IN THE

SUPREME COURT OF CALIFORNIA

REBECCA HOWELL,
Plaintiff and Appellant,

v.

HAMILTON MEATS & PROVISIONS, INC.,
Defendant and Respondent.

After a Decision By The Court of Appeal
Fourth Appellate District, Division One
Case No. D053620
(San Diego County Superior Court Case No. GIN053925)

REPLY TO ANSWER TO PETITION FOR REVIEW

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I.

INTRODUCTION

The *Howell* decision flat-out disagrees with and creates a conflict with established rules in *Nishihama v. City and County of San Francisco* (2001) 93 Cal.App.4th 298.) ("*Nishishama*") and *Greer v. Buzgheia* (2006) 141 Cal.App.4th 1150. Discussing *Nishihama,* the *Howell* court stated:

> We disagree with this holding in *Nishihama* and the the reasoning upon which it is based."
> (*Howell* opinion, p. 24.)

Turning to *Greer,* the *Howell* court wrote:

> We disagree with *Greer* to the extent it holds that a trial court in a personal injury action is authorized to hear and grant defendant's posttrial motion to reduce under *Hanif* and *Nishihama* with a privately insured plaintiff's recovery of economic damages for past medical expenses.
> (*Howell* opinion, p. 29.)

This direct conflict alone warrants review under California Rules of Court, rule 8.500(b)(1). It also conflicts with the 22 year-old case that started this all, *Hanif v. Housing Authority* (1988) 200 Cal.App.3d 635. *Hanif* clearly established a plaintiff may *not* recover an award of damages for past medical expenses in excess of what the medical care and services actually cost. *Id.* at 640-641. This Court approved the principles of *Hanif* in *Olszewski v. Scripps Health* (2003) 30 Cal.4th 595, 611-612, fn. 16. However, the application to privately insured patients was left open in *Olszewski.*

Appellant's attempt to argue these are not unresolved issues of law is ludicrous and contrary to all self-promoted press they have generated on the decision. Simply put, today there are trial courts holding post-trial *Hanif* motions and there are courts in other parts of the state which are not. There is clearly a conflict of law.

Also in a departure from established case law on the issue, *Howell* radically transformed the collateral source rule from one which bars offsets against plaintiffs' recoveries for amounts actually paid, to one which plaintiffs may recover damages for hypothetical bills that have never been paid, pursued, or collected by anyone. The collateral source rule has never been so construed in California.

The remaining question of how the issues should be handled *procedurally* remains open. *Greer* placed the burden on the defendant to distinguish "usual and customary charges" from the *actual* medical payments in a post-trial hearing. In contrast, *Howell* holds no statutory framework exists for a defendant to do so. These and other examples reflect the need for review of *Howell* to set the record straight on this issue substantively and procedurally, once and for all.

II.

DISCUSSION

A. THE PETITION SHOULD BE GRANTED DUE TO THE CONFLICT IN LAW ON THE OVERRIDING ISSUE

The virtual medical expenses which exceed the amount paid by Howell's healthcare insurer in full satisfaction of the debt are not owed by anyone. They are nothing more than hypothetical and imaginary in the calculation of damages allegedly incurred by a plaintiff. The healthcare providers seek payment from *no one* for such amounts. They were extinguished and satisfied in full pursuant to an agreed upon payment from Howell's healthcare insurer. Howell is not subject to collection for the amounts.

Unable to avoid this truth, Howell cites various California cases in an attempt to show the alleged "customary" charges of her healthcare providers really were incurred by her and therefore should be payable by Hamilton. (See, *Reply,* pp. 5-7.) The cases do not support this argument, as they discuss the concept in circumstances far different than presented here. More importantly, the cases relied upon by Howell do not affect the holdings in *Hanif, Nishihama* and other cases with which the *Howell* appellate decision collides. Therefore, this case remains ripe for review by this Court.

1. The Medical Lien Cases Cited by Howell Are Narrowly Focused and Inapplicable to the Petition Issue

The overriding reason why the petition should be granted are the issues raised in the *Howell* decision and its direct conflict with *Hanif, Nishihama* and related authorities excluding recovery for alleged medical expenses that are neither collected nor pursued by medical providers. In response, Howell cites several hospital lien claim and insurance policy interpretation cases to argue no review of *Howell* is necessary. The cases are irrelevant to the point.

For example, in *Parnell v. Adventist Health System/West* (2005) 35 Cal.4th 595 this Court ruled hospitals cannot assert liens under the Hospital Lien Act ("HLA") when no underlying debt is owed by the patient to the hospital. In *Parnell,* the plaintiff's private healthcare insurer reimbursed the hospital that treated plaintiff for his personal injuries an amount specified in the provider agreement. *Id.* at 599. The paid amount was accepted as "payment in full." *Id.* At that point, all debt owed by the plaintiff to the hospital was extinguished. Thus, an HLA lien was no longer viable: "[A]bsent an underlying debt, the hospital may not recover on the lien even assuming that the recovery comes from the tortfeasor." *Id. at 608.*

This does not conflict with *Hanif* and *Nishihama. Nishihama* is consistent in requiring that a collectible lien under the "Hospital Lien Act" be supported by an underlying debt by the patient. *See, Nishihama,* 93

Cal.App.4th 298, 307 and *Parnell,* 35 Cal.4th 595, 609. Similarly, a claim by Howell for recovery of medical expenses must be supported by an underlying debt by Howell to the healthcare provider. *Nishihama, supra,* 93 Cal.App.4th 298, 309. Hamilton never argued Howell was not in a debtor-creditor relationship with her healthcare providers for the *ultimate* amounts that would be accepted by the providers as payment in full for the medical services provided. Of course Howell was indebted for such amounts and incurred same. Those amounts, paid by Howell's insurer, were reimbursed and paid by Hamilton as part of the judgment. By doing so, Hamilton complied with the Collateral Source Rule as then composed in California.

It is the excess, virtual amounts above that which were collected or pursued that Howell, like the healthcare provider in *Parnell,* cannot recover from a third party tortfeasor. *Parnell, supra*, at 607-608. The leap by Howell that she "incurred the entire charges for past medical care" is groundless, for no remaining debt (or "detriment") exists for any amount. *Civil Code* §3281.

City and County of San Francisco v. Sweet (1995) 12 Cal.4th 105 is equally unavailing to Howell's position. The issue in *Sweet* was whether a county's lien for recovery of costs of medical care was subject to equitable reduction for a portion of the *attorney fees* incurred by the injured plaintiff in recovering damages from the third party tortfeasor. *Id.* at 108. The injured party in *Sweet* was unable to pay his medical bills, but obtained a sizable recovery from the third party tortfeasor. In ruling the county's lien was not

subject to reduction for attorney's fees, this Court noted the "creditor's right to payment is not contingent on litigation which creates a fund." *Id.* at 117. Thus, each party was to bear their own litigation costs and attorney fees.

Sweet did not involve private health insurers, reductions or credits for amounts paid by insurers (i.e., collateral sources), or a plaintiff seeking to recover imaginary damages for amounts above and beyond what his or her medical providers accepted as payment in full. *Sweet* only determined that a lien asserted under *Gov. Code* §23004.1 may not be reduced by a portion of the attorney's fees incurred by the injured party in recovering damages from the person responsible for the injury. That is not the issue here. *Sweet* has no relevance to this case, or petition for review.

Lindsey v. County of Los Angeles (1980) 109 Cal.App.3d 933 also focuses on the common fund/attorney's fees issue in liens and therefore is inapplicable here for the same reason. *See, Sweet, supra,* 12 Cal.4th at 114-116 ("The relevant facts of *Lindsey* are identical to those presented here... We conclude that the *Lindsey* court correctly distinguished actions to recover damages from the common fund/benefit decisions.").

The mere existence of a "creditor-debtor relationship" is not determinative. The existence of such relationship was the basis for Hamilton's payment of the amounts paid to Howell's medical providers, despite the fact her health insurer covered the bills. In other words, what is actually owed and incurred in the relationship between patient/plaintiff and his or her medical

providers, the "sum certain" ultimately accepted as payment in full for the services, is what defines the recovery by the plaintiff. *Nishihama, supra,* 93 Cal.App.4th 298, 306.

2. The Other Cases Cited by Howell Are Not Instructive On the Petition Issues

The additional laundry list of cases included by Howell in her Answer similarly have no effect on the issue presented here. For example, *Reichle v. Hazie* (1937) 22 Cal.App.2d 543 merely held gratuitous medical service provided by a county hospital to an indigent patient did not preclude the patient/plaintiff from recovering the "reasonable value" of the medical services from the third party tortfeasor. *Id.* at 547. The conclusion was found on the premise the law would "imply an agreement … [by the patient] to pay the reasonable value" of the services" in the absence of an express contract to pay for the care and treatment. *Id.* at 547. The holding merely affirms reimbursement by the tortfeasor for such non-modified amounts is proper. Indeed, *Hanif* held the same when it ruled the "home attendant" care provided by the plaintiff's parents were subject to reimbursement by the defendant for the prevailing hourly rate. *Hanif, supra,* 200 Cal.App.3d 635, 645-646, *Reichle* has nothing to do with recovery by the plaintiff of an amount *greater* than what was accepted by the hospital in full and final settlement of the account.

The case of *Appleman v. National-Ben Franklin Ins. Co. of Illinois* (1978) 84 Cal.App.3d 1012 misses the mark completely, as it merely interprets a clause in a health insurance policy to determine if the carrier was required to pay for cancer surgery where Medicare satisfied the bill. No third party tortfeasor was involved. The insurance policy precluded indemnity for any medical expenses the insured was "not required to pay." *Id.* at 1014. Due to payment by Medicare, the insured was "not required to pay." Thus, the policy exclusion applied and insurance benefits were not due for the surgery. *Id.* at 1015. Although expenses were technically "incurred" as the policy required, it was determined the government "incurred" the bills, *not* the insured. *Id.* at 1014. The definition of "incurred" and related principles in the case are limited to the confines of the insurance policy that was examined.

The case of *Holmes v. California State Automobile Assoc.* (1982) 135 Cal.App.3d 635 cited by Howell is similarly irrelevant. In *Holmes,* the plaintiff's *own* automobile insurer sought to be relieved of its *contractual* duty under the medical payments portion of the policy to pay hospital bills incurred by the plaintiff. The carrier's position rested on the fact the medical bills had been paid and satisfied by Medicare. *Id.* at 637. The plaintiff's automobile policy obligated the carrier to "pay all reasonable medical expenses **incurred** by the insured" arising from an automobile accident. *Id.* (Emphasis added.) Because the insured was a Medicare recipient, her hospital bills were "paid directly to the hospital" by Medicare. *Id.* When the insured submitted the

same bills to her automobile carrier for reimbursement, the carrier denied payment based on the argument the insured had not "incurred" the bills as the policy required. *Id.*

In *Holmes,* no analysis was performed regarding the application or non-application of the collateral source rule. No analysis was performed whether a *judgment* could be reduced by an amount of purported medical expenses that were never pursued, collected or owed. Rather, the *Holmes* court reasoned the legislative underpinning of Medicare required payment by the government only for expenses which are "incurred" by a patient. *Id.* at 639. Because Medicare in fact paid the bills, it was axiomatic the plaintiff was deemed to have "incurred" the hospital expenses. By extension, it was reasoned the plaintiff "incurred" the bills within the meaning of the automobile policy language. Accordingly, the auto carrier was required, contractually, to pay the insured for the hospital expenses. *Id.* at 639.

Here, there is no insurance policy language to be interpreted between Hamilton and Howell. The contractual and quasi-fiduciary relationship that exists between insurer and insured does not exist here. *Vu v. Prudential Property & Cas. Ins. Co.* (2001) 26 Cal.4th 1142, 1151. Moreover, Hamilton does not dispute Howell is entitled to recover for medical bills in the amount *paid* by her healthcare insurer. *Holmes, supra,* 135 Cal.App.3d at 638-639. No deduction was ever sought for what her carrier paid, thus the collateral source rule does not come into play. *Helfend v. Southern California*

Rapid Transit Dist. (1970) 2 Cal.3d 1. Rather, payment was only denied for those amounts never pursued or collected by Howell's medical providers, amounts for which she will never be liable.

Finally, the cited case of *Bell v. Blue Cross of Cal.* (2005) 131 Cal.App.4th 211 is not relevant because it does not involve personal injury plaintiffs seeking recovery for imaginary medical bills. In *Bell,* an emergency room physician filed a class action suit against a private health insurer (Blue Cross) to obtain additional reimbursement in excess of the amounts Blue Cross was willing to pay to non-contracting physicians for ER services rendered to Blue Cross enrollees. The gist of the claim was *Health and Safety Code* §1371.4 impliedly required a health plan to pay non-participating providers a customary and reasonable amount for ER services, rather than any amount the insurer simply chooses. *Id.* at 214. The court of appeal vacated the demurrer that was in favor of Blue Cross and placed the case back in the trial court, finding the doctors could pursue Blue Cross for additional monies. *Id.* at 223.

Bell has no significance to the issue at hand. Unlike the physicians in *Bell,* Howell's providers contracted with Howell's health insurer and accepted as payment in full the amounts paid by the insurer. This clearly distinguishes the situation from *Bell.* The *Howell* court itself described the difference as a "negotiated rate differential," thus acknowledging the fact the amount accepted by Howell's medical providers was negotiated. The final accepted monies were not merely some random amount which bears no

relation to the actual value of the services rendered. Since negotiated, the exchanged amounts were what the relevant parties agreed reflected the reasonable value of the services.

No additional amount is being sought from the carrier or Howell. No "balance billing" is being pursued by the medical providers. Howell has presented no evidence she remains liable for any additional amounts in excess of what her carrier paid to satisfy the bills. Thus, *Bell* has no application.

The foregoing hand-picked cases and related statutory citations by Howell in her Answer are nothing more than a distraction from the matter at the heart of the petition for review: the conflict among the published opinions of the courts of appeal on the issue of whether personal injury plaintiffs are entitled to recover damages greater than the actual paid amount for their medical bills, and the procedural manner for determining the amounts so paid and recoverable. The petition should therefore granted so this Court can resolve this matter once and for all.

B. THE *HOWELL* DECISION AVOIDS THE PROCEDURAL ISSUE AND LEAVES IT TO BE DETERMINED ON AN AD HOC BASIS

As mentioned above, *Greer v. Buzgheia* places the burden on the defense to segregate medical damages that are recoverable and those which are not. After a plaintiff introduces evidence of "usual and customary" medical

service charges, the defendant may obtain a verdict that distinguishes such charges from the amounts actually paid to and accepted by the medical providers as payment in full. *Greer* also holds the defendant bears the burden, post-trial, to move the court to reduce the verdict to reflect any excess amount. *Greer, supra,* 141 Cal.App.4th at 1156-1157.

In a departure from *Greer, Howell* rejects this procedure and declares it is unsupported by any statutory framework. *Howell* opinion, p. 29. This provides yet another reason for this Court to look at the issue anew and provide guidance to the trial courts struggling with this issue.

Contrary to Howell's take on the matter, the case of *Olsen v. Reid* (2008) 164 Cal.App.4th 200 referenced the post-trial hearing in that case and noted the "question of what form a motion to reduce the judgment under the purported *Hanif/Nishihama* rule should take is unclear, but need not be decided here." *Olsen,* 164 Cal.App.4th 200, 203, fn. 2. Thus, *Olsen* did not reject the propriety of a post-trial hearing for reduction of a verdict on this issue. It merely avoided the issue by deciding the case on other factors.

Clarity is needed on this point. The back and forth of whether a post-trial hearing should occur and what form should be followed for such a hearing can properly be decided as part of a substantive ruling on the overriding issue of the propriety of awarding plaintiffs amounts for medical expenses never paid, collected or actually incurred.

C. THE COLLATERAL SOURCE RULE SHOULD BE RE-EXAMINED AS OUTDATED LAW WHICH DOES NOT COMPORT WITH DAMAGES PRINCIPLES

It is a fundamental precept of California law that "'[a] plaintiff in a tort action is not, in being awarded damages, to be placed in a better position than he would have been in had the wrongful act not been done. [Citations.]'" *Safeco Ins. Co. v. J & D Painting* (1993) 17 Cal.App.4th 1199, 1202; accord *Metz v. Soares* (2006) 142 Cal.App.4th 1250, 1255; *Valdez v. Taylor Automobile Co.* (1954) 129 Cal.App.2d 810, 821-22; *Basin Oil Co. v. Baash-Ross Tool Co.* (1954) 125 Cal.App.2d 578, 605. "*The primary object of an award of damages* in a civil action, and the fundamental principle on which it is based, are *just compensation* or indemnity for the loss or injury sustained by the complainant, *and no more* [citations]." *Mozzetti v. City of Brisbane* (1977) 67 Cal.App.3d 565, 576 (original emphasis).

Though Howell argues she "incurred" the portion of the imaginary medical bills that were never collected nor owed by anyone, she cannot escape the fact neither she nor her collateral source insurer paid the excess amount. These so-called medical expenses cannot constitute recoverable damages because they do not fall within the definition of "detriment" in *Civil Code* §3282. The lack of any suffering of the excess billings also denies plaintiff the ability to recover "money" for such fictional amounts. *Civil Code* §3281.

The rule is and should remain that a plaintiff may not recover more as *compensatory* economic damages than has actually been paid or will be paid on her behalf, in those cases where payment has been made. Nothing in the traditional collateral source rule suggests otherwise. It should not be radically reformulated to create an unjust result.

The Supreme Court of California has the power to abolish the collateral source rule, a doctrine it created and has since "long adhered to." *Helfend v. Southern Cal. Rapid Transit Dist.* (1970) 2 Cal.3d 1, 6. Even there, Justice Tobriner explained the Court did not intend to determine the appropriateness of the rule's application in all situations, particularly those not discussed in this landmark case. *Helfend,* 2 Cal.3d at 6, fn. 3 ("We expressly do not consider or determine the appropriateness of the Rule's application in the myriad of possible situations which we have not discussed or which are not presented by the facts *of this case*.")(Emphasis added.)

Contrary to Howell's position, the collateral source rule does not apply to all situations in all cases. In the instant case, the rule was essentially applied twice: first in its traditional sense when Hamilton paid the same medical expenses previously paid by Howell's healthcare insurer, and; second, in a distorted, non-traditional manner when the *Howell* court ordered payment to Howell for the phantom medical bills never incurred, paid, or collected by anyone.

As a result, *Howell* broadened the scope of the rule beyond what this Court could have imagined in *Helfend.* Until *Howell,* the rule was a limitation on *deductions* to damages awards from amounts *actually paid* by a collateral source. After *Howell,* the rule will operate to *expand* damages beyond those actually incurred or suffered by a plaintiff and provide a windfall to a plaintiff. The collateral source rule is a common law rule, subject to modification or even abolishment if it outlives its purpose.

The original intent of the rule was to encourage the purchase of insurance by allowing plaintiffs to recover from defendants the amounts already paid by insurers for damages suffered by a plaintiff. *Helfend,* 2 Cal.3d 1, 9-10. The gross expansion of the rule under *Howell,* to multiply a plaintiff's purported damages well beyond the actual amount of money the health care provider receives and accepts for the medical services rendered to a plaintiff, demonstrates the need to revisit the rule and its purpose.

Another justification for the rule originally was the expanding subrogation rights of insurers to moneys paid on behalf of an insured. *Helfend,* 2 Cal.3d at 11. Yet subrogation only permits a recovery by the insurer of the actual money paid on the insured plaintiff's behalf. Hypothetical, virtual amounts never collected or pursued by a healthcare provider cannot be recouped by an insurer. No logic supports a plaintiff's recovery of the same imaginary amount. Permitting recovery of the amount under the guise of the

transformed version of the rule in *Howell* highlights the reason why the entire rule should be reconsidered and abolished as an antiquated principle.

Abolition of the collateral source rule would be in conformity with the concept of compensatory damages, which is to make a plaintiff "whole," nothing more. The rule effectively compensates plaintiff twice for the same injury, resulting in a windfall recovery to the plaintiff.

III.

CONCLUSION

This petition presents the opportunity for the Supreme Court to lay to rest the confusion and conflicting Courts of Appeal decisions on whether a plaintiff in a personal injury case may recover as economic damages an amount exceeding what his or her private health insurance has paid and the relevant healthcare provider has accepted as full payment for medical services. A clear, final decision is necessary to provide guidance to each and every courtroom that regularly hears and decides personal injury actions in California.

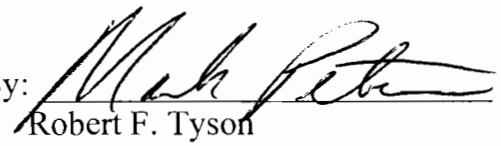
The *Howell* decision amplified the dispute between the Appellate Court districts on this issue. The decision also illustrated the abuse to which the collateral source rule is subject, by transforming it from a rule of limitation to one of unreasonable expansion of alleged damages. Accordingly, review of the *Howell* decision should be granted.

If review is not granted, this Court should order depublication of the *Howell* opinion.

Dated: January 29, 2010

Respectfully submitted,

TYSON & MENDES, LLP

By: 

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CERTIFICATE OF WORD COUNT

(Cal. Rules of Court, rule 8.504(d)(1).)

The text of this Petition consists of 3,839 words as counted by the Microsoft Word software word-processing program used to generate the Reply.

Dated: January 28, 2010

Mark T. Petersen

Rebecca Howell v. Hamilton Meats & Provisions, Inc., et al.

SUPREME COURT OF CALIFORNIA
Case No. S179115

Court of Appeal of the State of California, Fourth Appellate District, Div. One
Case No. D053620

San Diego Superior Court
Case Number: GIN053925

PROOF OF SERVICE

I, the undersigned, declare that I am over the age of 18 years and not a party to the within action or proceeding. I am employed in and am a resident of San Diego County where the mailing occurs; and my business address is 5661 La Jolla Blvd, La Jolla, CA 92037.

On January 29, 2010, I caused to be served the following document(s):

REPLY TO ANSWER TO PETITION FOR REVIEW

on the interested parties in this action by:

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I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed on January 29, 2010, at La Jolla, California.

Claudia Gonzalez

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Howell v. Hamilton Meats & Provisions, Inc., et al.

SUPREME COURT OF CALIFORNIA
Case No. S179115

Court of Appeal of the State of California, Fourth Appellate District, Div. One
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