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CALIFORNIA LAW UPDATE

By Michael Amaro

CAN A PLAINTIFF IN A PERSONAL INJURY LAWSUIT RECOVER MEDICAL BILLS THAT ARE "WRITTEN OFF" BY AN INSURANCE COMPANY?

One of the "hot" issues in "The People's Republic of California", is whether a plaintiff, in a personal injury lawsuit, may recover 100% of the medical bills charged, or whether such plaintiff is limited to a recovery of what a private insurance company has paid? Put another way, is a defendant in such a lawsuit entitled to an "offset" for any insurance adjustments or write-offs made by the private insurer?

The various courts in California have struggled with the issue over the past few years, and there are several different, and contradictory opinions, authored by the various courts of appeal in the state. The issue is currently being reviewed by California's Supreme Court, and we hope to get some clarification in the year to come. However, this update will provide a brief synopsis of the cases, and issues arising therefrom, and hopefully yield some suggestions of how to navigate the turbulent judicial seas in personal injury litigation in order to preserve the issue for later appellate review.

To fully understand the issues, the recent case of *Howell v Hamilton Meats Provisions, Inc.* (2009) 179 Cal. App. 4th 686 (which is the matter which is under review by our Supreme Court), presents a straightforward scenario as to why the issue is important. In such case, the plaintiff was injured in an automobile accident, and incurred $190,000 in past medical expenses. The plaintiff had private medical insurance, and such insurer paid $60,000 to the medical providers. The medical providers had contracts with the medical insurer, and agreed to "write off" the balance, pursuant to pre-determined rates that were considered "customary and reasonable". Hence, the issue was whether the plaintiff is entitled to $190,000 in medical economic damages, or rather, was limited to a recovery of $60,000 for the same? Obviously, the difference here, as in many cases, is significant.

The *Howell* case, comes out of San Diego, and was decided by California's Fourth Appellate District (there are six appellate districts in the State). The defendant in that matter, had received records from plaintiff's insurer, as to what amounts were billed on the one hand, and ultimately written off, on the other. Hence, defense counsel filed a pre-trial motion in limine seeking to exclude at trial any evidence of, or reference to the portions of the bills that were not paid by the insurance company, and which the plaintiff was not obligated to pay in the future. Plaintiff counsel opposed the motion, arguing that under the "collateral source rule" articulated in the Supreme Court case of *Helfend v Southern California Rapid Transit Dist.* (1970) 2 Cal.3d 1, the gross amount of the medical bills, and not the lesser amount, should be presented to the jury.

The trial court relied upon a 2006 case out of the Fourth Appellate District (Division 1 – San Diego), *Greer v Buzgheia* (2006) 141 Cal. App. 4th 1150, and allowed plaintiff to present the original bills to the jury, but decided to allow the "reduction" in the medical damages "post-verdict", ie- after the jury rendered its verdict. Thus, although plaintiff presented evidence of $190,000 in medical bills at trial, there was a post-verdict reduction by the judge of $130,000. The defendant, during trial, did not seek to offer any evidence of the reduction in bills, on the issue of "reasonableness" of the medical specials.

Plaintiff appealed, arguing that the reduction violated the long-standing "collateral source" rule in California, adopted in *Helfend v Southern Cal. Rapid Transit Dist.* (1970) 2 Cal.3d 1 and *Lund v San Joaquin Valley Railroad* (2003) 31 Cal4th 1. The *Helfend* court explained: "if an injured party receives some compensation for his injuries from a source wholly independent of the tortfeasor, such payment should not be deducted from the damages which the plaintiff would otherwise collect from the tortfeasor." *Id.* at 6. The court also added that the collateral source rule "embodied the venerable concept that a person who has invested years of insurance premiums to assure his medical care should receive the benefits of this thrift. The tortfeasor should not garner the benefits of his victim's providence." *Id.* at 9 – 10.

The *Howell* appellate court overturned the trial court's reduction of medical bills from $190,000 to $60,000, and ordered that the full amount of the jury's verdict be reinstated. The Supreme Court granted review, and a number of legal groups, on both sides of the bar, are expected to file amicus briefs (Consumer Attorneys of California; Association of Southern California Defense Counsel; Association of California Insurance Companies and Personal Insurance Federation).

Another case decided this week, *King v Willmett*, (August 9, 2010)(Third Appellate District – Sacramento), agreed with the *Howell* court, holding that the collateral source rule precluded a post-verdict reduction of the bills from $169,000 to $76,000, the latter amount which

was accepted by the injured party's medical insurer. The *King* court referenced two specific California statutes, where the legislature specifically abrograted the collateral source rule. Such statutes involve medical malpractice actions (*Civil Code* Section 3333.1), and cases against public entities (*Code of Civil Procedure Section* 659 and 985). Under both of these statutes, the injured party cannot get a "double recovery" where collateral source benefits are received from private medical insurers.

As such, both the Third and Fourth Appellate Districts now hold that based upon the California Supreme Court's rule in *Helfend*, the collateral source rule should not be abrogated by a judicial exception. Rather, the courts are leaving the matter for the legislature to decide whether the collateral source rule should be abrogated in all personal injury litigation.

The dissenting judge in *King*, however, made some rather astute comments. Justice Hull referenced the California statutes, defining the damages that are recoverable in personal injury actions. *Civil Code* Section 3281 provides: "Every person who suffers detriment from the unlawful act or omission of another, may recover from the person in fault a compensation therefor in money, which is called damages." The term "detriment" is statutorily defined as "a loss or harm suffered in person or property." *Civil Code* Section 3282. Finally, *Civil Code* Section 3359, provides "damages must, in all cases, be reasonable."

Justice Hull noted: "I have difficulty finding detriment, that is, a loss or harm suffered by plaintiff, arising from bills he did not have to pay. While some courts have found detriment in the mere fact of the original billing and a plaintiff's initial obligation to pay the bills for medical services, this detriment is, at best, evanescent under these circumstances, one soon to be extinguished by the formulas and agreements between the health care providers and the health insurance carrier."

Another recent case on the issue comes out of the First Appellate District (San Francisco Bay area), *Yanez v Soma Environmental* (2010 DJDAR 9720). In such case, the trial judge reduced the medical bills from $44,000 to $18,000 after the verdict, but before the judgment was prepared. Plaintiff appealed since the reduction had a significant impact on whether or not plaintiff was the prevailing party, based upon the offer of judgment (CCP 998) offer that was served by defendant prior to trial.

The *Yanez* court ruled first recognized the rule in the case of *Hanif v Housing Authority* (1988) 200 Cal. App. 3d 635, that where Medi-Cal benefits are made, a post-verdict reduction by

the judge **is** appropriate.[1] A Medi-Cal recipient does not pay premiums for insurance, and hence the collateral source rule does not come into play. However, where *private health insurance* is involved, the First District ruled that it was error for the judge to reduce the medical bills post-verdict based upon the collateral source rule.

What is interesting though, is that the *Yanez* Court seemed to create a new opening in the door, suggesting that a jury may be allowed to hear evidence about the medical bill reduction, on the issue of "reasonableness" of the medical billing. The Court noted:

> "It is also true the jury did not hear evidence of the sharply discounted amounts Aetna and Healthnet actually paid to the providers. Jurors might not have found $44,519.01 to be a reasonable damage award for past medical expenses if they had been informed that Yanez's health care providers had accepted $18,368.24 as full payment for thier services. It could be argued that, in fairness, the jury as fact finder should have heard evidence of both the billed and discounted amounts since both are relevant to determining the reasonable value of the services involved. But that issue is beyond the scope of this appeal."

WHAT SHOULD BE DONE ON A GOING FORWARD BASIS?

A few lessons can be learned from the host of cases on the issue.

1) First, where a plaintiff's medical bills are paid by Medi-Cal, the *Hanif* case should control, and the collateral source rule should *not* apply. In such a case, a defendant should be entitled to an offset for any medical bills that have been reduced by Medi-Cal.

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[1] The *Yanez* court also discussed an earlier case decided by the First Appellate District in 2001, called *Nishihama v City and County of San Francisco* (2001) 93 Cal. App. 4th 298. Such case involved a plaintiff that tripped and fell in a pothole in a crosswalk, and her medical bills were paid by her private insurance, Blue Cross. During the course of her medical treatment, Blue Cross paid a lesser amount to the medical providers, than the provider's "normal" rates. The medical provider, however, pursuant to The Hospital Lien Act (*Civil Code* Section 3045.1 et. seq.), filed a "lien" against plaintiff for the difference between the Blue Cross payments received, and the provider's normal rate. The appellate court was primarily focused on the validity of the lien claim, and found that the medical provider's lien right did not extend beyond the amount it agreed to receive from Blue Cross as payment in full. In dicta though, the court did state that the plaintiff was limited to a recovery of the medical bills *actually paid*, and not those that were billed. The defense counsel in *Nishihama* did not invoke Civil Code 659 and 985, which allowed for a reduction of medical bills that were actually paid, since the defendant was a public entity. Some of the cases that have been decided in the past two months have distinguished the *Nishihama* case, on the fact that there already exists a specific statute that abrogates the collateral source rule where public entities are involved.

2) Where a plaintiff has private insurance, defense counsel should be prepared to argue that the jury should be allowed to consider the amount of medical bills that have been billed, as well as the amount that was actually paid, on the issue of "reasonableness" of damages. A defense medical expert can also discuss the reasonableness of the original billing, as well as the amount that was actually paid.

3) Subpoena a representative from the medical insurance company, to testify at trial, as to why the medical bills have been reduced, and all that went into evaluations as to what fees are customary and reasonable in the geographic region where the treatment was rendered.

4) Prepare a trial brief for the court before the trial, addressing the issue, and specifically request the right to offer the evidence of the reduced medical billing. Make sure that an adequate record is made for a later appeal, noting several times that the trial judge is precluding the evidence from being offered. If the trial judge opines that evidence of private insurance is prejudicial, offer a limiting jury instruction that would obviate any purported prejudice.

5) Don't be afraid to argue the obvious in any legal brief, or in oral argument. Let's face it, many doctors who see plaintiffs on a lien basis, will artificially inflate their billing, knowing full well that the plaintiff attorney is going to attempt to get the doctor to reduce the billing later on down the road. Similarly, HMO's, such as Kaiser, who do not generate billing to its insured members, will also charge artificially high bills, since they know that the plaintiff attorneys will try to reduce any future lien claim, when the HMO retains a third-party collection group to collect the monies.

6) Lastly, a tip for claims handlers. During settlement negotiations, it should be argued that if and when the case is litigated, the jury will be allowed to hear that the medical bills have been reduced. As such, the medical bills that have actually been paid can be used as a settlement tool.

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