that involves balancing public interests and benefits.

Cities are interested in a tort system that fairly compensates injured persons while protecting taxpayers and citizens from undue expense. The issues raised by this case will have a significant effect on the ability of state and local government to provide vital services to all Californians.

II. HOW THE BRIEF WILL ASSIST THE COURT

This appeal raises the question of how to value past medical expenses in tort awards. The League's member cities are involved in thousands of claims and personal injury lawsuits each year. Cities are well-versed in the issues from the perspective of both tort defendants and the public interest. In addition, the League's members and its amicus committee have been involved in litigation concerning these issues for many years. The City and County of San Francisco was a party to one of the seminal cases, *Nishihama v. City and County of San Francisco* (2001) 93 Cal. App. 4th 298, and the author of this amicus brief was San Francisco's appellate counsel in that case. In addition, the League submitted amicus curiae briefs in this Court and the Court of Appeal in the earlier, related case *Parnell v. Adventist Health System/West* (2005) 35 Cal. 4th 595.

No party or counsel for any party authored the attached brief in whole or in part or made any monetary contribution toward the preparation or submission of the brief. No person or entity other than the undersigned

amicus curiae and counsel made a monetary contribution to fund the preparation or submission of this brief.

Dated: August 26, 2010

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INTRODUCTION

California courts have long permitted an award of "reasonable and necessary" medical costs as part of tort recovery. But major changes in the way medical care is paid for in this country have challenged our tort system. Courts and attorneys no longer share a uniform understanding of the traditional terminology, as shown by the polarized interpretations of the collateral source rule advanced in this case. Under the guise of preserving the collateral source rule, plaintiffs ask the Court to abandon established tort rules concerning the measure of tort recovery. That is not the answer. Rather, our trial procedures should be updated while retaining long-standing tort principles.

This case poses challenging questions as to how courts should determine the amount of tort awards for past medical expenses. At the heart of the problem is the new relationship between three basic factors that go into determining an award of medical costs: (1) the dollar amount on bills generated by doctors and hospitals; (2) the amount that is actually paid, either by the patient or insurance; and (3) the reasonable value of the services. These three elements were once so closely related that they were often seen as interchangeable. That is no longer the case. The full amount of a medical bill is now seldom paid, either by the patient or by insurance. The actual cost of health care in this country is set by provider contracts between insurers on the one hand and medical groups and hospitals on the other. Nearly all such contracts, as well as Medicare regulations, require service providers to accept the insurance reimbursement as "payment in full." Doctors and hospitals cannot collect anything more than the

insurance payment from a covered patient. *See, e.g., Parnell v. Adventist Health System/West* (2005) 35 Cal. 4th 595, 609 (holding that hospitals have no right to any part of a patient's tort recovery after the hospital has accepted an insurance reimbursement as payment in full).

However the Court resolves this case, it should not abandon the basic principle that the purpose of a tort award is to make the plaintiff whole. In the League's view, there are two alternative approaches to the task of awarding medical expenses that are consistent with tort principles and supported by case law. The Court should either (i) endorse the so-called *Hanif/Nishihama* procedure for post-verdict adjustment of medical expense awards, which would be limited to the amount actually paid by insurance, or (ii) modify the rule excluding evidence of insurance payments and let juries decide medical cost awards based on all relevant evidence. The trial court in this case followed the former approach, while the latter was recently endorsed by Justice Banke in her concurrence in *Yanez v. SOMA Environmental Engineering, Inc.* (2010) 185 Cal. App. 4th 1313, 111 Cal. Rptr. 3d 257.

The collateral source rule, which permits plaintiffs to recover medical costs that were paid by insurance, would survive under either alternative. Plaintiffs would continue to enjoy a "double recovery" in that they would be awarded the cost of medical services that were entirely paid by their health plan. Under no circumstances, however, should contractual write-offs or reductions in medical bills be treated like insurance payments, as the Court of Appeal held. This would radically change long-standing tort principles and unduly increase tort judgments. The refrain that "[t]ortfeasors seek that [insurance] benefit for themselves without paying

for it" (Pls. Answer Brief at 3) rings hollow. Moreover, as noted by other amici, there are compelling economic reasons to leave undisturbed centuries-old tort principles allocating costs and liability for risks.

Affirmance of the decision below would, among other detrimental consequences, increase payouts to plaintiffs and their counsel at the expense of vital services to all Californians. Cash-strapped State and local governments cannot absorb greater liabilities without cutting services.

ARGUMENT

I. THE COLLATERAL SOURCE RULE DOES NOT GOVERN THE MEASURE OF DAMAGES; IT IS A RULE CONCERNING THE RECOVERABILITY OF DAMAGES PAID BY INSURANCE.

Plaintiff states that "the correct measure of damages is simply the medical care's reasonable value." (Pls. Answer Brief at 38.) The League agrees. Where plaintiffs and the League diverge is plaintiffs' contention that contractual write-offs should be deemed "collateral source benefits" and treated the same as insurance payments. This is plaintiffs' central argument, and it is wrong.

A. Contractual Reductions of Medical Bills Are Not "Collateral Source Benefits."

Under the collateral source rule, when a source independent of the tortfeasor makes payments as compensation for an injury, those payments do not reduce the amount the injured person may recover from the tortfeasor. *Helfend v. Southern California Rapid Transit District* (1970) 2 Cal. 3d 1, 6. The rule exists to encourage the purchase of insurance even though the rule is antagonistic to usual tort principles because it gives the injured party a "double recovery from both the insurer and the wrongdoer."

Miller v. Ellis (2002) 103 Cal. App. 4th 373, 379. The rule thus permits an injured person to recover for hospital and other medical expenses even when those costs have been paid directly by his or her medical insurer. But the rule has nothing to do with the *measure* of the plaintiff's recovery. It only prevents the deduction of collateral source payments.

Plaintiffs argue that the contract between Ms. Howell's insurer and the hospital to provide medical services at a reduced rate represents the equivalent of a collateral source payment on behalf of Howell. But that is not the case. The hospital entered into a contract to provide specified services at a reduced rate in order to gain access to the insurer's pool of potential patients. *See* Daniel N. Burton & Michael S. Popok, *Managed Care 101* (Apr.1998) 72 Fla. Bar J. 26 (a managed care organization "uses the economic leverage gained from representing a high volume patient base to secure favorable rates and payment formulas with select providers"). That contract was not "compensation for [plaintiff's] injuries," even if it provided incidental benefits to Howell and other insureds in the form of lower insurance premiums. *See Helfend, supra*, 2 Cal. 3d at 6. It is therefore not a collateral source payment within the *Helfend* rule.

B. *Hanif* and *Nishihama* Do Not Conflict With the Collateral Source Rule.

The collateral source rule still applies when the reasonable value of services is capped at the amount actually charged for services. Thus, when Medi-Cal has paid for all of plaintiff's medical care, so that plaintiff has suffered no out-of-pocket loss, plaintiff may nonetheless obtain medical damages from a tortfeasor. *See Hanif v. Housing Authority* (1988) 200 Cal. App. 3d 635, 639-40. That is because the Medi-Cal benefits – the collateral

source payment – are not deducted from the recovery. But this rule does not resolve the issue on this appeal as to how reasonable and necessary charges are to be measured when the agreed contractual rate has been paid in full.

The present controversy requires updating our trial procedures. For trial practice during most of the 20th Century, a plaintiff would introduce her medical bills and elicit a doctor's testimony that the amount was reasonable and necessary. The full amount of the bills may have been paid by insurance, but the jury would not learn this. Court rulings have excluded evidence of insurance in most cases. As the amount actually paid by insurance shrank in comparison to the amount billed, courts starting with *Hanif, supra*, began to question whether the inflated billed amounts continued to represent the "reasonable value" of the services.[1]

The solution adopted by many (but not all) trial and appellate courts was to continue to exclude evidence of the amount paid by insurance and to conduct post-verdict hearings at which the amount awarded for past medical care was reduced if it was greater than the amount actually paid by insurance. *See Nishihama v. City and County of San Francisco* (2001) 93 Cal. App. 4th 298 (holding that medical costs award greater than the amount accepted by the providers as full payment was excessive as a matter of law and reducing judgment accordingly).

[1] The difference between the amounts billed and paid can be substantial, as in the case at bar. Ms. Howell's providers submitted bills for $189,978.63 and accepted payment in full at a contractual rate that worked out to 31 cents on the dollar.

Plaintiffs challenge such post-verdict reductions. They contend that the amount of the reduction based on medical provider contracts represents a benefit from a collateral source, and under *Helfend, supra,* 2 Cal. 3d 1, the verdict may not be reduced by these amounts. When this Court in *Helfend* and other cases adopted the collateral source rule, it could not have contemplated the situation today in which neither plaintiffs nor their insurers would be responsible for paying the full amount of medical bills. "Reasonable value," amount billed, and amount paid were, for most purposes, the same. For this reason, the collateral source rule was never considered a substantive rule for calculating the dollar amount that constituted the "reasonable value" of past medical services. Instead, it was a rule based on public policy regarding the recoverability of a particular category of damages. The collateral source rule as conceived and applied was a limited exception to the general tort rule against double recoveries.

As stated in *Hanif,* the measure of tort damages is based on certain bedrock principles:

> "In tort actions damages are normally awarded for the purpose of *compensating* the plaintiff for injury suffered, i.e., restoring him as nearly as possible to his former position, or giving him some pecuniary equivalent."

Hanif, supra, 200 Cal. App. 3d at 640 (quoting 4 Witkin, *Summary of Cal. Law* (8th ed. 1974) Torts, § 742, p. 3137 [emphasis in original]).

The *Hanif* court also cited the corollary of this principle: "A plaintiff in a tort action is not, in being awarded damages, to be placed in a better position than he would have been had the wrong not been done." (*Id.* [quoting *Valdez v. Taylor Automobile Co.* (1954) 129 Cal. App. 2d 810, 821-22].)

Hanif and *Nishihama* are consistent with this Court's ruling in *Parnell, supra*, 35 Cal. 4th 595, which held that under the Hospital Lien Act, Civ. Code § 3045.1, "reasonable and necessary" hospital charges cannot exceed the contractual rate that the hospital accepted as payment in full from the insurer. *Id.* at 609. It makes sense to apply a uniform definition of "reasonable and necessary" medical costs, whether the issue is a hospital's lien rights against a patient or a patient's claims against a tortfeasor.

Yet plaintiffs seek a much more generous rule of recovery than this Court has allowed hospitals. The rule as plaintiffs would have it means that the billed amount is presumed "reasonable" and contrary evidence (such as the amount actually paid) is both inadmissible during trial and cannot be deducted from the verdict after trial. Consider that a hospital may send a bill for $1,000 but accept $500 as payment in full. It is undisputed that when the hospital sent the bill, it knew the true charge was $500. The hospital cannot share any part of the tort recovery over $500. Plaintiffs contend that the collateral source rule was intended to give them $1,000 based on the amount that was printed on the hospital bill. That is not how the collateral source rule was meant to work.

Properly construed, the collateral source rule concerns what damages are "recoverable," not how to calculate damages. The two issues are distinct. Courts decide as a question of law what categories of damages are recoverable. Juries are charged with determining only the amount of damages. For example, if the jury finds liability and then assesses damages, the Court may reduce the award based on rules relating to the recoverability of speculative or punitive damages or statutory caps on

certain types of damages (e.g. Civ. Code § 3333.2 [limiting non-economic damages in medical negligence cases]).

No California court even contemplated the possibility of a conflict between the collateral source rule and the *Hanif/Nishihama* rule before 2008. *See Olsen v. Reid* (2008) 164 Cal. App. 4th 200, 213 (Moore, J., concurring) ("I believe the [*Hanif/Nishihama*] rule abrogates, in fact if not in law, the collateral source rule"); *compare id.* at 215 (Fybel, J., concurring) ("I write separately principally to express my view that the analysis and holdings of *Nishihama* and *Hanif* correctly apply and enforce the collateral source rule"). *Helfend* did not address the issue of whether hospital bills or the amounts actually paid were the proper measure of damages. Yet plaintiffs in effect argue that under *Helfend*, hospital bills are the sole measure of the amount of damages. In context, the *Helfend* Court created a rule of recoverability that did not suggest how the amount of "reasonable" damages should be measured.

Although it would be destructive both of tort principles and of sound public policy, the Court in this case could modify the collateral source rule as plaintiffs propose so that contractual write-offs are treated the same as insurance payments. The Court should understand, however, that to do so is not an extension of the original purpose of the rule. Such a change would incorporate into the rule a new and different basis for calculating tort damages.

II. THE *HANIF/NISHIHAMA* PROCEDURE IS NECESSARY BECAUSE COURTS EXCLUDE EVIDENCE DURING TRIAL OF THE AMOUNT ACTUALLY PAID FOR MEDICAL CARE.

The trial court in this case excluded during trial evidence of the amount actually paid for plaintiff's medical care and reduced the award post-verdict to reflect the sum paid. Plaintiffs argue that the "reasonable value" of past medical care is a question of fact and the post-verdict hearing deprives them of their right to have a jury make this finding. It is true that "reasonable value" is a classic jury question. But the amount stated on the bill is not irrefutable. "[I]t has long been the rule that the costs alone of medical treatment and hospitalization do not govern the recovery of such expenses. It must be shown additionally that the services were attributable to the accident, that they were necessary, and that the charges for such services were reasonable." *Dimmick v. Alvarez* (1961) 196 Cal. App. 2d 211, 216.

Awarding past medical damages based on an inflated bill – one commentator called medical bills "illusory"[2] – will lead to over-compensation in the absence of a procedure for taking into account the lesser amount actually paid. Between the bill that was sent (without any

[2] *Proving Medical Expenses: Time for a Change* (Spring 2005) 28 Am. J. Trial Advoc. 649, 650-657 ("Frequently, the difference between the stated charge and the reimbursement rate actually paid is extremely significant. It is therefore increasingly difficult to know what the true charges will be after they are reduced by the different reimbursement methodologies, schedules, computer programs, agreements, audits, regulations, adjustments, and pre-determined reimbursement rates.... [¶] ... [¶] ... Presenting [billed] charges to the jury is arguably against public policy because they represent illusory or illegal charges.")

expectation that it would be paid in full) and the amounts that the provider agreed to accept as payment in full, the latter is better evidence of the reasonable value of the services. *See, e.g.*, Ireland, *The Concept of Reasonable Value in Recovery of Medical Expenses in Personal Injury Torts* (March 2008) 14 J. Legal Econ. 87, 90 ("Given the choice between $500,000 billed by medical care providers and the $100,000 paid by third party payers in my example, it is likely that $100,000 is closer to whatever proxy for 'reasonable value' or 'competitive equivalent' that we might come up with.").

Neither party in this case disputes that doctors and hospitals are usually paid at contractual insurance rates. Nor has plaintiff pointed to any evidence that the contracts were not negotiated at arm's length between a willing buyer and a willing seller, both acting rationally and without collusion. This is persuasive evidence that the amount paid was – and would be in most cases – the reasonable value of the services. "Proof of payment is prima facie proof of the reasonableness of a bill . . . ." *Plonley v. Reser* (1960) 178 Cal. App. 2d Supp. 935, 938; *accord Dewhirts v. Leopold* (1924) 194 Cal. 424, 433 (amount paid is sufficient evidence of reasonable value of medical care); *Francis v. Sauve* (1963) 222 Cal. App. 2d 102, 124 (same as to reasonable value of funeral services).

In most cases, there is no genuine factual dispute as to how much insurance paid or whether plaintiff is liable for any amounts written off the bill. These questions can almost always be decided by the Court as a matter of law. And because the parties can readily determine the amount paid for past medical bills without the need for a trial, the *Hanif/Nishihama* rule has the additional benefit of promoting settlement.

The *Hanif/Nishihama* rule is workable, fair, and provides for certainty and predictability of outcomes. It also fits well with existing trial practice in which evidence of amounts paid is generally excluded at trial. As long as courts exclude such evidence during trial, the post-verdict reductions by the trial court are appropriate and necessary.

III. POST-VERDICT ADJUSTMENTS MAY NOT BE NECESSARY IF JURIES WERE PERMITTED TO CONSIDER ALL RELEVANT EVIDENCE – INCLUDING THE AMOUNT PAID – IN DETERMINING THE REASONABLE VALUE OF MEDICAL CARE.

The *Hanif/Nishihama* post-verdict procedure has much to recommend it, including its compatibility with the practice of excluding evidence of insurance payments during trial. But with the growing divergence between billed amounts and payments, it may be time for the Court to reconsider this practice. As stated by Justice Banke in her concurring opinion in *Yanez*:

> The ensuing decades [since *Helfend* and its progeny] have also brought us the medical billing and payment practices that now make evidence of what providers are paid highly relevant on the issue of the "reasonable value" of medical services. The Supreme Court recognized as much in *Prospect* when it stated: "In a given case, a reasonable amount might be the bill the doctor submits, or the amount the HMO chooses to pay, or some amount in between." (*Prospect* [*Medical Group v. Northridge Emergency Medical Group* (2009)], *supra*, 45 Cal.4th at p. 505, 87 Cal.Rptr.3d 299, 198 P.3d 86; . . ..) Thus, it seems beyond cavil that such evidence "is of substantial probative value." (*See Hrnjak* [*v. Graymar, Inc.* (1971)], *supra*, 4 Cal.3d at p. 733, 94 Cal. Rptr. 623, 484 P.2d 599.)

Yanez, supra, 185 Cal. App. 4th 1313, 1361, 111 Cal. Rptr. 3d at 297.

In order to enable juries to determine the reasonable value of medical care, jurors must be allowed all the relevant evidence. This would require the Court to modify the evidentiary component of the *Helfend* rule[3] and direct that in most cases, juries should receive the medical bills as well as, among other things, evidence of the amounts actually paid for plaintiff's care. In order to minimize the risk of prejudice to plaintiffs, juries would need to be instructed that the amount of damages should not be reduced based on the amount paid by insurance. "If properly instructed juries can handle this kind of potentially prejudicial evidence in very serious – even life and death – cases." *Id.* (Banke, J., concurring).

As noted above, plaintiffs want it both ways. They ask the Court to keep out probative evidence during trial and to prohibit post-verdict adjustment on the ground that the reasonable value of medical care is a question for the jury. But with appropriate guidance from the Court as to the trial judge's discretion to admit evidence of the amounts paid, post-verdict adjustment of verdicts would, in most cases, be unnecessary.

IV. DEFENDANTS DO NOT ENJOY A WINDFALL IF PAST MEDICAL DAMAGES ARE CAPPED AT ACTUAL AMOUNTS PAID FOR SERVICES.

Under well-established rules as to the measure of damages, tortfeasors are liable for the harm they cause, but not more. Double recoveries are not permitted. The collateral source rule is a limited

[3] Under *Helfend,* the "trial court's duty is to carefully weigh the relevance and probative value of evidence of plaintiff's receipt of collateral benefits against the inevitable prejudicial impact such evidence is likely to have on the jury's deliberations." *Hrnjak v. Graymar, Inc.* (1971) 4 Cal. 3d 725, 732.

exception to that rule. In plaintiffs' view, under the *Hanif/Nishihama* approach applied by the trial court in this case, defendants enjoy a windfall in that they would obtain the "benefit [of discounted medical costs] without paying for it." This is neither a windfall to the defendant nor a detriment to the plaintiff. It is an application of centuries-old tort damages principles. The purpose of tort damages is compensation for harm. Paying accident victims medical expenses that are two to three times as much as they (or their insurer) paid the doctors and hospitals serves no compensatory purpose.

Plaintiffs suggest that Hamilton Meats & Provisions, Inc. enjoyed another kind of windfall in that its employee had the good fortune of injuring someone covered by medical insurance. Plaintiffs posit that if Ms. Howell had been uninsured, defendant could have been liable for the full medical bills without any offset. This is a dubious premise because a defendant would be entitled to challenge an inflated hospital bill. In any event, a tortfeasor who injures an uninsured plaintiff *should* pay more if the higher charges were (1) reasonable and (2) actually paid or incurred by plaintiff. That is how the system works to make the plaintiff whole.

The fact that courts award different amounts for the same or similar injuries is an inherent feature of the tort system. The purpose of the tort system is to compensate for specific individual injuries; it is *not* a purpose of the system to equalize recoveries among different claimants based on the type of injury. *See Hanif, supra*, 200 Cal. App. 3d at p. 639. Identical injuries may have different economic effects on different victims. Thus, damage awards, by design, vary depending on the harm actually suffered by an individual plaintiff.

As a further example, consider the case of two hypothetical drivers who, in separate accidents, inflict identical physical injuries on pedestrians in a crosswalk. The first driver strikes a dishwasher making minimum wage, and this plaintiff recovers $10,000 in lost wages for the six months he cannot work. The second driver (who was no more negligent than the first) strikes a highly paid banker. The second plaintiff recovers $100,000 for the six months he cannot work. The disparity in awards between these two plaintiffs may be a telling commentary on economic inequality. But to say that the lower award to the first pedestrian is a "windfall" to the tortfeasor is not a valid criticism of the system.

V. THE STATUTE PERMITTING COURTS TO DEDUCT INSURANCE PAYMENTS FROM JUDGMENTS AGAINST PUBLIC ENTITIES IS UNAFFECTED BY THE OUTCOME OF THIS CASE.

Plaintiffs have argued in the past that cities should not be concerned with the issues raised in this case because public entities benefit from a special statutory procedure concerning collateral source payments. Government Code section 985creates a post-verdict proceeding in actions against public entities that allows the trial court discretion to ignore the collateral source rule and reduce a damage award by some or all of the amount paid by insurance. *See* Gov. Code § 985. But the Legislature created this procedure for policy reasons that are separate and apart from the issues in this case. Regardless of the existence of section 985, public entities are entitled to the same measure of tort damages as all litigants.

The purpose of section 985 is to eliminate in appropriate cases the windfall to private parties who can recover both from the tortfeasor and their insurer. It is a Legislative judgment that Courts may consider the

burden on taxpayers when a plaintiff obtains a double recovery. Section 985 procedures are in addition to – not an alternative to – a *Hanif/Nishihama* reduction. As noted above, the central issues of this appeal are the proper measure of damages for medical expenses and the recoverability of amounts in excess of the amount paid by insurance. Section 985, on the other hand, goes to a discretionary exception to the collateral source rule for public entities. The statute provides that in the discretion of the court and "on terms as may be just," a public entity (unlike a private defendant) may be entitled to a reduction in the verdict to eliminate a double recovery by plaintiff. *See* Gov. Code § 985(f). This reduction occurs at a hearing after the verdict.

Section 985 does not apply to contractual write-offs. The statute only addresses "collateral source payments," which it defines as either "direct provision of services" to the plaintiff (Gov. Code § 985(a)(1)(A)) or "[m]onetary payments paid or obligated to be paid for services or benefits that were provided . . . to or on behalf of the plaintiff" (*id.* § 985(a)(1)(B)). No matter how the Court decides the issues presented by this appeal, government entities would be allowed a post-verdict hearing to seek a discretionary reduction in the verdict by some or all of the amount of insurance payments.

The Court should be aware of another provision of section 985 which addresses the admissibility of insurance payments in tort actions against a public entity. Government Code section 985(b) states in part: "Any collateral source payment paid or owed to or on behalf of plaintiffs shall be inadmissible in any action for personal injuries or wrongful death where a public entity is a defendant."

If the Court decides this case by modifying the rule concerning the admissibility of insurance payments at trial, the Legislature should reconsider the statute's prohibition on the admission of insurance payments in public entity cases. But section 985 is not a complete bar to allowing juries to hear relevant evidence as to medical costs. The statute only requires exclusion of collateral source payments "to or on behalf of plaintiffs." The statute would permit the admission of evidence concerning the amounts typically accepted by the provider as full payment for the same services rendered to patients *other than* plaintiff.

CONCLUSION

This Court should reverse the opinion of the Court of Appeal and hold that contractual write-offs of medical bills are not treated the same as insurance payments under the collateral source rule. In addition, the Court should provide guidance for the trial courts as to appropriate procedures and evidentiary considerations for determining the reasonable value of past medical care in accordance with the *Hanif/Nishihama* rule.

Dated: August 26, 2010

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CERTIFICATE OF COMPLIANCE

Pursuant to California Rules of court, Rule 8.204(c)(1), I certify based on the "Word Count" feature in my Microsoft Word 2007 software, this brief contains 4,471 words not including the caption page, tables, and this certificate.

August 26, 2010.

David B. Newdorf WF

DAVID B. NEWDORF

Attorneys for Amicus Curiae the
League of California Cities

PROOF OF SERVICE

I, **KATHERINE A. DEBSKI**, declare as follows:

I am a citizen of the United States, over the age of eighteen years and not a party to the within entitled action. I am employed at Newdorf Legal, 220 Montgomery Street, Suite 1850, San Francisco, California 94104.

On August 26, 2010, I served the attached:

APPLICATION FOR PERMISSION TO FILE AMICUS CURIAE BRIEF AND AMICUS CURIAE BRIEF OF THE LEAGUE OF CALIFORNIA CITIES

on the interested parties in said action, by placing a true copy thereof in sealed envelope(s) addressed as follows:

SEE ATTACHED SERVICE LIST

and served the named document in the manner indicated below:

☒ **BY MAIL**: I caused true and correct copies of the above documents, by following ordinary business practices, to be placed and sealed in envelope(s) addressed to the addressee(s), at the Mills Building, 220 Montgomery Street, Suite 1850, San Francisco, California 94104, for collection and mailing with the United States Postal Service, and in the ordinary course of business, correspondence placed for collection on a particular day is deposited with the United States Postal Service that same day.

☐ **BY PERSONAL SERVICE:** I caused true and correct copies of the above documents to be placed and sealed in envelope(s) addressed to the addressee(s) and I caused such envelope(s) to be delivered by hand on the office(s) of the addressee(s).

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

Executed August 26, 2010 at San Francisco, California.

Katherine A. Debski

Katherine A. Debski

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