IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

FOURTH APPELLATE DISTRICT, DIVISION ONE

D053620

GIN053925

REBECCA HOWELL,

Plaintiff and Appellant,

v.

HAMILTON MEATS & PROVISIONS, INC.,

Defendant and Respondent.

Appeal from the Superior Court of San Diego County
The Hon. Adrienne Orfield, Judge

APPELLANT'S OPENING BRIEF

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CERTIFICATE OF INTERESTED ENTITIES OR PERSONS

CALIFORNIA COURT OF APPEAL
FOURTH DISTRICT, DIVISION ONE

D053620

Full Name of Interested Entity Entity/Person	Check One: Party	Non-party	Nature of Interest
Rebecca Howell	[X]	[]	Plaintiff/Appellant
	[]	[]	
	[]	[]	

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Name

February 18, 2009
Date

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Plaintiff and Appellant, REBECCA HOWELL ("HOWELL"), submits this Appellant's Opening Brief in support of her appeal from the trial court's ruling on Defendant/Respondent HAMILTON MEATS & PROVISION, INC.'s ("HMPI") Motion to Reduce Past Medical Specials Verdict.

I.

INTRODUCTION

A plaintiff in a personal injury action is entitled to collect as damages the amount that will compensate him or her for all of the detriment proximately caused by a defendant's tort. Despite the fact that HOWELL had private health insurance and incurred actual financial liability to her medical providers for the providers' full charges, HMPI moved the trial court for a post-verdict reduction of HMPI's liability for medical special damages to an amount less than the actual detriment caused by HMPI's tort. The reduction was granted by the trial court. The reduction was sought by HMPI based solely upon a benefit of HOWELL's financial investment in private collateral health insurance that was bargained for, and paid for, by HOWELL.

HMPI premised their conversion of HOWELL's collateral source benefit to their own benefit on three cases, none of which stands for the proposition HMPI has advanced:

- *Hanif v. Housing Authority of Yolo County* (1988) 200 Cal.App.3d 635, where, by statute, recovery is limited to Medi-Cal's actual benefits provided, and the right to recover Medi-Cal benefits belongs to Medi-Cal, not the patient;

- *Nishihama v. City and County of San Francisco* (2001) 93 Cal.App.4th 298, where neither the actual amounts paid for medical services nor the Collateral Source Rule were at issue; and
- *Greer v. Buzgheia* (2006) 141 Cal.App.4th 1150, which HMPI claims approves a post-trial reduction hearing, even though the propriety of such a procedure was explicitly not addressed due to forfeiture of that issue by the defendant in *Greer*.

Thus, the central issue presented is whether it was proper for the trial court to reduce the verdict for past medical special damages against a private (*i.e.* non-public) entity defendant to an amount less than the actual detriment caused by their tort, based on HOWELL's private collateral source investment benefits. HOWELL contends the trial court erred when it reduced the HMPI's liability post-verdict for two fundamental reasons: (a) the trial court's reduction violates the Collateral Source Rule; and (b) HMPI's motion was procedurally improper and lacked sufficient evidence to support the claimed reduction.

Based thereupon, HOWELL respectfully requests that this Court reverse the trial court's ruling on HMPI's post-verdict motion and remand with instructions to reinstate the jury's verdict for past medical specials and to enter judgment accordingly.

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II.

STATEMENT OF FACTS

A. Background of Incident and Injuries.

In November 2005, HOWELL was seriously injured when the car she was driving was hit by a truck driven by Juan Carlos Saenz, and operated by HMPI. (1 AA 53:26-54:5.)[1] HOWELL had two spinal surgeries and months of rehabilitation to address her injuries, as well as other procedures related to bone grafts needed for those surgeries. (1 AA 54:1-5.) By the time of trial, the past medical charges she incurred totaled at least $189,978.63. (2 AA 344:4-6, 344:28-345:1; 2 RT 195:23-25.)

B. Background Regarding Medical Care and Medical Insurance.

Before receiving treatment for accident-related medical care, HOWELL agreed to be personally responsible for all medical charges she incurred from her treatment by executing financial agreements with the various providers. (2 AA 344:12-21, 368-370.) HOWELL then received treatment and the medical providers issued bills reflecting their customary charge rates for the care provided. (2 AA 344:21-22.)

Fortunately, HOWELL had private health insurance with PacifiCare. In exchange for premium payments, PacifiCare agreed to indemnify HOWELL for any charges

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[1]All facts in this brief are supported by reference to Appellant's Appendix, abbreviated as: ([volume] AA [page(s)]:[line(s)]); Appellant's Compendium of Foreign Authorities, abbreviated as: ([volume] ACFA [page(s)]:[line(s)]); and the Reporter's Transcripts, abbreviated as: ([volume] RT [page(s)]:[line(s)]). Note: HOWELL will attempt to reduce each citation to pages/lines where possible, however, some citations can only be cited by page(s).

incurred which were covered by the health plan, subject to HOWELL's responsibility for deductibles and co-pays. (2 AA 344: 23-25.) The terms of this relationship are set forth in a health insurance policy issued by PacifiCare to HOWELL.

As a regular part of their business practice, and well before any care was provided to HOWELL, PacifiCare entered into contractual agreements with hospitals and healthcare providers to satisfy any bills incurred by PacifiCare plan members who obtained care from those providers. In this case, HOWELL's healthcare providers submitted the bills incurred by HOWELL to PacifiCare and the debts were satisfied pursuant to the various contracts between HOWELL and the providers, between HOWELL and PacifiCare, and between PacifiCare and the healthcare providers. The trial record contains no evidence of the actual terms of any of these contractual relationships. As discussed subsequently, HOWELL sought to conduct discovery and present evidence of these contractual relationships after trial, but was denied that opportunity by the trial court.

III.

PROCEDURAL BACKGROUND

A. Pre-Trial Pleadings.

The complaint was filed on July 10, 2006. (1 AA 1.) HMPI answered the complaint on August 31, 2006. (1 AA 8-12.) The parties exchanged expert designations on May 3 & 7, 2007. (1 AA 20-21.) The trial court held an Advance Trial Review Hearing on January 4, 2008, issuing a pre-trial order the same day. (1 AA 68-72.) The

case proceeded to trial on January 29, 2008, before the Hon. Adrienne A. Orfield. (1 AA 111.) HMPI admitted liability, but disputed causation and damages. (1 AA 54:16-25.)

In preparing for trial, HOWELL's counsel produced a Medical Billings/Expenses Summary as required by the Court's Advance Trial Order. (1 AA 116.1-116.2.) This document was identified by HOWELL as a trial exhibit in her Advance Trail Review Exhibit List. (1 AA 57 ["Exh. 57"].) This summary was also included on Plaintiff's Exhibit List as Trial Exhibit No. 57. (1 AA 115.)

HOWELL also listed on the Joint Trial Readiness Conference Report a designated expert witness, Timothy Peppers, MD, to testify as to the reasonable value of the past care provided. Percipient witness Michael Valle, HOWELL's spouse, was also on both trial witness lists. He testified as to the total amount of the past medical charges incurred, and that the charges had, in fact, been paid. (1 AA 60-61; 3 RT 195:23-25, 212:4-5).

HMPI did not list any potential trial exhibits evidencing the amounts "paid" by any source to satisfy the medical expense charges incurred by HOWELL. (1 AA 58-59.) No witnesses were identified who could competently testify about the contractual relationships between the providers and PacifiCare, the contract terms and/or consideration exchanged by these entities, or the contractual relationship between PacifiCare and HOWELL. (1 AA 60-61.)

B. HMPI's Motion in Limine to Limit HOWELL's Evidence of Past Medical Specials.

Before trial, HMPI filed a Motion in Limine seeking to "Exclude Evidence of Medical Bills and Expenses Not Paid by Plaintiff's Insurance." (1 AA 73-107.)

HOWELL opposed the motion, citing the longstanding law in California that HOWELL may recover the full reasonable cost/value of necessary care and that any payments to satisfy the debts incurred by collateral sources are inadmissible pursuant to *Helfend v. Southern Cal. Rapid Transit Dist.* (1970) 2 Cal.3d 1. (1 AA 108-109.)

During argument on the motion, the trial court expressed concern that there was no evidence before the court concerning: (a) what HOWELL's collateral private health insurer, PacifiCare, paid; (b) what PacifiCare's policies were concerning payments; (c) what PacifiCare's relationship was with the providers; and (d) what the healthcare providers agreed to accept to satisfy the charges incurred. The court also noted that the issue is not what was paid but what was reasonably *incurred*, opining that it was the HMPI's burden to evidence any compromise of the charges in prelude to any motion. HMPI's counsel noted that they did not have all the records and were anticipating receiving additional records during the trial. (1 RT 64:17-69:5.)

After consideration, the trial court denied the motion in limine, ruling: "I see this as a post trial issue. They're [HOWELL] entitled to put their bills in front of the jury. Whatever you [HMPI] can actually come up with to meet your burden. We can address that post trial." (1 RT 67:13-16.)

HMPI's counsel then indicated that he intended on cross-examining Dr. Peppers on the billing issue to establish what the doctor accepted to satisfy his bills. (1 RT 67:19-26.) HOWELL's counsel responded that he did not believe Dr. Peppers would be able to provide an answer, unless it was first established he was knowledgeable about the

accounting. (1 RT 68:2-21.) While the trial court clarified what HMPI's counsel intended on eliciting from Dr. Peppers, no ruling was made precluding an inquiry of Dr. Peppers by HMPI's counsel. HMPI therefore sought further clarification that the trial court's ruling was limited to denying the direct issue presented in the motion in limine - whether evidence of medical bills and expenses not paid by HOWELL's insurance would be excluded: "[s]o we're clear, I assume, it's the court's position and ruling that the jury gets to see the entire medical bills and so there's no need for us to argue that they just see the reduced one?" The court then responded "[c]orrect." (1 RT 68:27-69:3.)

In short, the trial court in no way restricted or limited HMPI's ability to examine witnesses or seek to introduce evidence related to the past medical charges incurred, billed or paid.

C. <u>Trial Proceedings.</u>

During the trial, the only evidence admitted relating to HOWELL's past medical bills was that they totaled $189,978.63. (1 AA 116.1-116.2.) This figure was confirmed by percipient witness Michael Valle. (3 RT 195:12-195:25.) Dr. Peppers also testified that past medical bills totaled $189,978.63 and that the amount of the charges were customary and reasonable. (2 RT 117:15-118:8.) In turn, HMPI did not dispute that the past medical bills incurred totaled $189,978.63. In fact, HMPI's counsel "accepted responsibility," for the past medical bills during closing argument. (4 RT 214:11-16.)

The jury was instructed with CACI 3903A and returned a Special Verdict which included an award of $189,978.63 in past medical expenses. (1 AA 118-119.) The

Special Verdict Form did not seek a finding of fact of the amount paid to or accepted by the healthcare providers to satisfy the charges incurred by HOWELL for past medical care. (1 AA 118-119.)

D. HMPI's Post-Trial Motion.

On February 15, 2008, before judgment was entered, HMPI filed a Motion to Reduce Past Medical Specials Verdict Pursuant to *Hanif v. Housing Authority* (1988) 2000 Cal.App.3d 635. (1 AA 120-176.) Included with HMPI's motion were declarations from employees of two of HOWELL's healthcare providers, Mourence Burris from Scripps Memorial in Encinitas, and Betsy Engstrom from CORE Orthopedic Medical Center. (1 AA 132-137.) Both declarations addressed the billing and payment history of HOWELL's accounts with these healthcare providers.

The trial court set the hearing for that motion on May 2, 2008. In the interim, on March 4, 2008, the trial court entered its Judgment on Special Verdict. (1 AA 177-179.) Notice of Entry of Judgment was served on HMPI on April 4, 2008. (1 AA 212-220.)

E. HOWELL's Request to Re-Open Discovery.

On April 4, 2008, HOWELL appeared *ex parte* to discuss scheduling issues concerning HMPI's motion. Specifically, since a full hearing on HMPI's motion would require the trial court to make a factual determination as to what was allegedly paid by HOWELL's collateral private health insurer to her healthcare providers (and what they, in turn, agreed to accept to satisfy the debts HOWELL incurred for medial care), HOWELL sought leave to re-open discovery so that subpoenas could be issued to obtain

the documents evidencing the relationships between: (a) HOWELL's health insurer and the healthcare providers; (b) HOWELL and her the health insurer; and (c) HOWELL and the healthcare providers. (1 AA 180-183.) HOWELL made that request as the issues presented in HMPI's motion had not been raised in HMPI's answer to HOWELL's complaint as an affirmative defense (1 AA 8-12), or in pre-trial discovery, and HOWELL therefore had no prior opportunity to seek documents evidencing these relationships in discovery.

F. <u>The Trial Court Sets a Hearing to Address the Substantive Legal Issues</u>.

During the *ex parte* hearing, HOWELL informed the trial court that while she was prepared to present grounds for denial of the motion based on procedural and/or evidentiary objections, as well as on factual grounds, she was also prepared to argue for denial of the motion based on the core substantive law issues - *i.e.* whether there was legal authority to support a post-verdict reduction of a jury's verdict for past medical specials to what was paid. (5 RT 224:6-19.) After some discussion, the trial court re-set the hearing for May 19, 2008, to solely address the substantive law issues. (5 RT 249:17-250:14, 253:26-28). The trial court further directed that if it found there was no authority to support a reduction of the jury's verdict for past medical damages, the motion would be denied and there would be no need to address the procedural, evidentiary and/or factual issues (*i.e.* factual finding as to what was paid). On the other hand, if the trial court found there was legal support for reducing the verdict, the court assured HOWELL

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that she would be provided the opportunity to brief and be heard on the procedural, evidentiary and factual issues as part of further proceedings. (5 RT 249:17-250:14.)

G. HMPI's Motion to Set Aside and Vacate Judgment.

On April 21, 2008, HMPI served a Notice of Motion to Set Aside and Vacate Judgment and Enter Different Judgment for the same date as the "*Hanif*" hearing. (1 AA 263-338.) The substance of that motion was the same *Hanif* arguments related to the amount of medical specials awarded. Since the trial court had previously ordered that the hearing on May 19, 2008, was to address the substantive law issues, the court calendared that duplicative motion for the same date. (5 RT 250:25-251:24.)

H. HOWELL's Opposition to HMPI's "*Hanif*" Motion.

HOWELL filed her opposition to HMPI's "*Hanif*" motion on April 24, 2008. (2 AA 339-360 for opposition, 361-463 for supporting lodgments of exhibits and foreign authorities.) Pursuant to the trial court's prior direction, the opposition addressed only the substantive law issues and otherwise did not: (a) address the procedural defects in the motion; (b) set forth/discuss evidentiary objections; and (c) present evidence and/or argue the factual issues presented. As HOWELL was directed by the trial court, those issues were reserved for further proceedings pending the trial court's threshold determination of the substantive law issue. (5 RT 249:17-250:14.)

On April 29, 2008, HOWELL filed an opposition to the Motion For New Trial, again confirming the trial court's direction to only brief the substantive law surrounding

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the "*Hanif*" issue and to reserve all other issues for a later determination. (2 AA 464-489.)

I. The "*Hanif*" Hearing and the Trial Court's Minute Order.

The hearing on the "*Hanif*" motion went forward on May 19, 2008. During the hearing, the trial court asked if counsel were aware of any pending appellate court cases dealing with the issues. HOWELL's counsel informed the court that the Fourth District Court of Appeals (Div. Three) had *Olsen v. Reid* (2008) 164 Cal.App.4th 200 before it, which had been briefed and was awaiting oral argument. The trial court asked counsel to provide copies of any briefs in the *Olsen* case that were readily available. (8 RT 328:16-239:12.) The trial court then took the matter under submission. (8 RT 334:28-335:2.) Thereafter, the briefs in the *Olsen* case were provided to the trial court by counsel.

On June 10, 2008, the trial court issued its order, granting HMPI's motion and reducing the jury's verdict for past medical damages. (2 AA 553-554.) The trial court's minute order states that the requested reduction in the jury's award of past medical specials did not violate the Collateral Source Rule. However, that minute order does not cite any authority. While granting HMPI's motion, the minute order sets forth no monetary figure as to what the trial court determined was paid by HOWELL's healthcare insurer or accepted by HOWELL's healthcare providers for payment of the charges incurred by HOWELL. The minute order makes no reference to any additional proceedings to be held. (2 AA 553-554.)

J. HOWELL's Motion for Reconsideration/Further Proceedings.

The same day the trial court issued the June 10, 2008, minute order, the opinion in *Olsen* was issued by Division Three of this court. On July 11, 2008, HOWELL appeared *ex parte* asking the trial court to calendar a Motion for Reconsideration based on new law. The trial court stated that it had read the *Olsen* opinion the day it came out and that there was no purpose in setting a Motion for Reconsideration based upon *Olsen*. (9 RT 336:11-337:16.)

HOWELL also asked the trial court to set an evidentiary hearing in prelude to making a factual determination of what was paid to satisfy the past medical charges incurred by HOWELL and awarded by the jury as past medical damages. HOWELL made an offer of proof that she could produce evidence to support a factual finding that the amount of consideration paid by HOWELL's collateral health insurer to the providers was, in fact, equal to the full charges incurred by HOWELL and awarded by the jury. HOWELL further made an offer of proof that she continued to receive billing statements from CORE (Dr. Peppers) and that CORE had a written lien, raising a significant question of fact as to whether HOWELL remained financially responsible to CORE beyond the payments CORE had received from PacifiCare. HOWELL also reminded the trial court that she had procedural and evidentiary objections to make that were not in the record because of the court's prior orders to hold those issues until after the substantive law issue was resolved. (9 RT 337:17-356:19.)

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The trial court responded that it saw no purpose in such a hearing. (9 RT 346:20-22.) Nevertheless, the trial court did indicate that HOWELL could submit further briefing if counsel felt it was necessary to complete the record. (9 RT 355:10-356:19.)

K. HOWELL's Additional Post-Trial Pleadings.

On July 15, 2008, HOWELL filed a Supplemental Brief Re: [HMPI's] Motion to Reduce the Jury Verdict for Past Medical Specials (3 AA 608-607), Evidentiary Objections (3 AA 604-607), and Declarations from Michael Valle (3 AA 571-590), and Lawrence Lievense (3 AA 591-603).

On August 14, 2008, the trial court issued a second order indicating that Plaintiff's Supplemental Brief (3 AA 608-617) was deemed filed as of July 16, 2008. (3 AA 618.) No further orders were issued by the trial court. No ruling was ever made on HMPI's Motion to Set Aside and Vacate the Judgment and Enter a Different Judgment.

On August 18, 2008, HOWELL filed a Notice of Appeal of the trial court's ruling on HMPI's Motion to Reduce Past Medical Specials Verdict Pursuant to *Hanif.* (3 AA 619-622.)

IV.

STANDARD OF REVIEW

The trial court's decision to grant HMPI's Motion to Reduce Past Medical Specials Verdict Pursuant to *Hanif v. Housing Authority* (1988) 2000 Cal.App.3d 635 is appealable pursuant to Code of Civil Procedure § 904.1, subd. (a)(4).

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To assist this Court in properly framing the different challenges that HOWELL raises to the trial court's order, HOWELL briefly discusses the applicable standard of review at the beginning of each corresponding section of this brief.

V.

DISCUSSION

A. The History and Development of the Collateral Source Rule.

1. A Tortfeasor is Legally Responsible for all Detriment Caused by His/Her Wrongdoing.

Civil Code § 3333 provides that tort damages compensate a plaintiff for all of their damages suffered as a legal result of defendant's wrongful conduct. (*North American Chemical Company v. Superior Court* (1997) 59 Cal.App.4th 764, 786.) A defendant is liable for the damages their wrongful conduct proximately causes to the plaintiff. (*Chaparkas v. Webb* (1960) 178 Cal.App.2d 257, 260.) Yet "[f]undamental principles," require that "an injured plaintiff," not "recover … more than the actual amount he paid or for which he incurred liability for past medical services." (*Hanif, supra*, 200 Cal.App.3d at 641.)

Under California law, the focus of damages is on the financial detriment the plaintiff personally sustains, and the amount a plaintiff may recover in past medical special damages turns on amounts they either personally pay, or personally incur, in liability for their past medical services. In California, a patient actually incurs liability for the full charges of their medical providers in exchange for medical services.

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In *Holmes v. California State Auto. Assoc.* (1982) 135 Cal.App.3d 635, a person injured in an automobile collision was a Medicare recipient and was also insured through CSAA for automobile coverage that included a medical payments provision. (*Id.* at 637.) Even though Medicare payments met the major portion of Holmes' hospital expenses, Holmes made a reimbursement claim under her auto medical payments coverage. (*Ibid.*) The medical payment clause of the policy provided that the insurer would pay "all reasonable expenses incurred by the insured," as a result of an automobile accident. (*Ibid.*) CSAA refused to pay, arguing "that no expenses were 'incurred' by [Holmes], because the agreement between the hospital and the United States would preclude the hospital from enforcing any claim against [Holmes]." (*Id.* at 638.)

The central question was whether Holmes "'incurred' any hospital expenses." (*Id.* at 637.) The court held that "[t]he insured 'incurred' the hospital expenses in question, even though she was also a beneficiary of the Medicare program." (*Id.* at 636.)

> "The Medicare legislation provides that no payments will be made for expenses which the patient has no legal obligation to pay; thus, expenses must, so far as concerns the contract between the hospital and the United States, be 'incurred' before they can be paid under the Medicare program...a legal obligation to pay was created upon the rendition of services." (*Ibid.*)

This Medicare legislation that informed the court's holding in *Holmes* parallels private health insurance legislation in California. As in the Medicare context, patient debt is a condition precedent to private health insurance payments. Health insurance payments are "contingent upon...expenses incurred." (Ins. Code § 10133(a).) "Disability

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insurer shall pay group insurance benefits contingent upon, or for expenses incurred on account of, hospitalization or medical or surgical aid." (Ins. Code § 10133.7(a).)

As a matter of law, patients (except the medically indigent) incur financial liability for the full usual charges of their medical providers at the time of service. (*Parnell v. Adventist Health System/West* (2006) 35 Cal.4th 595, 609 [setting forth a hospital lien is premised on the underlying debt the patient incurs at the time of service for usual charges of facility]; *City and County of San Francisco v. Sweet* (1995) 12 Cal.4th 105, 117 [holding a patient admitted to a county hospital and receiving medical services is a debtor for the full usual charges of the hospital]; *Holmes, supra,* 135 Cal.App.3d at 638-39 [stating Medicare Program beneficiaries incur full usual charges of their medical providers]; Ins. Code § 10133(a) [establishing direct payment of group medical insurance benefits by insurers is "contingent upon...expenses incurred...on account of," medical services].)

The sums medical providers charge for medical services "are based on a standard fee schedule registered with the state, and are the same...any patient would incur in the ordinary course of business." (*Katiuzhinsky v. Perry* (2007) 152 Cal.App.4th 1288, 1292; Health & Safety Code § 1339.51(a)(1), (b)(1).)

Patients admitted to a hospital or entering a physician's office for the first time usually sign contracts (often entitled "Conditions of Admission," or "Financial Responsibility Agreement") under which the patient expressly assumes debt for the full charges of their medical provider in order to receive medical care. Even when a patient

is admitted to a hospital without such an express contract to pay for his care and treatment, an agreement to pay for services rendered is implied. (*Reichle v. Hazie* (1937) 22 Cal.App.2d 543, 547.)

These holdings flow from a core premise of contract law, one which is codified in California as a maxim of jurisprudence: "He who takes the benefit must bear the burden." (Civil Code § 3521.)

2. The Collateral Source Rule Acts as Both an Evidentiary Exclusion Rule and a Substantive Rule on What Damages a Plaintiff May Recover.

California has long adhered to the doctrine that "damages recoverable for a wrong are not diminished by the fact that the party injured has been wholly or partly indemnified for his loss by insurance effected by him, and to the procurement of which the wrongdoer did not contribute." (*Helfend, supra,* 2 Cal.3d at 6, fn. 2 [citing *Peri v. Los Angeles Junction Ry. Co.* (1943) 22 Cal.2d 111, 131].) "A form of the rule has been a part of our jurisprudence since California's earliest days in the union." (*Smock v. State of California* (2006) 138 Cal.App.4th 883, 885; see *Clark v. Burns Hamman Baths* (1925) 71 Cal.App. 571, 575; see *Martin White v. Mary Ann* (1856) 6 Cal. 462, 470-71.)

The Collateral Source Rule developed at common law, with an emphasis on preventing tortfeasors from receiving a "windfall from the thrift and foresight of persons who have actually or constructively secured insurance...to provide for themselves and their families." (*McKinney v. California Portland Cement Company* (2002) 96 Cal.App.4th 1214, 1222 [citing *Arambula v. Wells* (1999) 72 Cal.App.4th 1006, 1009].)

Under the Collateral Source Rule, plaintiffs in personal injury actions can still recover full damages even though they already have received compensation for their injuries from such 'collateral sources' as medical insurance. (*Pacific Gas & Electric Co. v. Superior Court* (1994) 28 Cal.App.4th 174, 176.) That rule applies whenever and wherever an injured person is "wholly or partly indemnified for his loss by insurance effected by him." (*Helfend, supra,* 2 Cal.3d at 6, fn. 2.) A contrary rule would misallocate liability for tort-caused losses and discourage people from obtaining benefits from independent collateral sources. (*Lund v. San Joaquin Valley Railroad* (2003) 31 Cal.4th 1, 8 [recognizing the Collateral Source Rule as "generally accepted," citing *Helfend, supra,* 2 Cal.3d at 6, and Rest. 2d Torts, §§ 920, 920A]; *McKinney, supra,* 96 Cal.App.4th at 1222 [citing *Arambula, supra,* 72 Cal.App.4th at 1009].)

Helfend remains the guiding, binding, and leading authority in California on this issue. In *Arambula*, which was decided more than a decade after *Hanif*, the Fourth Appellate District (Div. Three) described *Helfend* as the "leading case," and observed that "the Supreme Court allowed the motorist to receive the advantage of his investment of 'years of insurance premiums to assure his medical care,'" noting "the tortfeasor should not garner the benefits of his victim's providence." (*Arambula, supra,* 72 Cal.App.4th at 1009-10.) The *Arambula* court explained that "[t]he collateral source rule operates both as a substantive rule of damages and as a rule of evidence." (*Id.* at 1015.) As a substantive rule, *Arambula* relied on *Helfend* for the proposition that a plaintiff's recovery cannot be reduced by virtue of payment or indemnity from collateral sources.

As an evidentiary rule "it precludes the introduction of evidence of the plaintiff being compensated by a collateral source unless there is a 'persuasive showing' that such evidence is of 'substantial probative value' for purposes other than reducing damages. (*Hrnjak v. Graymar, Inc.* (1971) 4 Cal.3d 725, 733.)" (*Arambula, supra,* 72 Cal.App.4th at 1015.)

In explaining the Collateral Source Rule, *Arambula* cited with approval *Montgomery Ward & Co., Inc. v. Anderson* (1998) 334 Ark. 561, in which a hospital partially forgave a patient's medical bills. (1 ACFA 49-53.) "The court held the patient was entitled to recover compensation for the full amount of the harm inflicted upon her, notwithstanding the discount, stating 'There is no evidence of record showing that [defendant] had anything to do with procuring the discount of [plaintiff's] bill by [the hospital]. The rationale of the rule favors her, just as it would had she been compensated by insurance for which she had arranged.'" (*Montgomery Ward, supra*, 334 Ark. at 565; *Arambula, supra,* 72 Cal.App.4th at 1012; see also *Acuar v. Letoutneau* (2000) 531 S.E.2d 316, 322-23 ["amounts written off are as much of a benefit for which [plaintiff] paid consideration as are the actual cash payments by his health insurance carrier to the health care providers"].) (1 ACFA 8-10, 51-52.)

In 2006, *Smock* cited *Helfend* with approval as the "most modern articulation," of the Collateral Source Rule. (*Smock, supra,* 138 Cal.App.4th at 886.) *Smock* involved yet, "another challenge to the application of the Collateral Source Rule to exclude from

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evidence and the computation of damages the payments a [plaintiff] receives from a source independent of the wrongdoer." (*Ibid.*) The court refused that challenge:

> "In the end, while barring the collateral source from consideration may confer a benefit on the victim, allowing it to be considered would benefit the wrongdoer. So, courts choose in such cases to benefit the victim. [citing *Arambula, supra*, 72 Cal.App.4th at 1014; *Philip Chang & Sons Associates v. La Casa Novato*, 177 Cal.App.3d 159, 170 (1986)] Application of the rule is not considered punitive, and it applies equally to private and government tortfeasors [citing *Helfend, supra*, 2 Cal.3d at 6, n. 2]." (*Smock, supra,* 138 Cal.App.4th at 888.)

The key to the operation of the Collateral Source Rule is the independence of the payment or indemnity source from the tortfeasor. In *Scott v. County of Los Angeles* (1994) 27 Cal.App.4th 125, the Second Appellate District (Div. Three) permitted evidence of an offset for insurance payments made to the tort victim by insurance carried by the county, but precluded evidence of payments and benefits provided to the victim by aid to families with dependent children (AFDC), Medi-Cal, and a private charity hospital. The *Scott* court referred to Gov't. Code § 985 as the proper procedural approach to dealing with such collateral source benefits in a case against a public entity defendant. (*Scott, supra,* 27 Cal.App.4th at 154.)

3. The Legislature Has Recognized the Collateral Source Rule and Created Exceptions for Discrete Classes of Defendants.

At present, there are only two such exceptions to the Collateral Source Rule: (a) Gov't. Code § 985 (actions against government entities – providing for discovery of collateral sources and payments, and also providing for a post-verdict hearing to determine whether a public entity will pay damages for which a collateral payor has paid

or indemnified the plaintiff); and (b) Civil Code § 3333.1 (providing for introduction of collateral insurance information into evidence in actions against health care providers for professional negligence.)

In both Gov't. Code § 985 and Civil Code § 3333.1, the Legislature also applied the maxim "he who takes the benefit must bear the burden," (Civil Code § 3521), to tortfeasors by permitting a defendant to potentially reap a plaintiff's collateral source benefits but offsetting that benefit by the cost of obtaining those benefits. Under Civil Code § 3333.1(a), if a defendant elects to introduce evidence of collateral insurance benefits, "the plaintiff may introduce evidence of any amount which the plaintiff has paid or contributed to secure his right to any insurance benefits concerning which the defendant has introduced evidence." Under Gov't. Code § 985(f)(3)(B) "[t]he court shall deduct from the reimbursement or reduction the amount of premiums the court determines were paid by or on behalf of the plaintiff to the provider of a collateral source payment."

To the extent that exceptions to the Collateral Source Rule are appropriate, the courts must defer to the Legislature, which has taken upon itself to carve out exceptions for certain discrete classes of defendants (of which HMPI herein is *not* a member). (See *Smock, supra,* 138 Cal.App.4th 888 ["If other modifications or limitations to [the Collateral Source Rule] are warranted, their creation is best left to the Legislature"]; see also *Helfend, supra,* 2 Cal.3d at 13 [stating "the proposed changes, if desirable, would be more effectively accomplished through legislative reform"].)

Here, HMPI wants more than what the Legislature was willing to give to public entity and medical malpractice defendants - they want the benefit of HOWELL's health insurance without bearing any of the costs of acquiring that benefit.

4. Collateral Source Rule, *Hanif* and *Nishihama.*

In *Helfend,* the California Supreme Court held that the Collateral Source Rule precludes a defendant from reducing the plaintiff's damages through plaintiff's collateral contractual benefits. (*Helfend, supra,* 2 Cal.3d at 6, fn. 2.) The *Helfend* court reserved the very issue that confronted the court in *Hanif,* where the plaintiff neither paid nor incurred responsibility for their medical services, which were instead dealt with through independent public benefits: "The question of gratuitous public benefits is not at issue here and invokes a host of other concerns, which must be considered in light of their specific factual contexts." (*Helfend, supra,* 2 Cal.3d at 9.)

The resolution of the "host of other concerns" in California (as it affects a plaintiff's recovery of damages) is that in addition to independence from the tortfeasor, the operation of the Collateral Source Rule in California requires that the plaintiff first pay or incur those damages. (*Olszewski v. Scripps* (2003) 30 Cal.4th 798, 820; see *Hanif, supra,* 200 Cal.App.3d at 640.) According to the *Hanif* court, the proper measure of recovery for past medical services is the actual amount paid or financial liability incurred by the plaintiff. (*Hanif, supra,* 200 Cal.App.3d at 640.) By statute, the right to recover as damages from a third party those benefits Medi-Cal provides to a Medi-Cal beneficiary does not belong to the beneficiary. Rather, that right belongs to the Medi-Cal program.

Medi-Cal may "institute and prosecute legal proceedings against the third person or carrier who may be liable for the injury," to a Medi-Cal beneficiary. (Welf. & Inst. Code § 14124.71(a).) When an injured beneficiary brings an action on their own behalf against the third person responsible for their injuries (as was the case in *Hanif*), "any settlement, judgment or award obtained is subject to the *director's right to recover*...benefits provided to the beneficiary under the Medi-Cal program." (Welf. & Inst. Code § 14124.72(c) [emphasis added].)[2]

That this right belonged to Medi-Cal, and not the Medi-Cal beneficiary, is the legal context that frames the *Hanif* court's observation that "[f]or purposes of analysis, plaintiff is deemed to have personally paid or incurred liability," to the extent "of Medi-Cal's subrogation and judgment lien rights." (*Hanif, supra,* 200 Cal.App.3d at 640 [citing Welf. & Inst. Code § 14124.70, *et. seq.*].) Since a Medi-Cal recipient is not financially responsible for the costs of their medical treatment, the *Hanif* court created a fiction ("deemed to have personally paid or incurred liability") so that the funds would be collected in the personal injury action for Medi-Cal to recover the benefits provided. (*Arkansas Dept. of Health & Human Services v. Ahlborn* (2006) 547 U.S. 268, 284-85; *In re Anthony M.* (2007) 156 Cal.App.4th 1010, 1018-1019; *Olszewski, supra,* 30 Cal.4th at 820; 42 C.F.R. § 447.15; Welf. & Inst. Code §§ 14019.3(d) & 14019.4(a).)

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[2]The term "benefits provided" is statutorily defined as "the Medi-Cal rate of payment, for the type of services rendered, under the schedule of maximum allowances authorized by," statute. (Welf. & Inst. Code § 14124.70(c)(1); *Olszewski, supra,* 30 Cal.4th at 805 [stating medical providers do "not receive full compensation for services rendered to Medicaid beneficiaries"].)

The *Hanif* decision is consistent with *Helfend* – payments made by Medi-Cal are not being used to reduce a Medi-Cal beneficiary's damages. There are no past medical special damages for the "detriment proximately caused," to a Medi-Cal beneficiary. (Civil Code § 3333.) The past medical special damages belong to Medi-Cal, not the plaintiff, and a Medi-Cal beneficiary neither pays nor incurs financial liability for their medical services.

The Medi-Cal statutes expressly provide that "the reasonable value of benefits means the Medi-Cal rate of payment, for the type of services rendered, under the schedule of maximum allowances." (Welf. & Inst. Code § 14124.70(c)(1).) The statutory framework in *Hanif* was unique to Medi-Cal, and takes the analysis outside of the confines of contract law by statutorily defining the legal rights of the Medi-Cal program and its beneficiaries.

That earned collateral financial benefits (such as private health insurance) and unearned, publicly-funded benefits (such as Medi-Cal) deserve distinct treatment as collateral sources is demonstrated by the separate treatment of these two categories of collateral benefits for purposes of post-trial motions under Gov't. Code § 985. (See Gov't. Code § 985(f), subd. (1) & (2).)[3]

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[3]Gov't. Code § 985 was not applicable in *Hanif*. Although the statute was newly enacted shortly before the *Hanif* appellate decision was issued, the statute was not retroactive, and therefore did not govern the trial court's ruling from which the appeal was taken. (*Evangelatos v. Superior Court* (1988) 44 Cal.3d 1188, 1209 ["in the absence of an express retroactivity provision, a statute will not be applied retroactively unless it is very clear from extrinsic sources that the Legislature or the voters must have intended a retroactive application"].)

The Medi-Cal situation is also distinct from medical care that is rendered gratuitously. "The fact that either under contract or gratuitously [medical] treatment has been paid for by another does not defeat the cause of action of the injured party to recover the reasonable value of such treatment from the tort-feasor." (*Fifield Manor v. Finston* (1960) 54 Cal.2d 632, 637; see *Hanif, supra,* 200 Cal.App.3d at 644 [setting forth an injured child is entitled to recover value of home care gratuitously provided by parents]; see *Rodriguez v. McDonnell Douglas Corp.* (1978) 87 Cal.App.3d 626, 662 [holding an injured person is entitled to recover value of nursing services provided by spouse].) "Any suggestion that Medi-Cal benefits are gratuities or otherwise intended as gifts to the recipient in this context is belied by Medi-Cal's subrogation and lien rights." (*Hanif, supra,* 200 Cal.App.4th at 643, fn. 3.) Providers are required by law to accept the amounts paid by Medi-Cal "as payment in full," and "shall not seek reimbursement nor attempt to obtain payment," from the beneficiary. (42 C.F.R. § 447.15; Welf. & Inst. Code § 14019.4.)

Nishihama, on the other hand, did not address, consider or analyze the Collateral Source Rule, nor did it discuss whether the extension of *Hanif* to the private health insurance context would violate the Supreme Court's decision in *Helfend.* (See *Nishihama, supra,* 93 Cal.App.4th 298.) "Cases are not authority for propositions not considered." (*Ginns v. Savage* (1964) 61 Cal.2d 520, 524, fn. 2 [opining "a case does not stand for a proposition neither discussed nor analyzed"]; *Peterson v. Lamb Rubber Co.* (1960) 54 Cal.2d 339, 343; *People v. Banks* (1959) 53 Cal.2d 370, 389.) The language

of an opinion must be construed with reference to the facts and evidence presented in the case, and the precedential value of the case is coextensive only with such facts. (*Harris v. Capital Growth Investors XIV* (1991) 52 Cal.3d 1142, 1157; *Security Pacific National Bank v. Wozab* (1990) 51 Cal.3d 991, 1003-04; *Southern Cal. Enterprises v. D.N. & E. Walter & Co.* (1947) 78 Cal.App.2d 750, 757; 9 Witkin, *Cal. Proc.* (4th Ed. 1997) Appeal, § 946, p. 988.) *Nishihama* may not be accorded precedential value for propositions that were not raised by the parties therein, nor considered or analyzed by the reviewing court.

In *Nishihama*, the defendant was a public entity. As such, it was statutorily entitled to discovery of the identity of the plaintiff's health insurer (Blue Cross) and that "at the time of plaintiff's care, Blue Cross had a contract with CPMC [plaintiff's hospital, California Pacific Medical Center] under which CPMC agreed that Blue Cross would pay reduced rates for specified services rendered to members." (*Nishihama, supra,* 93 Cal.App.4th at 306.)

The *Nishihama* court was informed that although the jury had awarded $17,168 for CPMC's hospital charges, the hospital had been paid only $3,600 in cash payments ("Plaintiff did not and does not contest the assertion that CPMC accepted $3,600 as payment in full for the services provided") and that CMPC had "filed a lien against the judgment reflecting its normal rates," under "California's Hospital Lien Act (HLA), Civil Code sections 3045.1-3045.6." (*Nishihama, supra,* 93 Cal.App.4th at 307.)

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The defendant in *Nishihama* did not want to pay the HLA lien, and the plaintiff did not want to be "put in the position of having to accept the lesser amount in this action while risking the possibility that she will then have to pay a greater amount to CPMC because of its lien." (*Id.* at 307.)

The court found that "CPMC has no lien rights in the damages awarded to plaintiff." (*Id.* at 306.) Since it was uncontested that $3,600 was all that had been actually paid, the *Nishihama* court found that the trial court "erred in permitting the jury to award," plaintiff any amount in excess of that "for the services provided by CPMC." (*Ibid.*)

The *Nishihama* court's finding "that the jury improperly awarded plaintiff certain medical costs that she did not incur," (*Id.* at 301), must be placed in the context that the plaintiff did not claim or contest that she had incurred any other amount, that the hospital had been paid any other amount, or that the Collateral Source Rule precluded the defendant from reaping the benefits of plaintiff's contract with her health insurer, Blue Cross. *The Nishihama decision does not even mention the Collateral Source Rule.* It simply is not considered, analyzed or discussed in the opinion.

Within five months of the *Nishihama* decision, the same three justice panel (Justices Stein, Swager and Marchiano of the First District Court of Appeal (Div. One)), issued their decision in *McKinney.* Unlike *Nishihama*, in *McKinney*, the Collateral Source Rule was analyzed and discussed by the court, which declined to permit the tortfeasor "to recover a windfall from the thrift and foresight of persons who have

actually or constructively secured insurance, " and recognized the rule that "in a case in which a tort victim has received partial compensation from medical insurance coverage entirely independent of the tortfeasor...the collateral source rule [] foreclosed defendant from mitigating damages by means of the collateral payments." (*McKinney, supra,* 96 Cal.App.4th at 1222 [citing *Arambula, supra,* 72 Cal.App.4th at 1009, and *Helfend, supra,* 2 Cal.3d at 13-14]; see also *Montgomery Ward, supra,* 334 Ark. 561, cited by *Arambula, supra,* 72 Cal.App.4th at 1012 [stating Collateral Source Rule precludes defendant from benefiting from discount plaintiff had negotiated with plaintiff's medical provider].) (1 ACFA 49-53.)

Thus, neither *Hanif* nor *Nishihama* are controling precedent for this case, in which HOWELL is not a Medi-Cal benficiary, HMPI is not a governmental entity and the applications of the Collateral Source Rule *is* in dispute.

5. <u>Confusion at the Margins of the Collateral Source Rule.</u>

Citing *Hanif* and *Nishihama*, defendants in personal injury cases routinely argue that a plaintiff should not be entitled to introduce evidence of the full charges of the cost of their medical care from healthcare providers. Rather, they argue that plaintiffs should be limited to claiming past medical damages only for the amounts of the cash payments made to their medical providers by their health insurers, without regard to whether the defendant is a public entity subject to Gov't. Code § 985, or whether a plaintiff's past medical bills have been paid by a private collateral health insurer or as a public benefit (*eg.* Medi-Cal).

Beginning in 2006, with the case of *Greer v. Buzgheia* (2006) 141 Cal.App.4th 1150, a series of appellate decisions have deftly avoided the issue, deciding the cases before them on procedural or evidentiary grounds without reaching the substantive law issue or how to deal with the contractual allowances that are a common feature of contracts between health insurers and medical providers.

Greer was one of four cases, including *Nishihama* (decided before *Greer*), and *Katiuzhinsky* and *Olsen* (decided after *Greer*), that have held that the full charges of medical providers are admissible evidence, and the so-called 'discounted' cash payment rates are not admissible.

It should come as a surprise that "[w]ithout statutory authority or the Supreme Court's blessing," *Hanif* and *Nishihama* have been relied upon as justification to have "divorced the collateral source rule from the complicated area of medical insurance," (*Olsen, supra,* 164 Cal.App.4th at 204), since *Hanif, Nishihama, Olszewski*, *Parnell*, *Greer* and *Katiuzhinsky* did not grapple directly with the Collateral Source Rule. Indeed, the California Supreme Court in *Parnell* expressly noted that the issue had not been addressed. (*Parnell, supra,* 35 Cal.4th at 611, fn. 16 ["we do not reach, and express no opinion, on whether *Olszewski* and *Hanif* apply outside the Medicaid context"].)

With this background, the concurring opinions in *Olsen* present the first time in California that an appellate authority has acknowledged and begun to consider: (a) the import of the statutory framework of our healthcare economy to the Collateral Source

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Rule; (b) the specific statutes that have developed around the Collateral Source Rule; and (c) the role of contract law in defining the legal setting of this issue:

> "In the modern medical setting...are a variety of private, public, and supplemental insurance requirements and conditions, a range of negotiating groups, copayment requirements, provider agreements, contractual and statutory liens, subrogation claims, reimbursement provisions, and statutory rights, both state and federal, that surround every visit to a doctor or hospital...This complicated and delicate scheme includes legislation specifically designed to work within the collateral source rule (see, *e.g.*, Civil Code § 3333.1; Gov't. Code § 985, subd. (f)), while at the same time recognizing that the measure of damages "is the amount which will compensate for all detriment proximately caused." (Civil Code § 3333.) Disastrous anti-consumer consequences could result if a court were to issue an opinion contrary to the legislative scheme which now surrounds a rule which was originally judge-made." (*Olsen, supra,* 164 Cal.App.4th at 212-213 [Acting Presiding Justice Moore, concurring opinion].)

B. The Trial Court's Ruling is Substantially Inconsistent and Incompatible with the Collateral Source Rule.

1. Standard of Review.

The standard for review of the trial court's order and judgment in this matter is well-settled. The interpretation and application of statutes presents a pure question of law subject to independent appellate determination. (*International Engine Parts, Inc. v. Feddersen & Co.* (1995) 9 Cal.4th 606, 611.) Thus, this Court may determine *de novo* the application of the Collateral Source Rule and the post-verdict reduction of the jury's award for past medical special damages and is not bound by the trial court's interpretation. (*People ex rel. Lockyer v. Shamrock Foods Co.* (2000) 24 Cal.4th 415, 432.) This is especially so where that application involves the "resolution of a legal issue, in which the court does not make credibility determinations, weigh the evidence, nor

draw inferences from the facts." (*Aquino v. Superior Court* (1993) 21 Cal.App.4th 847, 850, 855.)

While sitting without a jury, trial courts are undoubtedly empowered to make findings of fact supported by the evidence. They are not, however, allowed to make those factual findings based upon a misapprehension of the controlling law, and as such, any claimed errors of law are subject to a *de novo* review standard. (See *Ghirardo v. Antonioli* (1994) 8 Cal.4th 791, 799-801 [where the Cal. Supreme Court distinguishes between a trial court's initial resolution of disputed historical facts – subject to a substantial evidence standard – and its application of the law to those facts to make a legal conclusion – subject to a *de novo* standard of review].) It is this latter function, questioned herein by HOWELL, where that interpretation and application of the law led to the granting of a post-verdict motion to reduce the jury's verdict for past medical special damages.

2. Limiting HOWELL's Recovery of Past Medical Specials to the Amounts Paid in Cash by Her Private Health Insurer Violates the Collateral Source Rule.

At its core, the trial court ruling allows HOWELL to recover only what her private health insuer paid in cash (the "alternative rate" payments) to her healthcare providers. The trial court ruling does not allow HOWELL to recover the full amount of the debts she incurred with the providers which were awarded by the jury. Implicit in the ruling is a finding that the difference between the alternative rate payments and the total charges incurred to the providers has no value to any of the involved parties. However, in doing

so, the trial court ignored the statutory framework that governs the interactions of patients, medical providers and health insurers, as well as the codification of narrow and specific exceptions to the Collateral Source Rule.

The definition of "payment" is not constrained solely to the actual remitting of cash but includes other means of discharging a debt or obligation. Both *contractual discounts* and *cash payments* are "payments" made on behalf of a plaintiff. (See *Goble v. Frohman* (2005) 901 So.2d 830.) (1 ACFA 35-41.) Synonyms for "payment" include cash, discharge, and indemnification. Roget's New Millennium Thesaurus, 1st Ed., Vol. 1.3.1 (Lexico Publishing Group, LLC, 2007).

That the health plans, in contracting with medical providers, give consideration in exchange for the reduced cash payment rates is not really subject to challenge:

> "In most commercial bargains there is a rough equivalence between the value promised and the value received as consideration. But the social functions of bargains include the provision of opportunity for free individual action and exercise of judgment and the fixing of values by private action...Those functions would be impaired by judicial review of the values so fixed. Ordinarily, therefore, courts do not inquire into the adequacy of consideration, particularly where one or both of the values exchanged are difficult to measure." Rest. 2d Contracts, § 71, comment c.

Where private health insurance provides coverage for medical services delivered to its members, the legal presumption of the contract between those entities is that the entire charge for a service has been satisfied through a combination of cash payment and other contractual consideration. (Civil Code § 1614 ["[a] written instrument is presumptive evidence of a consideration"].)

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There is no "free lunch" for health insurers or for their contracting medical providers. In negotiating and entering into contracts, both health insurers and medical providers bear costs in order to take the benefits of the contract. While cash payments made by health insurers are less than contracting medical providers' charges, under these negotiated contracts, medical providers also receive consideration in the form of non-cash benefits and services, as well as the cash payments.

Quite apart from the Collateral Source Rule, California law explicitly recognizes that contractual consideration is not limited to cash transactions:

> "Any benefit conferred, or agreed to be conferred, upon the promisor, by any other person, to which the promisor is not lawfully entitled, or any prejudice suffered, or agreed to be suffered, by such person, other than such as he is at the time of consent lawfully bound to suffer, as an inducement to the promisor, is a good consideration for a promise." (Civil Code § 1605 [defining good consideration].)

The most obvious benefit of the contract to a medical provider is the "preferred provider" listing (an endorsement and advertisement for the medical provider) and a status that guarantees a flow of patients who are members of that insurer's plan. In the absence of contracts with health insurers, medical providers would have to advertise and market themselves to attract patients, and would then have to manage the prospect of collecting payment for services rendered. This leads to another obvious benefit of the contract: substitute collection of timely payment. Rather than a medical provider having to collect payment from patients (which would also entail collection actions and loss of payment to bad debts), health insurers pre-collect payment through pooled premiums, and payments are made to providers under the terms defined by the contract. (3 AA 591-603.)

Operating a health insurance enterprise – advertising and marketing to obtain members, collecting premiums, tracking accounts, communicating with members and delivering services to both plan members and contracting medical providers – is not without expense. Quite apart from the cash payments health insurers make to medical providers when a plan member receives medical services, these other services health insurers perform for medical providers are the cost they bear to secure the contractual credits. All of the operations of a health insurer are funded by the premiums invested by plan members. It is the insureds' premium payments that ultimately secure the contractual credit benefits. (3 AA 591-603.)

The cost of the contract to medical providers is found in the contractual credit extended to plan members, variously described as "contractual allowance," "discount," "write-off," "adjustment," and the like. Those contractual credits are medical providers' payment to the health insurer for the benefits it bestows on the medical provider. Rather than: (a) having the patient pay all cash to the provider; (b) the insurer reimburse/ indemnify the plan member; and (c) the provider then remit money to the health plan, internalizing this exchange of benefits provides obvious convenience and savings, since it reduces the number of transactions involved, and thus saves time, effort, and expense. What remains after this payment in the form of a contractual credit is the negotiated "alternative rate of payment" – the cash-basis payments made by health insurers to medical providers. (*Brown v. Stewart* (1982) 129 Cal.App.3d 331, 346 [concurring opinion of Justice Blease][benefits provided by health insurers include "benefits secured

both directly as cash and indirectly as services"].) The term "alternative rates" is the label assigned in a number of Insurance Code, Health & Safety Code, and Business & Professions Code statutes governing medical providers and disability health insurers. (Ins. Code §§ 10123.12, 10133, 10133.2, 10133.3, 10133.5, 10133.55, 10133.65, 10180; Health & Safety Code §§ 1373.9, 1373.18; Bus. & Prof. Code § 16770.)

In California, the Legislature has codified a health insurer's obligation to push their plan members to contracting medical providers for health care. (Health & Safety Code § 1395.6(a) ["it is the intent of the Legislature that every arrangement that results in a payor paying a health care provider a reduced rate for health care services based on the health care provider's participation in a network...that the payor shall actively encourage beneficiaries to use the network"].) The statute encourages health plans to do so by imposing "financial penalties directly attributable to the nonuse of a provider panel." (Health & Safety Code § 1395.6(b)(2)(A).) Other statutes expressly permit health insurers to require plan members to only utilize contracting providers as a condition of receiving insurance benefits. (Ins. Code §§ 10123.12, 10133(c).)

California law actively encourages both patients and medical providers to pool resources and form negotiating groups to enter into such contractual arrangements. (Ins. Code § 10133.6; Health & Safety Code § 1342.6; Bus. & Prof. Code § 16770.) Although legislatively sanctioned, the use of contractual "alternative payment rates" and contractual credits under negotiated financial agreements has led to a common misperception that contracting medical providers are paid less than their full charges by health insurers.

While the cash payments from insurers to contracting medical providers are less than the provider's market rates, *the total consideration they receive under the contract equals those market rates.*

To appreciate that collateral indemnity benefits encompass both cash payments and contractual allowances, you need only reverse the ultimate beneficiary of the collateral source, and extend to a defendant an offset for a plaintiff's entire collateral benefit. That is precisely what was at issue in *Goble.* (See *Goble, supra,* 901 So.2d 8.) (1 ACFA 35-41.).

Florida's Negligence Damages Statute, Section 768.76, provides that:

> "In any action...in which damages are awarded to compensate the claimant for losses sustained, the court shall reduce the amount of such award by the total of all amounts which have been paid for the benefit of the claimant, or which are otherwise available to the claimant, from all collateral sources." (Florida Statutes Annotated § 768.76.) (1 ACFA 54-56).

The plaintiff in *Goble* argued that the jury award in his favor should have been reduced only by the cash payments from his health insurer, and not by the amounts "written off" or discounted by medical providers contracting with the plaintiff's health insurer. The court disagreed:

> "The definition of "payment" is not constrained solely to the actual remitting of cash but includes other means of discharging a debt or obligation...both contractual discounts and cash payments...are "payments made on behalf of the plaintiff"...the contractual discounts discharged Goble's obligation to his medical providers; therefore, the discounts are "payments made" on Goble's behalf and so are "collateral sources."" (*Goble, supra,* 901 So.2d at 832.) (1 ACFA 37.)

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The *Goble* discussion should not be regarded as hypothetical for California courts. By statute, California provides certain classes of defendants the opportunity for the same relief that the Florida statute discussed in *Goble* provides – an offset for plaintiff's entire collateral benefit. Pursuant to Civil Code § 3333.1, a defendant in a medical malpractice case that so elects cannot, consistent with statute, be precluded from introducing evidence that plaintiff's health insurer provided complete indemnity for their medical charges, and instead is limited to introducing only the cash payments into evidence. Simlarly, a public entity defendant's post-trial reduction for collateral benefits cannot be limited to cash payments by a plaintiff's health insurer any more than a public entity defendant could be precluded from discovery of both cash and non-cash collateral indemnity benefits. (Gov't. Code § 985(b).)

It is not that the trial court's decision is incorrect to have focused on what a plaintiff "paid" or "incurred." Rather, what is incorrect is: (a) to substitute the cash element of the contractual exchange between a health insurer and a medical provider for the legal detriment "actually incurred" by the patient; and (b) to pretend that medical providers quite literally have nothing to gain by entering into a contract with health insurers.

Under the law of contract, a patient "actually incurs" liability for the full charges of their medical providers. Under the collateral source doctrine, a plaintiff is entitled to the benefit of the bargain, which is indemnity against the full medical charges for which the plaintiff contractually incurred detriment due to defendant's conduct. To the extent

that plaintiff's health insurer fulfilled its indemnity obligations other than through cash payments, any such contractual adjustments, discounts, or write-offs, are elements of the contractual exchange of consideration between plaintiff's health insurer and plaintiff's medical providers, and "the discounts are payments made on [plaintiff's] behalf and so are 'collateral sources.'" (*Goble, supra,* 901 So.2d at 832.) (1 ACFA 37.)

To find otherwise, a court would have to find that there is no contractual consideration for a medical providers' contractual allowance/discount/write-off. Providing that evidence is a defendant's burden: "The burden of showing a want of consideration...lies with the party seeking to invalidate or avoid it." (Civil Code § 1615; see Rest. 2d Contracts, § 71, comment c. [stating "[o]dinarily, therefore, courts do not inquire into the adequacy of consideration, particularly where one or both of the values exchanged are difficult to measure"].) Because the *billed amount* for providing medial care (as opposed to the amount of cash payment) is the best measure of the *actual costs incurred*, there is no basis for abrogating the Collateral Source Rule by permitting evidence of, or recovery of, only the cash amount paid by an insurer for a plaintiff's medical care.

The trial court erred when it reduced the verdict by an amount that was paid by a collateral source.

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3. The Exceptions to the Collateral Source Rule are not Applicable in this Case.

This case involves private health insurance purchased by HOWELL to indemnify her from the costs incurred for medical care. There are no public benefits involved, such as Medi-Cal. As such, *Hanif* has no application.

This case also does not involve a defendant who is either a healthcare professional (bringing the case within the MICRA statutory farmework pursuant to Civil Code § 3333.1) or a government defendant (implicating Gov't. Code § 985). HMPI is a private entity defendant and the cause of action which recovery is based upon is negligent operation of a vehicle by an HMPI employee. As such, neither of these statutory exceptions to the Collateral Source Rule are applicable to this case.

C. The Trial Court's Ruling is Procedurally Incompatible with the Collateral Source Rule and Otherwise Unworkable.

1. Standard of Review.

With respect to HOWELL's appeal herein, the issue of statutory application to undisputed facts is again subject to independent review by this Court. (*Groth Bros. Oldsmobile, Inc. v. Gallagher* (2002) 97 Cal.App.4th 60, 65.) This is applicable to the trial court's ruling: (a) to hold a post-verdict hearing on HMPI's motion seeking to reduce to jury's verdict for past medical specials; and (b) to then sit as the trier of fact on disputed factual issues.

In deciding the disputed questions of fact, it is beyond dispute that the substantial evidence standard of review applies where an appealed ruling turns on the trial court's

determination of disputed factual issues. However, the substantial evidence rule is based on the assumption the trial court actually performed its function of weighing the evidence and, thus, actually resolved the factual dispute. If the record demonstrates otherwise – as where the judgment is based upon an erroneous legal ruling or mere speculation – then a reviewing court need not affirm merely because there was substantial evidence upon which the trial court might have ruled against the appellant. (*Estate of Larson* (1980) 106 Cal.App.3d 560, 567 [substantial evidence rule inapplicable because trial judge failed to weigh all relevant evidence and determine fact issues].)

2. The Trial Court Should Have Properly Denied HMPI's Motion on Procedural Grounds Because California Law Does Not Provide for a Post-Trial "*Hanif*" Reduction Hearing for Non-Public Entity Defendants.

The only authority for a 'post-verdict reduction hearing' concerning the role of collateral source payments in recovery of damage awards is Gov't. Code § 985, and that procedure is exclusively reserved to public entity defendants. (Gov't. Code § 985(b).) Section 985 provides:

> "[A]fter a verdict has been returned against a *public entity* that includes damages for which payment from a collateral source . . . the *defendant public entity* may . . . request a posttrial hearing for a reduction of the judgment against the HMPI public entity for collateral source payments." (Gov't. Code § 985(b) [emphasis added].)

Even in cases involving multiple defendants, Gov't. Code § 985 provides that *only* the public entity defendant is entitled to the benefit of that section.

Courts cannot presume that the Legislature engaged in an idle act or enacted a superfluous statutory provision. (*Wolski v. Fremont Investment & Loan* (2005) 127

Cal.App.4th 347, 352.) Both Civil Code § 3333.1 (MICRA) and Gov't. Code § 985 provide for discovery of collateral source investments and payments, and both provide a procedural framework for handling the information so obtained. Both statutes are narrowly tailored to a specific class of defendants – medical providers (Civil Code § 3333.1), and public entities (Gov't. Code § 985.) Both statutes make the premiums invested to obtain collateral indemnity coverage an offsetting factor in the consideration of collateral source payments. (Gov't. Code § 985(f)(3)(B); Civil Code § 3333.1(b).) Both statutes also provide for disposition of, or limitations upon, lien claims or reimbursement claims by collateral source providers. (Gov't. Code § 985(f); Civil Code § 3333.1(b).)

Gov't. Code § 985 constrains the degree to which any reduction ordered in a § 985 hearing may affect a plaintiff's net recovery (Gov't. Code § 985(g)), and counterbalances the public entity defendant's right to share in collateral source benefits by providing offsets to reductions. (Gov't. Code § 985(f)(3)(A) [offset for plaintiff's comparative fault]; Gov't. Code § 985(f)(3)(B) [offsets for premiums paid to obtain collateral source coverage]; Gov't. Code § 985(f)(3)(C) [offset to share pro rata in attorney fees and litigation expenses].)

Civil Code § 3333.1 provides that collateral source benefits and costs are admissible as evidence (and hence, discoverable), where they are subject to the discretion of the finders of fact. (*Hernandez v. California Hospital Medical Center* (2000) 78

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Cal.App.4th 498, 506 [stating Civil Code § 3333.1 "allows the jury to decide how to apply the evidence [of collateral source payments] in calculation of damages"].)

HMPI seeks much more than either of these statutes provide, rendering nugatory the Legislature's enactments concerning discovery of collateral benefits, and seeking to mandate a post-trial reduction without an offset for attorney's fees, litigation costs, or premiums invested by, or on behalf of, HOWELL.

In *Greer*, the appellate court expressly did not address the propriety of a *"Hanif/Nishihama"* motion because the defendant had failed to preserve the issue:

> "Here, in denying the motion in limine, the trial court informed defense counsel that, while a post-verdict reduction of the jury's award of medical expenses might be justified, defendant could not prevent the jury from hearing evidence regarding reasonable medical costs for plaintiff's care in the first instance. The court made it clear that if the jury rendered an award that was excessive under *Hanif/Nishihama,* it would consider a post-trial motion to reduce the recovery. [¶] The court's ruling was correct." (*Greer, supra,* 141 Cal.App.4th at 1157.)

When the court in *Greer* stated "[t]he court's ruling was correct," they were referring to the trial court's ruling on the motion in limine, in which the trial court denied defendant's motion to preclude the full charges from evidence, not the propriety of a post-verdict hearing: in the next section of the opinion, entitled "Postverdict *Hanif/Nishihama* Issues," the court states "[w]e need not address these claims [relating to post-verdict *Hanif/Nishihama* issues] individually, for we find they have all been forfeited by defendant's failure to request a verdict form containing a separate entry for plaintiff's past medical expenses." (*Greer, supra,* 141 Cal.App.4th at 1158.)

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Providing a "*Hanif/Nishihama* reduction" for non-public entity defendants, or even granting a non-public entity defendant discovery of collateral source providers and collateral benefits received by a plaintiff (outside of medical malpractice cases), would render the provisions of Gov't. Code § 985 and portions of Civil Code § 3333.1 superfluous and unnecessary. It is "the fundamental rule of statutory construction that particular provisions or phrases should be interpreted so as not to render them superfluous or unnecessary." (*People v. Tanner* (2005) 129 Cal.App.4th 223, 236.)

3. The Trial Court Improperly Acted as Trier of Fact on the Question of What Was Paid, Invading the Provence of the Jury.

The issue of what was paid to satisfy the charges incurred by HOWELL to her past healthcare providers is a question of fact. Questions of fact are ordinarily reserved for resolution by the jury. (Code Civ. Proc. § 592.) At no time did HOWELL waive her right to have all questions of fact determined by the jury. At no time did HOWELL agree or stipulate that the trial court could act as trier of fact in determining how much was "paid" by HOWELL's private collateral health insurer to satisfy the charges she incurred for past medical care. (See Code Civ. Proc. § 631 [no waiver of right to jury trial on factual issue].)

While ruling on HMPI's motion in limine to limit what evidence HOWELL could put before the jury concerning the past medical bills, the trial court did indicate that it would "handle that [issue] at [a] post-trial *Hanif* motion." (1 RT 68:27-69:6, 67:2-5, 67:13-16.) This was directed at the substantive legal issue of whether the reduction sought was called for under California law. The trial court's ruling did not make any

determination or ruling to limit or restrict what evidence HMPI might seek to elicit or introduce on the issue during the course of the trial. If HMPI believed such a finding of fact was relevant to any post-trial motion it intended on bringing, it had the clear opportunity to seek to admit such evidence during the trial and get a determination of the factual issue from the jury. The trial court erred in invading the province of the jury and acting as trier of fact on the issue of what was "paid."

While clearly acting as the trier of fact on the disputed issue of what was "paid" to satisfy the medical charges incurred by HOWELL, the trial court's minute order granting HMPI's post-trial motion states only that the motion is granted. (2 AA 553.) No finding of fact or dollar amount is stated in the minute order, nor is any calculation set forth as to how much the jury's verdict for past medical damages is the reduced by or what the final judgment figure should be. No ruling was ever issued on HMPI's Motion to Set Aside and Vacate the Judgment (1 AA 263-338), and the orignal judgment was never amended or revised.

4. The Trial Court Should Have Properly Denied HMPI's Motion on Evidentiary Grounds Because There Is No Evidence in the Trial Record of What Was Paid to Satisfy the Medical Charges Incurred by HOWELL and No Finding of Fact upon Which Any Post-Verdict Reduction Could Be Based.

HMPI's motion is, at heart, an effort to mitigate HOWELL's damages. As such, HMPI had the burden of proof in producing competent, admissible evidence concerning any payments. (*Fontaine v. National R.R. Passenger Corp.* (1997) 54 Cal.App.4th 1519,

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1530; *Conrad v. Ball Corp.* (1994) 24 Cal.App.4th 439, 444; *Hanif, supra,* 200 Cal.App.3d at 643; Evid. Code § 500.)

The only evidence offered or admitted during the course of the trial was that $189,978.63 was the reasonable cost/value of the past medical expenses incurred by HOWELL and the jury awarded the same amount. HMPI did not present or seek to admit any evidence at trial concerning any payments of any kind to any healthcare provider and sought no factual finding from the jury as to what was "paid," if anything, to HOWELL's healthcare providers to satisfy the debts for medical care incurred by HOWELL. Indeed, no documentary evidence or witnesses were listed on HMPI's Trial Readiness Conference Report or the Joint Trial Exhibit/Witness Lists to address the issue. (1 AA 53-63.)

Similarly, HMPI never brought the issue of what was "paid" to the jury for the jury to make that factual determination. HMPI agreed to the Special Verdict Form that did not ask the jury to make a finding of fact on the issue. (4 RT 214:3-16.) Without authenticated and admissible evidence and a finding of fact as to what was "paid," the trial court had no dollar amount upon which it could base any proposed reduction.

In *Greer*, the trial judge faced an analogous situation when the jury awarded a single amount of special damages without itemizing how much was awarded for past medical expenses. This left the court with no finding of fact on the figure necessary to start the calculation. The defendant there had also failed to put into evidence the amount if claimed was "paid." (*Greer, supra,* 141 Cal.App.4th at 1154-60.) The defendant's

motion was denied and the decision upheld on appeal. (*Ibid.*) The court never reached the legal issue of whether any reduction was proper procedurally or substantively. (*Id.* at 1158-1159.)

While the special verdict in this case did specifically list the amount awarded for past medical expenses, the lack of any evidence and/or finding of fact as to what was "paid" made undertaking any calculation of any alleged reduction impossible. Like in *Greer*, the issue was moot without the trial court reaching the substantive legal issue of whether a reduction is proper.

5. The Trial Court Erred in Considering the Declarations Submitted by HMPI in Making a Factual Determination as to What Was Paid to Satisfy the Charges Incurred by HOWELL for Past Medical Care.

HMPI's post-trial motion included two declarations which HMPI claimed evidenced the amount of payments received and accepted by two of HOWELL's healthcare providers, Scripps Memorial Encinitas and CORE (Dr. Peppers' office). (1 AA 132-137.) From these, HMPI invited the trial court to conclude that the jury's verdict of $189,978.63 should be reduced by $130,286.90 to $59,691.73.[4] The trial court should not have considered these declarations for several reasons:

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[4]HMPI's requested past medical specials amount ($59,537.78) was determined by using an inaccurate figure for total past medical expenses ($189,824.68). (1 AA 127:1-4.) The correct figure for total past medical expenses is $189,978.63, as was stipulated to by the parties (and previously set forth herein). When using the correct amount for total past medical expenses is used, the amount HMPI should have presented to the trial court, post-reduction, is $59,691.73.

(a) The declarations are out of court statements offered to the truth stated and, as such, are hearsay without exception;

(b) Neither Mr. Burris nor Ms. Engstrom, nor their declarations, were identified in HMPI's discovery responses as potential witnesses/exhibits, nor listed on their Trial Witnesses List/Trial Joint Exhibit List, in violation of the Trial Readiness Conference Order for Department No. 31 (1 AA 64-71), and San Diego County Local Rule 2.1.15 & Appendix B thereto;

(c) The declarations and the attachments lack foundation; and

(d) The declarations state impermissible expert opinion from witnesses not identified or designated as expert witnesses.

HOWELL made clear to the trial court from the outset that she disputed both the factual statements and conclusions set forth in the declarations. Evidentary objections were filed and served to these declarations. (3 AA 604-607.)

The trial court should not have considered these delcarations. Absent these declarations, there was no evidence before the trial court of any other amount paid or incured by HOWELL to her healthcare providers, other than the $189,978.63 awarded by the jury.

6. The Trial Court Erred in Not Allowing HOWELL an Opportunity to Confront and Rebut Evidence on the Issue of What Was Paid to Satisfy the Charges Incurred by Her for Past Medical Care.

HOWELL made very clear to the trial court that she disputed the facts and conclusions set forth in the declarations of Mr. Burris and Ms. Engstrom as to what was

paid by HOWELL's private collateral healthcare insurer and/or accepted by the healthcare providers to satisfy the charges incurred by her for past medical care. The trial court directed that HOWELL hold these issues/objections, pending the court's determination of the substantive law issue. (5 RT 249:17-250:14.) The trial court acknowledged that these issues had not been briefed or argued as part of the hearing on the substantive law, yet the trial court issued its final ruling in the matter prior to permitting HOWELL an opportunity to state objections to the declarations, confront the declarants or present evidence to rebut the evidence presented by HMPI.

7. Had HOWELL Been Permitted, She Would Have Presented Undisputed Evidence that the Value Paid by Her Private Health Insurer to Her Healthcare Providers Equals the Full Amount Billed.

The declarations submitted by HMPI seek to evidence the cash payments received by Scripps and CORE and claim that the balance between the cash received and the total charges incurred had been "written off." However, HMPI's position is factually false. While it is true that the direct cash payments made by collateral insurers to the healthcare providers that are credited against a specific patient's account are often less than the total billed charges, as set forth above, *these cash payments constitute only part of the consideration being paid* as part of a contractual or statutory relationship between collateral insurers and the healthcare providers. Neither healthcare provider's nor private health insurers deny that more than just cash payments are negotiated for and accepted by the providers as considerthatation to discharging the debts incurred by the patient/insured. The phrase "written-off" as used in health providers' accounting

statements simply does not mean that the provider has not been fully paid for the full value of the charges incurred.

HOWELL was prepared to cross-examine any witness HMPI offered on the issue of what was paid/exchanged by the healthcare providers and HOWELL's collateral private insurer. HOWELL sought to conduct discovery prior to the hearing so that the actual contracts evidencing the relationships between the parties could be obtained. HOWELL's request for discovery was denied. (5 RT 249:25-28.)

HOWELL was prepared to present testimony evidencing the relationship between the healthcare providers and private health insurer from Mr. Lawrence Lievense. Mr. Lievense is a hospital industry professional with many years of experience negotiating and administrating contracts between healthcare insurers and hospitals/providers. Mr. Lievense could and would have testified in person that, indeed, the healthcare providers received value for their full charges through both cash and 'in-kind' payments as part of negotiated contracts between the parties. (3 AA 591-603.)

Mr. Lievense's proffered testimony concerning the relationship between the healthcare providers and HOWELL's private health insurer is not subject to dispute. A trier of fact, be it a jury or the court, hearing evidence on the issue of what was paid by HOWELL's health insurer to the healthcare providers to satisfy the debts incurred for past medical expenses, would find support for only one conclusion: *the total value of the consideration paid by the insurer to the providers is the full value of the charges incurred.* In other words, the amount paid is the same as the amount awarded by the jury

as the reasonable cost/value. With such a factual finding, there would be no need for the court to go further to reach the underlying legal issue of whether the reduction sought by HMPI is required by California law.

8. Without All Evidence on the Contracts Between HOWELL, Her Healthcare Providers and Her Private Health Insurer, the Trial Court Cannot Determine What Was Paid or Remains Owed.

Absent the trial court having before it the documents reflecting the contractual relationship between the healthcare providers and the private health insurer, there is no way to determine what consideration the insurer agreed to convey, and what the healthcare providers agreed to accept, in exchange for satisfying the charges incurred by HOWELL.

The terms of these contracts could also directly impact HOWELL's personal financial responsibility to the healthcare providers. For instance, did Scripps or CORE bargain with HOWELL's perosnal health insurer (PacifiCare) for the right to seek further cash payments directly from HOWELL above and beyond those paid by PacfiCare (commonly referred to as 'balance billing')? In *Parnell*, the Supreme Court addressed whether such a practice was permissible through a hospital's assertion of a Civil Code § 3045 hospital lien (also known as the 'Hospital Lien Act'). The *Parnell* court held that the hospital could not assert a lien because it had contracted with the private health insurer to fully resolve the charges incurred by the plaintiff in return for bargained-for consideration paid by the private health insurer. (*Parnell, supra,* 35 Cal.4th at 619.) However, the *Parnell* court stated that had the hospital bargained with the private health

insurer for the right to seek further payments direct from the patient (*i.e.* 'balance the bill'), that this practice might well be permissible. (*Id.* at 611.)

The record is also unclear as to what amounts, if any, of the charges incurred by HOWELL to Scripps and/or CORE remain outstanding, for which these providers may seek direct payment from HOWELL. As to CORE, HOWELL continues to receive billing statements from CORE reflecting a balance due and a written lien exists obligating HOWELL to satisfy all charges incurred. (3 AA 571-578).

The importance of having evidence of the contractual relationships between and amongst HOWELL, her private health insurer and her healthcare providers, was noted by Justice Fybel in his concurring opinion in *Olsen*:

> "Our record contains no proof that plaintiff is protected from being charged additional amounts for any of those services by the provider or by the health plan (beyond an agreed-upon deductible or copayment). Unlike *Nishihama*, plaintiff in this case has not acknowledged that the provider has accepted payment in full. Indeed, in its motion to request the reduction of the jury verdict, defendant in this case stated: "However, plaintiff's billing records reflect that at least $57,394.24 were written off by her medical provider; have not been paid; and are not *currently* owed by any person or entity." (Italics added.) This equivocal statement raises insurmountable questions as to the amount of plaintiff's liability. The judgment could not be affirmed on the basis of this statement of "current" liability by defendant alone. Furthermore, we do not know if the provider in this case was in "network" or not, or was a "preferred provider" or not. Thus, we do not know whether the provider asserts so-called "balance billing" to recover money from plaintiff (i.e., the claimed additional amount due if a patient is treated by an "out of network" provider under certain circumstances).
>
> Nor is there any statement by the health plan that plaintiff has no further obligation to the plan itself. We do not know if the health plan will charge plaintiff for using an out-of-network provider or for other charges under the plan documents.

> For all of these reasons, the trial and appellate records are woefully inadequate and we could not affirm this judgment even if we followed *Nishihama*." (*Olsen, supra,* 164 Cal.App.4th at 216-218 [concurring opinion of Justice Fybel].)

HOWELL sought to conduct discovery to ensure that evidence of these relationships was before the trial court at the time the court considered HMPI's post-trial motion to reduce the verdict. However, the trial court denied the request to conduct such discovery or place evidence concerning the relevant relationships into the record.

This case is postured very much like *Olsen*, with the record failing to include sufficient evidence to support the reduction granted by the trial court. The same result in *Olsen* should follow here: reversal of the trial court's ruling on HMPI's post-verdict motion and remand with instructions to reinstate the jury's verdict for past medical specials and to enter judgment accordingly.

VI.

CONCLUSION

Whenever the California Legislature has enacted a statutory exception to the Collateral Source Rule, it: (a) has done so narrowly for strong public policy purposes; (b) has done so only for a discrete class of defendants; and (c) has counterbalanced the exception by accounting for a plaintiff's costs in investing/securing the collateral source.

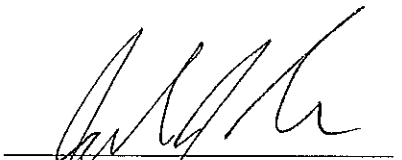
Providing HMPI, a non-public entity, with a procedure for reducing their liability to an amount less than the actual detriment caused by their tort, based on the involvement of a bargained-for and paid-for benefit of HOWELL's private collateral health insurance investment, would render Gov't. Code § 985 a nullity and would give HMPI the benefit

of a bargain without requiring them to share in the burden which HOWELL and her health insurers bore to obtain that benefit.

Accordingly, HOWELL respectfully requests that this Court reverse the trial court's ruling on HMPI's post-verdict motion and remand with instructions to reinstate the jury's verdict for past medical specials and to enter judgment accordingly.

Dated: February 18, 2009

Respectfully submitted,

By: 

John J. Rice
Attorney for Appellant/Plaintiff
REBECCA HOWELL

CERTIFICATE OF COMPLIANCE PURSUANT TO THE

CALIFORNIA RULES OF COURT, RULE 8.204(c)

Pursuant to the California Rule of Court, Rule 8.204(c), I certify that the foregoing brief is proportionally spaced, has a typeface of 13 points, is double-line spaced, and based upon the word count feature contained in the word processing program used to produce that brief (WordPerfect ver.12), contains 13696 words.

Date: February 18, 2009

John J. Rice

Rebecca Howell v. Hamilton Meats & Provisions, Inc., et al.
Court of Appeal of the State of California, Fourth Appellate District,
Division One, Case No.: D053620
SDSC Case Nos: GIN053925

PROOF OF SERVICE

STATE OF CALIFORNIA, COUNTY OF SAN DIEGO

I, Paul C. Berner, am employed in the County of San Diego, State of California. I am over the age of 18 and not a party to the within action; my business address is 2333 First Avenue, Suite 201, San Diego, California, 92101. On February 18, 2009, I served the foregoing document(s) described as:

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APPELLANT'S APPENDIX (VOLS. I, II & III)
APPELLANT'S COMPENDIUM OF FOREIGN AUTHRITIES

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

Executed on February 18, 2009, at San Diego, California.

Paul C. Berner