ATTORNEYS AT LAW

801 SOUTH FIGUEROA STREET, 19TH FLOOR LOS ANGELES, CALIFORNIA 90017-5556

www.sedgwicklaw.com 213.426.6900 *phone* 213.426.6921 *fax*

Sedgwick LLP

Christina Imre
(213) 615-8049
christina.imre@sedgwicklaw.com

January 15, 2013

Via Messenger

Court of Appeal
State of California
Second Appellate District, Division 3
300 S. Spring St.
Second Floor, North Tower
Los Angeles, CA 90013
Attn: Z. Clayton, Deputy Clerk

Re: *Corenbaum v. Lampkin* (B236227) c/w *Carter v. Lampkin* (B237871)

To the Clerk of the Court:

On behalf of the Personal Insurance Federation of California (PIFC), the Pacific Association of Domestic Insurance Companies (PADIC), the Property Casualty Insurers' Association of America (PCI) doing business in California as the Association of California Insurance Companies (ACIC), and the National Association of Mutual Insurance Companies (NAMIC), we accept the court's invitation to brief the issues presented in its letter dated November 26, 2012.

QUESTIONS PRESENTED

"Although evidence of the amount billed for medical expenses is irrelevant, and thus inadmissible, on the issue of past medical damages, to what extent is such evidence relevant and admissible on (a) future medical expenses and/or (b) noneconomic damages?"

SHORT ANSWER

After the Supreme Court decision in *Howell v. Hamilton Meats & Provisions, Inc.* (2011) 52 Cal. 4th 541, the face amount of the bill for past medical expenses is, and must be, irrelevant and inadmissible for all purposes. *Howell* recognizes that where the plaintiff's medical provider and health insurer have negotiated the rate in advance, it is *that* amount which represents the real price of the service on the open market, not the arbitrary amount the provider may have "billed." As *Howell* concluded, in today's world of medical billing practices, the billed amount (often referred to as the "chargemaster" price) typically is an artificial number unrelated to the value of the service on the open market, to the provider's cost of providing the service, and to a reasonable profit. Indeed, in these circumstances, the provider has no expectation it will receive payment in the face amount. *Howell* concluded that the amount billed is irrelevant to and inadmissible on the amount of a tort plaintiff past medical special damages because it is, at bottom, an essentially arbitrary, artificial number. A number that is meaningless is meaningless for *all* purposes. The billed amount is and must be irrelevant on the issues of plaintiff's noneconomic and future medical special damages as well.

Discussion

THE PRINCIPLES OF *HOWELL* DICTATE THAT THE FACE OR BILLED AMOUNT OF PAST MEDICAL BILLS IS IRRELEVANT TO PROVING ANY DAMAGES ISSUES AND THEREFORE INADMISSIBLE FOR ALL PURPOSES.

A. Recognizing The Radical Change In Medical Billing Practices, *Howell* Altered The Landscape And Underlying Assumptions That Apply When Setting An Injured Plaintiff's Damage Awards.

Under California law, a tort plaintiff is entitled to recover the "reasonable" cost of reasonably necessary medical care he or she has received. (*Howell, supra,* 52 Cal. 4th at 551 (citations omitted); see also CACI 3903A; *Dimmick v. Alvarez* (1961) 196 Cal.App.2d 211, 216 [charges for medical services to treat plaintiff's injury must be "reasonable," the costs of medical treatment and hospitalization not necessarily recoverable].)

Howell recognized that medical billing practices have changed dramatically in the last few decades. (*Howell, supra,* 52 Cal.4th at 560-561.) The Supreme Court found that in 1960, "'everyone paid the same rates' [for medical services] -- usually cost plus ten percent." (*Id.* at 561, citing Hall & Schneider, Patients as Consumers: Courts, Contracts, and the New Medical Marketplace (2008) 106 Mich. L.Rev. 643, 663, fns. omitted (hereafter "Patients as Consumers").) That represented the going, reasonable rate for the medical service. But with the advent of managed care and prenegotiated rates between health insurers and medical providers, medical billing practices have changed drastically in recent years.

Now, providers set charges according to competing influences unrelated to cost and reasonable profit. *Howell* found, for example, that:

> "'Disparities between charges and costs [have] been growing over time as many existing charges were set before hospitals had a good idea of their costs and/or were set in response to budgetary and competitive considerations other than resource consumption. Hospital charges are set within the context of hospitals' broader communities, including their competitors, payers, regulators, and customers. . . . These competing influences and hospitals' efforts to address them often produce charges *which may not relate systematically to costs*.'"

(*Howell, supra*, at 560, citation omitted (emphasis added).)

The Supreme Court also pointed to the enormous discrepancies between what different California hospitals "charge" for the identical service, citing this as further evidence that the provider's "billed" amount does not reflect the service's reasonable value on the open market. Billed or "chargemaster" prices for a given service "can vary tremendously, sometimes by a factor of five or more, from hospital to hospital in California." (*Id.* at 561-562, citation omitted [the "chargemaster" price for a chest x-ray can run from a low of $200 to a high of around $1,500].) "For this reason as well, it is not possible to say generally that providers' full bills represent the *real value* of their services, nor that the discounted payments they accept from private insurers are mere arbitrary reductions." (*Id.* at 562 (emphasis added).)

Moreover, *Howell* rejected the notion that the difference between the billed and paid amounts – the "negotiated rate differential" – may be properly termed a "writeoff" or "discount." (*Howell, supra*, 51 Cal.4th at 559.) The Court concluded that the term "writeoff" is a misnomer; the word implies that the billed amount actually represents the reasonable market value of the medical services, which the provider then discounted. (*Ibid.* ["dissent's repeated description of the negotiated

rate differential as a writeoff from the provider's bill illustrates the confusion between negotiated prices and gratuitous provision of medical services"].) "But in cases like that at bench, the medical provider has agreed, before treating the plaintiff, to accept a certain amount in exchange for its services. *That amount constitutes the provider's price*, which the plaintiff and health insurer are obligated to pay *without any writeoff*." (*Ibid.* (emphasis added).) Therefore, "it is not possible to say generally that providers' full bills represent the real value of their services, nor that the discounted payments they accept from private insurers are mere arbitrary reductions." (*Id.* at 562.)

The bedrock premise of *Howell* is that the billed or chargemaster amount does not represent the service's reasonable value on the open market; it is essentially an artificial number that is not the product of negotiation, but rather, often put on the table as prologue to negotiations. "Given this state of medical economics, how a market value other than that produced by negotiation between the insurer and the provider could be identified is unclear." (*Id.* at 562.) That is why *Howell* held the "insincere" billed price (*id.* at 561) is irrelevant and inadmissible on the issue of what past medical specials the tort plaintiff may recover.

Howell's conclusion is amply supported by the commentators (and the Court relied on many of them), though the commentators characterize the billed amount in far blunter terms: "The evolution of the nation's health care payment systems" has created a world in which "a hospital's list price is relatively meaningless," the prices are "ad hoc," and they lack any "external constraints." (*James McGrath, Overcharging The Uninsured*, 26 QUINNIPIAC L. REV. 173, 185 (2007) ["relatively meaningless"]; *Patients As Consumers*, *supra*, 106 MICH. L. REV. at 664-665, quotation and citations omitted, [prices "ad hoc," "without any external

constraints"].) "Hospital executives confess that 'the vast majority of [charges] have *no relation to anything*, and certainly not to cost.'" (*Patients As Consumers*, *supra*, 106 MICH. L. REV. at 665, emphasis added, citation and quotation omitted.) "Rational markets do not produce such bizarre prices." (*Ibid.*) Moreover, "[p]rices in American medicine often have little relationship to any notion of what is reasonable or what might be the prices in a competitive market." (Ireland, Review and Cases of Note: The Concept of Reasonable Value in Recovery of Medical Expenses in Personal Injury Torts, 14 J. LEGAL ECON. 87, 90 (March 2008).)

Though *Howell* left open the precise questions presented here, its reasoning permits only one conclusion: the face amount of the bill is an artificial, ad hoc, and largely meaningless number that is not the product of negotiation on the open market. The amount billed is just as meaningless, irrelevant and inadmissible on noneconomic and future medical specials as it is on past medical special damages. A meaningless number is meaningless for all purposes, and can carry no legal significance whatever.

B. Under *Howell*, The Billed Amount Must Be Irrelevant And Inadmissible For All Purposes.

As noted, *Howell*'s fundamental premise, on which the entire opinion turns, is that the "chargemaster" billed price does not bear a relation to the reasonable, objective value of the service, or to what the provider could, or expect to, collect on the open market. "[I]t is not possible to say generally that providers' full bills represent the real value of their services . . . ." (*Howell, supra*, at 562.)

If such a number is arbitrary, as *Howell* clearly concluded, it is arbitrary, irrelevant and inadmissible across the board. The billed amount cannot be

irrelevant to the calculation of plaintiff's past medical specials, yet somehow magically be relevant to the plaintiff's pain and suffering award or the amount of future medical expenses. The amount billed, which is divorced from reality because it does *not* represent the service's reasonable value on the open market, has no tendency in reason to prove either the dollar value of plaintiff's past pain and suffering or of plaintiff's future medical special damages. (Evid. C., § 210.)

The test for relevance is logical connection: "whether the evidence tends 'logically, naturally, and by reasonable inference' to establish material facts . . . ." (See, e.g., *Bristow v. Selma Comm. Hospital* (2008) 164 Cal. App. 4th 1478, 1510 n 17, citation omitted, internal punctuation simplified.) But there is no logical connection between the "bizarre" and "ad hoc" chargemaster billed price and either the dollar amount of noneconomic damages or of projected future medical costs. The "insincere" billed number has no logical tendency to prove *any* damage issues in the case precisely because it is arbitrary.

For example, the face amount of the provider's bill cannot be relevant on the issue of noneconomic damages. Such damages represent the law's attempt to compensate the plaintiff in money for a subjective injury and are notoriously difficult to quantify in dollars. Juries are told that "[n]o fixed standard exists for deciding the amount of these noneconomic damages. You must use your judgment to decide a reasonable amount based on the evidence and your common sense." (CACI 3905A.) Even the CACI Use Note acknowledges that pain and suffering "represent[s] a detriment which can be translated into monetary loss only with great difficulty." (*Ibid.*, citation omitted.) Given the problems inherent in placing a dollar amount on subjective pain and suffering, the cost of plaintiff's medical care is

frequently used as a benchmark by judges, lawyers, adjusters and juries, to help evaluate the plaintiff's general damages.

Using such a "multiplier" approach to evaluate subjective noneconomic damages is a common practice because the cost of medical care, an *objective* number representing the *reasonable* value of the services necessary to treat the tort plaintiff's injury, helps to place the severity of the plaintiff's always difficult-to-quantify pain and suffering into perspective. The logical inference is that the greater the medical expenses, the more severe the subjective injury may be. "[T]he cost of medical care often provides both attorneys and juries in tort cases with an important measure for assessing the plaintiff's general damages." (*Helfend v. So. Calif. Rapid Transit Dist.* (1970) 2 Cal.3d 1, 11-12 (citations omitted); and see *id.* at 11 [collateral source rule "performs entirely necessary functions in the computation of damages"]; see also *Katiuzhinsky v. Perry* (2007) 152 Cal.App.4th 1288, 1298 [recognizing that the amount of medical specials will have an effect on the jury's assessment of the amount of general damages – "little doubt that the erroneous limit on the amount of recoverable special damages had a significant effect on the jury's overall damages award"]; see also *Fein v. Permanente Medical Group* (1985) 38 Cal.3d 137, 164-165 (fn. omitted) [Legislature, in enacting MICRA collateral source rule, "apparently assumed that in most cases the jury would set plaintiff's damages at a lower level because of its awareness of plaintiff's 'net' collateral source benefits"].)

But *Howell* shows that the face or "chargemaster" amount billed does not represent the objective, reasonable cost of the medical care necessary to treat the injury. It is, to put it mildly, an "insincere" number. (*Howell, supra,* 52 Cal.4th at 561.) It can have no tendency to aid the jury in putting the severity of plaintiff's

injury into perspective or helping to place a dollar amount on subjective pain and suffering. By contrast, the amount of past medical specials accepted in full satisfaction pursuant to prior negotiation is an *objective* number, validated by negotiation and market forces in a real world environment. It represents the value of the services in the real world, and therefore does help place into perspective the severity of the plaintiff's subjective pain and suffering by measuring it against an objective, validated number. Permitting the use of the fictitious "chargemaster" billed amount would mean that, while the jury may only award the amount paid in full satisfaction of the bill for past medical special damages, it could base its other damage awards on the artificial amount billed, even though that latter number has no relationship to reality.

What's more, permitting evidence of the billed amount could mislead the jury in making its difficult evaluation. A jury told that the hospital billed $25,000 may have a different view of the severity of pain and suffering than one who knows that the total reasonable cost of the medical expenses incurred to treat that injury was only a fraction, e.g., $5,000. But in this example, the $25,000 billed chargemaster amount is essentially a fanciful number.[1]

---

[1] This is not an exaggeration. Asked to explain how U.S. hospitals price their service, the Chief Financial Officer of UC Davis Health Services, a 30-year veteran of hospital financing, candidly replied: "There is no method to this madness. As we went through the years, we had these cockamamie formulas. We multiplied our costs to set our charges." (Reinhardt, The Pricing Of U.S. Hospital Services: Chaos Behind A Veil Of Secrecy, 25 HEALTH AFFAIRS 57 (2006), citing Lagnado, California Hospitals Open Books, Showing Huge Price Differences, WALL ST. J. (DEC. 27, 2004) [available at: http://content.healthaffairs.org/cgi/content/full/25/1/57 [as of 1/14/13].)

And no limiting instruction could cure the confusion. The chargemaster billed price cannot be *irrelevant* for purposes of past medical special damages yet somehow "relevant" to other items of damage. Either the billed price is meaningful, and therefore relevant and admissible, on *all* damages issues, or it is meaningless, irrelevant and inadmissible on every damages issue. The Supreme Court has already concluded that the billed amount is inadmissible on past medical specials because it is does not reflect economic reality. A meaningless number cannot carry legal significance or relevance for some purposes but not others. In fact, evidence of the billed amount as supposedly "relevant" to pain and suffering could serve only to artificially inflate the noneconomic damage award, because the "billed" amount is *itself* artificially and arbitrarily inflated. If the provider's billed but never collected charges are admitted as relevant to general damages, that evidence cannot help but taint the jury's award of general damages.

The same is true of future medical expenses, and for the same reasons. The billed amount is just as irrelevant on the reasonable value of the service as the lawyer who bills $5,000 an hour, knowing she can never collect that sum and who winds up accepting a minute fraction of the billed amount. Evidence of the face amount of the past bill would have no tendency in reason to prove the amount of the plaintiff's future medical costs. That is especially true because California law requires that an award of future medical special damages must be reduced to present value, since an award paid in today's dollars will grow through investment with the passage of time. (See, e.g., CACI 3904A.) The amount of past medical specials actually paid represents the present reasonable value of services. The amount of past medical specials billed does not. And it is not a projection of what the provider expects medical services will cost in future. It is not a projection of anything.

CONCLUSION

Howell has radically changed the landscape for proof of damages in tort injury cases. Its overarching lesson is that the amount billed by a medical provider, in circumstances where the plaintiff has private insurance which has prenegotiated rates with the provider, is no longer a number that bears any legal significance. To be sure, *Howell* will require lawyers and courts to rethink how to prove many elements of damages in a personal injury case. But it is not the purpose of this letter to suggest a global solution to how litigants may prove damages in the post-*Howell* era. This court has inquired only whether the amount billed for past medical specials is relevant to noneconomic or future medical special damages and therefore admissible. The principles of *Howell* plainly show that it cannot be relevant, and it must be inadmissible. Any other conclusion would stand the Supreme Court's reasoning on its head.

Respectfully submitted,

Christina J. Imre
Sedgwick LLP

CJI/pfc

Proof of Service attached

SERVICE LIST

Michael Scott Sutton SUTTON & MURPHY 26056 Acero Mission Viejo, CA 92691	Counsel of Record for Plaintiffs and Respondents John Corenbaum, Charles Carter and Daniella Carter
Regan Dean Phillips Warren Dean RIGG & DEAN 3 Park Plaza, Suite 1560 Irvine, CA 92614	Counsel of Record for Plaintiffs and Respondents John Corenbaum, Charles Carter and Daniella Carter
Kenneth R. Brown CHO & BROWN 770 County Square Drive, Suite 215 Ventura, Ca 93003	Counsel of Record for Defendant and Appellant Dwight Eric Lampkin
Thomas M. Phillips Gregory Seth Mitchell Timothy E. Kearns THE PHILLIPS FIRM 601 South Figueroa St., Suite 1450 Los Angeles, CA 90017	Counsel of Record for Defendant and Appellant Dwight Eric Lampkin
Mitchell Francis Ducey MASSERMAN & DUCEY LLP 15260 Ventura Blvd., Suite 1000 Sherman Oaks, CA 91403	Counsel of Record for Defendant and Appellant Dwight Eric Lampkin
David S. Ettinger Robert H. Wright HORVITZ & LEVY LLP 15760 Ventura Blvd., 18th Floor Encino, CA 91436-3000	Counsel of Record for Defendant and Appellant Dwight Eric Lampkin

PROOF OF SERVICE

I am a resident of the State of California, over the age of eighteen years, and not a party to the within action. My business address is Sedgwick LLP, 801 South Figueroa Street, 19th Floor, Los Angeles, CA 90017-5556. On January 15, 2013, I served the within document(s):

AMICUS CURIAE LETTER BRIEF

☑ MAIL - by placing the document(s) listed above in a sealed envelope with postage thereon fully prepaid, in the United States mail at Los Angeles, California addressed as set forth below.

☐ PERSONAL SERVICE - by personally delivering the document(s) listed above to the person(s) at the address(es) set forth below.

SEE ATTACHED SERVICE LIST

I am readily familiar with the firm's practice of collection and processing correspondence for mailing. Under that practice it would be deposited with the U.S. Postal Service on that same day with postage thereon fully prepaid in the ordinary course of business. I am aware that on motion of the party served, service is presumed invalid if postal cancellation date or postage meter date is more than one day after date of deposit for mailing in affidavit.

I declare 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 January 15, 2013, at Los Angeles, California.

Patricia Cloutier