
MICRA MANUAL

2023 Edition

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A. THE LEGISLATIVE INTENT BEHIND MICRA.

1. The importance of legislative intent.

The principal purposes of this Manual are to collect and analyze the case law construing the MICRA reforms, and to suggest approaches to MICRA issues not yet resolved by the appellate courts. Of course, in order to understand what the courts have done and are likely to do, it is essential to understand the legislative intent behind MICRA. “[O]ur first task in construing a statute is to ascertain the intent of the Legislature so as to effectuate the purpose of the law.” (*Central Pathology Service Medical Clinic, Inc. v. Superior Court* (1992) 3 Cal.4th 181, 186, internal quotation marks omitted.)

2. The overall purpose of MICRA.

The best statement of MICRA’s overall purpose is by the Supreme Court in *Western Steamship Lines, Inc. v. San Pedro Peninsula Hospital* (1994) 8 Cal.4th 100, 111-112: “[T]he Legislature enacted MICRA in response to a medical malpractice insurance ‘crisis,’ which it perceived threatened the quality of the state’s health care. [Citation.] In the view of the Legislature, ‘the rising cost of medical malpractice insurance was imposing serious problems for the health care system in California, threatening to curtail the availability of medical care in some parts of the state and creating the very real possibility that many doctors would practice without insurance, leaving patients who might be injured by such doctors with the prospect of uncollectible judgments.’ [Citations.] The continuing availability of adequate medical care depends directly on the availability of adequate insurance coverage, which in turn operates as a function of costs associated with medical malpractice litigation. [Citation.] Accordingly, MICRA includes a variety of provisions all of which are calculated to reduce the cost of insurance by limiting the amount and timing of recovery in cases of professional negligence. [Citations.] [¶] MICRA thus reflects a *strong public policy to contain the costs of malpractice insurance by controlling or redistributing liability for damages, thereby maximizing the availability of medical services to meet the state’s health care needs.*” (Emphasis added.)

- Other Supreme Court cases stating the overall purpose of MICRA are: *Lopez v. Ledesma* (2022) 12 Cal.5th 848, 855-865; *Reigelsperger v. Siller* (2007) 40 Cal.4th 574, 577-578; *Preferred Risk Mutual Ins. Co. v. Reiswig* (1999) 21 Cal.4th 208, 214-215; *Barris v. County of Los Angeles* (1999) 20 Cal.4th 101, 108; *Delaney v. Baker* (1999) 20 Cal.4th 23, 33-34; *Russell v. Stanford University Hospital* (1997) 15 Cal.4th 783, 786; *Burgess v. Superior Court* (1992) 2 Cal.4th 1064, 1082-1083; *Woods v. Young* (1991) 53 Cal.3d 315, 319, 325; *Fein v. Permanente Medical Group* (1985) 38 Cal.3d 137, 158-159; *Roa v. Lodi Medical Group, Inc.* (1985) 37 Cal.3d 920, 930; *Barme v. Wood* (1984) 37 Cal.3d 174, 178-179; *American Bank & Trust Co. v. Community Hospital* (1984) 36 Cal.3d 359, 363-364, 371-372; see *Potter v. Firestone Tire & Rubber Co.* (1993) 6 Cal.4th 965, 992-993. An excellent statement of MICRA's overall purpose by the Court of Appeal is found in *Perry v. Shaw* (2001) 88 Cal.App.4th 658, 667-668.
- Several MICRA statutes were amended by Assembly Bill No. 35, approved by Governor, May 23, 2022, and effective January 1, 2023 (2021-2022 Reg. Sess.) (AB-35), which states: "Nothing contained herein shall be interpreted in a manner to alter or nullify existing case law interpreting MICRA and its statutory provisions." (AB-35, § 1.)

3. The specific purpose of each MICRA statute.

(a) Business and Professions Code section 6146 (limiting contingent attorney fees).

One purpose is to reduce the cost of settlements: "[B]ecause section 6146 permits an attorney to take only a smaller bite of a settlement, a plaintiff will be more likely to agree to a lower settlement since he will obtain the same net recovery from the lower settlement." (*Roa, supra*, 37 Cal.3d at p. 931.) Another purpose is to "reduc[e] plaintiffs' attorneys' incentive to encourage their clients to pursue marginal claims . . ." (*Id.* at pp. 931-932.) Another purpose is to protect the plaintiff's recovery, already reduced by MICRA, from "further reduction by high contingency fees." (*Id.* at p. 932; see *Waters v. Bourhis* (1985) 40 Cal.3d 424, 437.)

The new tiered contingency fee limit structure enacted in 2022 (AB-35, § 2) was intended to make the fee award “logically tied to the stage of representation in which the amount was recovered, loosely approximating the amount of work that it takes to secure the judgment or settlement.” (Assem. Com. on Judiciary, Analysis of Assem. Bill No. 35 (2021-2022 Reg. Sess.) May 7, 2022, p. 10.)

**(b) Civil Code section 3333.1, subdivision (a)
(allowing evidence of collateral source payments).**

“The purpose of section 3333.1, subdivision (a) has generally been viewed as an attempt to eliminate the so-called ‘double recovery’ obtained by plaintiffs who have their medical expenses paid by their own health insurance and still obtain damages for such expenses from defendant tortfeasors.” (*Barme, supra*, 37 Cal.3d at p. 179, fn. 5.) The jury is given the opportunity to “set plaintiff’s damages at a lower level because of its awareness of plaintiff’s ‘net’ collateral source benefits.” (*Fein, supra*, 38 Cal.3d at pp. 164-165, fn. omitted.)

**(c) Civil Code section 3333.1, subdivision (b)
(precluding subrogation by collateral source).**

One purpose is to protect the plaintiff from the “‘double deduction’” that would occur if the jury reduced its award because of collateral source benefits, yet the collateral source could obtain repayment of those benefits from the plaintiff’s tort recovery. (*Fein, supra*, 38 Cal.3d at p. 165.) Another purpose is to “assure[] that any reduction in malpractice awards that may result from the jury’s consideration of the plaintiff’s collateral source benefits will inure to [the defendant health care provider’s] benefit rather than to the benefit of the collateral source” (*ibid.*); in other words, to “shift[] some of the costs in the area [of medical malpractice] to other insurers” (*id.* at p. 166; see *Barme, supra*, 37 Cal.3d at p. 181; *California Physicians’ Service v. Superior Court* (1980) 102 Cal.App.3d 91, 97).

(d) Civil Code section 3333.2 (limiting recovery of noneconomic damages).

One purpose is to “provide a more stable base on which to calculate insurance rates” by eliminating the “unpredictability of the size of large noneconomic damage awards, resulting from the inherent difficulties in valuing such damages and the great disparity in the price tag which different juries placed on such losses.” (*Fein, supra*, 38 Cal.3d at p. 163; see *Lopez, supra*, 12 Cal.5th at pp. 859-860, 864; *Western Steamship, supra*, 8 Cal.4th at p. 112; *Lathrop v. HealthCare Partners Medical Group* (2004) 114 Cal.App.4th 1412, 1419; *Perry, supra*, 88 Cal.App.4th at p. 668.) Another purpose is to “promote settlements by eliminating ‘the unknown possibility of phenomenal awards for pain and suffering that can make litigation worth the gamble.’” (*Fein*, at p. 163.) “The prospect of a fixed award of noneconomic damages not only increases plaintiffs’ motive to settle, as noted in *Fein*, but also restrains the size of settlements. Settlement negotiations are based on liability estimates that are necessarily affected by the [applicable MICRA] cap. By placing an upper limit on the recovery of noneconomic damages at trial, the Legislature indirectly but effectively influenced the parties’ settlement calculations.” (*Rashidi v. Moser* (2014) 60 Cal.4th 718, 727.) Another purpose is to be fair to medical malpractice plaintiffs by “reduc[ing] only the very large noneconomic damage awards, rather than to diminish the more modest recoveries for pain and suffering and the like in the great bulk of cases.” (*Fein*, at p. 163.)

The original \$250,000 MICRA fixed limit on noneconomic damages was replaced by AB-35, section 3, to include separate caps on healthcare providers and healthcare institutions (new categories of MICRA defendants), and the cap amounts adjust annually to account for inflation and depend on whether the action involves wrongful death. (Sen. Com. on Judiciary, Analysis of Assem. Bill No. 35 (2021-2022 Reg. Sess.) May 2, 2022, pp. 9-10.) AB-35, section 3, thus raises the limit on recovery for noneconomic losses, provides for fixed annual increases in the new higher limits for 10 years, and thereafter annually adjusts the limit by 2 percent. (Civ. Code, § 3333.2, subs. (b), (c), (g), (h).)

**(e) Code of Civil Procedure section 340.5
(shortening the statute of limitations).**

“The Legislature’s objective was to reduce the number of ‘long tail’ claims attributable to the tolling provisions formerly available in malpractice actions.” (*Photias v. Doerfler* (1996) 45 Cal.App.4th 1014, 1019-1020.) “Commentators had observed that the delayed discovery rule and the resulting ‘long tail’ claims made it difficult to set premiums at an appropriate level. [Citations.] Presumably, the legislative goal in amending section 340.5 was to give insurers greater certainty about their liability for any given period of coverage, so that premiums could be set to cover costs.” (*Young v. Haines* (1986) 41 Cal.3d 883, 900; see *David M. v. Beverly Hospital* (2005) 131 Cal.App.4th 1272, 1277.)

**(f) Code of Civil Procedure section 364
(requiring 90 days’ notice of intent to sue).**

“The purpose of the notice of intent to sue and the 90-day [statute-of-limitations] tolling period of section 364 was to decrease the number of actions premised on professional negligence by establishing a procedure to encourage the parties to negotiate ‘outside the structure and atmosphere of the formal litigation process.’ ” (*Preferred Risk, supra*, 21 Cal.4th at p. 214.)

**(g) Code of Civil Procedure section 667.7
(allowing periodic payment of future damages).**

One purpose is to reduce “the need for insurance companies to retain large reserves to pay out sizable lump sum awards. The adoption of a periodic payment procedure permits insurers to retain fewer liquid reserves and to increase investments, thereby reducing the costs to insurers and, in turn, to insureds.” (*American Bank & Trust Co., supra*, 36 Cal.3d at pp. 372-373.) Another purpose is to “limit[] a defendant’s obligation to those future damages that a plaintiff actually incurs, eliminating the so-called ‘windfall’ obtained by a plaintiff’s heirs when they inherit a portion of a lump sum judgment that was intended to compensate the injured person for losses he in fact never sustained.” (*Id.* at p. 369; see *Deocampo v. Ahn* (2002) 101 Cal.App.4th 758, 772.) Another

purpose is to prevent the dissipation of damages for future losses by improvident expenditures or investments: “The fundamental goal of the statute is ‘matching losses with compensation by helping to ensure that money paid to an injured plaintiff will in fact be available when the plaintiff incurs the anticipated expenses or losses in the future’ [citations], i.e., ‘affording a fair correlation between the sustaining of losses and the payment of damages’ [citations].” (*Holt v. Regents of University of California* (1999) 73 Cal.App.4th 871, 881.) “The goal is to prevent early dissipation of an award, and ensure that when the plaintiff incurs losses or expenses in the future, the money awarded to him [or her] will be there.” (*Deocampo*, at p. 772.)

AB-35 amended only one aspect of Code of Civil Procedure section 667.7—it increased the minimum future damages award in the judgment from \$50,000 to \$250,000 before periodic payments may be demanded.

**(h) Code of Civil Procedure section 1295
(encouraging and facilitating arbitration).**

“The purpose of section 1295 is to encourage and facilitate arbitration of medical malpractice disputes. [Citations.] Accordingly, the provisions of section 1295 are to be construed liberally.” (*Reigelsperger, supra*, 40 Cal.4th at p. 578.) “In other words, the encouragement of arbitration ‘“as a speedy and relatively inexpensive means of dispute resolution” ’ [citation] furthers MICRA’s goal of reducing costs in the resolution of malpractice claims and therefore malpractice insurance premiums.” (*Ruiz v. Podolsky* (2010) 50 Cal.4th 838, 844.) “The purpose . . . is to encourage and facilitate the arbitration of medical malpractice claims by specifying uniform language to be used in binding arbitration agreements, so that the patient knows what he or she is signing and knows its ramifications.” (*County of Contra Costa v. Kaiser Foundation Health Plan, Inc.* (1996) 47 Cal.App.4th 237, 246; see *Gross v. Recabaran* (1988) 206 Cal.App.3d 771, 775-776.)

4. MICRA should be liberally construed.

“The cases agree that MICRA provisions should be construed liberally in order . . . to reduce malpractice insurance premiums.” (*Preferred Risk, supra*, 21 Cal.4th at p. 215; see *Lopez, supra*, 12 Cal.5th at p. 859; *Reigelsperger, supra*, 40 Cal.4th at p. 578.)

B. DEFINITIONS COMMON TO ALL MICRA STATUTES.

1. In general.

The MICRA statutes apply in an action for injury (1) against a health care provider (2) based on professional negligence. (Bus. & Prof. Code, § 6146, subd. (a); Civ. Code, §§ 3333.1, subd. (a), 3333.2, subd. (a) [which also applies against health care institutions]; Code Civ. Proc., §§ 340.5, 364, subd. (a), 667.7, subds. (a) & (e)(4), 1295, subd. (a).)

2. “Health care provider” defined.

(a) Statutory definition.

Most of the MICRA statutes define “health care provider” as follows: “‘Health care provider’ means any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or licensed pursuant to the Osteopathic Initiative Act, or the Chiropractic Initiative Act, or licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code; and any clinic, health dispensary, or health facility, licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code. ‘Health care provider’ includes the legal representatives of a health care provider.” (Bus. & Prof. Code, § 6146, subd. (c)(2); Civ. Code, §§ 3333.1, subd. (c)(1), 3333.2, subd. (c)(1); Code Civ. Proc., §§ 340.5, subd. (1), 364, subd. (f)(1), 667.7, subd. (e)(3), 1295, subd. (g)(1).)

As amended by AB-35, Civil Code section 3333.2 includes unique definitions for both “health care provider” and “health care institution.” (See Section E(5), *post.*)

(b) An inadequately supervised physiscian’s assistant is a “health care provider.”

In *Lopez v. Ledesma* (2020) 46 Cal.App.5th 980, affirmed (2022) 12 Cal.5th 848, the Court of Appeal held in a split decision that “the presence of a legal agency relationship between a physician assistant and a supervising physician is the dispositive factor in determining whether the physician assistant was acting outside the scope of licensed services for purposes of [former Civil Code] section 3333.2, subdivision

(c)(2).” (*Id.* at p. 995 [former Civil Code section 3333.2, subdivision (c)(2), defining “‘[p]rofessional negligence,’” is now reflected under subdivision (j)(4)].) “[A] physician assistant acts within the scope of his or her license for purposes of [former] section 3333.2, subdivision (c)(2) if he or she has a legally enforceable agency agreement with a supervising physician, regardless of the quality of actual supervision.” (*Id.* at p. 985.) The dissent opined that physician assistants fail to practice within their license restrictions if they knowingly practice autonomously, without any meaningful physician supervision. (*Id.* at pp. 999, 1005-1006 (dis. opn. of Ashmann-Gerst, J.).)

The Supreme Court granted review and affirmed, holding that MICRA “applies to a physician assistant who has a legally enforceable agency relationship with a supervising physician and provides services within the scope of that agency relationship, even if the physician violates his or her obligation to provide adequate supervision.” (*Lopez, supra*, 12 Cal.5th at p. 853.) The Court rejected the plaintiff’s argument that a physician assistant acts within the scope of his or her license only when adequately supervised by a licensed physician. (*Id.* at pp. 855, 858-864.) The Court explained that the relevant statutory definition of “‘supervision’” is met when a physician undertakes legal responsibility for a physician assistant. (*Id.* at p. 859, citing Bus. & Prof. Code, § 3501, former subd. (a)(6) [now subd. (f)(1)].) Moreover, the plaintiff’s proposed standard would both undermine MICRA’s goal of reducing malpractice premiums and lead to inconsistent damages awards whenever a plaintiff sued both a supervising physician (who is covered by MICRA) and a physician’s assistant (who would not be covered by MICRA under the proposed test). (*Id.* at pp. 859-860.) Furthermore, physician assistants have limited ability to control how they are being supervised, and deciding whether to apply MICRA based on whether a physician assistant knew that supervision was inadequate would complicate litigation and reduce the predictability of results, contrary to MICRA’s goals. (*Id.* at pp. 860-861.)

The Court also held that “a physician assistant does not render services ‘within [a] restriction imposed by the licensing agency’ ([former Civil Code] § 3333.2, subd. (c)(2)) simply by engaging in unprofessional conduct, such as the noncompliance with supervisory regulations at issue in this case.” (*Lopez, supra*, 12

Cal.5th at pp. 862-864.) If that were the case, “medical malpractice plaintiffs could avoid MICRA’s damages cap by identifying one member of a health care team who violates a single regulation governing that team,” subjecting that individual, and potentially the entire team, to unlimited liability for noneconomic damages in contravention with MICRA’s purpose. (*Ibid.*) The Court explained that “Neither our case law nor the language of MICRA suggests that the possibility of professional discipline or criminal liability necessarily places a health care provider’s actions outside ‘the scope of services for which [he or she] is licensed’ or ‘within any restriction imposed by the licensing agency or licensed hospital.’ ([former] § 3333.2, subd. (c)(2).)” (*Id.* at p. 865.) Thus, the fact that a physician assistant’s “conduct could give rise to professional discipline or criminal liability does not render MICRA inapplicable.” (*Ibid.*)

(c) An emergency medical technician is a “health care provider.”

In *Canister v. Emergency Ambulance Service, Inc.* (2008) 160 Cal.App.4th 388, the Court of Appeal held that an EMT is a health care provider within the meaning of MICRA. When MICRA was enacted, it covered mobile intensive care paramedics because they were licensed pursuant to Chapter 2.5 of Division 2 of the Health and Safety Code, which is one of the statutory categories listed in MICRA’s definition of “health care provider.” Subsequently, the paramedic act was repealed and comprehensive legislation governing prehospital emergency medical services was enacted. The new statutes were located in Division 2.5 of the Health and Safety Code, which is not one of the statutory categories listed in MICRA’s definition of “health care provider.” Thereafter, the Legislature added a statute to Division 2.5 providing that any reference in any provision of law to mobile intensive care paramedics shall be deemed a reference to EMT’s. The Court of Appeal held this cross-reference “indicates a legislative intent that EMT’s . . . be deemed ‘health care providers’ within MICRA’s purview.” (*Id.* at pp. 396-403.)

(d) An unlicensed social worker, registered with the Board of Behavioral Sciences and working toward licensure, is a “health care provider.”

In *Prince v. Sutter Health Care* (2008) 161 Cal.App.4th 971, the Court of Appeal held that “an unlicensed social worker, registered with the appropriate agency and working toward licensure, is a ‘health care provider’ ” within the meaning of MICRA. (*Id.* at p. 974.) First, “Business and Professions Code section 23.7 . . . states ‘Unless otherwise expressly provided, “license” means license, certificate, *registration*, or other means to engage in a business or profession regulated by this code’ (Italics added.) Stevenson’s profession is regulated by that code, and she registered with the Board. In effect, she was licensed.” (*Id.* at p. 976; see *Consumer Watchdog v. Department of Managed Health Care* (2014) 225 Cal.App.4th 862, 881.) Second, “MICRA’s purpose would be frustrated by eliminating its protections from persons, such as Stevenson, lawfully practicing a healing art as part of their training to become licensed.” (*Prince*, at p. 977.) The facts that Stevenson was not receiving the supervision required by law and failed to disclose to the patient that she was not licensed did not change her status as a health care provider. (*Id.* at pp. 977, 978.)

(e) A medical student lawfully practicing under a statutory exemption to the licensing requirement is a “health care provider.”

In *Chosak v. Alameda County Medical Center* (2007) 153 Cal.App.4th 549, the Court of Appeal held that, because an optometry student serving her internship was “practicing lawfully under an express exemption from the licensing and certification requirements of Division 2 [of the Business and Professions Code], . . . she was within the definition of ‘health care provider’” (*Id.* at p. 567.) “An action based on the negligence of a medical student or an out-of-state doctor legally practicing in California under the licensing and certification exemptions of Division 2 is just as much a medical malpractice action as an action against a licensed or certified doctor. If the statute was intended, as it unquestionably was, to cover all medical malpractice claims, it should be construed to cover all actions against medical professionals operating lawfully under

the licensing and certification statutes, whether licensed or exempt.” (*Id.* at p. 566.) “[T]he activities of medical students and other exempt professionals in California affect ‘the insurance premiums that health care providers pay,’ just as the activities of licensed health care providers do [W]e are unwilling to interpret the statute in a manner that would work at cross-purposes to the Legislature’s objective in enacting . . . MICRA.” (*Id.* at p. 567.)

(f) A pharmacy is a “health care provider.”

In *Goldsmith v. CVS Pharmacy, Inc.* (C.D.Cal., May 5, 2020, No. CV 20-00750-AB (JCx)) 2020 WL 3966004, at page *7 [nonpub. opn.], the district court ruled that “[p]harmacies, which are licensed under Division 2 of the Business and Professions Code, are considered ‘healthcare providers’ under MICRA.” (Accord, *Ambritz v. CVS Pharmacy, Inc.* (E.D.Cal., Apr. 3, 2020, No. 1:19-cv-01391-NONE-SKO) 2020 WL 1660018, at p. *3 [nonpub. opn.].)

(g) A blood bank is a “health care provider.”

In *Coe v. Superior Court* (1990) 220 Cal.App.3d 48, the Court of Appeal held a blood bank is a health care provider within the meaning of MICRA. Specifically, the court held a blood bank is a health dispensary licensed pursuant to Division 2 of the Health and Safety Code because “a blood bank dispenses a product and provides a service inextricably identified with the health of humans.” (*Id.* at p. 53, fn. omitted.) The court also noted that, by referring to divisions of the codes in defining “health care provider,” the Legislature “provided for the evolution of health care professions and organizations. New categories of providers could be automatically covered by MICRA simply by regulating them within the same statutory scheme as other health care providers.” (*Id.* at p. 52, fn. omitted.) The court used home dialysis agencies as an example. (*Id.* at p. 52, fn. 3.)

(h) A sperm bank is a “health care provider.” So is a tissue bank.

In *Johnson v. Superior Court* (2002) 101 Cal.App.4th 869, the Court of Appeal held a sperm bank is a health care provider

within the meaning of Code of Civil Procedure section 425.13 (which governs the inclusion of a punitive damage claim in an action for professional negligence against a health care provider). (*Id.* at pp. 877-883.) Section 425.13 uses the same definition of “health care provider” as MICRA and has a similar legislative purpose; therefore, the Legislature intended that “health care provider” have the same meaning in section 425.13 and MICRA. (*Id.* at pp. 877-879; see *Palmer v. Superior Court* (2002) 103 Cal.App.4th 953, 961.) A sperm bank is a health dispensary licensed pursuant to Division 2 of the Health and Safety Code because a sperm bank “dispenses a product (sperm), and provides a service (provision of donor sperm to health care practitioners and their clients)” (*Johnson*, at p. 881), and “the service provided . . . is ‘inextricably identified with the health of humans’” (*id.* at p. 882).

In *Cryolife, Inc. v. Superior Court* (2003) 110 Cal.App.4th 1145, the Court of Appeal held a tissue bank is a health care provider within the meaning of Code of Civil Procedure section 425.13. (*Cryolife, Inc.*, at pp. 1158-1160.) A tissue bank is a health dispensary licensed pursuant to Division 2 of the Health and Safety Code “because it dispenses human tissue for transplantation and provides tissue-related services that are identified with human health.” (*Id.* at p. 1160.)

(i) A skilled nursing facility is a “health care provider.”

“A skilled nursing facility is a health care provider for purposes of [MICRA].” (*Guardian North Bay, Inc. v. Superior Court* (2001) 94 Cal.App.4th 963, 974, citing *Alcott Rehabilitation Hospital v. Superior Court* (2001) 93 Cal.App.4th 94, 99-100.)

(j) A residential care facility is not a “health care provider.”

In *Kotler v. Alma Lodge* (1998) 63 Cal.App.4th 1381, the Court of Appeal held a residential care facility is not a health care provider within the meaning of MICRA. Specifically, the court held that, although a residential care facility is licensed pursuant to Division 2 of the Health and Safety Code, it is not a clinic, health dispensary, or health facility. (*Id.* at pp. 1390-1395.)

(k) There are conflicting decisions on whether a medical group is a “health care provider.”

In *Palmer, supra*, 103 Cal.App.4th 953, the Court of Appeal held a medical corporation is a health care provider within the meaning of Code of Civil Procedure section 425.13 (which governs the inclusion of a punitive damage claim in an action for professional negligence against a health care provider). (*Id.* at pp. 962-967.) Section 425.13 uses the same definition of “health care provider” as MICRA and has a similar legislative purpose; therefore, the Legislature intended that “health care provider” have the same meaning in section 425.13 and MICRA. (*Johnson, supra*, 101 Cal.App.4th at pp. 877-879.)

The defendant in *Palmer*, Sharp Rees-Stealy Medical Group, Inc. (SRS), “is a corporation which is a medical group made up of licensed physician/shareholders, and it provides clinic or health facility outpatient services. SRS operates as a medical group under a fictitious name as allowed by Business and Professions Code section 2415, subdivision (a): ‘Any physician and surgeon . . . , who as a sole proprietor, or in a partnership, group, or professional corporation, desires to practice under any name that would otherwise be a violation of Section 2285 may practice under that name if the proprietor, partnership, group, or corporation obtains and maintains in current status a fictitious-name permit issued by the Division of Licensing . . . under the provisions of this section.’ Under Business and Professions Code sections 2406 and 2408, a medical corporation comprised of licensed professionals may render professional services as long as it is in compliance with the Moscone-Knox Professional Corporation Act (Corp. Code, § 13400 et seq.), which requires that only licensed persons render professional services on behalf of the corporation. (Corp. Code, §§ 13405, 13406, subd. (a).)” (*Palmer, supra*, 103 Cal.App.4th at p. 963, fn. omitted.)

“SRS must be considered to fall under the statutory definition in [Code of Civil Procedure] section 425.13, subdivision (b) of a health care provider, because it is a medical group comprised of licensed medical practitioners, who provide direct medical services to patients, albeit under a fictitious name. (Bus. & Prof. Code, § 2415.) The statutory scheme does not contemplate that an additional license need be obtained for the medical

group itself. (Bus. & Prof. Code, §§ 2406[,] 2408; Corp. Code, § 13400 et seq.) Rather, the definition in section 425.13, subdivision (b) of ‘health care provider’ should be read broadly to implement its statutory purpose, protecting this type of health care provider, which delivers services to patients, from potentially unfounded punitive damages claims.” (*Palmer*, *supra*, 103 Cal.App.4th at pp. 966-967.)

In *Scripps Clinic v. Superior Court* (2003) 108 Cal.App.4th 917, the Court of Appeal held a medical group is a health care provider within the meaning of Code of Civil Procedure section 425.13. “Scripps is a group medical practice governed by a group of physicians who represent Scripps’s physicians.” (*Id.* at p. 926.) “Scripps is a health care provider, governed by a group of representative physicians. Scripps’s governing physicians established the policy [at issue].” (*Id.* at p. 942.)

Despite the logic of *Palmer*, *supra*, 103 Cal.App.4th at pages 962-967, and *Scripps Clinic*, *supra*, 108 Cal.App.4th at page 942, another Court of Appeal held in *Lathrop v. HealthCare Partners Medical Group* (2004) 114 Cal.App.4th 1412, that “a medical group consisting of a partnership of physicians is not a ‘health care provider’ as that term is defined under the Medical Injury Compensation Reform Act (MICRA), because the medical group is not itself licensed to practice medicine.” (*Id.* at p. 1416; see *id.* at pp. 1419-1421.) The *Lathrop* court reasoned:

“The statutory definition refers to ‘any *person*.’ While a ‘person’ includes a corporation as well as a natural person [citation], there is no clear indication that a ‘person’ includes an unincorporated group or partnership. In any event, the definition of ‘health care provider’ extends only to a ‘person *licensed*’ under the Business and Professions Code. The Business and Professions Code sets out the licensing provisions pertaining to medicine in the Medical Practice Act [citation], and that act is quite explicit that ‘only natural persons shall be licensed’ to practice medicine. [Citation.] . . . The Medical Practice Act clearly intends only individual persons to be licensed to practice medicine.

“Distinct from the concept of medical licensing is the concept of conducting a medical business. . . . [P]hysicians have been

statutorily authorized to conduct their medical practices in the *form* of a medical corporation, group, or partnership as long as the shareholders or partners and the employees rendering professional services are themselves licensed. [Citations.] An artificial legal entity needs a *permit* from the Division of Licensing in order to conduct the business under a fictitious name [citation], and HealthCare Partners had such a permit. But having authority to conduct business as an artificial entity is not the same as having a license to practice medicine. Again, only natural persons are *licensed* to practice medicine. [Citation.] Because HealthCare Partners is not itself a medically licensed person, it does not qualify as a ‘health care provider.’” (*Id.* at pp. 1420-1421, original emphasis.)

- One cannot help but wonder whether the *Lathrop* court’s unwillingness to broadly construe the licensed *practitioners* category of health care provider was influenced by the court’s apparent belief that HealthCare Partners had dropped the ball by not arguing that it fell within the licensed *facilities* category of health care provider. (See *Lathrop, supra*, 114 Cal.App.4th at pp. 1419-1420 [“A clinic is defined by the Health and Safety Code as an establishment providing direct outpatient health services]; Health & Saf. Code, § 1200.)

“There was evidence that HealthCare Partners provided outpatient health services to [the plaintiff], but the trial court ruled that HealthCare Partners had failed to show it qualified as a clinic.” (*Lathrop, supra*, 114 Cal.App.4th at p. 1419.) The Court of Appeal’s holding did not reach that issue, but its dicta suggests confusion on the point. (*Ibid.* [“On appeal, HealthCare Partners has eschewed its status as a clinic, health dispensary, or health facility and does not challenge the trial court’s ruling on this point”]; see *id.* at p. 1421, fn. 1 [“We *emphasize* that we do not reach the question whether HealthCare Partners could qualify as a health care provider under MICRA as a licensed *facility*” (first emphasis added)].) At first blush, the Court of Appeal’s reading of the Health and Safety Code seems mistaken. The definition of “clinic” is broad, but few clinics are actually required to be *licensed*. (Health & Saf. Code, §§ 1201, 1204, 1205,

1206.) In particular, a medical group's outpatient facility is *exempt* from licensing. (Health & Saf. Code, § 1206, subd. (a).) But an exemption from licensing is treated the same as a license (see *Chosak, supra*, 153 Cal.App.4th at pp. 566-567), so the Court of Appeal in *Lathrop* was correct in suggesting that a medical group that meets the definition of a clinic is a health care provider within the meaning of MICRA.

Because *Lathrop* conflicts with *Palmer* and *Scripps Clinic*, the trial courts can choose which to follow. (*Auto Equity Sales, Inc. v. Superior Court* (1962) 57 Cal.2d 450, 456.) *Palmer* and *Scripps Clinic* are *much* better reasoned than *Lathrop*. It makes little sense to apply MICRA in a professional negligence action against a natural person who is a licensed health care provider, but not in a professional negligence action against a legal entity that is wholly owned and entirely controlled by natural persons who are licensed health care providers. MICRA should be interpreted to effectuate the Legislature's intent to "contain the costs of malpractice insurance by controlling or redistributing liability for damages, thereby maximizing the availability of medical services to meet the state's health care needs." (*Western Steamship Lines, Inc. v. San Pedro Peninsula Hospital* (1994) 8 Cal.4th 100, 112; see *Preferred Risk Mutual Ins. Co. v. Reiswig* (1999) 21 Cal.4th 208, 215 ["The cases agree that MICRA provisions should be construed liberally in order . . . to reduce malpractice insurance premiums"].) In order to effectuate legislative intent, the definition of "health care provider" in MICRA should be interpreted to include not just individual licensed physicians, but also groups of licensed physicians practicing under fictitious names in medical corporations, unincorporated medical groups, and medical partnerships. All of this having been said, it usually does not matter whether a medical group is covered by MICRA. The medical group's liability is vicarious, and if the group member or employee whose conduct injured the plaintiff is a health care provider, then MICRA applies to the medical group as well. (See Section B(2)(m), *post*.) Only if the employee whose conduct injured the plaintiff is not a health care provider does it matter whether the medical group itself is a health care provider.

(l) A HMO is not a “health care provider.”

Health care service plans and managed care entities are not health care providers within the meaning of MICRA. (Civ. Code, § 3428, subd. (c); Health & Saf. Code, § 1367.01, subd. (m); *Palmer, supra*, 103 Cal.App.4th at pp. 970-971 & fn. 9.)

(m) A federally employed doctor or a federal hospital is a “health care provider.”

Taylor v. United States (9th Cir. 1987) 821 F.2d 1428, 1431-1432; *Fetter v. United States* (S.D.Cal. 1986) 649 F.Supp. 1097, 1099-1101; see *Turner v. United States* (N.D.Cal., Feb. 26, 2019, No. 17-cv-02265-WHO) 2019 WL 935978, at pp. *1, *3 [nonpub. opn.].

(n) Vicarious liability.

(1) For the professional negligence of a health care provider.

MICRA applies. (*Lathrop, supra*, 114 Cal.App.4th at pp. 1421-1427.) “Because the vicarious liability of [an] employer is *wholly* dependent upon or derivative from the liability of the employee, any substantive defense that is available to the employee inures to the benefit of the employer. [Citation.] An employer cannot be held vicariously liable for an amount of compensatory damages that exceeds the amount for which the employee is liable.” (*Id.* at p. 1423, emphasis added.) “Nothing in MICRA reflects any legislative intention to abrogate the common law rules related to the doctrine of respondeat superior. Accordingly, we conclude that the liability of HealthCare Partners, as employer or principal, is limited to the liability of its employees or agents, Drs. Friedman, Diamond, and Rapaport. Under Civil Code section 3333.2, HealthCare Partners cannot be held vicariously liable for noneconomic damages in excess of [the MICRA limit].” (*Id.* at p. 1424.) “We reject the argument made by plaintiffs that the rule limiting damages from a vicariously liable employer applies only when a judgment is also entered against the

employee. . . . The rationale for limiting damages operates to the same effect whether the limitations on the employee's liability are set by the judgment or by statute. In either event, the employer can have no greater liability than the employee." (*Ibid.*) "Exempting vicariously liable defendants from the [statutory] damages cap would undermine the legislative goal of replacing unpredictable jury awards with an across-the-board limit. Plaintiffs would need only to sue the entity employing the negligent physician to circumvent the MICRA cap. In order to preserve the purposes and policies of MICRA, the [statutory] limit on noneconomic damages imposed by Civil Code section 3333.2 must be applied to actions against the employers of health care providers based on respondeat superior just as the limit is applied to actions against health care providers directly." (*Id.* at p. 1426.)

Citing *Lathrop*, the court in *Canister*, *supra*, 160 Cal.App.4th 388, said: "Under the respondeat superior doctrine, MICRA applies to an employing entity held vicariously liable for the professional negligence of its agents, if such agents are health care providers. [Citation.] When the liability of an employer in a medical malpractice action is wholly derivative and not based on fault, the vicariously liable employer is entitled to invoke against the injured plaintiff whatever limitations on liability are available to its health care provider employee." (*Id.* at p. 395, fn. 4; see *id.* at p. 403 ["The services that EMT's provide to patients are 'inextricably identified' with the health of patients, and an ambulance company vicariously assumes the same standing with such patients through its licensed employees"].)

The Court of Appeal in *Cochrum v. Costa Victoria Healthcare, LLC* (2018) 25 Cal.App.5th 1034, 1051-1053 distinguished *Lathrop* and held that the MICRA cap on noneconomic damages was inapplicable to the owner of the skilled nursing facility where plaintiff died after choking on his food. The *Cochrum* court explained that the facility owner was not held vicariously responsible for the professional negligence of the healthcare

providers at the skilled nursing facility, but instead was vicariously liable for negligent understaffing of the facility by a facility administrator who was not a healthcare provider under MICRA.

(2) For the negligence of an unlicensed employee of a health care provider.

MICRA should apply. (See *Taylor, supra*, 821 F.2d at p. 1432 [MICRA applied where patient in Army hospital became disconnected from ventilator for unknown reason; hospital had professional duty to prevent disconnection “regardless of whether separation was caused by the ill-considered decision of a physician or the accidental bump of a janitor’s broom”]; *Scholz v. Metropolitan Pathologists, P.C.* (Colo. 1993) 851 P.2d 901, 905 [Colorado’s version of MICRA applied to health care provider that employed unlicensed lab technician who mislabeled slides].) The *Scholz* case was cited with approval in *Chosak, supra*, 153 Cal.App.4th at page 567. *Chosak* said the following about *Scholz*: “In *Scholz* . . . , the plaintiff suffered an unnecessary surgery as a result of a laboratory technician’s error in labeling tissue sample slides. [Citation.] Like California, Colorado has a statute limiting noneconomic damages in medical malpractice actions. The Colorado statute covers actions against ‘health care professionals,’ defined as persons licensed to practice medicine. [Citation.] The plaintiff argued that his claims against the technician were not covered by the statute because the technician was not a licensed professional. In rejecting the argument, notwithstanding the language of the statute, the court noted, ‘In seeking to curb the increasing costs of malpractice insurance in this state, there is nothing in the [statute limiting noneconomic damages] which suggests the legislature sought to do so only by limiting recoveries for actions brought against licensed professionals or professional corporations and entities whose liability results solely from the conduct of those professionals. The reason that no such suggestion exists is clear: the negligent conduct of unlicensed employees, such as [the laboratory technician], who contribute to providing health care services affects the insurance

premiums that health care providers pay, just as the conduct of professionals within those entities does.’” (*Ibid.*)

(o) The phrase “legal representatives” in the definition of “health care provider” has been construed to mean a health care provider’s estate.

This seems incorrect. In *Flores v. Natividad Medical Center* (1987) 192 Cal.App.3d 1106, 1116, footnote 3, the Court of Appeal said: “The apparent intent of the Legislature in including the term ‘legal representatives’ in the code definition of a health care provider was to extend to the heirs of a physician, or other medical classifications considered therein, the same protection afforded to the medical provider in suits against the provider’s estate if the provider is deceased at the time the legal action is brought.” This narrow construction of the term “legal representatives” seems incorrect. If the Legislature only intended to refer to cases in which the health care provider is deceased, it would have used the term “*personal* representative” instead of “legal representatives.” A health care provider’s estate has a *personal* representative—the executor or administrator. (See Prob. Code, §§ 58, 8400 et seq.)

More likely, the Legislature used the term “*legal* representatives” in the same sense that this term is used in Code of Civil Procedure section 473, subdivision (b), which provides in part: “The court may, upon any terms as may be just, relieve a party or his or her *legal representative* from a judgment” (Emphasis added.) In *Clemmer v. Hartford Insurance Co.* (1978) 22 Cal.3d 865, the Supreme Court held that a party’s insurer was its “legal representative”: “The term ‘legal representative’ has been interpreted with considerable liberality to permit one who would not normally be considered a ‘representative’ of a party but has a *sufficient interest in the action* to maintain the [section 473] motion.” (*Id.* at p. 885, emphasis added.) “The standing of Hartford to move to set aside the default judgment which it might otherwise *be required to satisfy* is therefore clear.” (*Id.* at p. 886, emphasis added.)

By parity of reasoning, the “legal *representatives*” of a health care provider should include *any* person or entity that might be required to pay damages as a result of the health care provider’s professional negligence, such as a vicariously liable employer.

(p) The law in other states.

See generally Annotation, Medical Malpractice: Who Are “Health Care Providers,” or the Like, Whose Actions Fall Within Statutes Specifically Governing Actions and Damages for Medical Malpractice (1993) 12 A.L.R.5th 1.

3. “Based upon professional negligence” defined.

(a) Statutory definition.

The MICRA statutes each define “professional negligence” as follows: “ ‘Professional negligence’ means a negligent act or omission to act by a health care provider in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death, provided that such services are within the scope of services for which the provider is licensed and which are not within any restriction imposed by the licensing agency or licensed hospital.”

(Bus. & Prof. Code, § 6146, subd. (c)(3); Civ. Code, §§ 3333.1, subd. (c)(2), 3333.2, subd. (c)(2); Code Civ. Proc., §§ 340.5, subd. (2), 364, subd. (f)(2), 667.7, subd. (e)(4), 1295, subd. (g)(2).)

(b) “Professional negligence” case law.

(1) Broadly construed.

The Supreme Court has construed “professional negligence” to include more than negligence in the rendering of services that require medical skills.

(a) *Flores v. Presbyterian Intercommunity Hospital* (2016) 63 Cal.4th 75.

The hospitalized plaintiff was injured when he fell out of bed. The plaintiff alleged the bed rail collapsed because the locking mechanism was

negligently maintained. The Court of Appeal held that equipment failure is ordinary, not professional, negligence. The Supreme Court reversed: “The rail had been raised according to doctor’s orders following a medical assessment of her condition. Because plaintiff’s injury resulted from alleged negligence in the use and maintenance of equipment needed to implement the doctor’s order concerning her medical treatment, we conclude that plaintiff’s claim sounds in professional, rather than ordinary, negligence.” (*Id.* at p. 79.)

Flores provides considerable guidance for courts faced with determining what is and what is not professional negligence, especially in the hospital setting. “ ‘[T]he test is not whether the situation calls for a high or a low level of skill, or whether a high or low level of skill was actually employed ’ ” (*Flores, supra*, 63 Cal.4th at p. 86.) “A medical professional or other hospital staff member may commit a negligent act in rendering medical care, thereby causing a patient’s injury, even where no particular medical skills were required to complete the task at hand.” (*Id.* at p. 85.) On the other hand, professional negligence is not so broad that it “cover[s] essentially every form of ordinary negligence that happens to occur on hospital property.” (*Id.* at p. 86.) It does not extend to “the obligations hospitals have, simply by virtue of operating facilities open to the public, to maintain their premises in a manner that preserves the well-being and safety of all users.” (*Id.* at p. 87.)

For example, professional negligence does not extend to “a visitor’s action for injuries resulting from a custodian’s negligence in leaving a broom on the hallway floor, or a doctor’s action against the hospital for failure to place a warning sign on a wet, recently mopped floor.” (*Flores, supra*, 63 Cal.4th at p. 86.) “Even those parts of a hospital dedicated primarily to patient care typically

contain numerous items of furniture and equipment—tables, televisions, toilets, and so on—that are provided primarily for the comfort and convenience of patients and visitors, but generally play no part in the patient’s medical diagnosis or treatment. Although a defect in such equipment may injure patients as well as visitors or staff, a hospital’s general duty to keep such items in good repair generally overlaps with the ‘obligations that all persons subject to California’s laws have’ [citation], and thus will not give rise to a claim for professional negligence. If, for example, a chair in a waiting room collapses, injuring the person sitting in it, the hospital’s duty with respect to that chair is no different from that of any other home or business with chairs in which visitors may sit.” (*Id.* at pp. 88-89.) Professional negligence “does not extend to negligence in the maintenance of equipment and premises that are merely convenient for, or incidental to, the provision of medical care to a patient.” (*Id.* at p. 88.)

In contrast, “Flores’s injuries . . . resulted from [the hospital’s] alleged negligence in the use or maintenance of equipment integrally related to her medical diagnosis and treatment. When a doctor or other health care professional makes a judgment to order that a hospital bed’s rails be raised in order to accommodate a patient’s physical condition and the patient is injured as a result of the negligent use or maintenance of the rails, the negligence occurs ‘in the rendering of professional services’ and therefore is professional negligence” (*Flores, supra*, 63 Cal.4th at p. 89.) In short, “whether negligence in maintaining hospital equipment or premises qualifies as professional negligence depends on the nature of the relationship between the equipment or premises in question and the provision of medical care to the plaintiff. A hospital’s negligent failure to maintain equipment that is necessary or otherwise integrally related to

the medical treatment and diagnosis of the patient implicates a duty that the hospital owes to a patient by virtue of being a health care provider.” (*Id.* at p. 88.)

For example, a “hospital’s negligent failure to prevent a patient from becoming separated from an oxygen ventilator . . . occurs in the ‘rendering of professional services’ [citation], ‘regardless of whether separation was caused by the ill-considered decision of a physician or the accidental bump of a janitor’s broom’ [citation]. If a doctor has determined that a hospitalized patient’s medical needs require a special diet, and the patient is injured because a hospital employee negligently gives the patient the wrong food, the hospital has inflicted injury in the rendering of professional services to the patient. And if hospital staff place a violently coughing patient on a gurney for X-rays, and the patient falls to the ground after the staff negligently leave her unsecured while the film is developed, the hospital has caused injury in the rendering of professional services to the patient, even though fastening straps requires no special skill.” (*Flores, supra*, 63 Cal.4th at pp. 85-86.)

- (b) ***Hedlund v. Superior Court***
(1983) 34 Cal.3d 695.

The health care provider defendants, seeking to apply a shorter period of limitations than MICRA allows, argued that “professional negligence” involves only acts in the course of diagnosis or treatment resulting in injury to the patient, and an injury to a third person resulting from a therapist’s failure to warn of a threat made by the patient is “ordinary negligence.” (*Id.* at p. 702.) However, the Court later “rejected that contention in *Hedlund*, concluding that the duty to warn was ‘inextricably interwoven’ with the doctor’s professional responsibilities. We reasoned: ‘*Tarasoff [v. Regents of University of California*

(1976) 17 Cal.3d 425] recognizes a right to expect that a licensed psychotherapist will realize when a patient poses a serious danger to another and, if that potential victim is identifiable, will act reasonably to protect the victim. The diagnosis and the appropriate steps necessary to protect the victim are not separate or severable, but together constitute the duty giving rise to the cause of action.’” (*Waters v. Bourhis* (1985) 40 Cal.3d 424, 432; see *Turner v. Rivera* (9th Cir. 2021) 835 F.Appx. 273, 274-275 [nonpub. opn.] [wrongful disclosure by therapist that patient was a threat to a third party constituted professional negligence].)

Following *Hedlund*, in *Limon v. College Hospital* (Aug. 17, 2011, B230179), 2011 WL 3612229 [nonpub opn.], the Court of Appeal held that a psychiatric hospital’s negligence in failing to protect a patient from sexual assault by another patient was professional, not ordinary negligence. “Acute psychiatric hospitals . . . admit patients who generally are, as a result of a mental disorder, a danger to themselves or others. [Citation.] Thus, just as the duty to warn a third party of a patient’s dangerousness is interwoven with a psychologist’s professional duty to properly diagnose the patient’s condition, here, [the hospital’s] duty to ensure the physical safety of psychiatric patients from themselves and each other cannot be extricated from its professional duty to properly diagnose and treat the patients’ mental disorders.” (*Id.* at p. *5; but see *Samantha B. v. Aurora Vista Del Mar, LLC* (2021) 72 Cal.App.5th 1092 [2021 WL 5996835, at pp. *6-*7], reh’g. granted Jan. 14, 2022 [evidence an acute psychiatric facility was aware female patients were vulnerable to sexual predation by male staff and implemented policies exposing patients to this high degree of risk sufficiently supported jury’s reckless neglect finding, establishing right to recover under the Elder Abuse Act, rather than MICRA].)

- (c) ***Mitchell v. Los Robles Regional Medical Center*** (2021) 71 Cal.App.5th 291.

A hospital patient sustained injuries when she fell because her legs “ ‘gave out’ ” while walking to the restroom. (*Id.* at pp. 294-295.) She sued the hospital for general negligence and premise liability based on the nurses’ refusal to assist her in walking to the bathroom. (*Id.* at pp. 295-296.) The trial court ruled the complaint was time-barred under Code of Civil Procedure section 340.5 because it involved “professional negligence,” and the patient appealed. (*Id.* at p. 296.) Relying on *Flores, supra*, 63 Cal.4th at p. 86, the Court of Appeal affirmed, reasoning that a nurse’s duty to protect a patient from falling while walking to the bathroom is a “duty owed to a patient, not a member of the general public.” (*Id.* at p. 299.) Because the alleged negligence concerned patient safety, rather than the conditions of the floor, her claims were based on professional negligence and subject to the MICRA statutes. (*Id.* at p. 298.)

- (d) ***Johnson v. Open Door Community Health Centers*** (2017) 15 Cal.App.5th 153.

After concluding her medical treatment, the plaintiff was leaving the treatment room when she tripped over a scale that partially obstructed her path from the room to the hallway. She suffered serious injuries. The Court of Appeal, applying *Flores*, held this was not professional negligence. “Johnson was injured after her care was completed. Although she tripped on medical equipment coincidentally used as part of her earlier medical treatment, she does not allege that Open Door’s failure to properly maintain the scale affected the quality of her medical treatment. She was weighed without incident. Had she alleged the improper placement of the scale caused her to fall off the scale and injure herself, MICRA might apply. Had she alleged that

Open Door’s failure to properly calibrate the scale resulted in inaccurate information and inappropriate medical care, any resulting claim would almost certainly be subject to MICRA. However, she alleges that Open Door’s placement of the scale posed a tripping hazard, implicating Open Door’s duty to *all users* of its facility, including patients, employees, and other invitees, to maintain safe premises.” (*Id.* at p. 160.) “[T]he nature of the object does not matter—the scale could have just as easily been a broom or a box of medical supplies—what is material is that the duty owed by Open Door was not owed exclusively to patients.” (*Ibid.*)

- (e) ***Nava v. Saddleback Memorial Medical Center*** (2016) 4 Cal.App.5th 285.

The hospitalized plaintiff was being transferred from a gurney when it tipped and the plaintiff fell to the ground, suffering bone fractures. The Court of Appeal, applying *Flores*, held “the alleged negligence in the use or maintenance of the gurney from which Nava fell was integrally related to his medical diagnosis or treatment. Whether the fall occurred while Nava was being transferred from the gurney to an X-ray table in the radiology department, or from the gurney to an ambulance [it was unclear which had occurred], such a transfer must have been made subject to a medical professional’s directive. . . . Therefore, the negligence occurred in the rendering of professional services” (*Id.* at p. 292; see *id.* at p. 288, fn. 1; *Tate v. UC Davis Medical Center* (Apr. 9, 2021, A156602) 2021 WL 1326485, at p. *2 [nonpub. opn.] [although pled as a contract claim, the gravamen was the doctor’s decision to discharge and arrange for transportation, which is “undoubtedly a component of the rendering of medical care ‘within the scope of services for which the provider is licensed’ ”].)

(f) ***Aldana v. Stillwagon***
(2016) 2 Cal.App.5th 1.

The plaintiff was in an auto accident with a pickup truck driven by a paramedic supervisor who was en route to an injured fall victim to supervise the responding emergency medical technicians and, if necessary, provide assistance. The trial court applied MICRA and the plaintiff appealed, arguing the paramedic supervisor was not providing professional services when the accident occurred. The Court of Appeal agreed with the plaintiff: “While Stillwagon’s status as a paramedic may demonstrate that he was a medical professional, the automobile collision remains a ‘garden-variety’ accident not resulting from the violation of a professional obligation but from a failure to exercise reasonable care in the operation of a motor vehicle. [Citations.] The obligation was one that he owed to the general public by virtue of being a driver and not one that he owed to a patient by virtue of being a paramedic.” (*Id.* at p. 5.) “Driving to an accident victim is not the same as providing medical care to the victim. A paramedic’s exercise of due care while driving is not ‘necessary or otherwise integrally related to the medical treatment and diagnosis of the patient’ [citing *Flores, supra*, 63 Cal.4th at p. 88], at least when the patient is not in the vehicle. Accordingly, MICRA does not apply here.” (*Id.* at p. 8.)

The Court of Appeal in *Aldana* had this to say about the *Canister* case: “*Canister* concluded that both the EMT driving the ambulance and the EMT attending the patient were rendering professional services. [Citation.] In light of *Flores*, it is questionable whether this conclusion was correct. The Supreme Court . . . explained that MICRA does not apply to a medical professional’s negligent act or omission ‘merely because it violates a state licensing requirement.’” (*Aldana, supra*, 2 Cal.App.5th at p. 7.) Moreover, “[e]ven if

Canister was correctly decided, it is distinguishable. . . . Driving a non-ambulance vehicle to the scene of an injured victim is outside the scope of the duties for which a paramedic is licensed. Under *Canister*, MICRA would not apply.” (*Id.* at pp. 7-8.)

In *Johnson v. Open Door Community Health Centers, supra*, 15 Cal.App.5th 153, the Court of Appeal said:

While the court’s rationale, in *Canister*, does not comport with *Flores*’s analysis, the outcome is arguably correct, in that (1) the negligent performance of tasks requiring no medical skill or training may nonetheless implicate professional medical services and trigger the application of MICRA [citation]; and (2) the EMTs who allegedly operated an ambulance without due care were rendering professional services at the time and their failure to do so competently caused the officer’s injuries.

(*Id.* at p. 162; see *King v. McMichael* (Nov. 29, 2022, B322579) 2022 WL 17260874, at p. *8 [nonpub. opn.] [acknowledging that driving an ambulance might not always constitute a professional medical service under MICRA but holding that it does when transporting patients].)

- (g) ***Arroyo v. Plosay***
(2014) 225 Cal.App.4th 279.

The Court of Appeal said negligently disfiguring a decedent’s body when placing it in a refrigerated compartment in a hospital morgue is professional negligence. (*Id.* at pp. 297-298.)

- (h) ***Canister v. Emergency Ambulance Service, Inc.*** (2008) 160 Cal.App.4th 388.

The Court of Appeal held that negligence by an emergency medical technician (EMT) while

driving an ambulance transporting a patient was “professional negligence” within the meaning of MICRA. The plaintiff, a police officer, was accompanying an arrestee in the back of the ambulance when it hit a curb, injuring the officer. “The accident occurred while EAS’s employees were transporting the patient from one hospital to another An integral part of the duties of an EMT includes transporting patients and driving or operating an ambulance.” (*Id.* at p. 407.) “We hold, as a matter of law, that the act of operating an ambulance to transport a patient to or from a medical facility is encompassed within the term ‘professional negligence.’” (*Id.* at p. 404.) “That appellant was not a patient does not affect application of MICRA. By their terms, MICRA statutes apply to negligent conduct by a health care provider in the rendering of professional services and is [*sic*] not limited to actions by the recipient of professional services. [Citations.] Indeed, MICRA limitations apply ‘to any foreseeable injured party, including patients, business invitees, staff members or visitors, provided the injuries alleged arose out of professional negligence.’ [Citation.] As applied to the present facts, it is foreseeable as a matter of law that a police officer accompanying an arrestee in an ambulance might be injured in the operation of the ambulance.” (*Id.* at pp. 407-408.)

King, supra, 2022 WL 17260874, at page *6, agreed with *Canister*, holding that an EMT’s negligent operation of an ambulance qualified as professional negligence under MICRA where the EMT rear-ended plaintiff’s vehicle while transporting a patient to the hospital. Even though the EMT was not licensed by the DMV to drive the ambulance, the requirement “that the professional services rendered fall within the scope of the health care provider’s license” was met by the driver’s EMT license. (*Ibid.*)

- (i) ***Titolo v. Cano***
(2007) 157 Cal.App.4th 310.

The Court of Appeal said, “Communications between physicians and insurance companies regarding the diagnosis and treatment of patients are a necessary part of the provision of medical services to those patients.” (*Id.* at p. 318.)

- (j) ***David M. v. Beverly Hospital***
(2005) 131 Cal.App.4th 1272.

The Court of Appeal held that “allegations that a physician negligently failed to report suspected child abuse, which should have been discovered during a medical examination while rendering professional services, constitute a claim for professional negligence within the meaning of [MICRA]” (*Id.* at pp. 1274-1275; see *id.* at pp. 1277-1278, 1281.) Also, “negligence in the failure of [a] hospital to fulfill its duty to ensure compliance by its doctors, nurses and other agents with the mandatory child abuse reporting requirements . . . would amount to professional negligence within the meaning of [MICRA]” (*Id.* at p. 1281.)

- (k) ***Francies v. Kapla***
(2005) 127 Cal.App.4th 1381.

The Court of Appeal held that a doctor’s violation of the Confidentiality of Medical Information Act, by disclosing the patient’s HIV status to the patient’s employer, was based on professional negligence. (*Id.* at p. 1386, fn. 11.)

- (l) ***Cryolife, Inc. v. Superior Court***
(2003) 110 Cal.App.4th 1145.

The Court of Appeal held that a tissue bank provides professional services, not a product. (*Id.* at p. 1158.)

- (m) ***Scripps Clinic v. Superior Court***
(2003) 108 Cal.App.4th 917.

The Court of Appeal held that “a decision to withdraw from the treatment of a patient is a medical decision, not an administrative decision, which falls within the context of medical negligence because it is a decision that occurs during medical treatment and is governed by the law of abandonment.” (*Id.* at pp. 942-943.) Therefore, “Scripps’s termination of medical care [because the patient sued two Scripps physicians for medical malpractice] arose in the context of professional negligence” within the meaning of Code of Civil Procedure section 425.13. (*Id.* at p. 942.)

- (n) ***Palmer v. Superior Court***
(2002) 103 Cal.App.4th 953.

The Court of Appeal held that “allegedly injurious utilization review” (i.e., advising whether requested medical services, equipment, or supplies were “medically necessary”), performed under a contract between an HMO and a medical group by a physician employed by the medical group, “amounted to a medical clinical judgment such as would arguably arise out of professional negligence. We disagree . . . that this was a purely administrative or economic role played by [the medical group]. Rather, the statutes require that utilization review be conducted by medical professionals, and they must carry out these functions by exercising medical judgment and applying clinical standards.” (*Id.* at p. 972.) “The [medical group’s] medical director who made the disputed ‘lack of medical necessity’ decision was acting as a health care provider as to the medical aspects of that decision. That there was also a financial coverage consequence of that decision is not dispositive for purposes of applying [Code of Civil Procedure] section 425.13 definitions of professional negligence of a health care provider.

Such medical necessity decisions take place in the context of professional duties of care.” (*Id.* at p. 969; see *Scripps Clinic, supra*, 108 Cal.App.4th at p. 942.)

Palmer involved Code of Civil Procedure section 425.13, which governs the inclusion of a punitive damage claim in an action for professional negligence against a health care provider. But section 425.13 uses the MICRA definition of “professional negligence.” (*Williams v. Superior Court* (1994) 30 Cal.App.4th 318, 322-323; see *Palmer, supra*, 103 Cal.App.4th at p. 961 [“It is well established that the legislative history of the term, ‘professional negligence,’ as found in MICRA, may be used to interpret that term as used in section 425.13, to determine the scope of conduct afforded these protections under MICRA-related provisions. [Citation.] It is also well accepted that ‘statutory sections relating to the same subject must be read together and harmonized.’”].) Therefore, negligent utilization review should be considered “professional negligence” within the meaning of MICRA as well as section 425.13.

- On September 25, 2020, California Governor Gavin Newsom signed Senate Bill No. 855 (2019-2020 Reg. Sess.) (S.B. 855) into law, which alters California’s regulation of mental health and substance use disorders (MH/SUD). S.B. 855 applies to all California health plans and disability insurance policies issued, amended, or renewed on or after January 1, 2021, and establishes a uniform definition of “medical necessity” for MH/SUD services. (*Id.*, § 4, subd. (a)(1), (2).) The bill defines a “‘medically necessary treatment of a mental health or substance use disorder’” as “a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or

treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms.” (*Id.*, § 4, subd. (a)(3)(A) [new Health and Safety Code section 1374.72].) The “service or product” must address those needs in a manner that is (1) “[i]n accordance with the generally accepted standards of mental health and substance use disorder care”; (2) “[c]linically appropriate in terms of type, frequency, extent, site, and duration”; and (3) “[n]ot primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider.” (*Ibid.*) “‘Generally accepted standards of mental health and substance use disorder care’ means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties” and can be “peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the” FDA. (*Id.*, § 5, subd. (f)(1).)

- (o) ***Johnson v. Superior Court***
(2002) 101 Cal.App.4th 869.

The Court of Appeal held that doctors employed by a sperm bank were providing professional services when they interviewed and approved a donor. (*Id.* at pp. 883-886.)

- (p) ***Bellamy v. Appellate Department***
(1996) 50 Cal.App.4th 797.

The plaintiff fell off an X-ray table that was not secured. The Court of Appeal followed *Murillo v. Good Samaritan Hospital* (1979) 99 Cal.App.3d 50 (discussed below), reasoning: “That the alleged negligent omission was simply the failure to set a brake on the rolling X-ray table or the failure to hold the table in place, neither of which requires any particular skill, training, experience or exercise of professional judgment, does not affect our decision. We presume that during the course of administering an examination or therapy like that which Bellamy underwent, an X-ray technician may perform a variety of tasks, such as assisting the patient onto the table, manipulating the table into one or more desired positions, instructing the patient to move from one position to another, activating the X-ray machine, removing the photographic plates, assisting the patient from the table, etc. Some of those tasks may require a high degree of skill and judgment, but others do not. Each, however, is an integral part of the professional service being rendered. Trying to categorize each individual act or omission, all of which may occur within a space of a few minutes, into ‘ordinary’ or ‘professional’ would add confusion in determining what legal procedures apply if the patient seeks damages for injuries suffered at some point during the course of the examination or therapy. We do not see any need for such confusion or any indication the Legislature intended MICRA’s applicability to depend on such fine distinctions.” (*Id.* at p. 808, fn. omitted; see *Hirzallah v. Regents of the University of California* (May 24, 2021, G058914) 2021 WL 2068726, at pp. *2-*3 [nonpub. opn.] [Doctor opened exam room door, striking and injuring the plaintiff who was laying on the exam table. Relying on *Bellamy*, the Court of Appeal found plaintiff’s claims were based on professional negligence, rather than premise liability.

“Plaintiff was injured because the table was negligently placed, but defendants’ duty to place the table properly is owed only to those likely to mount the table and be injured—namely, patients.”].)

- (q) ***Mero v. Sadoff***
(1995) 31 Cal.App.4th 1466.

The plaintiff filed a workers’ compensation claim and was examined by a doctor retained by the employer’s attorney. The plaintiff sued the doctor, alleging that her injury was exacerbated by the examination. The Court of Appeal held the limitations period applicable to “medical malpractice” applied. “[A] negligence action involving services rendered by a physician will be considered one for medical malpractice if it involves or substantially relates to the rendition of medical treatment by a licensed physician.” (*Id.* at p. 1479.)

- (r) ***Williams v. Superior Court***
(1994) 30 Cal.App.4th 318.

“We agree with the *Murillo* court that it is not the degree of skill required but whether the injuries arose out of the rendering of professional services that determines whether professional as opposed to ordinary negligence applies.” (*Id.* at p. 327.) Allegations that the defendant became aware of a patient’s dangerous propensities and failed to warn a nonemployee who was drawing blood from the patient were directly related to the manner in which professional services were rendered. Accordingly, the action was one for “professional negligence.” (*Id.* at pp. 325-326.)

- (s) ***Osborn v. Irwin Memorial Blood Bank***
(1992) 5 Cal.App.4th 234.

The Court of Appeal said “there is no question that donor screening and blood testing are ‘professional services’ for purposes of MICRA. . . .” (*Id.* at p. 271.)

- (t) ***Bell v. Sharp Cabrillo Hospital***
(1989) 212 Cal.App.3d 1034.

The Court of Appeal held “professional negligence” includes a hospital’s failure to fulfill its duty under *Elam v. College Park Hospital* (1982) 132 Cal.App.3d 332, 346, to screen the competency of its medical staff to insure the adequacy of medical care rendered to patients at its facility. “Because a hospital’s effectiveness in selecting and periodically reviewing the competency of its medical staff is a necessary predicate to delivering quality health care, its inadequate fulfillment of that responsibility constitutes ‘professional negligence’ involving conduct necessary to the rendering of professional services within the scope of the services a hospital is licensed to provide.” (*Bell*, at p. 1051.) “Employing the terminology in *Hedlund*[, *supra*, 34 Cal.3d at pages 703-704], the competent performance of this responsibility is ‘inextricably interwoven’ with delivering competent quality medical care to hospital patients.” (*Bell*, at p. 1051.)

- (u) ***Rose v. Fife***
(1989) 207 Cal.App.3d 760.

The plaintiff alleged both professional negligence and ordinary negligence. The Court of Appeal said: “All of Fife’s alleged wrongful acts in these two causes of action stem from actions taken in his capacity as plaintiff’s doctor and therefore come within the terms of [the MICRA statute of limitations].” (*Id.* at p. 767, fn. 6.)

- (v) ***Atienza v. Taub***
(1987) 194 Cal.App.3d 388.

The Court of Appeal said, “a physician who induces a patient to enter into sexual relations is liable for professional negligence only if the physician engaged in the sexual conduct on the pretext that it was a necessary part of the treatment for which the patient has sought out the physician. . . . Appellant does not allege that she was induced to have sexual relations with respondent in furtherance of her treatment. Essentially, appellant complains that she had an unhappy affair with a man who happened to be her doctor. This is plainly insufficient to make out a cause of action for professional negligence” (*Id.* at pp. 393-394, fn. omitted.)

- (w) ***Murillo v. Good Samaritan Hospital***
(1979) 99 Cal.App.3d 50.

The plaintiff was injured when she fell out of bed while a patient in the hospital. Seeking to apply a shorter period of limitations than would be available under MICRA’s Code of Civil Procedure section 340.5, the hospital argued the failure to raise the bedrails was “ordinary negligence” rather than “professional negligence.” (*Id.* at p. 53.) The Court of Appeal disagreed: “[T]he test is not whether the situation calls for a high or low level of skill, or whether a high or low level of skill was actually employed, but rather the test is whether the negligent act occurred in the rendering of services for which the health care provider is licensed. When a seriously ill person is left unattended and unrestrained on a bed or gurney, the negligent act is a breach of the hospital’s duty as a hospital to provide appropriate care and a safe environment for its patients.” (*Id.* at p. 57.)

- In *Flowers v. Torrance Memorial Hospital Medical Center* (1994) 8 Cal.4th 992, the

Supreme Court disapproved *Murillo* “to the extent [it] may be inconsistent with the analysis herein.” (*Id.* at p. 1002, fn. 6.) *Flowers* held, “whether the cause of action is denominated ‘ordinary’ or ‘professional’ negligence or both, ultimately only a single standard [of care] can obtain under any given set of facts and any distinction is immaterial to resolving a motion for summary judgment.” (*Id.* at p. 1000, fn. omitted.) It is difficult to see what, if anything, in *Murillo* “may be” inconsistent with *Flowers*. The Supreme Court itself said *Murillo* was irrelevant to the issue presented in *Flowers*. (*Id.* at p. 999.)

- In *Flores*, *supra*, 63 Cal.4th 75, the Supreme Court discussed *Murillo* at length. (*Id.* at pp. 83-84.) The Supreme Court agreed with *Murillo* that “‘the test is not whether the situation calls for a high or a low level of skill, or whether a high or low level of skill was actually employed’” (*Id.* at p. 86.) But the Supreme Court disagreed that the test is whether the negligent act occurred in the rendering of services for which the health care provider is licensed. (*Id.* at pp. 84-87.) “In our view, a hospital’s negligent act or omission does not qualify as negligence ‘in the rendering of professional services’ [citation] merely because it violates a state licensing requirement” (*Id.* at p. 86.) The test is whether the “action[] alleg[es] injury suffered as a result of negligence in rendering the professional services that hospitals and others provide by virtue of being health care professionals: that is, the provision of medical care [(medical diagnosis and treatment)] to patients.” (*Id.* at p. 88; see *id.* at p. 85; see also *ante*, Section B(3)(b)(1)(a) [discussing *Flores*].)

- (x) ***Taylor v. United States***
(9th Cir. 1987) 821 F.2d 1428.

The plaintiff's husband was hospitalized in an Army hospital and became disconnected from the ventilator on which he was dependent for oxygen. The Ninth Circuit, relying on *Murillo*, held this was a case of "professional negligence," reasoning: "There is little evidence concerning the reason that Taylor's husband's ventilator became disconnected. However, Taylor's husband was under the care of government physicians at the time of the incident, the injury occurred in the hospital, and the injury was caused by removal of medical equipment integral to treatment [¶] The government had a professional duty to prevent Taylor's husband from becoming separated from his ventilator, regardless of whether separation was caused by the ill-considered decision of a physician or the accidental bump of a janitor's broom." (*Id.* at p. 1432.)

- (y) ***Hernandez v. Baxter Healthcare Corp.***
(C.D.Cal., Aug. 25, 2015, No. SACV 15-01075-CJC(DFMx)) 2015 WL 5031960 [nonpub. opn.].

The district court said that negligence claims related to training a home patient to use dialysis equipment are professional negligence. (*Id.* at pp. *2-*3.)

- (z) ***Manion v. Vintage Pharmaceuticals LLC***
(N.D.Cal., Oct. 16, 2013, No. C-13-2996 EMC) 2013 WL 5645159 [nonpub. opn.].

The plaintiffs alleged that CVS Pharmacy negligently waited 11 days to notify her that the pills she was taking had been recalled. (*Id.* at p. *1.) The district court ruled that this was professional negligence: "CVS was rendering professional services . . . when it notified Plaintiffs of the . . . recall. . . . Notifying a patient of a drug's defect is communication to 'promote patient

health.’ The purpose of CVS’s conduct was to deliver health care” (*Id.* at p. *3.)

(2) Some unusual circumstances.

- (a) ***Romero v. Kaiser Foundation Health Plan, Inc.***
(Jan. 19, 2018, B277499) 2018 WL 481564,
[nonpub. opn.].

In *Romero*, an attorney appealed from an order granting his petition for an award of attorney fees made in connection with the approval of his minor client’s compromise of a medical malpractice claim. (*Id.* at p. *1.) The complaint asserted one claim for “ ‘Professional Negligence’ ” and a second claim for “ ‘Wilful Misconduct.’ ” (*Id.* at pp. *1, *9.) The first cause of action “plainly fell within the scope of MICRA” but the court had to consider “whether the inclusion of the second purported claim for ‘Wilful Misconduct’ removed this action and settlement from MICRA’s purview.” (*Id.* at p. *9.) “Notwithstanding the ‘Wilful Misconduct’ label, the conduct alleged against the Physician Defendants in the complaint’s second cause of action plainly constitutes ‘professional negligence’ as defined by MICRA. The complaint allege[d] Plaintiff’s mother ‘employed [Physician] Defendants . . . to diagnose and treat her high risk condition of pregnancy, and to take appropriate action for her care and the care of the fetus within her, including . . . pre-natal care, delivery and post-delivery care.’ The ‘Wilful Misconduct’ cause of action allege[d] the Physician Defendants ‘were aware of the possibility of severe neurological damage to Plaintiff if she were not delivered promptly,’ and ‘[n]otwithstanding this knowledge, none of [the Physician Defendants] took any steps to expedite a “crash” cesarian [*sic*] section and allowed Plaintiff to linger in utero, developing hypoxic ischemic encephalopathy to the point it became irreversible.’ ” (*Ibid.*) The Court of Appeal held that “[u]nder any fair and reasonable

interpretation of the complaint's allegations, the alleged failure to expedite a crash cesarean section was an 'omission to act by a health care provider in the rendering of professional services' and the alleged 'proximate cause of [Plaintiff's] personal injury.' [Citation.] Thus, the claim as pled plainly constituted 'an action for injury or damage against a health care provider based upon such person's alleged professional negligence.' ” (*Ibid.*)

- (b) ***Vazquez de Mercado v. Superior Court***
(2007) 148 Cal.App.4th 711.

The plaintiffs hired a veterinarian to examine a horse before they purchased it. Subsequently, they sued the veterinarian seeking damages for the purchase price of the horse and costs of its care. The Court of Appeal held a veterinarian is a “health care provider” within the meaning of MICRA, but the harm the plaintiffs alleged did not fall within MICRA’s definition of “professional negligence,” i.e., a “‘negligent act or omission to act by a health care provider in the rendering of professional services, which act or omission is the proximate cause of a *personal injury or wrongful death . . .*’” (*Id.* at p. 715, emphasis added.) The court concluded, quite simply, that the plaintiffs “did not suffer personal injuries or wrongful death.” (*Ibid.*) In response to the plaintiffs’ argument that, if personal injury or wrongful death applies only to humans, “veterinarians will never fall within the statute,” the court said: “We can conceive of situations where an animal’s owner could experience personal injury based on a veterinarian’s professional negligence. That this might not be the norm or occur with frequency does not lead to the conclusion that the statute defining professional negligence should be interpreted any more broadly than its plain language. We express no opinion whether the statute covers injuries to or the death of animals being treated by veterinarians.” (*Id.* at p. 716; see

Scharer v. San Luis Rey Equine Hospital, Inc.
(2012) 204 Cal.App.4th 421, 427-429.)

- (c) ***Flores v. Natividad Medical Center***
(1987) 192 Cal.App.3d 1106.

The Court of Appeal held that MICRA does not apply to an action by a prisoner against the State for failure to summon medical aid, even though the employees who failed to summon medical aid, i.e., failed to transfer the plaintiff to a hospital, were doctors. The court explained: “If the gravamen of the action against the State were professional negligence, MICRA would not apply as the State is immune from liability for such negligence of its employees.” (*Id.* at p. 1116.) In response to the State’s argument that “it would be anomalous to apply MICRA limitations to recovery against the State doctors but not to recovery against the State itself based upon the same negligent acts of the doctors in failing to summon medical care,” the court said, “It would be at least equally anomalous, we think, to insulate the State from liability simply because, fortuitously, the employees who failed to summon assistance were doctors rather than other prison personnel.” (*Id.* at pp. 1116-1117.)

- (d) ***Ellis v. City of San Diego***
(9th Cir. 1999) 176 F.3d 1183.

The plaintiff, an arrestee, brought a federal civil rights action against a doctor who catheterized him against his will. The Ninth Circuit held that MICRA does not apply to suits for violation of federal civil rights. (*Id.* at pp. 1186, 1190-1191.) The court explained, “Ellis is suing [the doctor] not for incorrectly inserting the catheter or needle while treating him, but for searching his bladder and bloodstream without a warrant or probable cause, and for using excessive force while doing so. [The doctor] is therefore not being sued for the manner in which she performed *medical services*

or *treatment*, but because of her assumption of the function of a law enforcement official; MICRA does not protect her with respect to the latter form of conduct.” (*Id.* at p. 1191, original emphasis.)

(3) A statutory proviso.

In *Waters, supra*, 40 Cal.3d at pages 435-436, the Supreme Court construed the proviso in MICRA’s definition of “professional negligence” that excepts acts or omissions of a health care provider that are “within any restriction imposed by the licensing agency or licensed hospital.” The Court held the proviso “was not intended to exclude an action from . . . MICRA . . . simply because a health care provider acts contrary to professional standards or engages in one of the many specified instances of ‘unprofessional conduct.’ Instead, it was simply intended to render MICRA inapplicable when a provider operates in a capacity for which he is not licensed—for example, when a psychologist performs heart surgery.” (*Id.* at p. 436.)

(c) “Based upon” professional negligence.

(1) Intentional torts.

The Court of Appeal has consistently held that MICRA does not apply to true intentional torts, i.e., that intentional torts are not “based upon” professional negligence. The Supreme Court seems to agree.

(a) *Covenant Care, Inc. v. Superior Court*
(2004) 32 Cal.4th 771.

The Supreme Court held that Code of Civil Procedure section 425.13, restricting punitive damage claims in actions “arising out of the professional negligence of a health care provider,” does not apply to a claim for punitive damages against a health care provider under the Elder Abuse Act. “In its ordinary sense, ‘professional negligence’ is failure to exercise ‘knowledge,

skill, and care ordinarily employed by members of the profession in good standing.”’ [Citation.] Hence, such misconduct as plaintiffs alleged—intentional, egregious, elder abuse—cannot be described as mere ‘professional negligence’ in the ordinary sense of those words. But . . . in light of our prior pronouncements respecting section 425.13[, subd.](a) [referring to *Central Pathology, supra*, 3 Cal.4th at pages 191-192], that fact is not necessarily dispositive.” (*Covenant Care, Inc.*, at pp. 781-782.) *Central Pathology* held that section 425.13 applies in medical malpractice actions alleging intentional torts. (*Id.* at p. 782.) “Were we to hold otherwise, we reasoned, ‘injured patients seeking punitive damages in an action involving professional negligence could readily assert that their health care providers committed an intentional tort’ and thus by ‘artful pleading’ effectively ‘annul the protection afforded [health care providers] by that section.’” (*Ibid.*) “No analogous threat looms here; praying for punitive damages in an action based on a violation of the Elder Abuse Act does not substantively transform the action as does adding an intentional tort claim in a malpractice action. While ‘minimally culpable defendants are often charged with intentional torts’ [citation] supporting punitive damage claims, elder abuse triggering the Act’s heightened remedy provisions entails by its nature egregious conduct. [Citations.] And while in the medical malpractice context ‘there may be considerable overlap of intentional and negligent causes of action’ [citation], no such overlap occurs in the Elder Abuse context, where the Legislature expressly has excluded ordinary negligence claims from treatment under the Act [citation].” (*Id.* at pp. 788-789.) “*Central Pathology* . . . guarantees that, notwithstanding our [decision] in this case, section 425.13 will continue to apply to a broad range of intentional torts typically pled in medical malpractice cases.” (*Id.* at p. 790.)

- (b) ***Barris v. County of Los Angeles***
(1999) 20 Cal.4th 101.

The Supreme Court held, “A claim under EMTALA [the federal Emergency Medical Treatment and Active Labor Act] for failure to stabilize [the plaintiff’s emergency medical condition before transfer to another facility] is . . . necessarily ‘based on professional negligence’ within the meaning of MICRA . . .” (*Id.* at p. 110.) The Supreme Court refused, however, to adopt the Court of Appeal’s rationale that the broad interpretation of the phrase “arising out of professional negligence” in *Central Pathology* should be extended to all MICRA provisions. (*Id.* at p. 115.) “We have not previously held that MICRA applies to intentional torts. Nor does *Central Pathology*, which involved a nonMICRA provision, so hold. As explained in our recent decision in *Delaney v. Baker* (1999) 20 Cal.4th 23, 40 . . . , *Central Pathology* did not purport to define the meaning of the term ‘professional negligence’ as used in MICRA. Rather, *Central Pathology* emphasized that the scope and meaning of the phrases ‘arising from professional negligence’ and ‘based on professional negligence’ could vary depending upon the legislative history and ‘the purpose underlying each of the individual statutes.’” (*Barris*, at pp. 115-116.)

In a footnote, the Supreme Court strongly suggested that MICRA does not apply to intentional torts, citing *Waters, supra*, 40 Cal.3d at page 437, and *Noble v. Superior Court* (1987) 191 Cal.App.3d 1189, 1190. (*Barris, supra*, 20 Cal.4th at p. 116, fn. 9.)

- (c) ***Delaney v. Baker***
(1999) 20 Cal.4th 23.

The Supreme Court narrowly interpreted the phrase “based on professional negligence” in the Elder Abuse Act to exclude reckless, oppressive,

fraudulent, or malicious conduct by a health care provider. (*Id.* at pp. 31-32, 35.) The Supreme Court said: “The *Central Pathology* court made clear that it was not deciding the meaning of the term ‘professional negligence’ used in MICRA or in statutes other than [Code of Civil Procedure section 425.13, subdivision (a)].” (*Id.* at p. 39.) The Supreme Court also said: “We emphasize that our interpretation of the phrase ‘based on professional negligence’ found in the unique statutory scheme of the Elder Abuse Act is not necessarily applicable to other statutes in which that phrase appears. Consistent with the *Central Pathology* court, we stress that the meaning of the phrase would depend upon the legislative history and underlying purpose of each of the statutes. [Citation.] Specifically, we do not purport to construe the meaning of the same phrase within the context of the MICRA statutes.” (*Id.* at p. 41.)

(d) ***Central Pathology Service Medical Clinic, Inc. v. Superior Court*** (1992) 3 Cal.4th 181.

The Supreme Court held that Code of Civil Procedure section 425.13, which restricts punitive damage claims in actions “arising out of the professional negligence of a health care provider,” applies to claims directly related to the manner in which professional services were provided, even if the claims could be characterized as intentional torts. In reaching this conclusion, the Supreme Court noted that the MICRA statutes are not limited to pure negligence actions: “We recognize that in the medical malpractice context, there may be considerable overlap of intentional and negligent causes of action. Because acts supporting a negligence cause of action might also support a cause of action for an intentional tort, we have not limited application of MICRA provisions to causes of action that are based solely on a ‘negligent act or omission’ as provided in these statutes. To ensure that the legislative intent underlying MICRA is implemented, we

have recognized that the scope of conduct afforded protection under MICRA provisions (actions ‘based on professional negligence’) must be determined after consideration of the purpose underlying each of the individual statutes.” (*Id.* at p. 192.)

- (e) ***Waters v. Bourhis***
(1985) 40 Cal.3d 424.

In this fee dispute between a former medical malpractice plaintiff and her attorney, the attorney argued that the plaintiff’s recovery in the underlying medical malpractice action “was based on *intentional misconduct* in which the psychiatrist engaged for personal, as opposed to professional, motives” (*Id.* at p. 433, original emphasis; see *id.* at pp. 434-435.) The Supreme Court viewed the underlying action as a “‘hybrid’ proceeding” alleging both non-MICRA and MICRA theories. (*Id.* at p. 436.) The Court held that Business and Professions Code section 6146, MICRA’s limit on contingent attorney fees, did not apply “when a plaintiff knowingly chooses to proceed on both non-MICRA and MICRA causes of action, and obtains a recovery that may be based on a non-MICRA theory” (*Id.* at p. 437.)

- (f) ***Brown v. Bleiberg***
(1982) 32 Cal.3d 426.

The Supreme Court held, without discussion, that the MICRA statute of limitations applied to the plaintiff’s professional negligence theory, but not to the plaintiff’s battery and breach-of-warranty theories. (*Id.* at pp. 431, fn. 1, 437.)

- (g) ***Burchell v. Faculty Physicians & Surgeons of Loma Linda University School of Medicine*** (2020) 54 Cal.App.5th 515.

The Court of Appeal held that the MICRA limitation on noneconomic damages applies to actions based on professional negligence but does not apply to certain types of medical battery. (*Id.* at pp. 523-524.) The court distinguished two types of medical battery. First, a battery is an intentional tort outside the scope of MICRA “ ‘when a physician obtains the patient’s consent to perform one type of treatment, but performs a substantially different treatment for which the plaintiff gave no consent.’ ” (*Id.* at p. 524.) Second, a battery is rooted in negligence within the scope of MICRA “ ‘when a physician performs the treatment for which consent was obtained and an infrequent complication occurs that the physician failed to disclose when obtaining the patient’s consent.’ ” (*Ibid.*) Here, the court held that the doctor committed the first type of medical battery and therefore the MICRA limitation did not apply. (*Ibid.*)

- (h) ***Bigler-Engler v. Breg, Inc.*** (2017) 7 Cal.App.5th 276.

The plaintiff was injured by a medical device prescribed by her doctor and rented from the medical group the doctor belonged to. The plaintiff sued the medical group on theories of medical malpractice, negligent failure to warn, and breach of fiduciary duty, and sued the doctor on theories of medical malpractice and intentional concealment. The Court of Appeal said: “[The plaintiff’s] cause of action for negligent failure to warn . . . rests on [the medical group’s] negligence in rendering professional services, i.e., its prescription and dispensation of the [medical device to the plaintiff] without adequate warnings [The plaintiff’s] claim for breach of fiduciary duty is equivalent to a cause of action

for lack of informed consent, also a form of professional negligence.” (*Id.* at pp. 321-322.) On the other hand, the cause of action against the doctor for intentional concealment “rests not on any negligent act or omission by [the doctor], but on [the doctor’s] intentional conduct.” (*Id.* at p. 322.) Apparently, the doctor did not inform the plaintiff that the doctor had a financial interest in the rental or that the device was available from sources other than the doctor’s medical group. (*Id.* at p. 287.) The Court of Appeal reasoned that “[the plaintiff’s] cause of action for concealment does not require proof of a standard of care. Instead, it requires proof of failure to disclose and, most critically, intent to deceive. It is not based on mere negligence . . . [W]e have no reason to conclude the Legislature intended [that MICRA apply to] fraudulent conduct merely because it occurred during medical treatment.” (*Id.* at p. 323.)

In contrast, in *Butler v. Paraguya* (June 19, 2015, A138792) 2015 WL 3814274, at pages *4-*6 [nonpub. opn.], and *Sam v. Garfield Beach CVS, LLC* (Jan. 15, 2015, E057531) 2015 WL 222497, at pages *6-*7 [nonpub. opn.], the Courts of Appeal rejected the plaintiffs’ attempts to get around MICRA by alleging fraud instead of, or in addition to, medical malpractice. In *Butler*, the Court of Appeal said: “[T]he factual nucleus of the fraud claim is indistinguishable from a claim for malpractice. The gravamen of Butler’s complaint is that [his doctor] failed to consult a nephrologist before discharging him, that she lied in order to cover up her professional failure, and that he suffered injuries through being discharged without proper treatment. Thus, in effect, plaintiff contends that because of [his doctor’s] tortious actions, he did not receive adequate medical care and suffered resulting harm.” (*Butler*, at p. *5.) “[A]lthough plaintiff has couched his allegations in terms of intentional fraud, the focus of his lawsuit is that he suffered a collapse and had to undergo

emergency medical procedures because he was discharged without having received a proper assessment by a nephrologist.” (*Id.* at p. *6.) In *Sam*, the Court of Appeal said: “Plaintiff asserts that his fraud claim is not founded on the rendering of professional services but, rather, is founded on marketing that induced customers to believe CVS’s quality control would prevent mistakes in filling customers’ prescriptions.” (*Sam*, at p. *6.) “[T]he gravamen of the malpractice and fraud causes of action does not differ. Both causes of action are founded on malpractice arising from CVS misfilling [*sic*] plaintiff’s prescription, causing him to overdose” (*Id.* at p. *7.)

Similarly, in *Altraide v. Keene* (Oct. 24, 2022, C094191) 2022 WL 13804075, at page *8 [nonpub. opn.], where plaintiff provided written notice of her intent to file a medical malpractice action two years before filing an action for fraud, the court held that her “attempt to recast her professional negligence claims as claims for fraud, breach of fiduciary duty, and breach of the covenant of good faith and fair dealing, d[id] not entitle her to a longer statute of limitations.”

In *Berlin v. Kim* (Apr. 27, 2021, B299116) 2021 WL 1624695, at page *8 [nonpub. opn.], the Court of Appeal affirmed that a fraud claim is based on professional negligence when it “relies on the same facts as, and is inextricably intertwined with, plaintiff’s professional negligence claim.” Defendants had performed spinal surgery on the plaintiff, which was to include certain procedures that were confirmed on the postsurgical notes. (*Id.* at p. *1.) However, a subsequent surgery determined the procedures had not been performed, and the plaintiff sued, alleging fraud based on the doctors’ failure to disclose that fact, rather than their negligence in performing the surgery. (*Id.* at pp. *1-*2.) The Court of Appeal rejected plaintiff’s argument, finding “the alleged

fraud cannot be separated from the alleged professional negligence because the information alleged to have been concealed from plaintiff is the alleged negligence *itself*.” (*Id.* at p. *8.)

- (i) ***Larson v. UHS of Rancho Springs, Inc.***
(2014) 230 Cal.App.4th 336.

The Court of Appeal held that MICRA applied to claims for battery and intentional infliction of emotional distress because they were based on the health care provider’s professional negligence. The plaintiff alleged the defendant “was the anesthesiologist for his surgery and injured [him] by forcefully grabbing and twisting his arm while conducting a preoperative checkup, and by prying open [his] mouth and violently punching, lifting, and pushing [his] face as he put on the mask to administer anesthesia.” (*Id.* at p. 351.) The Court of Appeal said “[t]hese allegations challenge the manner in which [the anesthesiologist] rendered the professional health care services he was hired to perform; they do not allege intentional torts committed for an ulterior purpose.” (*Ibid.*) “[The plaintiff] simply claims [the anesthesiologist] performed his professional services in an unnecessarily harsh and forceful manner, which amounts to a claim [the anesthesiologist] failed to meet the applicable standard of care in rendering his services.” (*Id.* at p. 352.) The plaintiff did not allege “some collateral source of conduct pursued for [the anesthesiologist’s] own gain or gratification.” (*Ibid.*) The Court of Appeal distinguished *So v. Shin* (2013) 212 Cal.App.4th 652: “[The plaintiff here] does not allege [the anesthesiologist] acted for any reason other than rendering professional services.” (*Larson*, at p. 354.)

In contrast, the Court of Appeal in *Eliason v. Ranken* (Oct. 18, 2022, C092879) 2022 WL 10250076, at page *4 [nonpub. opn.] held that MICRA did *not* apply to a claim for intentional

infliction of emotional distress against a therapist. Plaintiff alleged that his daughter's therapist intended to harm him by making false statements about him in a court document, resulting in plaintiff losing custody of his daughter. (*Ibid.*) The court held that such "alleged acts cannot be characterized as professional negligence," and thus section 340.5 did not bar the claim (even though plaintiff claimed negligence in the alternative). (*Ibid.*) Without explaining its rationale in detail, the *Eliason* court found *Larson*, where the claims were grounded in professional negligence based on the defendant's conduct "in the course of administering anesthesia," inapposite. (*Ibid.*)

- (j) ***So v. Shin***
(2013) 212 Cal.App.4th 652.

The plaintiff underwent a dilation and curettage (D&C) procedure following a miscarriage. She alleged that she was administered inadequate anesthesia and awoke during the procedure. When she later confronted the anesthesiologist, the anesthesiologist became angry, shoved a container filled with the plaintiff's blood and tissue at her, then urged the plaintiff not to report the incident. The plaintiff sued for negligence, assault and battery, and intentional infliction of emotional distress. (*Id.* at p. 656.) The Court of Appeal said: "[P]rofessional negligence is only that negligent conduct engaged in *for the purpose* of (or the purported purpose of) delivering health care to a patient . . . [T]ortious actions undertaken for a different purpose . . . are not [professional negligence]. [¶] . . . [P]laintiff alleges that [the anesthesiologist] engaged in the alleged tortious conduct for the purpose of persuading plaintiff not to report to the hospital or medical group that plaintiff had awakened during surgery. In other words, plaintiff alleges that [the anesthesiologist] acted for her own benefit, to forestall an embarrassing report that might

damage her professional reputation—not for the benefit of the patient.” (*Id.* at pp. 666-667.) “[N]egligent conduct allegedly undertaken by a doctor for the doctor’s own benefit, rather than for a legitimate medical reason,” is not “*professional negligence*.” (*Ibid.*)

The *So* case was distinguished in *Safeway, Inc. v. Superior Court* (June 19, 2014, A141505/A141513/A141514) 2014 WL 2772306 [nonpub. opn.], in which the plaintiff argued that Safeway’s corporate decision to give its pharmacy patients an abbreviated monograph (that left out some of the possible side effects of a prescription drug) was not professional negligence; it was motivated by the desire to save money. The Court of Appeal said Safeway’s decision to use an abbreviated monograph “was, at most, a contributing factor to the failure of Safeway to provide [the plaintiff] adequate warnings when her prescriptions were filled by Safeway pharmacies.” (*Id.* at p. *7.) “Whatever may have been Safeway’s motive in using the abbreviated monograph, the [plaintiffs] are suing Safeway for the omission of information that should have been provided them when Safeway dispensed the prescription medication. In other words, Safeway is being sued for deficiencies within the scope of its professional responsibilities as a pharmacy.” (*Id.* at p. *8.) By contrast, in *So*, the wrongdoing by a health care provider “occurred outside the scope of the provision of professional services.” (*Ibid.*)

- (k) ***Unruh-Haxton v. Regents of University of California*** (2008) 162 Cal.App.4th 343.

The Court of Appeal held that MICRA does not apply to a genetic material stealing case. “It is settled that additional causes of action may arise out of the same facts as a medical malpractice action that do not trigger MICRA. [Citation.] A problem that sometimes arises is when a plaintiff

hoping to evade the restrictions of MICRA, will choose to assert intentional torts, ‘seemingly non-MICRA causes of action. Thus, when a cause of action is asserted against a health care provider on a legal theory other than medical malpractice, the courts must determine whether it is nevertheless based on the “professional negligence” of the health care provider so as to trigger MICRA.’ [Citation.] [¶] ‘The answer is sometimes yes and sometimes no, depending on the particular cause of action and the particular MICRA provision at issue.’” (*Id.* at pp. 352-353.) “Based on our review of the complaints, we conclude the patients’ claims for fraud, conversion, and intentional infliction of emotional distress related to wrongful intentional conduct, not mere negligence. The allegations of stealing and then selling a person’s genetic material for financial gain is an intentional act of egregious abuse against a particularly vulnerable and trusting victim. None of the patients assert the egg harvesting medical procedures fell below the standard of care. Rather, it is the intentional and malicious quest to steal genetic material that is the focus of the lawsuit. [¶] . . . The legislators deliberately used the limiting term ‘professional negligence.’ It would be inconsistent with the letter and spirit of the statutory scheme to hold allegations of intentional fraud, emotional distress, and stealing are really just other forms of professional negligence. . . . MICRA’s statute of limitations would not apply to these intentional tort claims against the doctors directly, or against the Regents and the Medical Center based on a theory of vicarious liability or joint venture liability.” (*Id.* at pp. 355-356; see *Xiu Li Chen v. UCSF Medical Center* (Mar. 15, 2021, A161127) 2021 WL 960507, at p. *4 [nonpub. opn.] [“allegations of intentional conduct for the purportedly wrongful retention of the frozen embryos after the failed inter-facility transfer are unrelated to [plaintiff’s] IVF medical treatments,

and do not fall within the scope of professional negligence as defined in section 340.5”].)

- (l) ***Smith v. Ben Bennett, Inc.***
(2005) 133 Cal.App.4th 1507.

In the course of holding that Code of Civil Procedure section 364 (90-day notice of intent to sue) does not apply in an elder abuse action, the Court of Appeal observed: “The problem is that additional causes of action frequently arise out of the same facts as a medical malpractice cause of action. These may include battery, products liability, premises liability, fraud, breach of contract, and intentional or negligent infliction of emotional distress. Indeed, a plaintiff hoping to evade the restrictions of MICRA may choose to assert *only* seemingly non-MICRA causes of action. Thus, when a cause of action is asserted against a health care provider on a legal theory other than medical malpractice, the courts must determine whether it is nevertheless based on the ‘professional negligence’ of the health care provider so as to trigger MICRA. [¶] The answer is sometimes yes and sometimes no, depending on the particular cause of action and the particular MICRA provision at issue. [Citations.] The Supreme Court has cautioned repeatedly that ‘the scope and meaning of the phrases “arising from professional negligence” and “based on professional negligence” could vary depending upon the legislative history and “the purpose underlying each of the individual statutes.” ’ ” (*Id.* at pp. 1514-1515, original emphasis.)

- (m) ***David M. v. Beverly Hospital***
(2005) 131 Cal.App.4th 1272.

The Court of Appeal said: “Had plaintiff alleged that defendant physician intentionally concealed his failure to report [suspected child abuse] [citation] or that he intentionally failed to report known or suspected abuse, the restrictive

limitations period provided by [Code of Civil Procedure] section 340.5 would not apply.” (*Id.* at p. 1278, citing *Noble, supra*, 191 Cal.App.3d at p. 1193; *Waters, supra*, 40 Cal.3d at pp. 432-433; and *Perry, supra*, 88 Cal.App.4th at p. 668.)

- (n) ***Guardian North Bay, Inc. v. Superior Court***
(2001) 94 Cal.App.4th 963.

The Court of Appeal held that a health care provider who is sued for damages after being convicted of felony elder abuse (Pen. Code, § 368) is not covered by MICRA. “To be convicted of a violation of Penal Code section 368, the defendant custodian or caretaker must have willfully caused or permitted injury to or endangerment of an elder person. [¶] The willful nature of criminal conduct in violation of Penal Code section 368 takes this conduct beyond the scope of professional negligence, and, therefore, beyond the scope of MICRA.” (*Id.* at pp. 977-978.)

- (o) ***Perry v. Shaw***
(2001) 88 Cal.App.4th 658.

The Court of Appeal said: “We take the Supreme Court at its word [in *Barris, supra*, 20 Cal.4th at pages 115-116, that the meaning of ‘based on professional negligence’ may vary depending upon the legislative history and the purpose underlying each of the individual statutes] and hold in this case that where, as here, a common law battery—something more than a ‘technical battery’ [where patient consented to treatment given, but doctor failed to disclose pertinent information]—has been proved, the limitation imposed by [Civil Code] section 3333.2 does not apply.” (*Id.* at p. 661.) *Perry* emphasized: “Although we sometimes refer to ‘intentional torts’ generally . . . our holding is limited to the type of battery that occurred in this case” (*id.* at p. 668, fn. 4), i.e., performing an operation to which the patient did not consent (*id.* at p. 664).

- (p) ***Noble v. Superior Court***
(1987) 191 Cal.App.3d 1189.

The plaintiff alleged battery by unauthorized surgery. (*Id.* at p. 1191.) The Court of Appeal held that Code of Civil Procedure section 364, subdivision (d), the MICRA provision that tolls the statute of limitations when a notice of intent to sue is served within 90 days of the end of the limitations period, did not apply to the statute of limitations for battery. (*Id.* at pp. 1192-1194.)

- (q) ***Nelson v. Gaunt***
(1981) 125 Cal.App.3d 623.

The Court of Appeal held the plaintiff's fraud claim against her doctor fell under the fraud statute of limitations, not MICRA's Code of Civil Procedure section 340.5. (*Id.* at pp. 635-636.) The court said the case law cited by the defendant "involved professional negligence and the application of Code of Civil Procedure section 340.5. Here, each of Nelson's causes of action was for an intentional tort." (*Id.* at p. 636.) "The 1975 amendments to Code of Civil Procedure section 340.5, which narrowly define professional negligence, indicate that the Legislature attempted to curb fraud by health care providers by another route." (*Id.* at p. 636, fn. 6.)

(2) Equitable indemnity action.

- (a) ***Preferred Risk Mutual Ins. Co. v. Reiswig***
(1999) 21 Cal.4th 208.

The Supreme Court held the MICRA provision tolling the statute of limitations for 90 days after notice of intent to sue is served (Code Civ. Proc., § 364, subd. (d)) applies in an equitable indemnity action against a health care provider. The Court held the indemnity action is "based upon" professional negligence: "[A]lthough we have never attempted to define for all purposes the

phrase ‘based upon’ professional negligence, we have recognized that, in deciding whether an action is ‘based upon’ professional negligence, the test is whether it flows or originates from a healthcare provider’s negligent act or omission. (See *Central Pathology Service Medical Clinic, Inc. v. Superior Court* (1992) 3 Cal.4th 181, 187-188, fn. 3, 192 . . . [court must examine allegations of complaint to determine whether plaintiff’s injury is related to manner in which professional services were rendered].)” (*Preferred Risk*, at p. 217.) “[E]quitable indemnity actions that flow from professional negligence actions (as opposed to unrelated tort actions) are ‘based upon’ professional negligence . . .” (*Id.* at p. 218.)

The Supreme Court stressed the need to effectuate the purpose of MICRA’s 90-day notice provision: “By applying section 364, subdivision (d), to cases based upon a health care provider’s professional negligence, including derivative claims for equitable indemnity that follow settlement of the original action, we further the legislative purpose of the 90-day tolling period, and MICRA in general, to give doctors and their insurers an opportunity to negotiate with prospective plaintiffs and settle derivative claims without unnecessary litigation.” (*Preferred Risk*, *supra*, 21 Cal.4th at pp. 218-219; see *id.* at pp. 214-215.)

The Supreme Court also held the MICRA statute of limitations (Code Civ. Proc., § 340.5) does not apply to an indemnity action against a health care provider. (*Preferred Risk*, *supra*, 21 Cal.4th at p. 213, fn. 2; see *id.* at pp. 219-222 (dis. opn. of Kennard, J.).)

- (b) ***Western Steamship Lines, Inc. v. San Pedro Peninsula Hospital***
(1994) 8 Cal.4th 100.

A concurrent tortfeasor sued a health care provider for partial equitable indemnity. (*Id.* at p. 104.) The Supreme Court “assumed that an action for partial equitable indemnity may be based upon professional negligence” (*Preferred Risk, supra*, 21 Cal.4th at p. 217), and held: “After careful review of the legislative intent underlying MICRA in general and [Civil Code] section 3333.2 in particular, we conclude that as a necessary adjunct to effectuating the statutory purpose and goals, a health care provider may invoke the [statutory] limit on noneconomic damages in an action for partial equitable indemnity based upon professional negligence.” (*Western Steamship*, at p. 111; see *id.* at pp. 111-114.)

- (c) ***County of Contra Costa v. Kaiser Foundation Health Plan, Inc.***
(1996) 47 Cal.App.4th 237.

The Court of Appeal refused to require arbitration of an indemnity claim against a health care provider. The court relied on a suggestion in *Western Steamship, supra*, 8 Cal.4th at pages 114-115, that procedural, as opposed to substantive, MICRA provisions, such as the statute of limitations, might not apply to indemnity actions. (*County of Contra Costa*, at p. 244.)

Subsequently, however, in *Preferred Risk, supra*, 21 Cal.4th 208, the Supreme Court expressly declined to rely on procedural versus substantive, noting that *Western Steamship* itself relied on an out-of-state case that construed a medical malpractice statute of limitations to apply to contribution actions against health care providers. The Supreme Court concluded that the Legislature intended the parallel “based upon professional negligence” language in the MICRA

statutes to be construed identically. (*Id.* at pp. 216-217.) After *Preferred Risk*, *County of Contra Costa* may not be good law.

- (d) ***SeaRiver Maritime v. Industrial Medical Services*** (N.D.Cal. 1997) 983 F.Supp. 1287.

A federal district court applied MICRA's collateral source provision (Civ. Code, § 3333.1) in an equitable indemnity action against health care providers. (*SeaRiver Maritime*, at p. 1301.)

(3) **EMTALA action.**

In *Barris*, *supra*, 20 Cal.4th 101, the Supreme Court held: "A claim under EMTALA [the federal Emergency Medical Treatment and Active Labor Act] for failure to stabilize [the plaintiff's emergency medical condition before transfer to another facility] is . . . necessarily 'based on professional negligence' within the meaning of MICRA—it involves 'a negligent . . . omission to act by a health care provider in the rendering of professional services' [citation]—although it requires more." (*Id.* at p. 110.) "The trier of fact must, under EMTALA as in a medical negligence claim, consider the prevailing medical standards and relevant expert medical testimony to determine whether material deterioration of the patient's condition was reasonably likely to occur." (*Id.* at p. 114.)

The Supreme Court majority expressed no opinion on whether a *medical screening claim* under EMTALA would be based on professional negligence within the meaning of MICRA. (*Barris*, *supra*, 20 Cal.4th at p. 111, fn. 4.) Two concurring justices said a medical screening claim would be based on professional negligence. (*Id.* at pp. 117-118 (conc. opn. of Baxter, J., joined by Chin, J.).)

In *Romar v. Fresno Community Hosp. and Medical Center* (E.D.Cal. 2008) 583 F.Supp.2d 1179, the federal district court held that an EMTALA action for disparate medical screening is not based on professional negligence within the meaning of MICRA. "[U]nder a

disparate screening theory, [the hospital's] conduct is not judged against the prevailing professional standard of care. [Citations.] Rather, [the hospital's] conduct is compared to its own individualized screening standards or protocols in order to determine if [the patient] received the same screening as other similarly symptomed patients. . . . The key is whether Plaintiff was treated differently, it is not whether [the hospital] breached the standard of professional medical care, i.e. did not act like a reasonable hospital under the circumstances.” (*Id.* at p. 1187.)

(4) Elder abuse action.

The Elder Abuse and Dependent Adult Civil Protection Act (Welf. & Inst. Code, § 15600 et seq.) provides heightened remedies (award of reasonable attorney fees and costs; recovery for pain and suffering by a decedent plaintiff's estate) if the defendant abused or neglected an elderly or dependent adult with recklessness, oppression, fraud, or malice. (See *Winn v. Pioneer Medical Group, Inc.* (2016) 63 Cal.4th 148, 155, 156; *Covenant Care, supra*, 32 Cal.4th at pp. 779-780; *Delaney, supra*, 20 Cal.4th at p. 26.) In *Delaney*, the Supreme Court held the Elder Abuse Act applies to health care providers like nursing homes and other health care facilities because an action against a health care provider under the Elder Abuse Act is not “based on . . . professional negligence” within the meaning of the exclusion for professional negligence in that Act. (*Delaney*, at p. 26.) In *Covenant Care*, the Supreme Court held an action against a health care provider under the Elder Abuse Act does not “aris[e] out of the professional negligence of a health care provider” within the meaning of Code of Civil Procedure section 425.13, the statute that restricts punitive damage claims in medical malpractice actions. (*Covenant Care*, at pp. 779-780; see *Country Villa Claremont Healthcare Center, Inc. v. Superior Court* (2004) 120 Cal.App.4th 426, 435 [extending *Covenant Care* to common law intentional torts where the gravamen of the action is violation of the Elder Abuse Act].)

In *Winn*, the Supreme Court held the Elder Abuse Act does not apply to a health care provider who has no custodial relationship with the patient—the patient was an outpatient who did not live in a nursing home or other facility. “[N]othing in the legislative history suggests that the Legislature intended the Act to apply *whenever* a doctor treats any elderly patient. Reading the [A]ct in such a manner would radically transform medical malpractice liability relative to the existing scheme.” (*Winn, supra*, 63 Cal.4th at p. 163.)

In *Benun v. Superior Court* (2004) 123 Cal.App.4th 113, the Court of Appeal, relying on *Covenant Care* and *Delaney*, held that an action against a health care provider under the Elder Abuse Act is not “based upon professional negligence” within the meaning of MICRA; therefore, Code of Civil Procedure section 340.5, the MICRA statute of limitations, does not apply. “[A] cause of action for custodial elder abuse against a health care provider is a separate and distinct cause of action from one for professional negligence against a health care provider.” (*Benun*, at p. 124.) “[T]he legislative history of the Elder Abuse Act indicates that [Welfare and Institutions Code] section 15657.2 was added to specify that ‘professional negligence’ is to be controlled by other statutes specifically applicable thereto, and ‘professional negligence’ is mutually exclusive of the elder abuse and neglect specified in [Welfare and Institutions Code] section 15657 as actionable under the act.” (*Id.* at p. 126.) This is a point the Supreme Court emphasized in *Covenant Care*: “It is true that statutory elder abuse includes ‘neglect as defined in [s]ection 15610.57’ (Welf. & Inst. Code, § 15657), which in turn includes negligent failure of an elder custodian ‘to provide medical care for [the elder’s] physical and mental health needs’ (*id.*, § 15610.57, subd. (b)(2)). But as we explained in *Delaney*, ‘neglect’ within the meaning of Welfare and Institutions Code section 15610.57 covers an area of misconduct distinct from ‘professional negligence.’ As used in the Act, neglect refers not to the substandard performance of medical services but, rather, to the ‘failure of those responsible for attending to the basic needs and comforts of elderly or dependent adults,

regardless of their professional standing, to carry out their custodial obligations.’ (*Delaney, supra*, 20 Cal.4th at p. 34.) Thus, the statutory definition of neglect speaks not of the *undertaking* of medical services, but of the failure to *provide* medical care.” (*Covenant Care, supra*, 32 Cal.4th at p. 783, original emphasis.)

Benun also reasoned that, “*Delaney*, in determining that elder abuse causes are separate and distinct from professional negligence causes, recognized that the intent of the Elder Abuse Act is to subject health care providers to its ‘heightened remedies’ when their acts or omissions are reckless or willful and, thus, more culpable than professional negligence. No reason is apparent why this analysis does not apply equally to the statute of limitations issue.” (*Benun, supra*, 123 Cal.App.4th at p. 126.)

In *Samantha B., supra*, 72 Cal.App.5th 1092 [2021 WL 5996835, at p. *5], rehearing granted January 14, 2022, the Court of Appeal held that, under *Delaney*, when the jury finds both professional negligence and reckless neglect, plaintiffs’ Elder Abuse Act claims are “not bound by the laws specifically applicable to professional negligence.”

In *Smith, supra*, 133 Cal.App.4th 1507, the Court of Appeal held that Code of Civil Procedure section 364, subdivision (d), the MICRA provision that tolls the statute of limitations for 90 days when notice of intent to sue is served within the last 90 days of the limitations period, does not apply to an action against a health care provider under the Elder Abuse Act. “Under *Delaney*, [the Elder Abuse Act] works like a toggle switch. If a claim is a ‘cause of action . . . based on . . . professional negligence [within the meaning of the Elder Abuse Act],’ then ‘those laws which specifically apply to . . . professional negligence causes of action’ apply, and the Elder Abuse Act does not. If, on the other hand, a claim is *not* a ‘cause of action . . . based on . . . professional negligence,’ then the Elder Abuse Act *can* apply . . . ; moreover, ‘those laws which specifically apply to . . . professional negligence causes of action’ *cannot*. . . . This

is true regardless of whether the claim is based on ‘professional negligence’ within the meaning of such other laws. Moreover, it is true regardless of whether such other laws *would* apply *but for* [the Elder Abuse Act].” (*Smith*, at pp. 1522-1523.)

In *Cochrum*, *supra*, 25 Cal.App.5th at page 1048, the Court of Appeal held that only egregious understaffing supports elder abuse liability against a nursing facility. The court noted that plaintiff failed to show the nursing facility was reckless in its care. (*Ibid.*) Plaintiff pointed primarily to understaffing at the facility as proof of recklessness, but the court noted that the facility met the legally minimum staffing level and that there was no evidence that staff shortages had contributed to patient safety issues. (*Id.* at pp. 1047-1048.)

In *Higgins v. Providence Health System—Southern California* (Dec. 11, 2018, B283488) 2018 WL 6503435, at pages *1, *3 [nonpub. opn.], the Court of Appeal held that, in a lawsuit alleging causes of action for elder abuse, negligence, and wrongful death, MICRA caps the plaintiff’s recovery of noneconomic damages unless the jury finds the defendant acted recklessly.

(5) Privacy actions.

MICRA may or may not apply to lawsuits alleging claims for violation of privacy rights, depending on whether the breach was caused by the professional negligence of a healthcare provider. For example, in *Turner*, *supra*, 2019 WL 935978, at page *1, the district court ruled that claims for violation of the Confidentiality of Medical Information Act (Civ. Code, § 56 et seq.) were covered by MICRA where the defendant physician disclosed the plaintiff’s private information “because of her asserted belief that she had a duty to warn under Civil Code [section] 43.92.” Accordingly, MICRA applied because the physician’s “decision was directly related to the professional services she provided.” (*Ibid.*) On the other hand, in *Holly v. Alta Newport Hospital, Inc.* (C.D.Cal., Apr. 10, 2020, No. 2:19-cv-07496-ODW (MRWx)) __ F.Supp.3d __

[2020 WL 1853308, at page *5] the district court ruled that MICRA did not apply to medical privacy claims stemming from the hospital's "alleged negligent training and supervision of its [administrative] employee, which led to the disclosure of [plaintiff's] private information." The court reasoned that the hospital's alleged negligence that led to the public disclosure of the plaintiff's private health information "occurred after the completion of her medical treatment. It was thus not a predicate to her receiving medical care and therefore did not occur in the rendering of professional services for purposes of MICRA." (*Ibid.*)

(6) Civil rights claims.

In *Fruciano v. Regents of University of California* (N.D.Cal., Sept. 5, 2018, No. 18-cv-04452-JSC) 2018 WL 4219232, at page *5 [nonpub. opn.], the district court ruled that discrimination claims under the Unruh Civil Rights Act (Civ. Code, § 51 et seq.) based on alleged "shabby" medical treatment were barred by the MICRA statute of limitations because "[t]he allegations all sound in medical negligence." Conversely, in *Estate of Michael Lee v. California Department of Correction and Rehabilitation* (E.D.Cal., Feb. 1, 2021, No. 2:20-cv-01161-JAM-CDK) 2021 WL 325676, at page *2 [nonpub. opn.], the district court ruled that the MICRA statute of limitations did not apply to a claim of "deliberate indifference to serious medical needs in violation of the Eighth Amendment under 42 U.S.C. § 1983" because that claim was "not based on Defendant's professional negligence but rather on her deliberate indifference," and because borrowing the more general state statute of limitations promoted the goal of uniformity. (See *id.* at p. *3 [a wrongful death claim based on deliberate indifference "is categorically different than a medical negligence claim"]; see also *Townsend through Townsend v. County of Santa Cruz* (N.D.Cal., Sept. 1, 2021, No. 19-cv-00630-BLF 2021) 2021 WL 3913174, at p. *12 [nonpub. opn.] ["[Defendant] has not cited, and the Court has been unable to locate, any case in which a plaintiff's § 1983 recovery on a Monell claim for deliberate indifference to serious medical or mental

health issues was limited by MICRA. . . . In this Court's view, capping damages on a claim for deliberate indifference to serious medical or mental health issues likewise would run afoul of the purpose of § 1983."].)

(d) The law in other states.

See generally Annotation, What Patient Claims Against Doctor, Hospital, or Similar Health Care Provider Are Not Subject to Statutes Specifically Governing Actions and Damages for Medical Malpractice (1991) 89 A.L.R.4th 887; Annotation, What Nonpatient Claims Against Doctors, Hospitals, or Similar Health Care Providers Are Not Subject to Statutes Specifically Governing Actions and Damages for Medical Malpractice (1991) 88 A.L.R.4th 358; see, e.g., *Kostkoglanis v. Yates* (Iowa 2021) 956 N.W.2d 157, 161-162 (Iowa Supreme Court holds plaintiff's fraud and breach of contract claims are actually professional negligence subject to a statute of limitations similar to MICRA where "injuries [arose] out of the doctor-patient relationship and the patient care defendants provided or allegedly failed to provide to her").

C. BUSINESS AND PROFESSIONS CODE SECTION 6146: LIMITING CONTINGENT ATTORNEY FEES.

1. Text of section 6146.

(a) An attorney shall not contract for or collect a contingency fee for representing any person seeking damages in connection with an action for injury or damage against a health care provider based upon such person's alleged professional negligence in excess of the following limits:

(1) Twenty-five percent of the dollar amount recovered if the recovery is pursuant to settlement agreement and release of all claims executed by all parties thereto prior to a civil complaint or demand for arbitration being filed.

(2) Thirty-three percent of the dollar amount recovered if the recovery is pursuant to settlement, arbitration, or judgment after a civil complaint or demand for arbitration is filed.

(3) If an action is tried in a civil court or arbitrated, the attorney representing the plaintiff or claimant may file a motion with the court or arbitrator for a contingency fee in excess of the percentage stated in paragraph (2), which motion shall be filed and served on all parties to the action and decided in the court's discretion based on evidence establishing good cause for the higher contingency fee.

The limitations shall apply regardless of whether the recovery is by settlement, arbitration, or judgment, or whether the person for whom the recovery is made is a responsible adult, an infant, or a person of unsound mind.

(b) If periodic payments are awarded to the plaintiff pursuant to Section 667.7 of the Code of Civil Procedure, the court shall place a total value on these payments based upon the projected life expectancy of the plaintiff and include this amount in computing the total award from which attorney's fees are calculated under this section.

(c) For purposes of this section:

(1) "Recovered" means the net sum recovered after deducting any disbursements or costs incurred in connection with

prosecution or settlement of the claim. Costs of medical care incurred by the plaintiff and the attorney's office-overhead costs or charges are not deductible disbursements or costs for such purpose.

(2) "Health care provider" means any person licensed or certified pursuant to Division 2 (commencing with section 500), or licensed pursuant to the Osteopathic Initiative Act, or the Chiropractic Initiative Act, or licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code; and any clinic, health dispensary, or health facility, licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code. "Health care provider" includes the legal representatives of a health care provider.

(3) "Professional negligence" is a negligent act or omission to act by a health care provider in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death, provided that the services are within the scope of services for which the provider is licensed and which are not within any restriction imposed by the licensing agency or licensed hospital.

2. Summary of section 6146.

Section 6146 prohibits the plaintiff's attorney from collecting a contingent fee in excess of the statutory fee schedule. This section previously determined fees using a decreasing sliding scale. (See Stats. 1987, ch. 1498, § 2.) As amended by AB-35, section 2, this section ties the contingency fee limits to the stage of the representation. Thus, the maximum fee permitted by the statute is: 25 percent if recovery is pursuant to a settlement agreement and release of all claims by all the parties *before* a civil complaint or arbitration demand is filed; or 33 percent if recovery is pursuant to a settlement, arbitration, or judgment *after* a civil complaint or arbitration demand is filed. (§ 6146, subd. (a)(1), (2).) Where an action is arbitrated or tried in civil court, an attorney may move for a contingency fee exceeding 33 percent that the court will decide based on evidence of good cause. (§ 6146, subd. (a)(3).) The statutory fee schedule applies whether the recovery is by settlement, arbitration, or judgment, and whether the plaintiff is an adult, minor, or incompetent. (§ 6146, subd. (a).) The plaintiff's attorney's disbursements and costs must be deducted from the recovery before the fee schedule is applied. (§ 6146, subd. (c)(1).) "Rais[ing] the issue

of the proper calculation of the attorney fee award . . . necessarily requires consideration of the effect of MICRA.” (*Romero v. Kaiser Foundation Health Plan, Inc.* (Jan. 19, 2018, B277499) 2018 WL 481564, at p. *5 [nonpub. opn.])

3. Section 6146 is constitutional.

- (a) In *Roa v. Lodi Medical Group, Inc.* (1985) 37 Cal.3d 920, the Supreme Court upheld section 6146 against due process, equal protection, and separation of powers challenges. The Court held section 6146 is rationally related to the goal of reducing medical malpractice insurance costs because it encourages plaintiffs to accept lower settlement offers, discourages plaintiffs’ attorneys from filing frivolous or marginal suits, and protects the already diminished awards of malpractice plaintiffs from further reduction by high contingent fees. (*Id.* at pp. 931-932; see *Romero, supra*, 2018 WL 481564, at p. *9 [concluding “*Roa* remains the controlling authority regarding the constitutional validity of MICRA’s limits on attorney contingency fees in medical malpractice cases” and rejecting plaintiff’s “equal protection challenge to section 6146”].)
- (b) In *Fineberg v. Harney & Moore* (1989) 207 Cal.App.3d 1049, 1054-1055, the Court of Appeal held section 6146 does not deprive medical malpractice plaintiffs of the right to counsel.

4. Section 6146 cannot be waived.

In *Fineberg, supra*, 207 Cal.App.3d 1049, the Court of Appeal held section 6146 “was intended to further a significant public policy and . . . its protection cannot be waived” (*Id.* at p. 1050; accord, *Waters v. Bourhis* (1985) 40 Cal.3d 424, 439, fn. 15; *Schultz v. Harney* (1994) 27 Cal.App.4th 1611, 1618-1619, 1621-1622; *Wienholz v. Kaiser Foundation Hospitals* (1989) 217 Cal.App.3d 1501, 1503, fn. 1; *Hathaway v. Baldwin Park Community Hospital* (1986) 186 Cal.App.3d 1247, 1251-1253; see *Romero, supra*, 2018 WL 481564, at p. *6.)

5. Trial courts only have discretion to award fees as prescribed by MICRA.

After an action is tried or arbitrated, courts may only award contingency fees exceeding the 33 percent limit established by section

6146, subdivision (a)(2), based on evidence of good cause. (See § 6146, subd. (a)(3).) The court otherwise has no discretion to award fees above the limits set forth in MICRA. (See *Nguyen v. Los Angeles County Harbor/UCLA Medical Center* (1995) 40 Cal.App.4th 1433, 1449 [although the trial court is not required to award the maximum attorney fee award under section 6146, “it cannot exceed it”]; *Hathaway, supra*, 186 Cal.App.3d at p. 1253 [where MICRA applies, “a trial court does not have the power to award extraordinary attorneys’ fees” in excess of statutory maximum]; see also *Romero, supra*, 2018 WL 481564, at p. *5.)

6. Other contexts in which section 6146 may apply.

(a) Wrongful death action.

Section 6146 applies in a wrongful death as well as a personal injury action. (§ 6146, subd. (c)(3); see *Yates v. Pollock* (1987) 194 Cal.App.3d 195, 198-199.)

(b) Action against public entity or employee.

Section 6146 applies. (E.g., *Nguyen, supra*, 40 Cal.App.4th 1433 [applying section 6146 in an action against a county].)

(c) EMTALA action.

It is *unclear* whether section 6146 applies in an EMTALA action. The issue is one of federal law. EMTALA allows the plaintiff to “obtain those damages available for personal injury under the law of the State in which the hospital is located.” (42 U.S.C. § 1395dd(d)(2)(A).) But state procedural requirements do not apply. (*Power v. Arlington Hosp. Ass’n* (4th Cir. 1994) 42 F.3d 851, 865-866; see *Barris v. County of Los Angeles* (1999) 20 Cal.4th 101, 113, fn. 7.) In *Jackson v. United States* (9th Cir. 1989) 881 F.2d 707, 711-712, the Ninth Circuit held that section 6146 does not apply in an action brought under the Federal Tort Claims Act, which, like EMTALA, incorporates state damages law.

If section 6146 applies at all, it would apply to an EMTALA action for failure to stabilize, but probably not to an EMTALA action for failure to provide an appropriate medical screening examination. (See *ante*, Section B(3)(c)(3).)

(d) Elder abuse action.

The Elder Abuse Act itself requires the court to award reasonable attorney's fees to the plaintiff. (Welf. & Inst. Code, § 15657, subd. (a).) In theory, if the plaintiff also has a contingent fee contract, the contingent fee could be limited by section 6146. It is unlikely, however, that any of the MICRA statutes apply in an elder abuse action. (See *ante*, Section B(3)(c)(4).)

(e) Equitable indemnity action.

Other MICRA statutes apply in equitable indemnity actions. (See *ante*, Section B(3)(c)(2).) There is no apparent reason why section 6146 should not apply as well.

(f) Action under Federal Tort Claims Act.

Section 6146 does not apply. The federal statute permitting a maximum fee of 25 percent applies. (*Jackson, supra*, 881 F.2d at p. 713.)

7. Statutory definitions.

(a) Definition of "health care provider."

See *ante*, Section B(2).

(b) Definition of "based upon professional negligence."

See *ante*, Section B(3).

(c) Definition of "recovered."

(1) Deduction of costs.

The attorney's disbursements and costs must be deducted from the recovery before applying the fee schedule. (§ 6146, subd. (c)(1); *Ojeda v. Sharp Cabrillo Hospital* (1992) 8 Cal.App.4th 1, 8.)

(2) Recovery by multiple plaintiffs.

In *Yates v. Law Offices of Samuel Shore* (1991) 229 Cal.App.3d 583, the Court of Appeal held that former section 6146's decreasing sliding scale does not apply separately to each heir's share of the recovery in a wrongful death action; it applies once to the recovery of all the heirs combined. (*Id.* at pp. 588-590.) The court noted: "We need not and do not consider plaintiffs' broader suggestion that section 6146 mandates a single contingent fee calculation in all cases with multiple plaintiffs. Future cases, presenting different configurations of plaintiffs, claims, and incidents of professional negligence, will merit their own evaluation." (*Id.* at pp. 590-591, fn. 4.)

Under AB-35, section 2, the attorney's contingency fee recovery is determined as a percentage of the recovery depending only on (1) whether the recovery was obtained before or after a complaint or arbitration demand was filed, or (2) whether the court exercises its discretion to deviate from the statutory 33 percent contingency fee following a trial or arbitration. Accordingly, the issue confronted by the *Yates* court will no longer exist.

(3) Recovery against multiple defendants.

Prior to AB-35, when the plaintiff settled with one or more defendants and went to judgment against another, it was unclear whether the plaintiff's attorney was entitled to apply the decreasing sliding scale under former section 6146 separately to each settlement and to the judgment. (See *Schultz, supra*, 27 Cal.App.4th at p. 1617, fn. 3 [noting the issue, but expressing no opinion].) The answer should be no. Much of what was said in *Yates, supra*, 229 Cal.App.3d 583, about why the decreasing sliding scale applied once to the combined recovery of all the heirs in a death case, is pertinent to an injury case with multiple defendants. *Yates* reasoned that, since each heir in a death case could not recover a separate maximum of \$250,000 for noneconomic damages (under former Civil Code section 3333.2), each

heir should not have to pay a separate attorney fee based on the higher sliding scale percentages under former section 6146. (*Id.* at pp. 589-590.) Similarly, since the plaintiff in an injury case could not recover a separate maximum of \$250,000 for noneconomic damages from each defendant (under former Civil Code section 3333.2) (*Gilman v. Beverly California Corp.* (1991) 231 Cal.App.3d 121, 128, 129 [“a plaintiff cannot recover more than \$250,000 in noneconomic damages from all health care providers for one injury”]; *Colburn v. United States* (S.D.Cal. 1998) 45 F.Supp.2d 787, 793 [“MICRA provides a \$250,000 maximum aggregate recovery for a single plaintiff”]; see *Francies v. Kapla* (2005) 127 Cal.App.4th 1381, 1388-1389 & fn. 14 [noting that the plaintiff cited “no authority supporting the view that a separate \$250,000 limit applies to each health care provider who contributes to a single injury”]), the plaintiff should not have to pay a separate attorney fee on the recovery from each defendant. *Yates* also reasoned that the potential recovery in a death case is relatively stable regardless of the number of heirs; therefore, if each heir has to pay a fee based on the higher sliding scale percentages, “the size of the attorney’s fee would largely turn on how many close relatives the decedent left. This is not a rational intention to attribute to the Legislature.” (*Yates*, at p. 590.) Similarly, in an injury case, the potential recovery is the same regardless of the number of defendants. Basing the size of the fee on how many defendants are involved would not be a rational intention to attribute to the Legislature. Once again, AB-35 has mooted this issue.

8. The fee limit includes the hourly fee paid to an associate counsel to handle an appeal.

In *Yates, supra*, 229 Cal.App.3d 583, attorney Shore argued section 6146 did not apply to the hourly fees Shore paid to another attorney hired to represent the heirs on appeal from the judgment in a wrongful death action. The Court of Appeal disagreed. (*Id.* at pp. 591-592.) “[S]ection 6146 fixes the maximum allowable contingent fee for a medical malpractice action as a whole, including an appeal after judgment, and the limitation may not be avoided by charging

separate fees for segments of the case or by charging both contingent and hourly fees.” (*Id.* at p. 591.)

9. The fee limit includes the contingent fee paid to a medical-legal consultant.

In *Ojeda, supra*, 8 Cal.App.4th 1, the Court of Appeal held the plaintiff’s contract with a medical-legal consulting firm, which required payment of a contingent fee to the consulting firm, was not automatically invalid. But the court also held the total amount paid by the plaintiff to the consulting firm and to the attorneys must equal or be less than the MICRA limit. “Reduced to a mathematical formula, this means that what Ojeda pays in (A) attorney’s fees, (B) fees to the Foundation, and (C) separately identified expenses cannot exceed (1) the maximum attorney fee allowed under Business and Professions Code section 6146, subdivision (a) plus (2) all allowable ‘disbursements and costs’ within the meaning of section 6146, subdivision (c).” (*Id.* at p. 19.) The case was remanded to the trial court to determine the consulting firm’s reasonable fee and to decide “what portion of that fee is properly characterized as a ‘cost’ of prosecuting the case and what if any portion of that fee is for services which should properly be performed by the attorneys as part of the standard MICRA contingent fee.” (*Id.* at pp. 19-20.)

10. The fee limit applies to the contingent fee paid by a minor or incompetent.

(a) The usual pre-MICRA fee was 25 percent.

If the plaintiff is a minor or incompetent, the attorney fee must be approved by the court. (Fam. Code, § 6602; Prob. Code, §§ 2644, 3600-3601.) “[B]efore the enactment of MICRA, courts generally approved contingent fees for professional services rendered on behalf of minors . . . on the basis of 25 percent of the recovery.” (*Schneider v. Kaiser Foundation Hospitals* (1989) 215 Cal.App.3d 1311, 1320-1321, fn. 8, disapproved on another ground in *Moncharsh v. Heily & Blase* (1992) 3 Cal.4th 1, 27-28.)

(b) If the MICRA fee was less than 25 percent, the court had to award the MICRA amount.

In *Schultz*, *supra*, 27 Cal.App.4th 1611, the Court of Appeal held that 25 percent fee awards in orders approving compromise of a minor's claims (see *id.* at pp. 1616-1617) "were erroneous insofar as they awarded attorney's fees greater than are allowed by [former] Business and Professions Code section 6146" (*id.* at p. 1618; see also *Wienholz*, *supra*, 217 Cal.App.3d at p. 1508 ["The trial court had no discretion to order fees in excess of [section 6146's] statutory limits even if the contract's terms were subject to [judicial] modification" pursuant to Probate Code section 2644]).

(c) If the MICRA fee was greater than 25 percent, the court could award 25 percent.

A trial court making a fee award as part of a minor's compromise had the authority to award less than the MICRA fee limit. (*Schneider v. Friedman, Collard, Poswall & Virga* (1991) 232 Cal.App.3d 1276, 1280, fn. 4.)

(d) Now, courts must use the reasonable fee standard.

Rule 7.955(d) of the California Rules of Court has preempted all local rules relating to determination of the attorney fee to be awarded from the proceeds of a compromise, settlement, or judgment in an action to which a minor, a person with a disability, or a conservatee is a party. (See *Gonzalez v. Chen* (2011) 197 Cal.App.4th 881, 884-885.) Rule 7.955 lists 14 nonexclusive factors the court may consider in determining an attorney's reasonable fee. One of the factors is "[s]tatutory requirements for representation agreements applicable to particular cases or claims." (Cal. Rules of Court, rule 7.955(b)(14).) Presumably, then, in a medical malpractice action, the MICRA contingent fee cannot be exceeded absent an order granting a motion under Business and Professions Code section 6146, subdivision (a)(3). (See *Gonzalez*, at pp. 886-888 [on minor's compromise of medical malpractice claim, trial court must determine whether, within the limitations of MICRA, the requested fees are reasonable under rule 7.955]; see also *Romero*, *supra*, 2018 WL 481564, at p. *6.) Nor does the MICRA contingent fee have to be awarded. (*Gonzalez*, at

pp. 885-887, 888.) “MICRA establishes *caps* on a recovery, not guarantees.” (*Id.* at p. 885.)

In *Marquez v. County of Riverside* (Sept. 15, 2014, E057369) 2014 WL 4537609, at page *8 [nonpub. opn.], the Court of Appeal construed *Gonzalez* “as indicating that the trial court must not assume the maximum amount of attorney fees permissible under MICRA constitutes reasonable fees. Rather, the trial court is required to determine whether, within the limitations of MICRA, the requested fees are reasonable under rule 7.955.”

11. Factoring periodic payments into the fee calculation.

(a) The fee on periodic payments is based on the present value of the payments.

Where a recovery includes Code of Civil Procedure section 667.7 periodic payments, the attorney fee statute directs that “the court shall place a total value on these payments based upon the projected life expectancy of the plaintiff and include this amount in computing the total award from which attorney’s fees are calculated” (Bus. & Prof. Code, § 6146, subd. (b).) “The ‘total value’ is not the arithmetic sum of all future payments required by the award; it is the present value of the periodic payments.” (*Holt v. Regents of University of California* (1999) 73 Cal.App.4th 871, 883.) Moreover, the fee limit applies “regardless of whether the recovery is by settlement, arbitration, or judgment, or whether the person for whom the recovery is made is a responsible adult, an infant, or a person of unsound mind.” (Bus. & Prof. Code, § 6146, subd. (a); see *Romero, supra*, 2018 WL 481564, at p. *6.)

(b) Present value is based on the jury’s present value verdict. In the absence of a jury determination of present value, the cost of an annuity should be used.

“[W]hen the jury has made a specific finding of the present value of future damages, the trial court does not abuse its discretion by calculating attorney fees on that amount.” (*Holt, supra*, 73 Cal.App.4th at p. 884, fn. omitted; accord, *Hrimnak v. Watkins* (1995) 38 Cal.App.4th 964, 979-980; see *Padilla v.*

Greater El Monte Community Hospital (2005) 129 Cal.App.4th 667, 671 [“To the extent the statute should be read literally to require the court, not the jury, to make that calculation, the court discharged that duty when it entered judgment on the verdict [adopting the jury’s calculation of present value] without objection by the parties”).) When the jury has not made a specific finding, the present value of future damages is “normally best represented by the cost of the annuity purchased to fund the payments.” (*Schneider, supra*, 215 Cal.App.3d at p. 1314, disapproved on another ground in *Moncharsh, supra*, 3 Cal.4th at pp. 27-28; accord, *Nguyen, supra*, 40 Cal.App.4th at pp. 1440, 1448-1454; see *Salgado v. County of Los Angeles* (1998) 19 Cal.4th 629, 647-648, fn. 6 [declining to address the question “whether the cost of an annuity to fund the judgment can properly be used by the trial court as the basis for calculating attorney fees”].)

12. Ensuring compliance with the fee limit.

(a) It matters to the defendant.

The plaintiff’s attorney may take the position that the fee owed by the plaintiff is of no concern to the defendant. Not so. If a periodic-payment judgment will be entered, the defendant usually will have a financial interest in ensuring compliance with the fee limit. It is in the defendant’s best interest to maximize the portion of the judgment payable periodically. Generally, the larger the fee, the less money payable periodically — because more money has to be paid as upfront cash to cover the fee.

(b) An excessive fee can be exposed by anyone.

In *Jackson, supra*, 881 F.2d 707, the issue was whether the attorney fee in a Federal Tort Claims Act (FTCA) case arising from medical malpractice in a federal hospital in California is governed by section 6146 or by the FTCA’s fee limitation provision. The plaintiffs argued the government lacked standing to challenge the validity of a private contingent fee agreement. The Ninth Circuit disagreed: “[A]ll courts possess an inherent power to prevent unprofessional conduct by those attorneys who are practicing before them. This authority extends to *any* unprofessional conduct, including conduct that

involves the exaction of illegal fees. [Citations.] ¶ That the court's attention is drawn to such unprofessional conduct by an opposing party who otherwise lacks an interest in the outcome simply does not detract from the court's inherent authority to regulate the members of its bar." (*Id.* at p. 710, fn. omitted, original emphasis.)

D. CIVIL CODE SECTION 3333.1: ALLOWING EVIDENCE OF COLLATERAL SOURCE BENEFITS AND PRECLUDING SUBROGATION.

1. Text of section 3333.1.

(a) In the event the defendant so elects, in an action for personal injury against a health care provider based upon professional negligence, he may introduce evidence of any amount payable as a benefit to the plaintiff as a result of the personal injury pursuant to the United States Social Security Act, any state or federal income disability or worker's compensation act, any health, sickness or income-disability insurance, accident insurance that provides health benefits or income-disability coverage, and any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or other health care services. Where the defendant elects to introduce such evidence, 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.

(b) No source of collateral benefits introduced pursuant to subdivision (a) shall recover any amount against the plaintiff nor shall it be subrogated to the rights of the plaintiff against a defendant.

(c) For the purposes of this section:

(1) "Health care provider" means any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or licensed pursuant to the Osteopathic Initiative Act, or the Chiropractic Initiative Act, or licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code; and any clinic, health dispensary, or health facility, licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code. "Health care provider" includes the legal representatives of a health care provider;

(2) "Professional negligence" means a negligent act or omission to act by a health care provider in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death, provided that such services are within the scope of

services for which the provider is licensed and which are not within any restriction imposed by the licensing agency or licensed hospital.

2. Summary of section 3333.1.

(a) Collateral source rule.

“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.” (*Arambula v. Wells* (1999) 72 Cal.App.4th 1006, 1009; see generally *Smock v. State of California* (2006) 138 Cal.App.4th 883, 886-888.) The collateral source rule applies to medical insurance benefits (*Helfend v. Southern Cal. Rapid Transit Dist.* (1970) 2 Cal.3d 1, 4), pension and disability benefits (*Rotolo Chevrolet v. Superior Court* (2003) 105 Cal.App.4th 242, 248-249; *McKinney v. California Portland Cement Co.* (2002) 96 Cal.App.4th 1214, 1220-1227), gratuitous benefits from a private source (*Regalado v. Callaghan* (2016) 3 Cal.App.5th 582, 599-601; *Arambula*, at p. 1014), and Medi-Cal and county hospital benefits (*Hanif v. Housing Authority* (1988) 200 Cal.App.3d 635, 639-640; *Reichle v. Hazie* (1937) 22 Cal.App.2d 543, 547-548). It is an open question whether the rule applies to free public benefits, like special education, available to anyone with a qualifying disability. (See *Arambula*, at p. 1015.)

In *Howell v. Hamilton Meats & Provisions, Inc.* (2011) 52 Cal.4th 541, the Supreme Court held the collateral source rule does *not* apply to “amounts that were included in a [health care] provider’s bill but for which the plaintiff never incurred liability because the provider, by prior agreement [with the plaintiff’s health insurer], accepted a lesser amount as full payment.” (*Id.* at p. 548.) “[T]he negotiated rate differential—the discount medical providers offer the insurer—is not a benefit provided to the plaintiff in compensation for his or her injuries and therefore does not come within the rule.” (*Id.* at p. 566.)

(b) Section 3333.1, subdivision (a).

Subdivision (a) overrides the collateral source rule to a considerable extent in medical malpractice cases, allowing a health care provider to introduce evidence of benefits payable to the plaintiff from the following collateral sources: private health, sickness, accident, or disability insurance, state disability insurance (SDI), workers' compensation, Social Security survivor's insurance, Social Security disability insurance (SSDI), or the Supplemental Security Income (SSI) program. If such evidence is introduced by the defendant, the plaintiff is entitled to introduce evidence of any insurance premiums or other payments made to secure the right to those collateral source benefits.

While evidence of certain collateral source benefits is admissible under subdivision (a), "evidence of the tax treatment of those benefits is not." (*Cox v. Superior Court* (2002) 98 Cal.App.4th 670, 672 [precluding evidence that the plaintiff's disability insurance benefits, totaling \$180,000 per year, were not taxable].)

Subdivision (a) is a rule of evidence only. It does not mandate that the plaintiff's damages be reduced by the collateral source benefits. It is up to the jury to decide what to do with the collateral source evidence. (*Fein v. Permanente Medical Group* (1985) 38 Cal.3d 137, 165, fn. 21; *Barme v. Wood* (1984) 37 Cal.3d 174, 179, fn. 5; *Hernandez v. California Hospital Medical Center* (2000) 78 Cal.App.4th 498, 506.)

(c) Section 3333.1, subdivision (b).

Subdivision (b) provides that, if evidence of collateral source benefits is introduced, the benefit provider is precluded from recouping its payments, either directly from the plaintiff or in a subrogated action against the defendant.

3. Section 3333.1 is constitutional.

(a) Subdivision (a).

In *Fein, supra*, 38 Cal.3d 137, the Supreme Court upheld the constitutionality of subdivision (a) against due process and equal protection challenges. The Court ruled that plaintiffs do not have a vested right in a particular measure of damages, and that abolition of the collateral source rule is rationally related to the legitimate state goal of reducing medical malpractice insurance costs. (*Id.* at p. 166.) “[T]he Legislature apparently assumed that in most cases the jury would set plaintiff’s damages at a lower level because of its awareness of plaintiff’s ‘net’ collateral source benefits.” (*Id.* at pp. 164-165, fn. omitted.)

(b) Subdivision (b).

In *Barme, supra*, 37 Cal.3d 174, the Supreme Court upheld the constitutionality of subdivision (b), ruling that the providers of collateral source benefits have no vested right to subrogation, and that subdivision (b) is rationally related to the legitimate goals of MICRA because it shifts some of the costs imposed on medical malpractice insurers to other insurers. (*Id.* at p. 181; see *Fein, supra*, 38 Cal.3d at pp. 165-166.)

4. Other contexts in which section 3333.1 may apply.

(a) Wrongful death action.

Section 3333.1 applies in a wrongful death action as well as a personal injury action. (§ 3333.1, subd. (c)(2); see *Yates v. Pollock* (1987) 194 Cal.App.3d 195, 198-199.)

(b) Action against public entity or employee.

Government Code section 985, the collateral source statute generally applicable to suits against public entities or employees, does not apply if the defendant is a “health care provider” within the meaning of Civil Code section 3333.1. Instead, section 3333.1 applies. (Gov. Code, § 985, subd. (d).)

(c) EMTALA action.

Section 3333.1 should apply in an EMTALA action for failure to stabilize, but probably does not apply in an EMTALA action for failure to provide an appropriate medical screening examination. (See *ante*, Section B(3)(c)(3).)

(d) Elder abuse action.

It is unlikely that any of the MICRA statutes apply in an elder abuse action. (See *ante*, Section B(3)(c)(4).)

(e) Equitable indemnity action.

In *SeaRiver Maritime v. Industrial Medical Services* (N.D.Cal. 1997) 983 F.Supp. 1287, 1301, a federal district court applied section 3333.1 in an equitable indemnity action against health care providers. (See *ante*, Section B(3)(c)(2).)

(f) Action under Federal Tort Claims Act.

Section 3333.1 should apply in an action brought under the Federal Tort Claims Act. “A federal court applies state law in matters involving the collateral source rule.” (*In re Air Crash Disaster Near Cerritos, Cal.* (9th Cir. 1992) 982 F.2d 1271, 1277.)

5. Statutory definitions.

(a) Definition of “health care provider.”

See *ante*, Section B(2).

(b) Definition of “based upon professional negligence.”

See *ante*, Section B(3).

6. Meaning of other statutory terms.

(a) “. . . any amount payable as a benefit”

(§ 3333.1, subd. (a).) Section 3333.1 speaks in terms of benefits “payable” to the plaintiff, not just “paid” to the plaintiff. In *Cuevas v. Contra Costa County* (2017) 11 Cal.App.5th 163, the

Court of Appeal held that “section 3333.1 permits the introduction of evidence regarding future as well as past medical benefits.” (*Id.* at p. 178.) The court noted that “section 3333.1 was enacted in 1975 yet it appears no reported California state appellate decision has squarely addressed the statute’s application to future medical damages awards.” (*Id.* at p. 178, fn. 12.) But, the Supreme Court long ago implied that section 3333.1 applies to future collateral source benefits.

In *Fein, supra*, 38 Cal.3d 137, the Supreme Court said: “Plaintiff, pointing out that he may not be covered by medical insurance in the future, apparently objects to any reduction of future damages on the basis of potential future collateral source benefits.” (*Id.* at p. 165, fn. 21.) The Supreme Court did not respond to this issue by holding that section 3333.1 applies only to past collateral source benefits. Instead, the Court pointed out that, under the terms of the (somewhat unusual) judgment, the defendant’s liability for future medical expenses would be reduced only to the extent the plaintiff in fact received medical insurance payments. (*Ibid.*) The Supreme Court went on to say: “Indeed, if anything, the trial court may have given plaintiff more than he was entitled to, since it did not reduce the jury’s \$63,000 award by the collateral source benefits plaintiff was *likely to receive . . .*” (*Ibid.*, emphasis added.) The implication is strong that the statute applies to future as well as past collateral source benefits.

The Court of Appeal in *Cuevas* discussed this aspect of *Fein* (*Cuevas, supra*, 11 Cal.App.5th at pp. 174-175), then went on to consider MICRA’s purpose and legislative history. “Interpreting section 3333.1 as abrogating the collateral source rule with respect to future medical benefits as well as past benefits is consistent with the legislative purpose of reducing malpractice insurance costs.” (*Id.* at p. 177.) Also, the predecessor bills to the bill that became MICRA “identified the Legislature’s desire to eliminate duplicative damages, including duplicative future damages, ‘for the cost of medical care . . . when such care has already been *or will be* provided by a collateral source.’” (*Ibid.*) “Since the adopted bill . . . incorporated ‘the concepts or language’ of the prior bills, it is not unreasonable to conclude the legislative intent to extend the statute’s reach to future damages was adopted as well.” (*Ibid.*)

Of course, with regard to any of the collateral source benefits listed in section 3333.1, evidence must be presented to show that the benefits will actually be available in the future. In *Cuevas*, the trial court excluded evidence of future benefits available to the plaintiff under the Affordable Care Act (ACA) on the ground it was speculative to assume the ACA will continue to exist. The Court of Appeal held this was an abuse of discretion because the “[d]efendant presented evidence sufficient to support the continued viability of the ACA, as well as its application to plaintiff’s circumstances.” (*Cuevas, supra*, 11 Cal.App.5th at p. 180.) A defense expert’s offer of proof “opined that the ACA is reasonably certain to continue well into the future and that plaintiff will be able to acquire comprehensive health insurance notwithstanding his disability. [The expert] reviewed [the plaintiff’s] life care plans and compared them . . . to insurance available on the Covered California health care exchange. [The expert] identified specific California insurance plans that would be available to meet many of [the plaintiff’s] needs.” (*Ibid.*)

In *Leung v. Verdugo Hills Hospital* (Jan. 22, 2013, B204908) 2013 WL 221654 [nonpub. opn.], the Court of Appeal said that, by analogy to the standard for recovering future medical expenses and future lost earnings, future collateral source benefits must be something the plaintiff is “reasonably certain” to receive. (*Id.* at p. *3 & fn. 5.) The court went on to explain what type of evidence is required to show “reasonable certainty”: “To show the amount of future insurance coverage that is reasonably certain, the evidence would have to: (1) link particular coverage and coverage amounts to particular items of care and treatment in the life care plan, (2) present a reasonable basis on which to believe that this particular plaintiff is reasonably certain to have that coverage, and (3) provide a basis on which to calculate with reasonable certainty the time period such coverage will exist. . . . [N]onspecific evidence of future insurance, such as its availability through government programs, . . . standing alone, is irrelevant to prove reasonably certain insurance coverage as a potential offset against future damages, because it has no tendency in reason to prove that specific items of future care and treatment will be covered, the amount of that coverage, or the duration of that coverage.” (*Id.* at p. *11.) For a suggested jury instruction

when evidence of future collateral source benefits is admitted, see Section D(13)(d)(2), *post*.

In *Graham v. Workers' Comp. Appeals Bd.* (1989) 210 Cal.App.3d 499, the Court of Appeal held section 3333.1 applies to *future* workers' compensation benefits. (*Id.* at pp. 503-506.) The workers' compensation subrogation statutes include both reimbursement provisions and credit provisions that apply when an injured employee recovers from a third party tortfeasor. (*Id.* at p. 503.) "[R]eimbursement applies to benefits paid *prior to* a third party judgment or settlement. With respect to *future* workers' compensation benefits due the injured party, a different mechanism applies—credit. An employer is entitled to a credit against its obligation to pay further compensation benefits in the amount of the worker's *net* recovery against the third party tortfeasor." (*State Comp. Ins. Fund v. Workers' Comp. Appeals Bd.* (1997) 53 Cal.App.4th 579, 583, original emphasis.) The *Graham* court concluded, "the sensible interpretation of Civil Code [section] 3333.1 is that it includes [i.e., bars] the employer's credit remedies as well as its reimbursement remedies." (*Graham*, at p. 506.) The court explained, "the California Supreme Court noted in *Fein* that the medical malpractice defendant may introduce evidence of benefits *received by or payable to* the plaintiff, and that the Legislature assumed that the jury would reduce the plaintiff's damages to reflect such benefits. (*Fein, supra*, 38 Cal.3d at pp. 164-165.)" (*Graham*, at p. 506, original emphasis.) Unless section 3333.1, subdivision (b) precludes the employer from exercising its credit rights as to the plaintiff's future workers' compensation benefits, the plaintiff's tort recovery could be hit by a double deduction. (*Ibid.*)

(b) "... pursuant to the United States Social Security Act"

(§ 3333.1, subd. (a).) In *Brown v. Stewart* (1982) 129 Cal.App.3d 331, superseded by statute on another ground as stated in *Garcia v. County of Sacramento* (2002) 103 Cal.App.4th 67, 78, the Court of Appeal held that subdivision (a) encompasses *only those Social Security programs that pay money directly to the plaintiff*, not those that pay for medical services provided to the plaintiff. (*Id.* at pp. 336-338; see *id.* at p. 343 (conc. opn. of Blease, J.)) "[P]ayments to recipients

under the Medi-Cal program are not ‘any amount payable as a benefit to the plaintiff pursuant to the United States Social Security Act. First, the funds provided are paid to the State of California, to be administered as part of its program of providing medical care for the needy. . . . Second, Medi-Cal payments are made directly to the medical service providers upon proof of rendition of health care services to an eligible Medi-Cal beneficiary. In a technical sense, a benefit is conferred upon the Medi-Cal recipient by the receipt of medical services but the thrust of the statutory language is directed to sums payable to the plaintiff.” (*Id.* at p. 337.) The concurring justice disagreed with the majority on this issue and concluded that subdivision (a) applies to the monetary value of medical services provided under the Social Security Act. (*Id.* at p. 343 (conc. opn. of Blease, J.).)

In *Cuevas, supra*, 11 Cal.App.5th 163, the Court of Appeal, in the course of holding that regional center benefits are a collateral source not covered by section 3333.1, noted: “Regional center benefits, like Medi-Cal benefits, are not paid to the disabled directly. They are paid to the providers by the State Department of Developmental Services.” (*Id.* at p. 181.)

(c) “ . . . any contract or agreement of any group, organization”

(§ 3333.1, subd. (a).) In *Brown, supra*, 129 Cal.App.3d 331, the Court of Appeal held the term “contract” means a “contract which includes as a contractual party the recipient of [the] health care services.” (*Id.* at p. 340.) “The statutory reference to a benefit provided pursuant to ‘any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of . . . health care services’ applies typically to such private health care plans, as Blue Cross, Blue Shield, and the Foundation Health Plan of Sacramento.” (*Id.* at p. 338.) “The term ‘contract’ . . . refers not to an implied, unilateral contract between the payor and the provider of services as . . . [exists for Medi-Cal], but rather to an express, bilateral contract between the payor and the recipient of services.” (*Id.* at p. 339.) “The statute contemplates a contract to which the hypothetical plaintiff is a party and by which an organization agrees to either provide directly or pay for health care services, or to reimburse the plaintiff in the

event he has expended personal funds for such services.” (*Ibid.*) The court also held the term “organization” does not include the state in the context of the Medi-Cal program. (*Id.* at p. 340, fn. 4.)

(d) “ . . . source of collateral benefits introduced pursuant to subdivision (a)”

(§ 3333.1, subd. (b).) In *Miller v. Sciaroni* (1985) 172 Cal.App.3d 306, the Court of Appeal held that, where evidence of some but not all benefits provided by a collateral source is introduced under subdivision (a), subdivision (b) bars recovery by the collateral source of *all* benefits conferred on the plaintiff by that source, even benefits not introduced into evidence by the defendant. (*Id.* at pp. 314-315.) The court reasoned that the purpose of section 3333.1 is not just to prevent double recovery by plaintiffs, but also to shift some of the costs of medical malpractice from malpractice insurers to other sources of indemnity. (*Ibid.*)

In *Graham, supra*, 210 Cal.App.3d 499, the Court of Appeal addressed the question whether subdivision (b) precludes an employer from obtaining credit for future workers’ compensation benefits where the employee’s medical malpractice claim was *settled*. The Court of Appeal held: “To harmonize Civil Code section 3333.1 with the Labor Code credit provisions, we interpret section 3333.1 as impliedly creating an exception to the credit provisions whenever an injured party has demonstrably had his recovery reduced to reflect collateral source contributions. In this case, the parties in the underlying medical malpractice case made an adequate factual record that Graham’s settlement was reduced to exclude any recovery for collateral source benefits.” (*Id.* at p. 508.) The court reasoned: “We cannot construe the collateral source benefit rules in a way that would discourage settlements and thus defeat the major purpose of the legislation.” (*Ibid.*)

The “adequate factual record” in *Graham* consisted of Graham’s counsel’s statement to the court at the settlement conference that Graham’s medical expenses and disability would not be considered in the settlement because the defense would introduce evidence at trial that workers’ compensation

benefits would pay those damages. (*Graham, supra*, 210 Cal.App.3d at p. 502.) The parties stipulated at the settlement conference to dismiss the claims for special damages. (*Id.* at p. 507.) “The settlement thus did not include any sum for past or future medical costs or economic loss, on the assumption that Graham had been compensated for such loss by his ‘collateral source,’ the workers’ compensation carrier.” (*Ibid.*)

Similarly, in *Quintanilla v. Sun Healthcare Group* (2021) 86 Cal.Comp.Cases 642 [2021 WL 4975157, at p. *6], the Worker’s Compensation Appeals Board panel found the “record, when considered in its entirety, contains substantial evidence that the settlement in the civil action was ‘demonstrably reduced’ to exclude any recovery for collateral source benefits.” The panel noted that, although there was no court reporter at the mediation, the employee’s attorney submitted a sworn declaration, consistent with his testimony at trial and contemporaneous correspondence, stating that he agreed to reduce the settlement amount based on his belief that the claim could be subject to MICRA. (*Id.* at p. *7.) The panel also rejected the administrative judge’s holding that the settlement’s payout of \$100,000 over MICRA’s cap undermined the employee’s claim of demonstrable reduction. (*Id.* at p. *8.) Noting that MICRA caps noneconomic, not special damages, the panel found the employee’s “wage loss claim would have most likely exceeded any reduction by the jury for any workers’ compensation lien[, the collateral source,] in this case, which is a more logical explanation than the [judge]’s for why the settlement included \$100,000.00 above the general damages cap.” (*Ibid.*)

To avoid unwarranted subrogation claims when a medical malpractice action is settled rather than tried, a factual record should be made at the time of settlement demonstrating that the collateral source benefits were taken into consideration in arriving at the settlement, the defendant expressed the intention to introduce evidence of the collateral source benefits at trial, and the settlement does not encompass any damages covered by the collateral source benefits.

7. Federal statutes authorizing reimbursement from a tort recovery prevail over section 3333.1.

(a) If a federal right to reimbursement exists, subdivision (b) of section 3333.1 is preempted.

In *Barne, supra*, 37 Cal.3d 174, the Supreme Court said: “[T]he right of reimbursement enjoyed by some of the . . . collateral sources enumerated in section 3333.1, subdivision (a) may be guaranteed by federal law. Under federal supremacy principles, of course, in such cases MICRA’s provisions will have to yield.” (*Id.* at p. 180, fn. 6.)

(b) If subdivision (b) is preempted, subdivision (a) should be unenforceable as well.

The plaintiff would suffer a double deduction if the jury reduced its award because of the collateral source benefits, yet the collateral source obtained reimbursement of those benefits from the plaintiff’s tort recovery. (See *Fein, supra*, 38 Cal.3d at p. 165 [stating that one purpose of subdivision (b) is to prevent such a double deduction].)

(c) Collateral sources with a federal right to reimbursement.

(1) Federal government.

Section 3333.1, subdivision (a), refers to benefits payable under the Social Security Act. For some of those benefits, however, the federal government has a right to reimbursement:

(a) Medi-Cal.

Medi-Cal benefits are partially federally funded under the Social Security Act. (*Lima v. Vouis* (2009) 174 Cal.App.4th 242, 246, 253-254; *Brown, supra*, 129 Cal.App.3d at pp. 336-337.) In *Brown*, the Court of Appeal held that section 3333.1 would be unenforceable if interpreted to encompass Medi-Cal benefits because reimbursement of the benefits from the plaintiff’s

tort recovery is authorized by federal law. (*Brown*, at pp. 336-337, 341; see *Cuevas*, *supra*, 11 Cal.App.5th at pp. 173, 181; *Garcia*, *supra*, 103 Cal.App.4th at pp. 80, 81; *Brown*, at pp. 346-347 (conc. opn. of Blease, J.); see also *Perez by and through Perez v. United States* (S.D.Cal., July 25, 2018, No. 16cv01911 JAH-MDD) 2018 WL 3570348, at p. *4 [nonpub. opn.] [“Payments made through Medi-Cal ‘fall outside the scope of Civil Code section 3333.1’ ”].)

(b) Medicare.

Medicare falls under the Social Security Act. (42 U.S.C. § 1395 et seq.) The Medicare Secondary Payer provisions of the Social Security Act authorize reimbursement of benefits when a Medicare beneficiary suffers an injury covered by a tortfeasor’s liability insurance. (42 U.S.C. § 1395y(b)(2)(B)(ii); see *Zinman v. Shalala* (9th Cir. 1995) 67 F.3d 841, 843.) Therefore, section 3333.1 is unenforceable with regard to Medicare benefits to which the right of reimbursement applies.

- In *Jordan v. Long Beach Community Hosp.* (1988) 248 Cal.Rptr. 651, 659-661, the Court of Appeal held the federal Medical Care Recovery Act preempts section 3333.1 with regard to Medicare benefits. *Jordan* was decertified by the Supreme Court, but its holding on this issue seems correct.

Note, however, that there is a major difference between Medicare benefits provided in the traditional manner under Medicare Part A (hospital services) or Medicare Part B (outpatient services), and benefits provided under Medicare Part C. The federal right to reimbursement applies to Part A and Part B benefits, but not to Part C benefits. In *Yee v. Tse* (Sept. 9, 2011, B222570) 2011 WL 3964647 [nonpub. opn.],

the Court of Appeal explained that, under Part C, which is called Medicare Advantage (MA), “an ‘MA organization’ contracts with Medicare to provide specified health services for Medicare beneficiaries in exchange for a monthly payment from Medicare for each person enrolled in the MA plan. [Citation.] The payment is referred to as the ‘capitation’ rate. [Citation.] The MA organization may contract in turn with a physicians group and hospitals to provide direct services to enrollees for a monthly fee per enrollee, regardless of the services actually provided in a given month.” (*Id.* at p. *16.) “Medicare paid a monthly sum to Health Net to provide for Yee’s medical care and Health Net made payments for Yee’s care. There is no evidence or authority to suggest that Medicare is entitled to recover the capitation amount paid to an MA organization, which Medicare paid regardless of whether Yee received any care or sustained any injuries. Nor is there any evidence or authority that Medicare is entitled to recover amounts spent by Health Net for Yee’s medical care.” (*Ibid.*) “The payments for Yee’s medical care under Health Net’s MA plan were admissible under section 3333.1. . . . Yee assigned her Medicare benefits to Health Net as part of her enrollment in [the Health Net Seniority Plus plan] to provide for her health care services. Therefore, the amounts that Health Net paid to Yee’s medical providers were amounts ‘payable as a benefit to the plaintiff as a result of the personal injury pursuant to . . . [a] contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or other health care services.’

([Civ. Code.] § 3333.1, subd. (a).)” (*Ibid.*)

“The trial court erred by excluding evidence of Health Net’s payments for Yee’s medical care which was explicitly admissible under section 3333.1. Dr. Tse was prejudiced by the exclusion of payment information which could have altered the jury’s award of past economic damages. Therefore, the judgment must be reversed for a new trial on the issue of economic damages.” (*Id.* at p. *17.)

(2) ERISA plans.

Section 3333.1, subdivision (a), refers to private health-related benefits. If, however, those benefits are payable pursuant to an employee benefit plan regulated by the federal Employee Retirement Income Security Act of 1974 (ERISA), section 3333.1 is unenforceable if the benefit plan is self-funded (uninsured).

- Cases that discuss how to determine whether a source of benefits is an employee benefit plan subject to ERISA include *Marshall v. Bankers Life & Casualty Co.* (1992) 2 Cal.4th 1045, 1051-1058; *Hollingshead v. Matsen* (1995) 34 Cal.App.4th 525, 533-539; and *Stuart v. UNUM Life Ins. Co. of America* (9th Cir. 2000) 217 F.3d 1145, 1149-1153.

In *FMC Corp. v. Holliday* (1990) 498 U.S. 52 [111 S.Ct. 403, 112 L.Ed.2d 356], the United States Supreme Court held that ERISA preempted a Pennsylvania law precluding employee benefit plans from exercising subrogation rights against a tort recovery. The employee benefit plan in question was self-funded; it did not purchase an insurance policy from an insurance company in order to satisfy its obligations to plan participants. The Supreme Court held: “if a plan is insured, a State may regulate it indirectly through regulation of its insurer and its insurer’s insurance contracts; if the plan is uninsured, the State may not regulate it.” (*Id.* at p. 64.)

In *United Food & Commercial Workers v. Pacyga* (9th Cir. 1986) 801 F.2d 1157, 1161-1162, the Ninth Circuit held that Arizona's medical malpractice anti-subrogation statute was preempted by ERISA because the benefits in question were not provided through insurance.

In *Medical Mutual of Ohio v. deSoto* (6th Cir. 2001) 245 F.3d 561, 572-574, the Sixth Circuit held that California's Civil Code section 3333.1, subdivision (b) was not preempted by ERISA because the benefits were provided through insurance.

In California, two unpublished United States District Court decisions held that Civil Code section 3333.1, subdivision (b) was preempted by ERISA. (*FMC Corp. Employee Welfare Benefits Plan Committee v. Good Samaritan Hosp.* (N.D.Cal., Dec. 5, 1988, No. C-88-3092-FMS) 1988 WL 424459 [nonpub. opn.]; *Budinger v. McGann* (C.D.Cal., June 26, 1987, No. CV 86-7499 MRP) 1987 WL 268934 [nonpub. opn.].) In each case, the benefit plan was self-funded (uninsured).

In sum, the key distinction under ERISA is between a law directly regulating an employee benefit plan and a law indirectly regulating the plan by directly regulating an insurance policy purchased by the plan. The former is preempted; the latter is not. (See *Inter Valley Health Plan v. Blue Cross/Blue Shield* (1993) 16 Cal.App.4th 60, 63-65.) Accordingly, section 3333.1, subdivision (b) is preempted by ERISA *unless the benefits in question are provided through insurance*. (See generally Annot., Treatment of Subrogation Rights of ERISA-Qualified, Self-Funded Employee Benefit Plans (1997) 138 A.L.R.Fed. 611.)

8. State statutes authorizing reimbursement of public benefits from a tort recovery prevail over section 3333.1.

(a) Medi-Cal.

In *Brown, supra*, 129 Cal.App.3d 331, the Court of Appeal held section 3333.1 does not apply to Medi-Cal benefits. One of the

reasons given was, “we do not perceive it was the intent of the Legislature to bail out doctors and other health providers by the use of public funds. At the time of the enactment of . . . [MICRA], the Governor had made it clear he would not be willing to use general funds to pay for malpractice premium increases. [Citation.] But . . . [if section 3333.1 is interpreted to encompass Medi-Cal benefits], this precise result is accomplished. Acceptance of this interpretation means the state is required to forego its statutory right and federal obligation to collect monies to reimburse and thereby partially fund the Medi-Cal program in favor of reducing tort liability damage awards against health care providers and derivatively malpractice insurance premiums.” (*Id.* at p. 341; see *Hernandez, supra*, 78 Cal.App.4th at p. 506.) “The reasonable assumption is if the Legislature had intended to preclude reimbursement of Medi-Cal payments by inclusion within section 3333.1, it would have explicitly so provided in either section 3333.1 or in [Welfare and Institutions Code] section 14124.70 et seq. [the Medi-Cal reimbursement statutes].” (*Brown*, at p. 342.)

(b) Regional center.

In *Cuevas, supra*, 11 Cal.App.5th 163, the defendant acknowledged that regional center benefits do not fall into any category enumerated by section 3333.1, but argued that such benefits are not collateral sources in the first place. The Court of Appeal disagreed, pointing out that “regional centers . . . have subrogation rights enforceable by a lien on a client’s recovery, just as does Medi-Cal. . . . [T]he general collateral source rule applies.” (*Id.* at p. 181; see Welf. & Inst. Code, § 4659.10 et seq.)

(c) County hospital.

County hospitals are not explicitly listed in section 3333.1. Because state law authorizes reimbursement from a tort recovery (Gov. Code, § 23004.1; see *Newton v. Clemons* (2003) 110 Cal.App.4th 1, 5), section 3333.1 should not be interpreted to apply to county hospital benefits. (See *Brown, supra*, 129 Cal.App.3d at pp. 340-342.)

(d) California Children's Services (CCS).

CCS is not explicitly listed in section 3333.1. Because state law authorizes reimbursement from a tort recovery (Health & Saf. Code, § 123982; see *Tapia v. Pohlmann* (1998) 68 Cal.App.4th 1126, 1132-1133; see also Health & Saf. Code, § 123872), section 3333.1 should not be interpreted to apply to CCS benefits. (See *Brown, supra*, 129 Cal.App.3d at pp. 340-342.)

9. Section 3333.1 prevails over state statutes allowing reimbursement of, or a credit against, workers' compensation benefits from a tort recovery.

(a) An employer has no right to reimbursement.

Labor Code section 3852 permits an employer to subrogate an employee's claim against a third party tortfeasor as to workers' compensation benefits conferred, less any amount attributable to the employer's negligence. In *Miller, supra*, 172 Cal.App.3d 306, the Court of Appeal held that, "where Labor Code section 3852 and [subdivision (b) of] Civil Code section 3333.1 are in conflict, the latter must prevail." (*Id.* at p. 311.)

(b) An employer has no right to a credit.

Labor Code section 3861 allows an employer a credit against its obligation to pay further compensation benefits in the amount of the worker's net recovery against a third party tortfeasor. In *Graham, supra*, 210 Cal.App.3d 499, the employer argued that section 3333.1, subdivision (b), only precludes a collateral source from "recover[ing] any amount against the plaintiff" and therefore does not restrict an employer's right to discontinue workers' compensation benefit payments until the amount of the benefits exceeds the amount of the employee's net recovery from the third party tortfeasor. (*Id.* at pp. 503-505.) The Court of Appeal rejected the employer's argument and held, "the sensible interpretation of Civil Code [section] 3333.1 is that it includes the employer's credit remedies as well as its reimbursement remedies." (*Id.* at p. 506; see *Quintanilla, supra*, 86 Cal.Comp.Cases 642 [2021 WL 4975157, at p. *6] [Because the parties agreed the civil action stated a claim for professional negligence under MICRA, the employer would only be entitled to third-party credit if the

employee's settlement was not " 'demonstrably reduced' " to reflect collateral source contributions].)

10. Summary: list of collateral sources encompassed by section 3333.1.

(a) Private health, sickness, accident, or disability benefits.

Section 3333.1, subdivision (a), applies to "any health, sickness or income-disability insurance, accident insurance that provides health benefits or income-disability coverage, and any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or other health care services." This seems to run the full gamut of private health-related benefits (except life insurance). Section 3333.1 is preempted by ERISA if the benefits are provided by a self-funded (uninsured) employee benefit plan. (See *ante*, Section D(7)(c)(2).)

(b) Medicare Part C (Medicare Advantage).

See *ante*, Section D(7)(c)(1)(b).

(c) State disability insurance (SDI).

Section 3333.1, subdivision (a), applies to "any state . . . income disability . . . act" SDI is payable when an employee cannot work because of sickness or injury not caused by the job, or when an employee is entitled to workers' compensation in an amount less than is payable under SDI. (Unemp. Ins. Code, § 2601 et seq.) SDI usually is payable for, at most, one year. (*Id.*, § 2653.)

(d) Workers' compensation.

Section 3333.1 applies to workers' compensation benefits. (*Barme, supra*, 37 Cal.3d at pp. 178, fn. 4, 179, fn. 5.) Workers' compensation is payable if the plaintiff was injured on the job. Besides medical bills, workers' compensation pays temporary and permanent disability benefits. (Lab. Code, § 3600 et seq.) Workers' compensation benefits continue even after a medical

malpractice tort recovery. (*Graham, supra*, 210 Cal.App.3d at pp. 503-506.)

(e) Social Security survivors benefits.

Section 3333.1 applies to money payable directly to the plaintiff under the Social Security Act. (See *ante*, Section D(6)(b).) Social Security survivors benefits are payable in the event of a covered employee's death; the spouse, children, and dependent parents may receive payments. (42 U.S.C. § 402 et seq.; see *Bryant v. New York City Health & Hosps. Corp.* (N.Y. 1999) 716 N.E.2d 1084, 1092-1094 [under New York's collateral source statute, child's monthly Social Security survivors benefits can be used to offset damages for lost economic support of deceased parent].) Survivors benefits should continue even after a tort recovery. (See 42 U.S.C. § 403 [listing the circumstances under which Social Security benefits can be reduced; a tort recovery is not one of them].) Therefore, preemption should not be a problem (see *ante*, Section D(7)), and evidence of future survivors benefits should be admissible on the issue of future lost economic support (see *ante*, Section D(6)(a); *Bryant*, at pp. 1092, fn. 7, 1093-1094).

(f) Social Security Disability Insurance (SSDI).

Section 3333.1 applies to money payable directly to the plaintiff under the Social Security Act. (See *ante*, Section D(6)(b).) SSDI pays a monthly income if a covered employee is unable to work because of a disability; the spouse and children may be entitled to payments as well. (42 U.S.C. § 423 et seq.) SSDI payments continue even after a tort recovery. (See *Richardson v. Belcher* (1971) 404 U.S. 78, 81, 85-86 [92 S.Ct. 254, 30 L.Ed.2d 231] (dis. opn. of Douglas, J.); *id.* at p. 89 (dis. opn. of Marshall, J.); *Lofty v. Richardson* (6th Cir. 1971) 440 F.2d 1144, 1151-1152.) Therefore, preemption should not be a problem (see *ante*, Section D(7)), and evidence of future SSDI benefits should be admissible on the issue of future lost earnings (see *ante*, Section D(6)(a)).

(g) Supplemental Security Income (SSI).

Section 3333.1 applies to money payable directly to the plaintiff under the Social Security Act. (See *ante*, Section

D(6)(b).) SSI, which falls under the Social Security Act, “is a uniform, federally administered, nationwide program guaranteeing a monthly federal payment to needy aged, blind and disabled persons.” (*Hodson v. Woods* (1984) 160 Cal.App.3d 1227, 1230-1231; see *Disabled & Blind Action Committee of Cal. v. Jenkins* (1974) 44 Cal.App.3d 74, 75-76.) Preemption should not be a problem because there does not appear to be any federal right to reimbursement from a tort recovery. (See *ante*, Section D(7); Welf. & Inst. Code, §§ 12103, 12350.) A plaintiff who obtains a tort recovery, however, probably will be ineligible for future SSI benefits. (See *White ex rel. Smith v. Apfel* (7th Cir. 1999) 167 F.3d 369; *Frerks v. Shalala* (2d Cir. 1995) 52 F.3d 412.)

11. Summary: list of collateral sources not encompassed by section 3333.1.

(a) Private life insurance.

The wording of subdivision (a) does not encompass private life insurance.

- Like section 3333.1, New York’s medical malpractice collateral source statute does not apply to life insurance, but does apply to Social Security survivors benefits. (*Bryant, supra*, 716 N.E.2d at p. 1093; see *ante*, Section D(10).)

(b) Private gratuitous benefits.

The wording of subdivision (a) does not encompass private organizations that offer medical and other benefits, usually without cost to the recipient. Examples are: Arthritis Foundation; Braille Foundation; City of Hope; Crippled Children’s Society; Kidney Foundation of Southern California; March of Dimes; Multiple Sclerosis Society; United Cerebral Palsy Association.

(c) Medicare Parts A and B.

See *ante*, Section D(7)(c)(1)(b).

(d) Medi-Cal.

See *ante*, Sections D(7)(c)(1)(a) and D(8)(a).

(e) Regional center.

See *ante*, Section D(8)(b).

(f) County hospital.

See *ante*, Section D(8)(c).

(g) California Children's Services (CCS).

See *ante*, Section D(8)(d).

(h) In-Home Supportive Services (IHSS).

The IHSS program “enable[s] aged, blind or disabled poor persons to avoid institutionalization by remaining in their homes with proper supportive services.” (*Marshall v. McMahon* (1993) 17 Cal.App.4th 1841, 1844.) IHSS falls under the Social Security Act. (*Id.* at p. 1844, fn. 2; *County of Sacramento v. State of California* (1982) 134 Cal.App.3d 428, 430-431.) In *Brown, supra*, 129 Cal.App.3d at pages 336-338, the Court of Appeal held section 3333.1 applies only to those Social Security Act programs that pay money directly to the plaintiff. (See *ante*, Section D(6)(b).) Because the federal money for IHSS benefits is paid to the State of California (*County of Sacramento*, at p. 431), section 3333.1 does not apply.

(i) Rehabilitation services.

The state Department of Rehabilitation provides vocational rehabilitation and independent living services, partially funded by the federal government, to individuals with physical or mental disabilities. (See Welf. & Inst. Code, § 19000 et seq.) Department of Rehabilitation benefits do not fall within the wording of section 3333.1, subdivision (a).

(j) Special education.

The special education needs of disabled children are met by the public school system. (See *County of Los Angeles v. Smith*

(1999) 74 Cal.App.4th 500, 507-514.) Special education benefits do not fall within the wording of section 3333.1, subdivision (a). Nevertheless, evidence of those benefits should be admissible on the ground the public school system is not a collateral source in the first place.

12. Benefits that are not collateral sources in the first place, evidence of which should be admissible without regard to section 3333.1: special education.

(a) Whether the collateral source rule applies is an open question.

The collateral source rule applies to public benefits with reimbursement rights, like Medi-Cal. (*Hanif, supra*, 200 Cal.App.3d at pp. 639-640.) But it is an open question whether the rule applies to free public benefits available to anyone with a qualifying disability, like special education. (*Arambula, supra*, 72 Cal.App.4th at p. 1015.) If the collateral source rule does not apply to free public benefits, then evidence of such benefits is admissible *without regard to section 3333.1*.

(b) Special education.

The public school system is required by federal and California law to provide what is needed for a free appropriate public education (20 U.S.C. § 1400 et seq.; Ed. Code, § 56000 et seq.), including, for example, physical, speech, and occupational therapy, in-school nursing, and placement in a public or private residential program (20 U.S.C. § 1401(9), (26) & (29); Ed. Code, §§ 56000-56001, 56363; *Cedar Rapids Community School Dist. v. Garret F.* (1999) 526 U.S. 66 [119 S.Ct. 992, 143 L.Ed.2d 154]; *County of Los Angeles, supra*, 74 Cal.App.4th at p. 512). There is no payment obligation. (20 U.S.C. § 1401(9), (29); Ed. Code, § 56040; Health & Saf. Code, § 123870, subd. (b).)

(c) Public policy considerations underlying the collateral source rule do not apply.

The issue is whether the public policy considerations underlying the collateral source rule, as expressed in *Hel fend, supra*, 2 Cal.3d 1 (private insurance benefits are a collateral

source), and *Arambula, supra*, 72 Cal.App.4th 1006 (gratuitous private benefits are a collateral source), apply to benefits provided by the public school system in a medical malpractice case. They do not.

(1) The *Helfend* case.

Below are the reasons the Supreme Court gave in *Helfend* for applying the collateral source rule to private insurance benefits. Following each is a response that explains why the reason has no application, or carries much less weight, when the issue is free public benefits available to anyone with a qualifying disability in a medical malpractice case:

(a) *Reason*: “The collateral source rule as applied here embodies the venerable concept that a person who has invested years of insurance premiums to assure his medical care should receive the benefits of his thrift. The tortfeasor should not garner the benefits of his victim’s providence. [¶] The collateral source rule expresses a policy judgment in favor of encouraging citizens to purchase and maintain insurance for personal injuries and for other eventualities.” (*Helfend, supra*, 2 Cal.3d at pp. 9-10, fn. omitted; see *McKinney, supra*, 96 Cal.App.4th at p. 1223 [“An independent collateral source is most often obtained as a result of plaintiff’s actual or constructive payment and planning”]; *People v. Birkett* (1999) 21 Cal.4th 226, 247, fn. 19.)

Response: This policy judgment has no bearing at all on benefits provided by the public school system. Applying the collateral source rule to those benefits would not encourage citizens to purchase and maintain insurance.

(b) *Reason*: “[I]nsurance policies increasingly provide for either subrogation or refund of benefits upon a tort recovery Hence, the plaintiff receives no double recovery.” (*Helfend, supra*, 2 Cal.3d at pp. 10-11.)

Response: Applying the collateral source rule to benefits provided by the public school system *would*

result in a double recovery because there is no requirement of reimbursement from a tort recovery. The benefits are free. Allowing a plaintiff to recover as damages the value of free public benefits available to anyone with a qualifying disability is pushing the collateral source rule much too far.

(c) *Reason*: “[T]he plaintiff rarely actually receives full compensation for his injuries as computed by the jury. The collateral source rule partially serves to compensate for the attorney’s share and does not actually render ‘double recovery’ for the plaintiff.” (*Helpend, supra*, 2 Cal.3d at p. 12.)

Response: In a medical malpractice case, the attorney fee is limited by Business and Professions Code section 6146. Moreover, full compensation for injuries is no longer public policy where medical malpractice is concerned. The overriding public policy is to reduce the cost of medical malpractice insurance so medical care will be fully available and patients will not be treated by uninsured doctors and face the prospect of obtaining only unenforceable judgments if they should suffer serious injury as a result of malpractice. (See *ante*, Section A(2).)

(d) *Reason*: “[T]he cost of medical care often provides both attorneys and juries in tort cases with an important measure for assessing the plaintiff’s general damages. [Citation.] To permit the defendant to tell the jury that the plaintiff has been recompensed by a collateral source for his medical costs might irretrievably upset the complex, delicate, and somewhat indefinable calculations which result in the normal jury verdict.” (*Helpend, supra*, 2 Cal.3d at pp. 11-12.)

Response: The “complex, delicate, and somewhat indefinable calculations” that underlie a jury’s determination of general damages are far less significant in a medical malpractice case by virtue of Civil Code section 3333.2, which limits damages for noneconomic losses. No longer are general damages the

largest component of a judgment. The focus in a medical malpractice case is on economic losses.

(2) The *Arambula* case.

In *Arambula, supra*, 72 Cal.App.4th 1006, the Court of Appeal had a public policy reason to apply the collateral source rule to gratuitous private benefits: “[W]e adhere to the [collateral source] rule to promote policy concerns favoring private charitable assistance. . . . Why would a family member (or a stranger) freely give of his or her money or time if the wrongdoer would ultimately reap the benefits of such generosity?” (*Id.* at p. 1012.) This policy judgment has no bearing at all on benefits provided by the public school system. The law requires that those benefits be provided to anyone with a qualifying disability.

(d) The law in other states.

Other states *are* split on the admissibility of evidence of free public benefits available to anyone with a qualifying disability. (See Annot., Collateral Source Rule: Admissibility of Evidence of Availability to Plaintiff of Free Public Special Education on Issue of Amount of Damages Recoverable from Defendant (1996) 41 A.L.R.5th 771.)

13. Litigation.

(a) Section 3333.1 should be pled as an affirmative defense.

While there is no case law determining whether section 3333.1 must be pled as an affirmative defense, defense counsel should do so. It could prove useful in meeting an argument at or after trial that section 3333.1 was not timely asserted. It follows that healthcare defendants should seek a stipulation or present evidence establishing that they are healthcare providers within the meaning of MICRA.

(b) The collateral source provider has no right to intervene.

A collateral source has no right to intervene in a medical malpractice action to litigate issues raised by section 3333.1. (*California Physicians' Service v. Superior Court* (1980) 102 Cal.App.3d 91, 98-99.)

(c) Consider retaining a defense rehabilitation expert.

Defense counsel should consider retaining a certified rehabilitation counselor or other rehabilitation specialist to do a work-up of benefits available to the plaintiff, particularly if the plaintiff is a minor and the injuries are serious.

(d) Proffer special jury instructions.

(1) Instruction if evidence of past collateral source benefits is admitted.

“Evidence of [health insurance or disability insurance or State Disability Insurance or workers’ compensation or Social Security Survivor’s Insurance or Social Security Disability Insurance or Supplemental Security Income] benefits paid to plaintiff has been admitted [along with evidence of the cost of those benefits]. If you find defendant liable, you should consider whether to reduce any damages for past economic loss by the amount of those benefits [less the cost of those benefits].”

(2) Instruction if evidence of future collateral source benefits is admitted.

“Evidence of [health insurance or disability insurance or State Disability Insurance or workers’ compensation or Social Security Survivor’s Insurance or Social Security Disability Insurance or Supplemental Security Income] benefits that may be payable to plaintiff in the future has been admitted [along with evidence of the cost of those benefits]. If you find defendant liable, and if you determine that those benefits are reasonably certain to be available to plaintiff in the future, you should consider whether to reduce any damages for future

economic loss by the amount of those benefits [less the cost of those benefits.]

(3) Instruction if evidence of special education benefits is admitted.

“Evidence of special education benefits that plaintiff [is receiving] [is entitled to receive] has been admitted. If you find defendant liable, and if you determine that those benefits are reasonably certain to be available to plaintiff in the future, you should consider whether to reduce any damages for future economic loss by the amount of those benefits.”

(e) Consider proposing a special verdict or special interrogatories.

If evidence of collateral source benefits is admitted and could become an issue on appeal, it may be important to know whether the jury reduced its award because of the benefits. A special verdict or special interrogatories should be used to elicit this information. The appellate courts have stressed the importance of special verdicts in applying MICRA provisions. (See *American Bank & Trust Co. v. Community Hospital* (1984) 36 Cal.3d 359, 377; *Gorman v. Leftwich* (1990) 218 Cal.App.3d 141, 150.)

E. CIVIL CODE SECTION 3333.2: LIMITING RECOVERY OF NONECONOMIC DAMAGES.

1. Text of section 3333.2.

(a) In any action for injury against a health care provider or health care institution based on professional negligence, the injured plaintiff shall be entitled to recover noneconomic losses to compensate for pain, suffering, inconvenience, physical impairment, disfigurement and other nonpecuniary damage, subject to the limitations in this section.

(b) In any action for injury that does not involve wrongful death against one or more health care providers or health care institutions based on professional negligence, the following limitations shall apply:

(1) Civil liability for damages for noneconomic losses against one or more health care providers, collectively, shall not exceed three hundred fifty thousand dollars (\$350,000), regardless of the number of health care providers, which does not include any unaffiliated health care providers that are responsible for noneconomic losses pursuant to paragraph (3).

(2) Civil liability for damages for noneconomic losses against one or more health care institutions, collectively, shall not exceed three hundred fifty thousand dollars (\$350,000), regardless of the number of health care institutions, which does not include any unaffiliated health care institutions that are responsible for noneconomic losses pursuant to paragraph (3).

(3) Civil liability for damages for noneconomic losses against one or more health care providers or health care institutions that are unaffiliated with a defendant described in paragraph (1) or (2) based on acts of professional negligence separate and independent from the acts of professional negligence of a defendant described in paragraph (1) or (2) and that occurred at, or in relation to medical transport to, a health care institution unaffiliated with a health care institution described in paragraph (2), collectively, shall not exceed three hundred fifty thousand dollars (\$350,000), regardless of the number of defendants described in this paragraph, which does not include any unaffiliated health care providers or unaffiliated health

care institutions that are responsible for noneconomic losses pursuant to paragraph (1) or (2).

(c) In any action for wrongful death against one or more health care providers or health care institutions based on professional negligence, the following limitations shall apply:

(1) Civil liability for damages for noneconomic losses against one or more health care providers, collectively, shall not exceed five hundred thousand dollars (\$500,000), regardless of the number of health care providers, which does not include any unaffiliated health care providers that are responsible for noneconomic losses pursuant to paragraph (3).

(2) Civil liability for damages for noneconomic losses against one or more health care institutions, collectively, shall not exceed five hundred thousand dollars (\$500,000), regardless of the number of health care institutions, which does not include any unaffiliated health care institutions that are responsible for noneconomic losses pursuant to paragraph (3).

(3) Civil liability for damages for noneconomic losses against one or more health care providers or health care institutions that are unaffiliated with a defendant described in paragraph (1) or (2) based on acts of professional negligence separate and independent from the acts of professional negligence of a defendant described in paragraph (1) or (2) that occurred at, or in relation to medical transport to, a health care institution unaffiliated with a health care institution described in paragraph (2), collectively, shall not exceed five hundred thousand dollars (\$500,000), regardless of the number of defendants described in this paragraph, which does not include any unaffiliated health care providers or unaffiliated health care institutions that are responsible for noneconomic losses pursuant to paragraph (1) or (2).

(d) No health care provider defendant shall be liable for damages for noneconomic losses in more than one of the categories set forth in this section, regardless of the application or combined application thereof.

(e) No health care institution defendant shall be liable for damages for noneconomic losses in more than one of the categories

set forth in this section, regardless of the application or combined application thereof.

(f) The applicable dollar amounts set forth in this section apply regardless of the number of defendant health care providers or health care institutions against whom the claim is asserted or the number of separate causes of actions on which the claim is based. For a claim subject to subdivision (b), the applicable dollar amounts set forth in subdivisions (b), (g), and (h) provide three separate limits of liability that may apply. For a claim subject to subdivision (c), the applicable dollar amounts set forth in subdivisions (c), (g), and (h) provide three separate limits of liability that may apply.

(g) This section shall be deemed effective as of, and shall apply to all cases filed or arbitrations demanded on or after, January 1, 2023. Thereafter, the dollar amounts set forth in subdivision (b) shall increase by forty thousand dollars (\$40,000) each January 1st for 10 years up to seven hundred fifty thousand dollars (\$750,000), and the dollar amounts set forth in subdivision (c) shall increase each January 1st by fifty thousand dollars (\$50,000) for 10 years up to one million dollars (\$1,000,000). The dollar amount in effect at the time of judgment, arbitration award, or settlement shall apply to an action, subject to subdivision (h).

(h) The applicable amounts for noneconomic damages for personal injury of \$750,000, and for wrongful death of \$1,000,000, as set forth in subdivision (g), shall be adjusted for inflation on January 1 of each year by 2 percent beginning on January 1, 2034.

(i) In no action shall the amount of damages for noneconomic losses exceed the applicable dollar amounts set forth in subdivisions (b), (c), (g), or (h).

(j) For the purposes of this section:

(1) “Health care provider” means any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or licensed pursuant to the Osteopathic Initiative Act, or the Chiropractic Initiative Act, or licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code; and any clinic, health dispensary, or health facility, licensed pursuant to Chapter 1 (commencing with Section 1200) or Chapter 1.3 (commencing with

Section 1248) of Division 2 of the Health and Safety Code, and does not include health care institutions that are defined in paragraph (2). “Health care provider” includes the legal representatives of a health care provider and the health care provider’s employer, professional corporation, partnership, or other form of legally recognized professional practice organization.

(2) “Health care institution” means one or more health care facilities licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code owned or operated by the same entity or its affiliates and includes all persons and entities for which vicarious liability theories, including, but not limited to, the doctrines of respondeat superior, actual agency, and ostensible agency, may apply.

(3) “Unaffiliated” means a specified health care provider, health care institution, or other entity not covered by the definition of affiliated, or affiliated with, as defined in Section 150 of the Corporations Code, or that is not employed by, performing under a contract with, an owner of, or in a joint venture with another specified entity, health care institution, health care provider, organized medical group, professional corporation, or partnership, or that is otherwise not in the same health system with that health care provider, health care institution, or other entity. Whether a health care provider, health care institution, or other entity is unaffiliated is determined at the time of the professional negligence.

(4) “Professional negligence” means a negligent act or omission to act by a health care provider in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death, provided that such services are within the scope of services for which the provider is licensed and which are not within any restriction imposed by the licensing agency or licensed hospital.

2. Summary of section 3333.2.

Section 3333.2 limits the *present value* of damages for noneconomic losses. (*Salgado v. County of Los Angeles* (1998) 19 Cal.4th 629, 642, 646-647.) Noneconomic losses are defined as “pain, suffering, inconvenience, physical impairment, disfigurement, and other nonpecuniary damage.” (§ 3333.2, subd. (a).) As enacted, section 3333.2 set a \$250,000 cap on noneconomic damages. As amended by

AB-35, section 3333.2 raises the caps and provides for future increases. It also establishes separate limits for personal injury actions and wrongful death actions and provides three separate categories of defendants who may be liable, up to the applicable damages limit, in each case.

In a *personal injury* action, damages for noneconomic losses are capped at \$350,000 against each of the following: one or more health care providers, collectively (§ 3333.2, subd. (b)(1)); one or more health care institutions, collectively (§ 3333.2, subd. (b)(2)); and health care providers or health care institutions *unaffiliated* with defendants under subdivisions (b)(1) and (2) for professional negligence that is separate and independent from the acts of defendants under subdivisions (b)(1) and (2) and that occurred at a health care institution unaffiliated with any institution under subdivision (b)(2) (§ 3333.2, subd. (b)(3)).

In a *wrongful death* action, damages for noneconomic losses are capped at \$500,000 against each of the following: one or more health care providers, collectively (§ 3333.2, subd. (c)(1)); one or more health care institutions, collectively (§ 3333.2, subd. (c)(2)); and health care providers or health care institutions *unaffiliated* with defendants under subdivisions (c)(1) and (2) for professional negligence that is separate and independent from the acts of defendants under subdivisions (c)(1) and (2) and that occurred at a health care institution unaffiliated with any institution under subdivision (c)(2) (§ 3333.2, subd. (c)(3)).

Although a plaintiff may seek damages, and recover up to the applicable cap, against all three groups of defendants, each defendant can only be liable for damages under one category in this section. (§ 3333.2, subds. (d), (e).) The damages caps for noneconomic loss apply regardless of the number of defendants. (§ 3333.2, subd. (f).)

The damages caps under section 3333.2 apply to all cases filed or arbitrations demanded on or after January 1, 2023. (§ 3333.2, subd. (g).) The caps will increase every year for 10 years: the cap in personal injury actions will increase by \$40,000 each January 1 up to \$750,000, and the cap in wrongful death actions will increase by \$50,000 every January 1 up to \$1 million. (*Ibid.*) Beginning in January 2034, the amounts of \$750,000 (for personal injury actions) and \$1 million (for wrongful death actions) will be adjusted by 2 percent every January 1 for inflation. (§ 3333.2, subd. (h).) The cap in

effect at the time of judgment, arbitration award, or settlement applies. (§ 3333.2, subd. (g).) The MICRA caps applicable each year through 2034 are listed in Appendix A.

A patient suing for physical injury and the patient's spouse suing for loss of consortium can each recover up to the statutory cap. (*Atkins v. Strayhorn* (1990) 223 Cal.App.3d 1380, 1394.) In a wrongful death case, however, the recovery of all the heirs combined is limited to the statutory cap. (*Yates v. Pollock* (1987) 194 Cal.App.3d 195, 200-201.) If the verdict exceeds the statutory cap and the plaintiff is partially at fault, the plaintiff's fault percentage is applied to the verdict first, then the remainder is reduced to the statutory cap if necessary. (*McAdory v. Rogers* (1989) 215 Cal.App.3d 1273, 1278-1279.) If the verdict exceeds the statutory cap and more than one health care provider is at fault, the verdict is reduced to the statutory cap first, then each defendant's fault percentage is applied. (*Gilman v. Beverly California Corp.* (1991) 231 Cal.App.3d 121, 129.) If the verdict exceeds the statutory cap and one health care provider is at fault, the health care provider's fault percentage is applied first. The result is reduced to the statutory cap if necessary. (*Bigler-Engler v. Breg, Inc.* (2017) 7 Cal.App.5th 276, 326, 327.)

3. Section 3333.2 is constitutional.

- a. In *Fein v. Permanente Medical Group* (1985) 38 Cal.3d 137, the Supreme Court upheld the constitutionality of section 3333.2 against due process and equal protection challenges. The Court held due process does not prohibit the Legislature from limiting the recovery of a particular type of damages where the limitation furthers a legitimate state interest. (*Id.* at pp. 157, 162.) In light of the malpractice insurance crisis, the state has a legitimate interest in reducing the cost of judgments for malpractice defendants and their insurance companies. (*Id.* at pp. 158-159.) The limitation on noneconomic damages naturally furthers that goal. (*Id.* at p. 159.) In rejecting the equal protection challenge, the Court held it is permissible to limit the application of section 3333.2 to medical malpractice cases because the insurance crisis arose in that context. (*Id.* at p. 162.) The Court also rejected a contention that the statute unlawfully discriminates among malpractice plaintiffs because it has a disproportionate effect on those who suffer the greatest noneconomic injuries. (*Id.* at pp. 162-163.)

- b. In *Chan v. Curran* (2015) 237 Cal.App.4th 601, the Court of Appeal held that section 3333.2 does not deny equal protection, violate due process, or violate the right to jury trial. Regarding equal protection, the plaintiff argued changed circumstances, namely, “(a) there no longer is a medical malpractice insurance crisis, (b) Proposition 103, under which the California Insurance Commissioner now sets medical malpractice insurance rates, has stabilized the insurance market, and (c) the ravages of inflation have decimated the economic significance of \$250,000 [the limit under former section 3333.2, subdivision (b)] in recoverable noneconomic damages.” (*Id.* at p. 613.) Each of these arguments was rejected. (*Id.* at pp. 613-621.) Turning to due process, the plaintiff argued that “\$250,000 does not yield enough in contingency fees to make prosecuting most medical malpractice claims economically feasible, effectively denying most malpractice victims access to the courts.” (*Id.* at p. 623.) This argument, too, was rejected. (*Id.* at pp. 623-627.) Regarding the right to jury trial, the Court of Appeal “join[ed] the other Courts of Appeal that have considered and rejected” this argument. (*Id.* at pp. 629-630, citing *Stinnett v. Tam* (2011) 198 Cal.App.4th 1412, 1433, and *Yates, supra*, 194 Cal.App.3d at p. 200.)
- c. In *Stinnett, supra*, 198 Cal.App.4th 1412, the Court of Appeal held that section 3333.2 does not deny equal protection or violate the right to jury trial. Regarding equal protection, the plaintiff argued changed conditions. (*Id.* at p. 1428.) The Court of Appeal rejected the plaintiff’s arguments that section 3333.2 has been rendered obsolete by subsequent events (*id.* at pp. 1430-1432) and that it denies equal protection because \$250,000 [the limit under former section 3333.2] does not have nearly the same purchasing power that it had in 1975 (*id.* at p. 1432; see *id.* at p. 1435, fn. 4 (conc. & dis. opn. of Dawson, J.)). Regarding the right to jury trial, the Court of Appeal followed *Yates, supra*, 194 Cal.App.3d 195. (*Stinnett*, at p. 1433; see *id.* at p. 1434 (conc. & dis. opn. of Dawson, J.)).
- d. In *Hoffman v. United States* (9th Cir. 1985) 767 F.2d 1431, 1437, the Ninth Circuit held section 3333.2 is consistent with the equal protection clause of the federal Constitution.
- e. In *Yates, supra*, 194 Cal.App.3d at page 200, the Court of Appeal held section 3333.2 does not violate the right to jury

trial. In *Stinnett*, *supra*, 198 Cal.App.4th 1412, the Court of Appeal followed *Yates* and held section 3333.2 does not violate the right to jury trial. (*Id.* at p. 1433; see *id.* at p. 1434 (conc. & dis. opn. of Dawson, J.).)

- f. There are also quite a few *unpublished and thus uncitable opinions* affirming the constitutionality of section 3333.2: *Lora v. Lancaster Hospital Corp.* (July 22, 2015, B250519) 2015 WL 4477952 (rejecting equal protection and right to jury trial arguments; extensive discussion of *Stinnett* and *Chan* cases); *Rashidi v. Moser* (Apr. 20, 2015, B237476) 2015 WL 1811971 (rejecting right to jury trial, equal protection, and separation of powers arguments); *Hughes v. Pham* (Aug. 22, 2014, E052469) 2014 WL 4162364 (rejecting right to jury trial, separation of powers, and equal protection arguments); *Van Buren v. Evans* (May 20, 2009, F054227) 2009 WL 1396235 (rejecting right to jury trial, separation of powers, and equal protection arguments); *Hooper v. Capobianco* (May 25, 2004, C040072) 2004 WL 1167395 (rejecting equal protection arguments); see *Marquez v. County of Riverside* (Sept. 15, 2014, E057369) 2014 WL 4537609, at page *8 (the plaintiff failed to establish that the need for MICRA no longer exists); *Lopez v. Contra Costa Regional Medical Center* (N.D.Cal., Sept. 2, 2014, No. C 12-03726 LB) 2014 WL 4349080 (section 3333.2 has not expired of its own accord).
- g. Additionally, other state courts have upheld similar provisions against constitutional challenges. In *Siebert v. Okun* (N.M. 2021) 485 P.3d 1265, 1266, the plaintiff alleged the Medical Malpractice Act (N.M. Stat. Ann., § 41-5-1 et seq.), which caps all damages except those for medical care and punitive damages, violated her right to a jury guaranteed under the New Mexico Constitution. The Supreme Court of New Mexico rejected the argument, finding that the right to a jury “is satisfied when evidence is presented to a jury, which then deliberates and returns a verdict based on its factual findings. The legal consequence of that verdict is a matter of law, which the Legislature has the authority to shape.” (*Siebert*, at p. 1277.) Because the statute “provides that the jury shall not be informed of the damages cap, [it] does not invade the jury’s role as fact-finder.” (*Id.* at p. 1279.) Thus, the cap restricts the scope of the available remedy but does not abridge the plaintiff’s right to present evidence to the jury. (*Id.* at p. 1277;

see *Pulliam v. Coastal Emergency Service of Richmond, Inc.* (Va. 1999) 509 S.E.2d 307, 310 [“the medical malpractice cap does not violate any constitutional guarantees”].)

4. Other contexts in which section 3333.2 may apply.

(a) Wrongful death action.

In *Yates, supra*, 194 Cal.App.3d at pages 198-199, the Court of Appeal held section 3333.2 *applies* in a wrongful death action. Subsequently, in *Horwich v. Superior Court* (1999) 21 Cal.4th 272, 283, the Supreme Court said the same.

As amended by AB-35 section 3, Civil Code section 3333.2 now expressly applies to wrongful death actions.

(b) Action against public entity or employee.

Section 3333.2 applies. (E.g., *Salgado, supra*, 19 Cal.4th 629 [applying section 3333.2 in an action against a county].)

(c) EMTALA action.

In *Barris v. County of Los Angeles* (1999) 20 Cal.4th 101, the Supreme Court held section 3333.2 applies in an EMTALA action for failure to stabilize (*id.* at pp. 116-117), but left open the question whether section 3333.2 applies in an EMTALA action for disparate medical screening (*id.* at p. 111, fn. 4). (See *ante*, Section B(3)(c)(3).) After *Barris*, two federal district court decisions that held the section 3333.2 limits do not apply in an EMTALA action (*Burrows v. Redbud Community Hosp. Dist.* (N.D.Cal. 1997) 188 F.R.D. 356, 359-360; *Jackson v. East Bay Hosp.* (N.D.Cal. 1997) 980 F.Supp. 1341, 1350) are no longer authoritative, at least with respect to an action for failure to stabilize. (See *Barris*, at pp. 114-115.) In *Romar v. Fresno Community Hosp. and Medical Center* (E.D.Cal. 2008) 583 F.Supp.2d 1179, the federal district court held that section 3333.2 does not apply in an EMTALA action for disparate medical screening.

(d) Elder abuse action.

It is unlikely that section 3333.2 applies in an elder abuse action. (See *ante*, Section B(3)(c)(4).) But the Elder Abuse Act

itself places a \$250,000 limit on noneconomic damages—in cases involving physical abuse or neglect, not in cases involving financial abuse. (Compare Welf. & Inst. Code, § 15657, subd. (b) with § 15657.5, subd. (b).) It has been argued that the Elder Abuse Act’s \$250,000 cap applies only in a survival action, not in an action where the victim of physical abuse or neglect is alive. This does not appear to be the way the Supreme Court reads the legislative history. (See *Delaney v. Baker* (1999) 20 Cal.4th 23, 36.) Legislative history documents are available that show the intent was to cap noneconomic damages in all actions, not just survival actions. However, in *Samantha B. v. Aurora Vista Del Mar, LLC* (2021) 72 Cal.App.5th 1092 [2021 WL 5996835, at p. *9], rehearing granted January 14, 2022, the Court of Appeal, Second District, held that the section 15657, subdivision (b), limitation on noneconomic damages applies only to survival actions; it does not cap the recovery of living plaintiffs.

(e) Equitable indemnity action.

In *Western Steamship Lines, Inc. v. San Pedro Peninsula Hospital* (1994) 8 Cal.4th 100, the Supreme Court held section 3333.2 applies in an equitable indemnity action. But this is of little significance. *Western Steamship* is not a Proposition 51 case. (*Id.* at p. 117, fn. 14.) Under Proposition 51, liability for noneconomic damages is not joint and several. (Civ. Code, § 1431.2.) One tortfeasor is not required to pay another tortfeasor’s share of noneconomic damages, so indemnity does not exist for noneconomic damages.

(f) Action under Federal Tort Claims Act.

In *Taylor v. United States* (9th Cir. 1987) 821 F.2d 1428, the Ninth Circuit held section 3333.2 applies in an action under the Federal Tort Claims Act.

5. Statutory definitions.

(a) Definition of “health care provider.”

Under section 3333.2, “ ‘Health care provider’ means any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions

Code, or licensed pursuant to the Osteopathic Initiative Act, or the Chiropractic Initiative Act, or licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code; and any clinic, health dispensary, or health facility, licensed pursuant to Chapter 1 (commencing with Section 1200) or Chapter 1.3 (commencing with Section 1248) of Division 2 of the Health and Safety Code, and does not include health care institutions that are defined in paragraph (2). ‘Health care provider’ includes the legal representatives of a health care provider and the health care provider’s employer, professional corporation, partnership, or other form of legally recognized professional practice organization.” (§ 3333.2, subd. (j)(1).)

This definition differs from the definition of “health care provider” provided in other MICRA statutes (see *ante*, Section B.2) in that it encompasses the health care provider’s employer and business organization, and distinguishes “health care institutions” for purposes of this section.

(b) Definition of “health care institution.”

Under section 3333.2, “ ‘Health care institution’ means one or more health care facilities licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code owned or operated by the same entity or its affiliates and includes all persons and entities for which vicarious liability theories, including, but not limited to, the doctrines of respondeat superior, actual agency, and ostensible agency, may apply.” (§ 3333.2, subd. (j)(2).)

(c) Definition of “unaffiliated.”

Under section 3333.2, “ ‘Unaffiliated’ means a specified health care provider, health care institution, or other entity not covered by the definition of affiliated, or affiliated with, as defined in Section 150 of the Corporations Code, or that is not employed by, performing under a contract with, an owner of, or in a joint venture with another specified entity, health care institution, health care provider, organized medical group, professional corporation, or partnership, or that is otherwise not in the same health system with that health care provider, health care institution, or other entity. Whether a health care

provider, health care institution, or other entity is unaffiliated is determined at the time of the professional negligence.” (§ 3333.2, subd. (j)(3).)

Subdivisions (b) and (c) do not expressly define the term “affiliated,” so arguably “affiliated” means any relationship that does not fall within the statutory definition of “unaffiliated.” At a minimum, by implication a health care provider and/or institution is affiliated with another health care provider and/or institution if:

- (1) “it directly, or indirectly through one or more intermediaries, controls, is controlled by or is under common control with the other specified corporation” (Corp. Code, § 150), *or*
- (2) it is “owned or operated by the same entity or its affiliates” (Civ. Code, § 3333.2, subd. (j)(2)), *or*
- (3) it “is . . . employed by, performing under a contract with, an owner of, or in a joint venture with another specified entity, health care institution, health care provider, organized medical group, professional corporation, or partnership, or that is otherwise not in the same health system with that health care provider, health care institution, or other entity” (Civ. Code, § 3333.2, subd. (j)(3)).

Corporations Code section 150 states: “A corporation is an ‘affiliate’ of, or a corporation is ‘affiliated’ with, another specified corporation if it directly, or indirectly through one or more intermediaries, controls, is controlled by or is under common control with the other specified corporation.”

Corporations Code section 150 has not often been construed in published appellate decisions. In *Otay Land Co., LLC v. U.E. Limited, L.P.* (2017) 15 Cal.App.5th 806, the current owner of a shooting range sued the prior owner seeking to recover hazardous waste remediation costs. The prior owner successfully asserted a release provision in the sale agreement. The Court of Appeal reversed, holding that the prior owners were not affiliates of the estate that executed the sales

agreement containing the release because the prior owners did not *control* the estate. (*Id.* at pp. 852-859.) The court explained that an “‘affiliate’ is a ‘corporation that is related to another corporation by shareholdings or other means of control.’” (*Id.* at p. 857, quoting Black’s Law Dict. (10th ed. 2014) p. 69, col. 2.) And “Control typically involves authority to direct the management of an entity.” (*Ibid.*, citing Corp. Code, § 160, subd. (a) [control generally “means ‘possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a corporation’ ”])

(d) Definition of “based upon professional negligence.”

The definition of “professional negligence” under section 3333.2 does not depart from the definition in other MICRA statutes. (See § 3333.2, subd. (j)(4); *ante*, Section B(3).)

6. A single plaintiff is limited to the statutory cap for a single injury caused by each statutory group of defendants, regardless of the number of defendants in each group.

Section 3333.2, subdivision (a), limits the recovery of noneconomic damages “[i]n any action for injury against a health care provider or health care institution.” If more than one health care *provider* is named as a defendant, the plaintiff may argue that separate limits apply to each defendant. This argument is without merit if the defendants jointly contributed to a *single injury*. (See § 3333.2, subd. (b)(1).) The same is true if more than one health care *institution* is named defendant. (See § 3333.2, subd. (b)(2).) However, a plaintiff may also recover up to the statutory cap against providers or institutions *unaffiliated* with those under subdivisions (b)(1) and (b)(2) for their “separate and independent” acts. (§ 3333.2, subd. (b)(3).) Thus, a plaintiff may potentially separately recover up to the statutory cap against the three distinct groups of defendants for injuries caused by each: health care providers, health care institutions, and unaffiliated health care providers or health care institutions.

The number of actors under each distinct group of defendants (see § 3333.2, subs. (b)(1)-(3), (c)(1)-(3)) or number of acts by those defendants is irrelevant under section 3333.2. The statute speaks to *damages*, limiting “damages for noneconomic losses.” (§ 3333.2,

subds. (b), (c).) “[D]amages flow from *injury*, not negligent acts.” (*Atkins, supra*, 223 Cal.App.3d at p. 1396, emphasis added.) Negligence without injury is not actionable. (*Budd v. Nixen* (1971) 6 Cal.3d 195, 200; *Gordon v. J & L Machinery Service Co.* (1963) 213 Cal.App.2d 711, 713.) Accordingly, it is the number of separate and distinct *injuries* the plaintiff sustained that is pertinent. “Under MICRA, where more than one health care provider jointly contributes to a single injury, the maximum a plaintiff may recover for noneconomic damages is \$250,000 [the former statutory limit].” (*Gilman, supra*, 231 Cal.App.3d at p. 128.) “[A] plaintiff cannot recover more than \$250,000 [the former statutory limit] in noneconomic damages from all health care providers for one injury.” (*Id.* at p. 129.) See also *Francies v. Kapla* (2005) 127 Cal.App.4th 1381, 1389, footnote 14, where the Court of Appeal said: “Francies . . . cites no authority supporting the view that a separate [statutory damages] limit applies to each health care provider who contributes to a single injury. It is unnecessary to address that question here.”

- In *Jordan v. Long Beach Community Hosp.* (1988) 248 Cal.Rptr. 651, 659, the court held the [statutory] limit cannot be multiplied by the number of health care providers who cause a discrete injury. *Jordan* was decertified by the Supreme Court, and a decertified opinion is uncitable. But *Jordan's* holding on this issue seems correct.

7. A single plaintiff may recover only the statutory limit, even for multiple injuries.

Since the key is the number of separate and distinct injuries the plaintiff sustained (see the discussion immediately above), logically, a plaintiff who sustains more than one injury should be entitled to recover a separate maximum of \$350,000 (personal injury) or \$500,000 (wrongful death) for each injury caused by the same statutory group of defendants. But, in *Colburn v. United States* (S.D.Cal. 1998) 45 F.Supp.2d 787, the federal district court held that, “MICRA provides a . . . maximum aggregate recovery for a single plaintiff.” (*Id.* at p. 793; see *id.* at p. 794.) The plaintiff in *Colburn* was a mother whose premature twins died three hours after birth. (*Id.* at p. 789.) She alleged the wrongful death of each twin, as well as negligent infliction of emotional distress under *Burgess v. Superior Court* (1992) 2 Cal.4th 1064, 1085. (*Colburn*, at pp. 793-794 & fn. 5.) Even though the plaintiff suffered three separate injuries, each with its own noneconomic losses, she was limited to a \$250,000 maximum

aggregate recovery (the former section 3333.2, subdivision (b), limit) for noneconomic losses.

8. The heirs in a wrongful death action are limited to an aggregate of the applicable statutory limit.

In *Yates, supra*, 194 Cal.App.3d 195, the Court of Appeal held all the heirs in a wrongful death action share one \$250,000 limit (the former section 3333.2, subdivision (b), limit). In *Schwarder v. United States* (9th Cir. 1992) 974 F.2d 1118, the Ninth Circuit held the heirs' \$250,000 limit was separate from the \$250,000 limits that would have applied to the patient and his spouse (see the next section below), who both sued and settled before the patient died (under former section 3333.2, subdivision (b)).

9. A spouse suing for loss of consortium is entitled to a separate recovery up to the statutory limit.

(a) The statutory limit applies to the spouse.

See *Williams v. Superior Court* (1994) 30 Cal.App.4th 318, 323-324; *Taylor, supra*, 821 F.2d at p. 1431, footnote 2.

(b) The spouse's recovery is separately limited.

In *Atkins, supra*, 223 Cal.App.3d 1380, the Court of Appeal held: "Where . . . a claim for loss of consortium is joined with a spouse's claim for physical injuries in an action for medical malpractice, each spouse is entitled to recover up to [the statutory limit] for his or her separate noneconomic losses." (*Id.* at p. 1394.) The court explained: "Had the legislature intended to limit the defendant's liability encompassing all legal proceedings arising from a single act of professional negligence . . . , it would have included the language 'single act of negligence' to accomplish this purpose. . . . [T]he statute does not limit noneconomic damages to 'a single injury-causing incident.' Rather, recovery is limited for the discrete *injury* to each spouse because damages flow from injury, not negligent acts." (*Id.* at p. 1396.) The court added in a footnote: "[W]e envision a situation where a single act by a health care provider negligently caused injury to multiple unrelated patients (e.g., contaminated medications). To say these plaintiffs were collectively entitled to [the statutory limit]

because there was only one negligent act would be to render the statute an absurdity.” (*Id.* at p. 1394, fn. 9.)

Atkins distinguished *Yates*, *supra*, 194 Cal.App.3d 195 (single statutory cap in wrongful death action) because, “[w]hile a wrongful death action is a joint, single and indivisible one, loss of consortium is a separate and independent claim from a spouse’s claim for personal injury.” (*Atkins*, *supra*, 223 Cal.App.3d at p. 1395.)

- In *Jordan*, *supra*, 248 Cal.Rptr. at pages 657-659, another Court of Appeal held a spouse suing for loss of consortium has a separate \$250,000 limit (under former section 3333.2, subdivision (b)). *Jordan* was decertified by the Supreme Court, and a decertified opinion is uncitable. Probably, the decertification was for other reasons.

(c) If the injured patient dies, the spouse’s loss-of-consortium claim merges into the spouse’s wrongful death claim. A single statutory limit applies.

If the injured patient remains alive for a time, then dies, the surviving spouse has both an action for loss of consortium and a wrongful death action. But the surviving spouse is not entitled to separate statutory limits for the two actions. The *noneconomic* losses for loss of consortium and wrongful death are equivalent (*Boeken v. Philip Morris USA, Inc.* (2010) 48 Cal.4th 788, 804; *Budavari v. Barry* (1986) 176 Cal.App.3d 849, 854, fn. 7; *Lamont v. Wolfe* (1983) 142 Cal.App.3d 375, 381), so the two actions amount to dividing the noneconomic damages for a *discrete injury* into two time periods: prior to death and after death (see *Boeken*, at p. 804 [“With respect to postdeath loss of consortium, the two actions concern the same plaintiff seeking the same damages from the same defendant for the same harm, and to that extent they involve the same primary right”]; *Lamont*, at p. 382 [wrongful death action is “not a wholly different cause of action but more a continuation under a different name of the original cause of action for loss of consortium”]). Because “recovery is limited for the discrete injury to each spouse” (*Atkins*, *supra*, 223 Cal.App.3d at p. 1396), the surviving spouse is limited to the MICRA cap for noneconomic damages between the two actions. If the MICRA

cap is recovered in the loss-of-consortium action, there are no noneconomic damages to be recovered by the surviving spouse in the wrongful death action, and vice versa. To the extent the surviving spouse seeks to recover noneconomic damages in the wrongful death action, those damages must be shared by all the heirs. (*Yates, supra*, 194 Cal.App.3d at pp. 200-201; see *Engalla v. Permanente Medical Group, Inc.* (1997) 15 Cal.4th 951, 969.)

10. A relative suing for negligent infliction of emotional distress is entitled to a separate statutory limit.

(a) The statutory limit applies to the relative.

See *Williams, supra*, 30 Cal.App.4th at pages 323-324; *Taylor, supra*, 821 F.2d at page 1431, footnote 2.

(b) The relative's statutory limit is separate.

Atkins, supra, 223 Cal.App.3d at pages 1394-1396, holds that a spouse suing for loss of consortium is entitled to a separate statutory limit. (See *ante*, Section E(9).) The reasoning of *Atkins* applies as well to a suit for negligent infliction of emotional distress. (See *Richards v. United States* (E.D.Cal., Feb. 2, 2022, No. 20-cv-00586-JLT-SAB) 2022 WL 316840, at pp. *14-*17 [nonpub. opn.] [relying on *Atkin*, district court holds birthing mother's negligent infliction of emotional distress claim and father's wrongful death claim are subject to separate MICRA caps because each claim is for a distinct personal injury even though they stem from the same negligent incident].)

11. The noneconomic damages are reduced to the statutory limit after applying the plaintiff's comparative fault percentage.

In *McAdory, supra*, 215 Cal.App.3d 1273, the Court of Appeal held that, first, the jury's verdict must be reduced to reflect the plaintiff's comparative fault, then the noneconomic damages must be reduced to the applicable statutory limit. The *McAdory* court refused to follow *Semsch v. Henry Mayo Newhall Memorial Hospital* (1985) 171 Cal.App.3d 162, 170, footnote 1, in which another Court of Appeal, without discussion, first reduced the noneconomic damages to the

statutory limit, then applied the plaintiff's comparative fault percentage. (*McAdory*, at pp. 1276-1277.) Subsequently, in *Atkins*, *supra*, 223 Cal.App.3d at pages 1391-1393, another Court of Appeal disagreed with *Semsch* and followed *McAdory*. And, in *Francies*, *supra*, 127 Cal.App.4th at page 1388, footnote 13, the Court of Appeal said: "[W]e agree with [*McAdory* and *Atkins*] that this issue was not fully considered in the footnote in *Semsch* . . . and that that case is not persuasive on this issue."

Under *McAdory* and *Atkins*, plaintiffs who contribute to their own substantial injuries are permitted to recover the same damages for noneconomic losses as wholly innocent victims of medical malpractice. This makes little sense. *Semsch* gives full effect to both section 3333.2 and the rule of comparative fault, by reducing the recovery for noneconomic losses below the statutory maximum in cases where the plaintiff has contributed to his or her own injury. After all, when the Legislature enacted section 3333.2, the Supreme Court already had adopted comparative fault in *Li v. Yellow Cab Co.* (1975) 13 Cal.3d 804, 829. If the Legislature intended that defendants not fully benefit from both section 3333.2 and the decision in *Li*, presumably it would have said so.

- 12. If there are multiple defendants to whom the statutory limit applies, the noneconomic damages are reduced to the limit before applying the defendants' comparative fault percentages under Proposition 51. If there is only one defendant to whom the limit applies, the noneconomic damages are reduced to the limit after applying the defendant's comparative fault percentage.**

Proposition 51 (Civ. Code, §§ 1431.1-1431.5) essentially abolished the principle of joint and several tort liability for noneconomic damages. In *Gilman*, *supra*, 231 Cal.App.3d 121, the Court of Appeal held the trial court correctly reduced the jury's verdict for noneconomic damages to the statutory maximum first, before applying the defendant's fault percentage under Proposition 51. (*Id.* at pp. 126-130.) Accordingly, in an action where more than one health care provider, health care institution, or unaffiliated health care provider or institution contributes to the plaintiff's injuries, section 3333.2 establishes a limit on the defendants' collective liability for noneconomic damages, and Proposition 51 defines how that liability is distributed among the defendants. For example, if the \$350,000

limit applies and defendant A is 30 percent liable for the plaintiff's injuries where the plaintiff's noneconomic damages total \$500,000, then defendant A is liable for \$105,000 in noneconomic damages (30% of \$350,000). *Gilman* was reaffirmed by *Mayes v. Bryan* (2006) 139 Cal.App.4th 1075, 1100-1102.

In *Francies, supra*, 127 Cal.App.4th 1381, the Court of Appeal explained that “*Gilman* . . . turns on the fact that the third party who shared responsibility for the plaintiff's injury was also a health care provider, making it necessary, in effect, to apportion the . . . MICRA limit.” (*Id.* at p. 1389.) “[T]here is no basis to reduce [the health care provider's] liability because of the fault of another party who is *not* a health care provider, and . . . since he is the only responsible party to whom MICRA applies, he may be liable for up to [the statutory limit] in noneconomic damages.” (*Ibid.*, emphasis added.) In other words, where the third party sharing responsibility for the plaintiff's injury is *not* a health care provider or health care institution, the noneconomic damages are reduced to the statutory limit *after* applying Proposition 51. (*Id.* at pp. 1387-1389.)

In *Bigler-Engler, supra*, 7 Cal.App.5th 276, the Court of Appeal held that, if there are multiple defendants and only one of them is subject to one of the MICRA limits, the noneconomic damages are reduced to the applicable limit *after* applying Proposition 51. (*Id.* at pp. 325-330.) The court reasoned in part: “Proposition 51 . . . determines a defendant's *liability* for noneconomic damages, according to that defendant's fault, whereas MICRA establishes a cap on the *recovery* of such damages for certain defendants. Because the applicability of MICRA's cap cannot be determined unless a defendant's liability is known, Proposition 51 logically must apply first. If one defendant is subject to the MICRA cap, and that defendant's liability, as determined by the jury's determination of noneconomic loss and proportionate fault, exceeds [the MICRA cap], a trial court must apply the MICRA cap to limit any judgment against that defendant to that amount. If the defendant's liability does not exceed [the MICRA cap], the MICRA cap does not apply.” (*Id.* at p. 327.) In contrast, if more than one defendant is subject to the MICRA cap, “the MICRA cap limits a plaintiff's recovery against all liable health care providers collectively [and all health care institutions collectively] to [the applicable MICRA cap]. If the health care providers collectively [or health care institutions collectively] are found to be liable for an amount exceeding [the MICRA cap], the MICRA cap applies and must be apportioned between them according

to their relative faults.” (*Id.* at p. 328, citing *Mayes, supra*, 139 Cal.App.4th at pp. 1101, fn. 16, 1102, and *Gilman, supra*, 231 Cal.App.3d at p. 129.)

13. A hypothetical combining the former \$250,000 limit and comparative fault by both the plaintiff and the defendant.

In *Gilman, supra*, 231 Cal.App.3d 121, the Court of Appeal gave a hypothetical (using the cap under former section 3333.2, subdivision (b)) to “illustrate the interplay between MICRA, Proposition 51, and comparative negligence principles as implicated in *McAdory, supra*, 215 Cal.App.3d 1273.” (*Gilman*, at p. 129, fn. 10.) “If a jury awards plaintiff \$1 million dollars in noneconomic damages and apportions fault as follows—25 percent to plaintiff; 25 percent to a drug company (not a health care provider under MICRA); 40 percent to Dr. A; and 10 percent to Dr. B—, then the judgment would be calculated as follows: First, plaintiff’s negligence will reduce the \$1 million verdict to \$750,000 . . . ; the drug company will be severally liable for 25 percent of the verdict, or \$250,000; the health care providers’ total liability will be \$250,000 pursuant to MICRA; this amount will be apportioned 80 percent to Dr. A and 20 percent to Dr. B according to their respective percentage of fault. If any of the concurrent tortfeasors is insolvent, the liability of the other tortfeasors remains unchanged.” (*Ibid.*)

14. The noneconomic damages should be reduced to the statutory limit before calculating the percentage of noneconomic damages in the verdict and using that percentage to allocate a settlement between noneconomic and economic damages.

- (a) The noneconomic damages in a settlement are not subject to setoff. To determine how much of the settlement is noneconomic damages, calculate the percentage of noneconomic damages in the verdict.**

Under Proposition 51, “each defendant is solely responsible for his or her share of the noneconomic damages. Thus, that portion of the settlement attributable to noneconomic damages is not subject to setoff.” (*Espinoza v. Machonga* (1992) 9 Cal.App.4th 268, 276; accord, *McComber v. Wells* (1999) 72 Cal.App.4th 512, 517-518.) The proper method of calculating a setoff is to allocate the settlement between noneconomic and economic damages using the same percentages as the jury’s verdict; thus, if the verdict is 50 percent noneconomic and 50 percent economic damages, the settlement should be considered 50 percent noneconomic and 50 percent economic damages. (*McComber*, at pp. 517-518; *Espinoza*, at pp. 273, 277.)

- This is only true for a *preverdict* settlement, not a *postverdict* settlement; for the latter, a “ceiling” approach is used. (*Torres v. Xomox Corp.* (1996) 49 Cal.App.4th 1, 40-42.)

- (b) The noneconomic damages should be reduced to the statutory limit before the percentage of noneconomic damages in the verdict is calculated.**

Whether the percentage of noneconomic damages is calculated before or after the reduction to the applicable statutory limit can make a big difference. Assume the total verdict in a personal injury action is \$2 million, of which \$1 million is noneconomic; therefore, the noneconomic portion of the verdict is 50 percent. In contrast, the total recovery (after eliminating the excess noneconomic damages) is \$1,350,000, of which \$350,000 is noneconomic; therefore, the noneconomic portion of

the *recovery* is only 26 percent ($\$350,000 \div \$1,350,000$). If the calculation is made before the reduction to \$350,000, the setoff is only 50 percent of the settlement amount. If the calculation occurs after the reduction to \$350,000, the setoff is 74 percent of the settlement amount.

If the calculation is made before the reduction to \$350,000, it is possible for a settlement to include more than \$350,000 in noneconomic damages. For example, in the hypothetical immediately above, if 50 percent of the settlement is noneconomic damages, and the total amount of the settlement is more than \$750,000, the noneconomic damages in the settlement will be more than \$350,000. This result is unrealistic. The settling parties no doubt took the \$350,000 limit into consideration when they agreed on the amount of the settlement: few if any settling health care providers or health care institutions would be willing to pay more than the maximum recovery the law allows for noneconomic losses. As the Supreme Court explained in *Rashidi v. Moser* (2014) 60 Cal.4th 718, 727, when defendants are protected by MICRA, their “[s]ettlement negotiations are based on liability estimates that are necessarily affected by the cap” and the MICRA cap “restrains the size of settlements.”

Thus, to be consistent with the settling parties’ actual behavior, the settlement should be allocated between noneconomic and economic damages in a manner that eliminates any possibility of the noneconomic damages exceeding the statutory limit. The noneconomic damages in the verdict should be reduced to the applicable statutory limit before the percentage of noneconomic damages is calculated.

In *Francies*, *supra*, 127 Cal.App.4th 1381, where the MICRA cap did not have any effect on the plaintiff’s settlement with a codefendant who was *not* a health care provider, the Court of Appeal held the trial court erred by reducing the noneconomic damages to the MICRA cap before calculating the percentage of noneconomic damages in the verdict. “The objective of this calculation is to determine the proper allocation between economic and noneconomic damages of the amounts previously recovered. [Citations.] The MICRA cap had no effect on the amounts recovered either from Francies’s employer or as workers’ compensation benefits. In using the allocation of

damages made by the trier of fact in the current proceedings as the appropriate allocation of the amounts previously recovered, the relevant ratio is the actual economic damages as a percentage of the total damages suffered by Francies, not the ratio between the economic damages and the amount of damages that Francies can recover from Kapla.” (*Id.* at p. 1387.) This makes sense. Since the settling codefendant was not covered by the MICRA cap, the cap played no role in its decision to settle; therefore, the cap should have played no role in allocating the settlement between economic and noneconomic damages.

On the other hand, in *Mayes*, *supra*, 139 Cal.App.4th 1075, where the settling codefendant *was* a health care provider, the Court of Appeal held the trial court properly reduced the noneconomic damages to the MICRA cap first, before calculating the percentage of noneconomic damages in the verdict. (*Id.* at pp. 1098-1103.)

However, in *Collins v. County of San Diego* (2021) 60 Cal.App.5th 1035, 1065-1068, the Court of Appeal affirmed a different calculation where the settling codefendants were health care providers but the remaining codefendants included both health care providers and other county personnel. The plaintiff sued the sheriff deputies involved in his wrongful arrest, the county nurses who did his intake, and the doctors who saw him once he was transferred to a hospital. (*Id.* at pp. 1045-1046.) The hospital and its doctors settled before trial. (*Ibid.*) The jury returned a verdict for the plaintiff against the remaining defendants, allocating 30 percent fault to the deputies and 70 percent fault to the nurses. (*Id.* at p. 1046.) In reducing the noneconomic damages and calculating the setoff, the court applied the following formula. First, it determined the percentage of economic damages relative to the total damages in the jury’s verdict to be 36.6 percent. (*Id.* at pp. 1063-1064, citing *Espinoza*, *supra*, 9 Cal.App.4th at pp. 276-277.) The court then apportioned 36.6 percent of the hospital’s and physicians’ \$2,750,000 settlement as economic damages and deducted that amount from the economic damages awarded against all the nonsettling defendants. (*Ibid.*) This meant the court allocated 63.4 percent of the \$2,750,000 settlement to noneconomic damages (\$1,743,500) because 63.4 percent of the jury’s \$12,617,674 award was for noneconomic

damages. (*Ibid.*) To determine the noneconomic damages, the court used the jury's allocation of fault to determine what percentage should be capped. (*Id.* at p. 1064 & fn. 16.) For the healthcare providers, the court took 70 percent of the noneconomic damages and reduced the amount to \$250,000 (the applicable MICRA cap at the time). (*Ibid.*) The court added this to the remaining 30 percent, attributed to the sheriff deputies, which did not need to be reduced. (*Ibid.*) Accordingly, the total damages were reduced from about \$12.6 million to \$6.2 million. (*Id.* at pp. 1046-1047.) The defendants appealed, contending the court was required to apply the MICRA cap before it calculated the relative percentage. (*Id.* at p. 1065.)

The Court of Appeal affirmed the trial court's calculations. Distinguishing the current case from *Mayes*, the court noted that all the *Mayes* defendants had been subject to MICRA and the jury had determined the settling defendants' proportionate liability. (*Collins, supra*, 60 Cal.App.5th at p. 1065.) Instead, the court relied on *Rashidi*, where the trier of fact had not been asked to apportion the settling defendants' degree of fault. (*Id.* at pp. 1065-1066.) The court found that "Rashidi, although not perfectly aligned with the facts here, strongly suggests that application of MICRA before calculating the setoff is not required [here] because MICRA applies to damages awarded at trial, and not settlements." (*Id.* at pp. 1066-1067.) Thus, the trial court did not abuse its discretion when it calculated the setoff because the nonsettling defendants "were not held liable for any portion of noneconomic *damages* attributed to another defendant by the finder of fact, and received the benefit of MICRA." (*Ibid.*)

Collins is flawed. It affirms a trial court's decision to allocate \$1,743,500 of a \$2,750,000 settlement by MICRA-protected defendants (a hospital and physicians) to noneconomic damages. That makes no sense. There's no rational justification for ruling that MICRA-protected defendants would have paid *seven times* more than their maximum potential liability for noneconomic damages in the settlement. (See *Rashidi, supra*, 60 Cal.4th at p. 727 [when defendants are protected by MICRA, their "[s]ettlement negotiations are based on liability estimates that are necessarily affected by the cap" and the MICRA cap "restrains the size of settlements"].) The

Collins court's reliance on *Espinoza*, *supra*, 9 Cal.App.4th 268 to justify the settlement allocation was misplaced since *Espinoza* did not involve a settlement by MICRA-protected defendants. Until *Collins* is expressly disapproved, counsel will need to explain why it is inconsistent with both logic and *Rashidi*, and should not be followed.

Another approach would be to calculate the percentage of noneconomic damages in the verdict first, before reduction to the applicable MICRA limit, but cap the amount of the settlement allocated to noneconomic damages at the applicable MICRA limit. *Torres*, *supra*, 49 Cal.App.4th 1 supports this approach. *Torres* involved a closely analogous situation—a *postverdict* settlement—where the settling defendant's liability for noneconomic damages was *known* at the time of the settlement. *Torres* explained that “the *Espinoza* approach is not a suitable means of apportioning a *postverdict* settlement because it may result in an allocation of more of the settlement to noneconomic damages than the settling defendant's liability for such damages under the verdict. Another approach is needed which would avoid that result.” (*Id.* at p. 40.) “We agree with [the defendant] that no more of the settlement could properly be allocated to noneconomic damages than [the settling defendant's] *postverdict* liability for those damages. When the *Torres* plaintiffs settled with [the settling defendant], both sides knew that [the settling defendant's] liability for noneconomic damages was only \$91,924.80, and no more than \$91,924.80 of the \$450,000 settlement could fairly be viewed as a payment on account of that liability. [¶] We perceive no justification for any other conclusion when a settlement is reached after the amount of the settling defendant's liability has been established at trial. . . . [A]uthorities applicable to good faith settlements permit credit for a *preverdict* settlement which is at odds with the settling defendant's actual liability as later determined by the trier of fact. [Citation.] This result is supportable in the case of a *preverdict* settlement, where the parties are dealing with unknowns and the settlement is based on potential, rather than actual, liability. However, no reason appears why credit against a judgment should not be based on the settling defendant's actual liability when the settlement occurs after the amount of that liability has been established.” (*Id.* at p. 39.) The same seems true where the MICRA cap is

concerned. The only distinction is the settling defendant's actual liability has been established by the Legislature instead of by the trier of fact. But this is a distinction without a difference.

Torres adopted what is called the "ceiling" approach, under which "the settlement would be allocated first to noneconomic damages, but only up to the amount of the settling defendant's liability for such damages, with the balance then allocated to economic damages." (*Torres, supra*, 49 Cal.App.4th at p. 40.) If a similar ceiling approach were used in a MICRA case, a settlement by a health care provider would be allocated first to noneconomic damages, but only up to the applicable MICRA cap.

15. Where a tort settlement in a medical malpractice case does not allocate between medical and noneconomic costs, the noneconomic damages may not exceed the applicable statutory limit.

In *Martinez v. State Dept. of Health Care Services* (2017) 19 Cal.App.5th 370, the California Department of Health Care Services (DHCS) asked the trial court to determine the amount of a Medi-Cal lien on plaintiff's \$150,000 settlement of a medical malpractice action. (*Id.* at p. 373.) Although plaintiff had received \$86,676.46 in Medi-Cal payments, the trial court determined the value of the lien to be \$39,004.41. (*Ibid.*) First, the trial court determined the total value of the plaintiff's case by adding the then \$250,000 maximum recovery of noneconomic damages permitted under MICRA to the \$86,676.76 in medical costs. (*Ibid.*) The trial court then calculated that the \$150,000 settlement represented about 45 percent of the total case value, and awarded the DHCS 45 percent of the medical costs. (*Ibid.*) Plaintiff appealed, arguing that the trial court erred (1) by failing to value his noneconomic damages at \$2.5 million, (2) by failing to consider his \$300,000 lost wage claim, and (3) by failing to utilize the full \$171,000 amount of the hospital bill, rather than the \$86,676.46 actually paid for medical services. (*Ibid.*)

The Court of Appeal affirmed in part. Following *Arkansas Department of Health and Human Services v. Ahlborn* (2006) 547 U.S. 268 [126 S.Ct. 1752, 164 L.Ed.2d 459], the court held it would have been irrational for the trial court to credit plaintiff with (1) \$2.5 million in noneconomic damages, when \$250,000 was the

maximum award allowed under MICRA at the time, (2) \$300,000 in lost wages when plaintiff failed to identify any evidence supporting his lost earnings claim, or (3) the full \$171,000 hospital bill, instead of the \$86,676.46 amount actually paid, since the lien was based on the lower amount paid. (*Martinez, supra*, 19 Cal.App.5th at pp. 373-375.) However, the court did reduce the lien amount by 25 percent to account for statutory attorney fees, as required by Welfare and Institutions Code section 14124.72, subdivision (d). (*Martinez*, at p. 375.)

16. The noneconomic damages owed by a nonsettling defendant are not impacted by the noneconomic damages paid by a settling codefendant.

Suppose one of two health care provider (or one of two health care institution) defendants, defendant A, settles before trial, and the other, defendant B, goes to trial in a personal injury action. The jury awards \$1 million for noneconomic losses, which the court reduces to \$350,000, the applicable cap. Based on the verdict, the portion of defendant A's settlement allocated to noneconomic losses (see *ante*, Section E(14)) is \$200,000. The jury allocates fault 50-50 between defendant A and defendant B. On these facts, defendant B is liable for at most 50 percent of \$350,000, or \$175,000. Defendant A, it turns out, paid more (\$200,000) for noneconomic losses than otherwise would have been required (\$175,000). Is the plaintiff entitled to a total of \$375,000—the \$200,000 from defendant A plus another \$175,000 from defendant B? Or, should the amount owed by defendant B be reduced to \$150,000 so the plaintiff recovers only a total of \$350,000 from all involved health care providers?

In *Rashidi v. Moser* (2014) 60 Cal.4th 718, the Supreme Court held: “It would be anomalous to allow a defendant to obtain a setoff against [noneconomic] damages for which he is solely liable [under Proposition 51]. . . . [T]he Legislature sought to address the problem of unpredictable jury awards. The limitation on noneconomic damages restrains settlements indirectly, by providing a firm ceiling on potential liability as a basis for negotiation. Only noneconomic damages awarded in court are actually capped.” (*Id.* at pp. 720-721.) The plaintiff is “entitled to recover . . . ‘noneconomic losses’ without limitation by way of *settlement* under [section 3333.2,] subdivision (a), while [the] recovery of ‘damages for noneconomic losses’ at *trial* was limited to \$250,000 under [former section 3333.2,] subdivision (b). . . . With no cap on settlement recoveries, [the plaintiff] would be entitled

to the full amounts of both the noneconomic portion of the . . . settlement . . . and the capped award of noneconomic damages at trial.” (*Id.* at p. 725.) Accordingly, in the above hypothetical, the plaintiff would recover \$375,000 for noneconomic damages—the \$200,000 settlement paid by defendant A plus the \$175,000 award paid by defendant B.

17. Litigation.

(a) Section 3333.2 should be pled as an affirmative defense.

While Code of Civil Procedure section 425.10 prohibits the plaintiff from stating a specific amount of damages in the prayer of a complaint for personal injury or wrongful death, nevertheless, defense counsel should plead section 3333.2 as an affirmative defense in the answer. It could prove useful in meeting an argument that section 3333.2 was not timely asserted. It follows that healthcare defendants should seek a stipulation or present evidence establishing that they are healthcare providers within the meaning of MICRA.

- In *Taylor, supra*, 821 F.2d at pages 1432-1433, the Ninth Circuit held that California law does not require that section 3333.2 be raised as an affirmative defense in the answer. (Accord, *Nevis v. Rideout Memorial Hospital* (E.D.Cal., Dec. 22, 2022, No. 2:17-cv-02295-DAD-AC) 2022 WL 17852045, at pp. *3-*4 [nonpub. opn.] .)

(b) The jury should not be told about the statutory limit.

In *Schiernbeck v. Haight* (1992) 7 Cal.App.4th 869, 880, the Court of Appeal said, “we recommend . . . that the jury not be told of the [then] \$250,000 ceiling for noneconomic damages.” The court made this statement in the context of ensuring fair application of the periodic-payment statute to noneconomic damages. (*Id.* at pp. 880-881.) For reasons explained elsewhere, the defendant should *never* request periodic payments for noneconomic damages. (See Section H(9)(e), *post.*) If the defendant has no intention of invoking the periodic-payment statute with regard to noneconomic

damages, the rationale behind the statement in *Schiernbeck* does not apply. This is not to say, however, that *Schiernbeck* is incorrect. There are other good reasons why the jury should not be told about the statutory limit.

In *Green v. Franklin* (1987) 235 Cal.Rptr. 312, 322-323, the Court of Appeal held the jury should not be told about the statutory limit. The Supreme Court directed the Reporter of Decisions not to publish *Green* in the Official Reports. Nevertheless, the Court of Appeal's reasoning on this issue is persuasive and should be used (*without* citing the *Green* opinion): "While the jury possesses the ultimate responsibility for computing the measure of damages which flow from a particular act of negligence, it is for the trial court to determine the actual amount of the judgment to be entered giving effect to rules which may increase or decrease the verdict as rendered. (See *Marshall v. Brown* (1983) 141 Cal.App.3d 408, 418) From our reading of Civil Code section 3333.2, we think it obvious the Legislature never intended a jury be informed of the limitations imposed by the statute or that it consider such limitations in assessing damages. First, and perhaps most importantly, the fact that an award will be reduced if it exceeds [the MICRA cap] is irrelevant to the jury's functions of calculating the dollar amount of a plaintiff's injury. Second, an instruction based on the terms of the statute would only serve to increase the possibility that a jury may simply label damages that otherwise would have been denominated noneconomic as economic losses. Moreover, in those instances where a plaintiff's noneconomic loss is relatively small, jurors, told [the MICRA] limit, may feel compelled to award the maximum where they otherwise would have awarded less. The Legislature's intent in limiting damages in medical malpractice litigation would be frustrated in either event. To avoid such results, the reduction of an award for noneconomic loss must be accomplished by the court as a matter of law without interference from the jury. Such a practice insures that neither party will be prejudiced by a potentially misleading instruction." (*Green*, at pp. 322-323; see *Estate of Nunez by and through Nunez v. County of San Diego* (S.D.Cal., May 23, 2019, No. 3:16-CV-01412-BEN-MDD) 2019 WL 2238655, p. *4 [nonpub. opn.] [granting motion in limine to exclude evidence of the MICRA cap because "the MICRA limit

is not relevant and could improperly influence the jury's verdict"].)

For a case holding that the jury should not be told its damage award will be trebled, see *Marshall, supra*, 141 Cal.App.3d at page 418.

In *Toland v. Vana* (1990) 271 Cal.Rptr. 457, the Court of Appeal held the trial court did not err by instructing the jury on the MICRA limit. The Supreme Court directed the Reporter of Decisions not to publish *Toland* in the Official Reports. Rule 8.1125(d) of the California Rules of Court provides that a depublication order “is not an expression of the court’s opinion of the correctness of the result of the decision or of any law stated in the opinion.” Nevertheless, because *Toland* was, for all intents and purposes, a one-issue case, the Supreme Court’s depublication order sends a message that it is not proper to instruct the jury on the applicable MICRA limit. (See *Conrad v. Ball Corp.* (1994) 24 Cal.App.4th 439, 443-444, fn. 2 [“[U]npublished opinions may be cited if they are not ‘relied on.’ [Citation.] That is our situation here. We cite *Romero* not to rely on it, but to discuss the effect of the depublication order.”]; *People v. Dee* (1990) 222 Cal.App.3d 760, 765 [“to insist that those depublication orders are without significance would be to perpetuate a myth”]; Grodin, *The Depublication Practice of the California Supreme Court* (1984) 72 Cal. L.Rev. 514, 514-515 [opinions are depublished because the Supreme Court “consider[s] the opinion to be wrong in some significant way”].)

Below are the reasons the Court of Appeal gave in the depublished *Toland, supra*, 271 Cal.Rptr. 457, for allowing disclosure of the applicable MICRA limit to the jury. Following each is a response that exposes the fallacy behind the reason:

- (a) *Reason*: In a treble damages case, a trial judge who triples the awarded amount is not interfering with the jury’s determination of the amount a plaintiff has been injured; whereas, in a MICRA case, a trial judge who reduces an award of noneconomic damages, if it exceeds the MICRA limit, is interceding with the jury’s determination of that amount. Accordingly, in a MICRA case, as opposed to a treble damages case, the fact that

an award of noneconomic damages will be reduced if it exceeds the applicable limit is relevant to the jury's determination of the amount a plaintiff has been injured.

Response: The fact that the limit may prevent recovery of some of the damages the jury has determined the plaintiff has suffered is irrelevant to the jury's determination of those damages. The amount of damages the plaintiff has suffered is the same regardless. Also, by this reasoning, a jury could be informed that its answers to special interrogatories on a statute of limitations defense may preclude the plaintiff from recovering anything, or that a joint tortfeasor's settlement with the plaintiff will reduce the recovery against the defendant who went to trial, or that the plaintiff's attorney's contingent fee will reduce the plaintiff's recovery. Whether the impact of a rule is to increase or decrease the plaintiff's recovery makes no difference. The rationale of the rule preventing the jury from knowing about the trebling of damages is exactly the same as the rationale for not telling the jury about the applicable MICRA limit—to avoid impacting the jury's determination of the damages suffered by the plaintiff. The recovery that will result from the jury's determination is of no concern to the jury. (See *In re Exxon Valdez* (9th Cir. 2000) 229 F.3d 790, 799 [“Juries are . . . not to be told of statutory caps on damages, or, in antitrust and RICO cases, that damages will eventually be trebled”; “juries are to be kept free of any outside influence that might lead them to inflate or reduce their damages award in order to ‘secure justice’ for the parties”].)

(b) *Reason:* In a MICRA case, a jury that has not been instructed on the applicable limitation and in which at least four members are convinced that the plaintiff should receive more than the applicable limit could spend needless hours in attempting to reach a verdict, or could even be unable to do so. Such a waste of court resources would not occur where a jury has not been instructed on treble damages.

Response: The rationale for not telling the jury about the trebling of damages is that the jury may award less than otherwise. In a case where the jurors are unable to readily agree on damages, knowledge that their award will be trebled could speed up the deliberation process by causing those jurors who desire a larger award to go along with those desiring a smaller award since the award will be trebled anyway. Similarly, telling a jury about a settlement setoff with a joint tortfeasor could speed up deliberations. And telling a jury that the answers to special interrogatories will determine whether the plaintiff's action is barred by the statute of limitations could speed up deliberations. So could telling the jury that the plaintiff's attorney will receive a large portion of the recovery, or that personal injury damages are not taxable, or that the defendant is insured. The object is not to speed up deliberations. The object is to keep the focus of deliberations on the task at hand without introducing extraneous considerations that are likely to impact the verdict. As for the potential of deadlock, if a jury informs the judge that it is deadlocked on the amount of noneconomic damages, and discrete questioning by the judge reveals that instructing the jury on the limit would resolve the deadlock, then the jury could be informed of the limit. A deadlock on noneconomic damages is not so likely to occur that jurors need to be informed of the limit beforehand.

(c) *Reason:* It is entirely speculative that informing the jury of the applicable MICRA limit will result in a higher verdict.

Response: There is justifiable fear that informing the jury will result in a higher verdict—just as there is justifiable fear that informing the jury about treble damages will result in a lower verdict. “The *justifiable fear* of anti-trust plaintiffs is that the juries will adjust the damage award downward or find no liability, therefore thwarting Congress’s purpose, because of some notions of a windfall to the plaintiff. One court has even suggested that a jury might take the revelation of the treble damage provision as an intimation from the court

to restrict the amount of damages. In sum, we agree . . . that informing a jury would serve no useful function and its *probable consequence* would be harmful—an impermissible lowering of the amount of damages.” (*Pollock & Riley, Inc. v. Pearl Brewing Company* (5th Cir. 1974) 498 F.2d 1240, 1243, fns. omitted, emphasis added; see *HBE Leasing Corp. v. Frank* (2d Cir. 1994) 22 F.3d 41, 46 [“courts [in antitrust cases] have uniformly concluded that mentioning treble damages . . . to the jury is improper”]; *id.* at p. 45 [“Every authority brought to this court’s attention upholds excluding references to trebling . . . in the RICO context”].)

(d) *Reason:* Instructing on the MICRA limit is supported by cases that allow the jury to be instructed on the limitation on liability of motor vehicle owners (see Veh. Code, § 17151).

Response: The Vehicle Code limit applies to all damages and therefore affords the jury no opportunity to increase one portion of the award to compensate for a limit on the other. The same cannot be said for the statutory limit on noneconomic damages. Also, the cases permitting a jury to be informed of the Vehicle Code limit on owner’s liability are out of step with the cases discussed above that preclude instructing the jury on matters relating to the plaintiff’s recovery as opposed to the plaintiff’s damages. The explanation may be that, because the limit is so low (\$15,000 per person and \$30,000 per accident), courts have not been too concerned about juries treating it as a floor.

(e) *Reason:* If the jury is not informed of the statutory limitation and awards more than that amount, then, when the trial court reduces the award, the plaintiff may feel cheated by a system that gives with one hand and takes away with the other. Similarly, if the jury spent time arguing over damages amounts in excess of the applicable limit, and jurors subsequently learned the awarded amount was reduced to such limit, they may have cause to resent the “system.”

Response: The fact a plaintiff may feel less “cheated” by the applicable MICRA limit if he or she never knows how much the jury would have awarded absent the limit does not outweigh the likelihood of subverting the important legislative objectives behind MICRA. The same is true for the possibility that jurors may harbor resentment if they argue about noneconomic damages and subsequently discover their verdict was reduced. This possibility pales beside the justifiable fear that a linchpin of MICRA will be seriously weakened if juries are instructed on the limit.

(f) *Reason:* Where the plaintiff has alleged a certain amount of damages in the complaint, the trial court is allowed to instruct the jury that no more than that sum may be awarded. Similarly, where the defendant has claimed a limitation on damages in the answer, a trial court should also be allowed to instruct the jury that no more than that sum may be awarded.

Response: Where the pleadings impose a limit on liability, there is no opportunity for the jury to inflate one portion of the award to compensate for a limit on another. Also, the rule that a jury may be told of the plaintiff’s damages claim bears little relevance to the question whether a jury may be told of a legislatively prescribed upper limit on recovery. Finally, the law no longer permits the plaintiff in a personal injury action to allege a certain amount of damages in the complaint. (Code Civ. Proc., § 425.10.)

(c) The verdict must separate noneconomic from economic damages.

If the defendant fails to request a special verdict that separates *noneconomic* from economic damages, section 3333.2 is waived. (*Moore v. Preventive Medicine Medical Group, Inc.* (1986) 178 Cal.App.3d 728, 746-747; but see *Pressler v. Irvine Drugs, Inc.* (1985) 169 Cal.App.3d 1244, 1251, fn. 20 [dictum: retrial on the issue of damages may be required]; see also *Semsch v. Henry Mayo Newhall Memorial Hospital* (1985) 171 Cal.App.3d 162, 169-170.) Defense counsel should use BAJI No. 16.01 or CACI No. VF-500.

(d) If the verdict for noneconomic damages exceeds the applicable statutory limit, immediately move to reduce it to the limit.

It also is advisable to request the court to instruct the clerk not to enter judgment on the verdict until further order of the court. (See *Craven v. Crout* (1985) 163 Cal.App.3d 779; Code Civ. Proc., § 663.) If a judgment for more than the applicable MICRA limit in noneconomic damages is entered by the clerk, file an appropriate motion to reduce the noneconomic damages to such limit. (See Section H(8)(e), *post.*) In *Taylor, supra*, 821 F.2d 1428, after judgment was entered, the defendant filed a motion to reduce the noneconomic damages to the MICRA cap. (*Id.* at p. 1430.) The Ninth Circuit held the defendant had not waived the protection of section 3333.2. (*Taylor*, at p. 1433.)

18. Arbitration.

In *Porter v. AG Arcadia, LLC* (Apr. 12, 2019, B285461) 2019 WL 1577439 [nonpub. opn.], plaintiffs sued Country Villa, a skilled nursing facility, for wrongful death, elder abuse, negligence, and violation of the Patient's Bill of Rights. (*Id.* at p. *1.) The matter proceeded to arbitration, resulting in a \$1 million award for wrongful death damages and additional damages for elder abuse. (*Ibid.*) County Villa appealed, contending the arbitrator exceeded her authority by awarding wrongful death damages in excess of the MICRA cap. (*Ibid.*) The Court of Appeal held that the wrongful death damages award was not subject to judicial review under Code of Civil Procedure section 1286.2, subdivision (a)(4), even if it exceeded the MICRA cap. (*Porter*, at pp. *4-*5.)

- The result in *Porter* can potentially be avoided by including a provision in the arbitration agreement requiring the arbitrators to apply MICRA, providing that the arbitrators have no power to apply MICRA incorrectly, and preserving the litigants' right to seek appellate review of the arbitration award for legal error so that it can be vacated or corrected on appeal based, for example, on the arbitrators' erroneous application of MICRA. This follows from *Cable Connection, Inc. v. DIRECTV, Inc.* (2008) 44 Cal.4th 1334, where the arbitration agreement provided that "[t]he arbitrators shall not have the power to commit errors of law or legal reasoning, and the award may be vacated or corrected on appeal to a court

of competent jurisdiction for any such error.’ ” (*Id.* at p. 1340.) The Supreme Court held that “[t]his contract provision is enforceable under state law.” (*Ibid.*) “[T]o take themselves out of the general rule that the merits of the award are not subject to judicial review, the parties must clearly agree that legal errors are an excess of arbitral authority that is reviewable by the courts. Here, the parties expressly so agreed, depriving the arbitrators of the power to commit legal error. They also specifically provided for judicial review of such error.” (*Id.* at p. 1361.) However, *Cable Connection* construes *California* law (the CAA) rather than federal law, so it does not control arbitration agreements that are governed by the FAA.

19. The law in other states.

See generally Annotation, Validity, Construction, and Application of State Statutory Provisions Limiting Amount of Recovery in Medical Malpractice Claims (1995) 26 A.L.R.5th 245; see, e.g., *Siebert, supra*, 485 P.3d 1265 (New Mexico Supreme Court upheld a similar provision capping damages at \$600,000 against due process challenges. In response, the New Mexico Legislature introduced a bipartisan bill that would raise the cap to \$700,000).

F. CODE OF CIVIL PROCEDURE SECTION 340.5: SHORTENING THE STATUTE OF LIMITATIONS.

1. Text of section 340.5.

In an action for injury or death against a health care provider based upon such person's alleged professional negligence, the time for the commencement of action shall be three years after the date of injury or one year after the plaintiff discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first. In no event shall the time for commencement of legal action exceed three years unless tolled for any of the following: (1) upon proof of fraud, (2) intentional concealment, or (3) the presence of a foreign body, which has no therapeutic or diagnostic purpose or effect, in the person of the injured person. Actions by a minor shall be commenced within three years from the date of the alleged wrongful act except that actions by a minor under the full age of six years shall be commenced within three years or prior to his eighth birthday whichever provides a longer period. Such time limitation shall be tolled for minors for any period during which parent or guardian and defendant's insurer or health care provider have committed fraud or collusion in the failure to bring an action on behalf of the injured minor for professional negligence.

For the purposes of this section:

- (1) "Health care provider" means any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or licensed pursuant to the Osteopathic Initiative Act, or the Chiropractic Initiative Act, or licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code; and any clinic, health dispensary, or health facility, licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code. "Health care provider" includes the legal representatives of a health care provider;
- (2) "Professional negligence" means a negligent act or omission to act by a health care provider in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death, provided that such services are within the scope of services for which the provider is licensed and which are not within any restriction imposed by the licensing agency or licensed hospital.

2. Summary of section 340.5.

(a) Limitations period for an adult.

“Section 340.5 creates two separate statutes of limitations [for adults], both of which must be satisfied if a plaintiff is to timely file a medical malpractice action.” (*Ashworth v. Memorial Hospital* (1988) 206 Cal.App.3d 1046, 1054.) “[T]he same ‘injury commences both the three-year and the one-year limitations periods.’” (*Filosa v. Alagappan* (2020) 59 Cal.App.5th 772, 737.)

(1) The one-year “discovery” limitations period.

The action must be brought within one year after the plaintiff first suffered appreciable harm and suspected, or a reasonable person would have suspected, that someone had done something wrong. (*Norgart v. Upjohn Co.* (1999) 21 Cal.4th 383, 397-398, 405-406; *Filosa, supra*, 59 Cal.App.5th at pp. 734-735, 737, 739-740; *Rose v. Fife* (1989) 207 Cal.App.3d 760, 768-771; see CACI No. 555.)

The one-year “discovery” limitations period can be tolled by service of a 90-day notice of intent to sue during the last 90 days of the one-year period. (Code Civ. Proc., § 364, subd. (d); see *Woods v. Young* (1991) 53 Cal.3d 315, 328.) The one-year period can also be tolled by non-MICRA tolling provisions. (*Belton v. Bowers Ambulance Service* (1999) 20 Cal.4th 928, 931-935; see *Neilsen v. Kazarian* (Mar. 19, 2019, B284287/B287623) 2019 WL 1253602, at p. *3 [nonpub. opn.] [delayed discovery tolls the MICRA one-year limitations period].) Section 340.5’s internal tolling provisions, however, do not apply. (*Belton*, at p. 934.)

(2) The three-year “outside” limitations period.

The action must also be brought within three years after the plaintiff first suffered appreciable harm. (*Filosa, supra*, 59 Cal.App.5th at pp. 734-735, 737-739; *Warren v. Schechter* (1997) 57 Cal.App.4th 1189, 1201-1205; *McNall v. Summers* (1994) 25 Cal.App.4th 1300, 1308-

1312; *Marriage & Family Center v. Superior Court* (1991) 228 Cal.App.3d 1647, 1652-1655.)

The three-year outside limitations period can be tolled by service of a 90-day notice of intent to sue during the last 90 days of the three-year period. (Code Civ. Proc., § 364, subd. (d); see *Russell v. Stanford University Hospital* (1997) 15 Cal.4th 783, 788-789.) The three-year period can also be tolled by fraud, intentional concealment, or the presence of a foreign object in the patient's body. (§ 340.5.) Non-MICRA tolling provisions do not apply. (*Belton, supra*, 20 Cal.4th at p. 931.)

(b) Limitations period for a minor.

If the plaintiff was less than six years old when appreciable harm was first suffered, the action must be brought within three years after the harm or prior to the plaintiff's eighth birthday, whichever is the longer period. If the plaintiff was at least six years old when appreciable harm was first suffered, the action must be brought within three years after the harm. (§ 340.5; *Steketee v. Lintz, Williams & Rothberg* (1985) 38 Cal.3d 46, 52-53; *Arredondo v. Regents of University of California* (2005) 131 Cal.App.4th 614, 618-619.)

The minor's limitations period is tolled for the same four reasons as the adult's three-year outside limitations period (service of 90-day notice of intent to sue during the last 90 days of the limitations period, fraud, intentional concealment, presence of a foreign object). (*Young v. Haines* (1986) 41 Cal.3d 883, 897-901; *Newman v. Burnett* (1997) 54 Cal.App.4th 722, 725.) In addition, the minor's limitations period is tolled if the parent or guardian and the health care provider or malpractice insurer have committed fraud or collusion. (§ 340.5.)

Non-MICRA tolling provisions do not apply. (See *Belton, supra*, 20 Cal.4th at p. 931; *Young, supra*, 41 Cal.3d at pp. 897-898; *Steketee, supra*, 38 Cal.3d at pp. 53-54, fn. 3.)

Section 340.5's one-year "discovery" limitations period does not apply to a minor. (*Young, supra*, 41 Cal.3d at p. 897, fn. 10.)

3. Section 340.5 is constitutional.

- a. In *Kite v. Campbell* (1983) 142 Cal.App.3d 793, overruled on other grounds in *Young, supra*, 41 Cal.3d at pages 895-901, the Court of Appeal held section 340.5 is constitutional as applied to a minor plaintiff. The court concluded the Legislature's decision to treat minors who are victims of medical malpractice differently does not violate equal protection. (*Kite*, at p. 800.) The court also held section 340.5 does not violate due process. (*Id.* at pp. 800-801.)
- b. As written, section 340.5 is keyed on the date of "injury" for an adult and the date of the "wrongful act" for a minor. In *Torres v. County of Los Angeles* (1989) 209 Cal.App.3d 325, the Court of Appeal held: "By defining the actions of adults and minors to accrue differently, section 340.5 violates the minors' right to the law's equal protection." (*Id.* at p. 334.) Accordingly, for both adults and minors, the accrual date is the date of "injury." (*Arredondo, supra*, 131 Cal.App.4th at pp. 618-619.)

4. Other contexts in which section 340.5 may apply.

(a) Wrongful death action.

Section 340.5 applies in a wrongful death action as well as a personal injury action. (*Ferguson v. Dragul* (1986) 187 Cal.App.3d 702, 708; see *Norgart, supra*, 21 Cal.4th at p. 405, fn. 5.) The statute does not commence to run until the decedent's death. (*Larcher v. Wanless* (1976) 18 Cal.3d 646, 659; *Ferguson*, at pp. 708-709; see *Norgart*, at p. 405, fn. 5.)

(b) Action against public entity or employee.

Government Code sections 945.6 and 950.6 provide that a suit against a public entity or employee must be filed within six months after a claim for damages is rejected by the public entity. These statutes "trump" Civil Code section 340.5. (*Martell v. Antelope Valley Hospital Medical Center* (1998) 67 Cal.App.4th 978, 982-983; *Anson v. County of Merced* (1988) 202 Cal.App.3d 1195, 1198-1202; see *Torres, supra*, 209 Cal.App.3d 325 [applying the Government Code section 911.2 claim filing requirement in a medical malpractice case].)

In *Martell* and *Anson*, the Government Code section 945.6 limitations period was shorter than the Code of Civil Procedure section 340.5 limitations period. Sometimes the reverse will be true. In *Roberts v. County of Los Angeles* (2009) 175 Cal.App.4th 474, the plaintiff's complaint was timely under section 945.6 (due to a non-MICRA tolling provision), but untimely under section 340.5's three-year outside limitations period. (*Id.* at pp. 479, 482.) The Court of Appeal held the complaint was untimely. "[P]laintiffs must comply with both the six-month statute of limitations in the Government Claims Act and the three-year statute in MICRA when bringing actions for medical negligence against public entities" (*Id.* at p. 486.) "Allowing plaintiff here to bring her lawsuit beyond the MICRA deadline because of the tolling provision in the Government Claims Act would violate the well-established authorities prohibiting tolling of MICRA's deadlines for reasons outside of Code of Civil Procedure section 340.5 itself." (*Id.* at p. 484; accord, *Ollison v. Alameda Health System* (N.D.Cal., Dec. 8, 2020, No. 20-CV-04944-LB) 2020 WL 7227201, at p. *4 [nonpub. opn.] ["In *Roberts*, the court construed the one-year MICRA statute of limitation 'as the outer limit by which a lawsuit may be filed against a public health care provider. This way, MICRA can apply to public health care providers without conflicting with the Government Claims Act.'"]; *Lozano v. County of Santa Clara* (N.D.Cal., Dec. 16, 2019, No. 19-CV-02634-EMC) 2019 WL 6841215, at p. *9 [nonpub. opn.] ["parties must comply with *both* the Government Claims Act requirements and [section] 340.5 of the California Code of Civil Procedure"].)

(c) EMTALA action.

A two-year statute of limitations is prescribed by federal law. (42 U.S.C. § 1395dd(d)(2)(C); see *Power v. Arlington Hosp. Ass'n* (4th Cir. 1994) 42 F.3d 851, 866.) "[W]here Congress has expressly set a limitations period on a federal claim, state statutes of limitations . . . do not apply." (*Bunnell v. Department of Corrections* (1998) 64 Cal.App.4th 1360, 1370.)

(d) Elder abuse action.

Section 340.5 does not apply; Code of Civil Procedure section 335.1 does. (*Benun v. Superior Court* (2004) 123 Cal.App.4th

113, 125-126; see *Samantha B. v. Aurora Vista Del Mar, LLC* (2021) 72 Cal.App.5th 1092 [2021 WL 5996835, at p. *5], reh'g. granted Jan. 14, 2022 [applying *Delaney*, when a jury finds reckless neglect, as well as professional negligence, the plaintiff is not bound by MICRA, including the one-year statute of limitations].)

(e) Equitable indemnity action.

Section 340.5 does not apply; Code of Civil Procedure section 335.1 does. (*Preferred Risk Mutual Ins. Co. v. Reiswig* (1999) 21 Cal.4th 208, 213, fn. 2; see *id.* at pp. 219-222 (dis. opn. of Kennard, J.).)

(f) Action under Federal Tort Claims Act.

The statute of limitations is prescribed by federal law. (28 U.S.C. § 2401; see *Bartleson v. United States* (9th Cir. 1996) 96 F.3d 1270, 1276-1277.) Section 340.5 does not apply. (See *Bunnell*, *supra*, 64 Cal.App.4th at p. 1370.)

(g) Fraud and negligent misrepresentation.

Section 340.5 may apply. Where the complaint alleges causes of action for fraud, negligent misrepresentation, and professional negligence arising from the same factual nucleus, it may be subject to the MICRA statute of limitations. (See *Barton v. Elias, Elliot, Lampasi, Fehn, Harris & Nguyen* (Aug. 21, 2019, E068331) 2019 WL 3943191, at pp.*8-*9 [nonpub. opn.] [“The gravamen of the misrepresentation causes of action . . . merely recast the allegations of professional negligence and challenged the purportedly inadequate manner in which Dr. Elias rendered health care services. They are thus subject to the MICRA statute of limitation.”]; *Berlin v. Kim* (Apr. 27, 2021, B299116) 2021 WL 1624695, at p. *8 [nonpub. opn.] [fraud claim based on doctors’ postsurgery misrepresentation that they had conducted a specified procedure constituted professional negligence subject to MICRA; “the alleged fraud cannot be separated from the alleged professional negligence because the information alleged to have been concealed from plaintiff is the alleged negligence *itself*”]; see also *ante*, Sections B(3)(c)(1)(g), (m), & (p).)

5. Statutory definitions.

(a) Definition of “health care provider.”

See *ante*, Section B(2).

(b) Definition of “based upon professional negligence.”

See *ante*, Section B(3).

6. An action by an adult must be brought within one year after the plaintiff first suffered appreciable harm and suspected, or should have suspected, that someone had done something wrong.

(a) The one-year “discovery” limitations period is triggered when the plaintiff actually suspects wrongdoing (the subjective test) or when a reasonable person would have suspected wrongdoing (the objective test), whichever occurs first.

Section 340.5 provides that an action for professional negligence must be *commenced* within “one year after the plaintiff discovers, or through the use of reasonable diligence should have discovered, the injury.”

The one-year “discovery” limitations period applies only to an adult, not to a minor. (*Young, supra*, 41 Cal.3d at p. 897, fn. 10.)

The one-year period is not triggered until the plaintiff “suffers ‘appreciable and actual harm, however uncertain in amount.’” (*Poosh v. Philip Morris USA, Inc.* (2011) 51 Cal.4th 788, 796; see *id.* at p. 797; accord, *Filosa, supra*, 59 Cal.App.5th at pp. 734-735.) But appreciable harm, while necessary, is insufficient; the one-year period is not triggered until the discovery of appreciable harm *and* negligence. (*Filosa*, at p. 735.) The Supreme Court explained, “We think that the Legislature in enacting section 340.5 intended . . . to adopt the prior [common law] ‘discovery’ rule, and that the word ‘injury’ retained . . . the broad meaning the courts had previously given to it.” (*Sanchez v. South Hoover Hospital* (1976) 18 Cal.3d 93,

99.) “[T]he word ‘injury’ had come to be used in the cases to denote both a person’s physical condition *and* its ‘negligent cause.’ ” (*Ibid.*, original emphasis.)

“[T]he same rules regarding discovery of one’s cause of action apply” to section 340.5 as to non-MICRA cases. (*Rose, supra*, 207 Cal.App.3d at pp. 768-769, fn. 9; accord, *Knowles v. Superior Court* (2004) 118 Cal.App.4th 1290, 1299; *Dolan v. Borelli* (1993) 13 Cal.App.4th 816, 824.) “[T]he plaintiff discovers the cause of action when he at least suspects a factual basis for its elements . . .—when, simply put, he at least ‘suspects that someone has done something wrong’ to him [citation], ‘wrong’ being used, not in any technical sense, but rather in accordance with its ‘lay understanding’ [citation].” (*Norgart, supra*, 21 Cal.4th at pp. 397-398, fn. omitted.) “He has reason to discover the cause of action when he has reason at least to suspect a factual basis for its elements. [Citation.] He has reason to suspect when he has ‘ “ “notice or information of circumstances to put a reasonable person on inquiry” ’ ”” (*Id.* at p. 398, original emphasis; see *id.* at p. 405, fn. 5 [section 340.5 “prescribes a limitations period of one year after the date on which the plaintiff comes at least to suspect, or have reason to suspect, a factual basis” for the elements of the cause of action].)

In short, the action must be brought within one year after the plaintiff first suffered appreciable harm and suspected, or a reasonable person would have suspected, that someone had done *something* wrong. (*Fox v. Ethicon Endo-Surgery, Inc.* (2005) 35 Cal.4th 797, 807-808; *Norgart, supra*, 21 Cal.4th at pp. 397-398, 405-406; *Jolly v. Eli Lilly & Co.* (1988) 44 Cal.3d 1103, 1110-1111, 1114; *Gutierrez v. Mofid* (1985) 39 Cal.3d 892, 896-897, 898; *Miller v. Bechtel Corp.* (1983) 33 Cal.3d 868, 875; *Filosa, supra*, 59 Cal.App.5th at pp. 734-737; *Clark v. Baxter Healthcare Corp.* (2000) 83 Cal.App.4th 1048, 1057; *Rose, supra*, 207 Cal.App.3d at pp. 768-771.) “This rule sets forth two alternate tests for triggering the limitations period: (1) a subjective test requiring actual suspicion by the plaintiff that the injury was caused by wrongdoing; and (2) an objective test requiring a showing that a reasonable person would have suspected the injury was caused by wrongdoing.” (*Kitzig v. Nordquist* (2000) 81 Cal.App.4th 1384, 1391; accord, *Filosa*, at pp. 734-735.)

(b) The plaintiff need not be aware of the specific facts necessary to establish the elements of the cause of action.

The plaintiff's ignorance of the " 'specific 'facts' necessary to establish' the cause of action" does not prevent the one-year period from starting to run. (*Norgart, supra*, 21 Cal.4th at p. 398; accord, *Fox, supra*, 35 Cal.4th at p. 807; *Jolly, supra*, 44 Cal.3d at p. 1111.) "[R]ather, he may seek to learn such facts through 'the process contemplated by pretrial discovery'; but, within the applicable limitations period, he must indeed seek to learn the facts necessary to bring the cause of action in the first place" (*Norgart*, at p. 398.)

(c) The plaintiff need not be aware of the defendant's identity.

The plaintiff's "ignorance of the identity of the defendant" does not prevent the one-year period from starting to run. (*Bernson v. Browning-Ferris Industries* (1994) 7 Cal.4th 926, 932; accord, *Fox, supra*, 35 Cal.4th at pp. 807, 813-815; *Norgart, supra*, 21 Cal.4th at p. 399; *Jolly, supra*, 44 Cal.3d at p. 1114; *Knowles, supra*, 118 Cal.App.4th at pp. 1298-1301; *Rose, supra*, 207 Cal.App.3d at p. 770.) The rationale is, "once the plaintiff is aware of the injury, the applicable limitations period (often effectively extended by the filing of a Doe complaint) normally affords sufficient opportunity to discover the identity of all the wrongdoers." (*Bernson*, at p. 932.)

(d) The plaintiff need not be aware of the applicable law.

The plaintiff's "ignorance of his legal remedy or the legal theories underlying his cause of action" does not prevent the one-year period from starting to run. (*Gutierrez, supra*, 39 Cal.3d at p. 898; accord, *Jolly, supra*, 44 Cal.3d at p. 1113; *Norgart, supra*, 21 Cal.4th at p. 397; *Graham v. Hansen* (1982) 128 Cal.App.3d 965, 972, 974.)

(e) **Cases applying the one-year “discovery” limitations period.**

(1) **Cases holding the plaintiff’s action is time-barred as a matter of law.**

(a) ***Gutierrez v. Mofid***
(1985) 39 Cal.3d 892.

The plaintiff gave consent for an exploratory operation to remove a tumor or her appendix, but the defendants did a complete hysterectomy. The plaintiff consulted an attorney who said there was no provable malpractice. A year and a half later, the plaintiff consulted another attorney and filed suit. “[T]he one-year ‘discovery’ limitations period for medical malpractice (§ 340.5) is not delayed, suspended, or tolled when a plaintiff with actual or constructive knowledge of the facts underlying his malpractice claim is told by an attorney that he has no legal remedy.” (*Id.* at p. 902, disapproving *Jones v. Queen of the Valley Hospital* (1979) 90 Cal.App.3d 700, 703.) The plaintiff’s “remedy is a suit for legal malpractice against his counsel.” (*Gutierrez*, at p. 900; see *Torres, supra*, 209 Cal.App.3d at p. 337; *Reyes v. County of Los Angeles* (1988) 197 Cal.App.3d 584, 591-592.)

(b) ***Sanchez v. South Hoover Hospital***
(1976) 18 Cal.3d 93.

The plaintiff suffered serious postoperative complications from a Caesarian section. She was suspicious that the defendants were negligent, but waited over one year after her discharge from the hospital to sue. “[T]he patient is fully entitled to rely upon the physician’s professional skill and judgment while under his care, and has little choice but to do so. It follows, accordingly, that during the continuance of this professional relationship, which is fiduciary in nature, the degree of diligence required of a patient in ferreting out and learning of the negligent causes

of his condition is diminished.” (*Id.* at p. 102; see *International Engine Parts, Inc. v. Feddersen & Co.* (1995) 9 Cal.4th 606, 628-630 (conc. and dis. opn. of Kennard, J.) [giving the history of the “continuous representation” rule]; *Brown v. Bleiberg* (1982) 32 Cal.3d 426, 438, fn. 9 [observing that “reliance on the fiduciary role of the physician may naturally continue after the physician-patient relationship has terminated”].) “Plaintiff admits she did not accept defendant [Dr.] Pilson’s assurances at face value. Under these circumstances, it is arguable that plaintiff was on notice of defendants’ negligence prior to [the date the doctor/patient relationship ended].” (*Sanchez*, at p. 102; see *Unjian v. Berman* (1989) 208 Cal.App.3d 881, 887-888.) “Regardless of the possibility of an earlier commencement, however, it is clear that the statute began to run no later than the date of plaintiff’s discharge from defendants’ care Plaintiff’s deposition reveals that, when released, she believed she had been a victim of malpractice.” (*Sanchez*, at p. 102.)

(c) ***Kleefeld v. Superior Court***
(1994) 25 Cal.App.4th 1680.

Within days after his wife’s death from a ruptured aortic aneurysm, the plaintiff contacted the Board of Chiropractic Examiners expressing his concern that the defendant may have excessively treated his wife. Two years after his wife’s death, but less than one year after learning that the Board had disciplined the defendant, the plaintiff sued. “[A] plaintiff’s diligence *after* he has become suspicious of wrongdoing is not relevant to the running of the statute of limitations. Diligence is only relevant to determine when he *should* have suspected wrongdoing. Once a plaintiff actually has the requisite suspicion, the statute of limitations commences to run. It is not tolled by efforts to learn more about the matter short of filing suit.” (*Id.* at p. 1684, original emphasis.)

- (d) ***Rose v. Fife***
(1989) 207 Cal.App.3d 760.

The defendant inserted an intrauterine device (IUD). Years later, the plaintiff was hospitalized with a pelvic infection and was told the IUD had caused the infection and the infection had caused sterility. A year and a half later, the plaintiff learned the IUD was a Copper 7. A year after that, the plaintiff read a newspaper article that linked the Copper 7 to a number of injuries to women. She then sued. “We hold as a matter of law that a reasonable person would have suspected wrongdoing by [Dr.] Fife and would have inquired [at the time of the plaintiff’s hospitalization]; she would have gone to find the facts rather than waiting . . . for the facts to come to her. [Citation.] [¶] Further, . . . plaintiff did not need to know the identity of the manufacturer of the IUD in order to file her action. She knew the identity of the person who prescribed the IUD and she could have timely sued him, naming the manufacturer as a Doe defendant. [Citation.] Nor did she need to know all the facts which prove fault before filing her action. It is pretrial discovery which brings out the specifics of wrongdoing, i.e., the facts to establish a plaintiff’s case.” (*Id.* at p. 770.)

- (e) **Other cases.**

Carter v. Prime Healthcare Paradise Valley LLC (2011) 198 Cal.App.4th 396, 413-414; *Campanano v. California Medical Center* (1995) 38 Cal.App.4th 1322, 1328-1330; *Henry v. Clifford* (1995) 32 Cal.App.4th 315, 322-323; *Dolan, supra*, 13 Cal.App.4th 816; *Barber v. Superior Court* (1991) 234 Cal.App.3d 1076, 1082-1084; *Graham, supra*, 128 Cal.App.3d at pp. 971-972; *Christ v. Lipsitz* (1979) 99 Cal.App.3d 894, 896-898; *Burton v. Kaiser Foundation Hospitals* (1979) 93 Cal.App.3d 813; *Bellah v. Greenson* (1978) 81 Cal.App.3d 614, 622-624; *Gray v. Reeves* (1977) 76

Cal.App.3d 567. Also, there are numerous unpublished opinions applying section 340.5. Some of them may have useful reasoning. Run a search for “340.5” on Westlaw or Lexis.

- Section 340.5’s one-year “discovery” limitations period is the same as Code of Civil Procedure section 340, former subdivision (3)’s one-year limitations period (now Code of Civil Procedure section 335.1’s two-year limitations period (see Stats. 2002, ch. 448, § 3 [amending section 340]; Stats. 2002, ch. 448, § 2 [reenacting as section 335.1])) for personal injury actions, on which case authority has engrafted the “discovery rule.” (*Bristol-Myers Squibb Co. v. Superior Court* (1995) 32 Cal.App.4th 959, 963, fn. 1, disapproved on other grounds in *Norgart, supra*, 21 Cal.4th at p. 410, fn. 8, and *Fox, supra*, 35 Cal.4th at p. 803.) “Hence, the rule governing the commencement of the statutory one-year period is the same whether [or not] the defendant is a medical doctor (or other health provider)” (*Bristol-Myers Squibb Co.*, at p. 963, fn. 1.) This means cases decided under sections 335.1 and 340, former subdivision (3), are pertinent and should be consulted.

(2) Cases holding the plaintiff’s action is not time-barred, or at least not time-barred as a matter of law.

- (a) ***Brown v. Bleiberg***
(1982) 32 Cal.3d 426.

The plaintiff had foot surgery to remove some corns. After the surgery, her feet were cut up. The defendant told her that he found and removed numerous small tumors. The plaintiff then suffered severe foot problems for 12 years before suing. “[R]easonable minds could differ [citations]

as to the sufficiency of plaintiff's explanation that she was prevented from suspecting defendants' negligence by Dr. Bleiberg's misrepresentations about the nature of the surgery he performed and why he performed it. Plaintiff says she was told by Bleiberg that the surgery which resulted in the pain and disfigurement of the feet was necessitated by his discovery of 'tumors' there. So far as she knew, her condition was an unavoidable consequence of a 'necessary' operation." (*Id.* at p. 434.)

(b) ***Kernan v. Regents of University of California*** (2022) 83 Cal.App.5th 675.

Plaintiff underwent a procedure to rotate her fetus to a headfirst position at defendant's hospital in November 2016. (*Id.* at p. 678.) The procedure was successful, but the next day she returned to the hospital after not detecting fetal movement and delivered a stillborn fetus. (*Ibid.*) She suspected negligence after reviewing the autopsy with a new doctor in July 2017. (*Id.* at p. 679.) She served a notice of intent to sue in November 2017, and in February 2018, commenced a medical malpractice action for negligent performance of the November 2016 fetal rotation procedure. (*Id.* at pp. 678-679.) The trial court granted summary judgment for defendant, ruling that the statute of limitations began to run in 2016 when plaintiff learned the fetus had died, and therefore plaintiff's action was time-barred under the one-year statute of limitations in section 340.5. (*Id.* at p. 679.)

The Court of Appeal reversed, holding there was a triable issue of fact regarding when the limitations period began. (*Kernan, supra*, 83 Cal.App.5th at p. 681.) First, the court was not persuaded that plaintiff subjectively suspected negligence in November 2016 when she learned her baby had died. It was not clear that she ordered an autopsy on that day, and even if she

had, she could have done so for a number of reasons apart from a suspicion of negligence (e.g., peace of mind). (*Id.* at pp. 679, 682.) Further, plaintiff stayed under the care of the same doctors after her fetus died, which suggested that she did not suspect wrongdoing by them. (*Id.* at p. 683.) Similarly, it was not clear whether plaintiff objectively should have suspected negligence when the fetus died because plaintiff's procedure was deemed successful, the fetal heartbeat following the procedure was "reassuring," and after the fetus died, the doctors saw no indication of a cause of death. (*Ibid.*)

- (c) ***Filosa v. Alagappan***
(2020) 59 Cal.App.5th 722.

Filosa stemmed from an alleged failure to detect early signs of a brain tumor on an MRI. The plaintiff had a history of worsening headaches and other symptoms, some of which his physician attributed to depression, stress, and anxiety due to plaintiff's disrupted life. (*Id.* at pp. 733-734.) The court explained that the "correct standard where a plaintiff alleges failure to diagnose a progressive condition . . . is that a plaintiff 'discover[s] the injury when the undiagnosed condition develops into a more serious condition With the worsening of the plaintiff's condition, or an increase in or appearance of significant new symptoms, the plaintiff with a preexisting condition either actually (subjectively) discovers, or reasonably (objectively) should be aware of, the physical manifestation of his or her injury.'" (*Id.* at p. 735.) "Although the undisputed evidence does establish that [plaintiff's] headaches continued to worsen in the years after [the initial MRI], it does not establish that . . . Plaintiff 'became aware of additional, appreciable harm from his preexisting condition' " due to the other possible causes. (*Id.* at p. 738.)

- (d) ***Doe v. Marten***
(2020) 49 Cal.App.5th 1022.

Plaintiff brought medical battery and medical malpractice claims against her plastic surgeon for damages sustained after he performed plastic surgery on her face and neck in November 2007. (*Id.* at p. 1025.) In June 2008, before filing suit, plaintiff sent defendant a letter stating she was considering suing him and demanded that he preserve her documents, files, and photos. (*Ibid.*) In November 2008, plaintiff's attorney served defendant with a written demand for arbitration. (*Id.* at p. 1026.) In January 2009, defendant's counsel responded, identifying an arbitrator, without questioning the origin of the agreement or disputing that defendant had signed it. (*Ibid.*) The applicable one-year statute of limitations under Code of Civil Procedure section 340.5 ran in March 2009. (*Doe*, at p. 1026) In May 2009, defendant subpoenaed and obtained records from a doctor whom plaintiff earlier consulted. (*Ibid.*) Those records included a signed arbitration agreement, a copy of which had been incorrectly served on the defendant. (*Ibid.*) Nearly three years later, defendant's counsel first confronted plaintiff with the arbitration agreement and secured a stay of the arbitration. (*Ibid.*) The plaintiff then filed suit in state court. The trial court granted defendant's motion for nonsuit on plaintiff's claim for medical battery and the jury rendered a verdict, finding defendant liable for medical malpractice. (*Id.* at p. 1027.) Following the verdict, the trial court found the malpractice claim time-barred and dismissed the action. (*Ibid.*) The Court of Appeal reversed, reasoning that "plaintiff did not realize that defendant had not signed the subject arbitration agreement when she served her arbitration demand, and defendant's failure to question or object to her arbitration demand, coupled with his written response indicating his express willingness to participate in arbitration proceedings, led plaintiff

to actually and reasonably believe that she and defendant would resolve their dispute through arbitration and that commencing a legal action was unnecessary.” (*Id.* at p. 1030.) In other words, “plaintiff did not timely file a lawsuit because she reasonably relied on defendant’s response to her arbitration demand, and the only reasonable conclusion to be drawn from the record is that defendant must be deemed estopped from relying on a statute of limitations bar.” (*Ibid.*)

(e) ***Brewer v. Remington***
(2020) 46 Cal.App.5th 14.

Plaintiff became paralyzed following carpal tunnel surgery. (*Id.* at pp. 16-17.) A different physician then performed a spinal decompression surgery on plaintiff, but plaintiff did not recover a substantial amount of function. (*Id.* at pp. 17-18.) Plaintiff and her husband filed a medical malpractice action against the initial surgeons, their medical group and facility, and various Doe defendants. (*Id.* at p. 17.) Plaintiffs later added the spinal surgeon as a defendant after their expert opined that he had negligently delayed the spinal surgery. (*Ibid.*) The spinal surgeon moved for summary judgment on the ground that plaintiff’s lawsuit was barred by the one-year statute of limitations under Code of Civil Procedure section 340.5 since she knew his identity and the acts giving rise to her claim when he performed the unsuccessful spinal decompression surgery. (*Brewer*, at p. 19.) The trial court granted the defendant’s motion and plaintiff moved for new trial, arguing that the court had erroneously failed to apply the delayed discovery rule. (*Id.* at pp. 20-21.) The court granted a new trial, ruling that whether plaintiff should have discovered any injury as a result of defendant’s medical treatment was a triable issue of material fact. (*Ibid.*) The Court of Appeal affirmed. “The limitation period of section 340.5 may commence, as a matter of law, once

appreciable harm unambiguously manifests which causes *actual* suspicion of wrongdoing.” (*Id.* at p. 25.) “The persistence of [plaintiff’s] symptoms during [defendant’s] care, without more, does not trigger the statute of limitations as a matter of law.” (*Id.* at p. 29.) “Moreover, simply because [defendant’s] treatment did not resolve or more fully mitigate [plaintiff’s] injuries did not, in itself, place plaintiffs on inquiry notice that [defendant] provided negligent care. Under such an interpretation of the limitation period and discovery rule, every time medical treatment did not yield positive results (even if such results were not expected, promised or even reasonable) patients would be immediately charged with discovering a negligent cause before there was any reason to suspect harm or injury.” (*Id.* at p. 30.)

- (f) ***Daley v. Regents of University of California*** (2019) 39 Cal.App.5th 595.

Plaintiff was pregnant with twins who suffered from twin-twin transfusion syndrome (TTTS), a congenital condition involving inter-twin vascular connections. (*Id.* at pp. 597-598.) As part of a National Institute of Health clinical study, she underwent two fetoscopic laser surgeries to treat the TTTS at UCSF’s Fetal Treatment Center. (*Id.* at pp. 598-599.) After the second surgery, she developed a bacterial infection which led to an induced delivery. (*Id.* at p. 600.) Neither twin survived. (*Ibid.*) Eleven years later, plaintiff sued her doctors and the Regents for medical battery, claiming she consented to percutaneous surgery (where the uterus is accessed via a needle puncture), but the surgeons exceeded the scope of her consent by performing open fetal surgery (where a subcutaneous incision is made in the abdominal wall to access the uterus), which caused her bacterial infection. (*Ibid.*) The trial court dismissed the complaint with prejudice based on the two-year statute of limitations,

ruling that the discovery rule—which delays accrual of a cause of action until a plaintiff has a reason to know or at least suspect wrongdoing caused her injury—does not apply to a medical battery claim. (*Id.* at p. 602.) The Court of Appeal reversed, holding “the discovery rule is available for medical battery claims” and may be particularly applicable to claims of a sedated plaintiff who does not learn of potential wrongdoing before the limitations period expires. (*Id.* at pp. 606-607.)

- (g) ***Drexler v. Petersen***
(2016) 4 Cal.App.5th 1181.

The plaintiff suffered serious injuries during surgery to remove a large brain tumor that the defendants had failed to diagnose. The plaintiff had reported headaches and shoulder and neck pain for several years, but there was no evidence that the headaches got worse or that the shoulder and neck pain was related to the headaches. It was not until the plaintiff reported double vision, an unsteady gait, hoarseness, and difficulty swallowing that an MRI was conducted and the brain tumor discovered. The Court of Appeal held: “[W]hen the plaintiff in a medical malpractice action alleges the defendant health care provider misdiagnosed or failed to diagnose a preexisting disease or condition, there is no injury for purposes of section 340.5 until the plaintiff first experiences appreciable harm as a result of the misdiagnosis, which is when the plaintiff first becomes aware that a preexisting disease or condition has developed into a more serious one.” (*Id.* at pp. 1183-1184.) “‘[T]he injury is not the mere undetected existence of the medical problem at the time the physician failed to diagnose or treat the patient or the mere continuance of the same undiagnosed problem in substantially the same state. Rather, the injury is the *development* of the problem into a more serious condition which poses greater danger to the patient or

which requires more extensive treatment.’ ” (*Id.* at p. 1193, original emphasis.) “[T]he plaintiff in such a case may discover the injury when the undiagnosed condition develops into a more serious condition, but before it causes the ultimate harm.” (*Id.* at p. 1194.)

- (h) ***Arroyo v. Plosay***
(2014) 225 Cal.App.4th 279.

The plaintiffs alleged in the alternative that the decedent (1) suffered disfiguring injuries after death, while being placed inside a refrigerated compartment in a hospital morgue, or (2) was prematurely declared dead and suffered disfiguring injuries trying to escape from the refrigerated compartment before freezing to death. The hospital argued that the plaintiffs’ awareness of the disfiguring injuries on the date of death triggered the one-year “discovery” limitations period for both alternatives. The Court of Appeal disagreed: “[I]t is the suspicion of the *factual basis* of wrongdoing that commences the limitation period under the discovery rule. Obviously, the factual basis of the wrongdoing that underlies the medical negligence and wrongful death claims (prematurely declaring the decedent dead and placing her in the morgue while alive) is completely different from the factual basis of the wrongdoing plaintiffs suspected as of [the date of death] (mishandling the decedent’s remains, causing disfiguring injuries after death). The difference is not in the theories of liability, but in the essential suspected facts. In short, suspected wrongdoing in handling the decedent’s remains after death is not the same as suspected wrongdoing in causing her death.” (*Id.* at p. 293, original emphasis.) “[P]laintiffs had absolutely no reason to suspect that the decedent was alive rather than dead when placed in the Hospital morgue and when the disfiguring injuries occurred, and thus had no reason to suspect or investigate potential wrongdoing by the

Hospital or [the doctor] in prematurely declaring the decedent dead.” (*Id.* at p. 294.)

- (i) ***Artal v. Allen***
(2003) 111 Cal.App.4th 273.

“Artal awoke after *pelvic* surgery with throat pain, which was severe and persisted. Artal knew she had been intubated for anesthesia by Dr. Allen for surgery and believed the throat pain was related to the intubation, but was unaware that the intubation had been performed in a negligent manner. Artal eventually underwent exploratory surgery, which revealed a thyroid cartilage fracture.” (*Id.* at p. 275, original emphasis.) Artal’s suspicion “that some sort of trauma was caused during intubation” (*id.* at p. 280, emphasis omitted) was not enough, however, to start the one-year period running: “[T]his evidence merely showed that Artal suspected there was a connection between the intubation and her throat pain. It does not support the conclusion that . . . Artal knew, or by reasonable diligence should have known, that the throat pain was caused by professional negligence. . . . [¶] In fact, Artal was a model of diligence. She consulted at least 20 specialists in the 18 months following the . . . surgery to no avail. She was given some two dozen possible diagnoses

None of these diagnoses implicated Dr. Allen. [¶] As it turned out, the necessary facts could not be ascertained without exploratory surgery. It was not until the exploratory surgery, which revealed the thyroid cartilage fracture, that Artal had reason to suspect Dr. Allen had *negligently* performed the intubation. Although a malpractice litigant is required to pursue her claim diligently through discovery of the cause of her injury, Artal’s duty of diligence did not extend to submitting to surgery sooner in order to discover the negligent cause of her injury. [Citation.] [¶]

Dr. Allen asserts the throat pain put Artal on notice of her negligent intubation claim, so as to commence the running of statute of limitations, and thereafter the specific facts necessary to establish the claim could have been developed through pretrial discovery. [Citation.] The flaw in this argument is that it presupposes that litigation would have been effective in revealing the information which Artal needed to support her case. However, there is nothing in the record to support the notion that Artal could have developed the necessary facts through routine pretrial discovery, such as by deposing Dr. Allen or by propounding interrogatories, or by consulting additional experts. [¶] Further, requiring a plaintiff to sue while still ignorant of her injury *and its negligent cause* would require a plaintiff to bring a lawsuit without any objective basis for believing that malpractice had occurred. Had Artal filed suit before acquiring the information she obtained through exploratory surgery, she surely could not have prosecuted the malpractice action successfully” (*Id.* at pp. 280-281, original emphasis.)

- (j) ***Kitzig v. Nordquist***
(2000) 81 Cal.App.4th 1384.

The plaintiff underwent a lengthy course of treatment for the placement of dental implants. At one point, the plaintiff had a hole in her sinus and was suspicious that the defendant may have done something wrong. She consulted a second dentist, who said everything looked okay and she should go back to the defendant to get the hole closed. The plaintiff continued her treatment by the defendant for another year before seeing a third dentist, who told her the implants were failing. The one-year period did not start on the date the plaintiff first suspected wrongdoing because (1) her suspicion about the hole in her sinus did not pertain to the injury for which she later sought recovery, and (2) the “suspicion must

be meaningful by having some effect on the patient's ongoing relationship with her doctor." (*Id.* at pp. 1392-1393.) "[W]e hold only that under the particular circumstances here, the plaintiff's subjective concerns leading to a consultation with a second dentist during her ongoing dental treatment did not as a matter of law trigger the limitations period." (*Id.* at p. 1394, fn. 3.) A strong dissent accuses the majority of "ignor[ing] settled law on accrual of causes of action" (*Id.* at p. 1402 (conc. and dis. opn. of O'Rourke, J.).)

- (k) ***Unjian v. Berman***
(1989) 208 Cal.App.3d 881.

The plaintiff had a face lift that left him looking worse. Two years after the surgery, but less than one year after the doctor/patient relationship ended, the plaintiff sued. "The fact an operation did not produce the expected result would not necessarily suggest to the ordinary person the operation had been performed negligently." (*Id.* at p. 885.) "Where . . . the injury is obvious but there is nothing to connect that injury to defendant's negligence it cannot be said as a matter of law the plaintiff's failure to make an earlier discovery of fault was unreasonable. [Citation.] This is especially true in cases . . . where the plaintiff continues under the doctor's care, does inquire about the cause of his apparent injury and is given an explanation calculated to allay any suspicion of negligence on the doctor's part." (*Ibid.*)

- (l) ***Zambrano v. Dorough***
(1986) 179 Cal.App.3d 169.

The plaintiff had emergency surgery after the defendant failed to properly diagnose the plaintiff's tubal pregnancy. The defendant admitted to the plaintiff's mother and husband that he had erred in his original diagnosis. More than a year later, the plaintiff was told she

required a complete hysterectomy and that the need for the operation might be connected to the previous ruptured atopic pregnancy. She sued, seeking damages for loss of her reproductive capacity. While the plaintiff was aware of the defendant's negligence more than a year before filing suit, the injury to her reproductive system "is of a different type than the . . . pain and suffering and out-of-pocket losses allegedly accompanying the negligent misdiagnosis." (*Id.* at p. 174.)

Zambrano is severely criticized in *DeRose v. Carswell* (1987) 196 Cal.App.3d 1011, 1021-1026.

The *DeRose* court said, "the 'appreciable and actual harm' that the plaintiff [in *Zambrano*] suffered at or before the time of the initial surgery would have 'commence[d] the statutory period.'" (*DeRose, supra*, 196 Cal.App.3d at p. 1023.) And see *Miller v. Lakeside Village Condominium Assn.* (1991) 1 Cal.App.4th 1611, 1625-1626, agreeing with the *DeRose* court's criticism of *Martinez-Ferrer v. Richardson-Merrell, Inc.* (1980) 105 Cal.App.3d 316, which is the case *Zambrano* relies on (see *DeRose*, at pp. 1024-1025; *Zambrano, supra*, 179 Cal.App.3d at pp. 173-174). See also *Bennett v. Shahhal* (1999) 75 Cal.App.4th 384, 391-392, which relies on *Miller*.

The continuing viability of each of these cases must be considered in light of the Supreme Court's subsequent decision in *Poosh's, supra*, 51 Cal.4th 788. *Poosh's* was a case in which "a single wrong gives rise to two [physical injuries], but the two injuries become manifest at different times and are alleged to be separate and distinct." (*Id.* at p. 801.) The Supreme Court held, "the earlier disease does not trigger the statute of limitations for a lawsuit based on the later disease." (*Id.* at p. 803.) In other words, "a plaintiff can have a single cause of action that accrues (for statute of limitations purposes) at

different times with respect to different types of harm, thus permitting some damage claims to proceed although others are time-barred.” (*Id.* at p. 800, fn. 6 [pulmonary disease and lung cancer caused by smoking were qualitatively different, so former did not trigger limitations period for latter].) Under the *Pooshs* decision, *Zambrano* and *Martinez-Ferrer* seem correctly decided. (See *ibid.*)

(m) **Other cases.**

Unruh-Haxton v. Regents of University of California (2008) 162 Cal.App.4th 343, 359-364; *Steingart v. White* (1988) 198 Cal.App.3d 406, 415-416; *Gilbertson v. Osman* (1986) 185 Cal.App.3d 308, 317-318, disapproved on other grounds in *Woods, supra*, 53 Cal.3d at p. 328, footnote 4; *Hills v. Aronsohn* (1984) 152 Cal.App.3d 753, 759-760; *Kilburn v. Pineda* (1982) 137 Cal.App.3d 1046; *Murillo v. Good Samaritan Hospital* (1979) 99 Cal.App.3d 50, 57-58; *Enfield v. Hunt* (1979) 91 Cal.App.3d 417; *Tresemmer v. Barke* (1978) 86 Cal.App.3d 656, 664-665; *Dujardin v. Ventura County Gen. Hosp.* (1977) 69 Cal.App.3d 350, 355-358; *Timmel v. Moss* (9th Cir. 1986) 803 F.2d 519. Also, there are numerous unpublished opinions applying section 340.5. Some of them may have useful reasoning. Run a search for “340.5” on Westlaw or Lexis.

- Cases decided under Code of Civil Procedure section 335.1 and section 340, former subdivision (3), are also pertinent and should be consulted. (See *ante*, Section F(6)(e)(1)(e).)

7. The one-year “discovery” limitations period can be tolled by service of a 90-day notice of intent to sue during the last 90 days of the one-year period, and by non-MICRA tolling provisions, but not by section 340.5’s internal tolling provisions.

(a) Section 340.5’s internal tolling provisions do not apply.

Belton, supra, 20 Cal.4th at page 934.

(b) The 90-day notice tolling provision applies.

MICRA’s Code of Civil Procedure section 364, subdivision (d), allows tolling for 90 days when the plaintiff serves the required notice of intent to sue during the last 90 days of the one-year period. (*Woods, supra*, 53 Cal.3d at pp. 325-326.) The plaintiff has one year and 90 days in which to file suit. (*Id.* at p. 325.)

(c) Non-MICRA tolling provisions apply.

The one-year period can be tolled by non-MICRA provisions. (*Belton, supra*, 20 Cal.4th at pp. 931-935.) The principal non-MICRA tolling provisions applicable to an adult are insanity or imprisonment at the time the cause of action accrued. (See Code Civ. Proc., §§ 352, subd. (a), 352.1, subd. (a).) Insanity or imprisonment occurring *after* the cause of action accrued will not stop the running of the limitations period. (*Larsson v. Cedars of Lebanon Hospital* (1950) 97 Cal.App.2d 704, 707.)

Tolling based on imprisonment is limited to two years (Code Civ. Proc., § 352.1, subd. (a)); i.e., section 340.5’s one-year limitations period can be tolled for at most two years after the plaintiff first suffered appreciable harm and suspected, or should have suspected, that someone had done something wrong. Also, section 340.5’s three-year outside limitations period, which runs from the date the plaintiff first suffered appreciable harm, is unaffected by the plaintiff’s imprisonment. (*Belton, supra*, 20 Cal.4th at pp. 930-931, 935, disapproving *Hollingsworth v. Kofoed* (1996) 45 Cal.App.4th 423.)

In *Bennett, supra*, 75 Cal.App.4th at page 392, the Court of Appeal held section 340.5's one-year limitations period is *not* tolled by insanity under Code of Civil Procedure section 352, subdivision (a). *Bennett* was decided three months after *Belton*, but failed to address *Belton*. Subsequently, in *Alcott Rehabilitation Hospital v. Superior Court* (2001) 93 Cal.App.4th 94, the Court of Appeal disagreed with *Bennett* and held: "the one-year statute of limitations contained in Code of Civil Procedure section 340.5 can be tolled by the insanity provision in Code of Civil Procedure section 352." (*Id.* at p. 105.)

"Insanity" is "‘a condition of mental derangement which renders the sufferer incapable of caring for [his or her] property or transacting business, or understanding the nature or effects of [his or her] acts.’" (*DeRose, supra*, 196 Cal.App.3d at p. 1027.) The one-year period is tolled as long as insanity continues, even if a guardian ad litem is appointed. (See *Tzolov v. International Jet Leasing, Inc.* (1991) 232 Cal.App.3d 117.) But section 340.5's three-year outside limitations period, which runs from the date the plaintiff first suffered appreciable harm, can cut off the plaintiff's action despite insanity. (See *Belton, supra*, 20 Cal.4th at pp. 930-931, 935.)

In *Kaplan v. Mamelak* (2008) 162 Cal.App.4th 637, the Court of Appeal held that Code of Civil Procedure section 351 tolls section 340.5's one-year "discovery" limitations period. (*Id.* at pp. 641-645.) Section 351 is a non-MICRA tolling provision that tolls the running of the statute of limitations for days that the defendant is outside California.

In *Blevin v. Coastal Surgical Institute* (2015) 232 Cal.App.4th 1321, the Court of Appeal held that Insurance Code section 11583 tolls section 340.5's one-year "discovery" limitations period. (*Id.* at p. 1324.) Section 11583 is a non-MICRA tolling provision that tolls the running of the statute when advance or partial payment is made to an injured and unrepresented person without notifying him or her of the applicable limitations period. The tolling is from the time of the advance or partial payment to the time of written notice of the applicable limitations period. (Ins. Code, § 11583.)

8. An action by an adult must be brought within three years after the plaintiff first suffered appreciable harm.

(a) The three-year period is an outside limit on the time for bringing an action.

Section 340.5 provides that an adult's cause of action for professional negligence must be commenced within "three years after the date of injury" The three-year period is an "outside limit on the period after plaintiff's injury in which an action for 'professional negligence' may be commenced, regardless of the patient's belated discovery of the cause of action." (*Brown, supra*, 32 Cal.3d at p. 437.) In other words, even if the three-year period expires before the plaintiff ever suspected, or should have suspected, that someone did something wrong, the plaintiff's suit is time barred. "The negligent cause of [the injury] is not a concern for the three-year period." (*Rose, supra*, 207 Cal.App.3d at p. 768; accord, *Marriage & Family Center v. Superior Court* (1991) 228 Cal.App.3d 1647, 1652; *Hills, supra*, 152 Cal.App.3d at p. 762.)

The three-year period begins to run when "'appreciable harm' [is] first manifested." (*Brown, supra*, 32 Cal.3d at p. 437, fn. 8; see *Filosa, supra*, 59 Cal.App.5th at 735 ["it is the surfacing of appreciable harm that marks the beginning of the three-year period"]; *Bispo v. Burton* (1978) 82 Cal.App.3d 824, 831.) "[D]amage is 'manifested' for purposes of commencing the three-year period when it has become evidenced in some significant fashion, whether or not the patient/plaintiff actually becomes aware of the injury." (*Marriage & Family Center, supra*, 228 Cal.App.3d at p. 1654; accord, *McNall, supra*, 25 Cal.App.4th at p. 1311; see *Photias v. Doerfler* (1996) 45 Cal.App.4th 1014, 1021.)

(b) Cases applying the three-year “outside” limitations period.

(1) Cases holding the plaintiff’s action is time-barred as a matter of law.

**(a) *Garabet v. Superior Court*
(2007) 151 Cal.App.4th 1538.**

The defendants performed LASIK surgery after the plaintiff signed a consent form disclosing numerous potential complications. Within weeks after the surgery, the plaintiff was experiencing a number of the disclosed complications. The plaintiff continued to be treated by the defendants for more than two and one-half years. By the time the plaintiff sued the defendants, over seven years had passed since the surgery. The plaintiff argued the complications that developed soon after the surgery did not trigger the three-year statute of limitations because the complications were disclosed beforehand. (*Id.* at pp. 1543-1544.) The Court of Appeal noted, however, that the plaintiff “does not allege that defendants failed to fully disclose potential complications which appeared after the surgery. Rather, [the plaintiff] alleges defendants should have refused to perform the surgery.” (*Id.* at p. 1551.) “Because [the plaintiff’s] symptoms, which constituted appreciable harm, were apparent immediately after the surgery, he is barred by application of the three-year outside limit contained in Code of Civil Procedure section 340.5.” (*Ibid.*)

**(b) *McNall v. Summers*
(1994) 25 Cal.App.4th 1300.**

The plaintiff received electroconvulsive therapy (ECT) that resulted in memory loss. Over seven years later, after an MRI revealed the plaintiff had suffered a stroke, she sued. “There was nothing hidden about her injury. McNall fully recognized she was continuously experiencing

harmful lapses in memory adversely affecting her professional and personal life. It is simply uncontroverted that McNall knew she was damaged in some way by the ECT treatments. That is sufficient to trigger the three-year period provided for in section 340.5.” (*Id.* at p. 1310.) “McNall’s serious and continuous loss of memory constitutes ‘injury’ for the purpose of triggering the three-year period even if McNall did not, or arguably could not, discover the actual organic injury causing the loss of memory or discern the negligent conduct of her doctors.” (*Id.* at p. 1311.)

- (c) ***Marriage & Family Center v. Superior Court*** (1991) 228 Cal.App.3d 1647.

The defendant therapist induced the plaintiff to have sexual intercourse. The plaintiff suffered psychological and emotional damage that was recognized by her successor therapist at least four years prior to filing suit, but he did not advise the plaintiff of the damage until much later. “We accept the . . . proposition that severe damage which does not show itself (hidden cancer, for instance) is not ‘injury’ until it is found by diagnosis. It does not follow, however, that damage which has clearly surfaced and is noticeable is not ‘injury’ until . . . the plaintiff . . . recognizes it.” (*Id.* at p. 1654.)

- (d) ***Hills v. Aronsohn*** (1984) 152 Cal.App.3d 753.

The defendant injected silicone into the plaintiff’s breasts. Eight years later, the plaintiff noticed lumps and experienced soreness in her breasts and promptly consulted another doctor. Four years after that, following a mastectomy, the plaintiff sued. “[The plaintiff] admits she experienced soreness and noticed lumps in her breasts . . . four years before filing suit. . . . This admission is sufficient to show that she suffered the damaging effect of the alleged malpractice on

that date.” (*Id.* at p. 762.) “[W]e reject [the plaintiff’s] conclusion that she did not experience injury until she suffered her ultimate harm in the form of subcutaneous mastectomy. The mastectomy was an operation designed to cure the injury, and not the injury itself.” (*Ibid.*)

(e) **Other cases.**

Trantafello v. Medical Center of Tarzana (1986) 182 Cal.App.3d 315, 319 & footnote 1; *Wells Fargo Bank v. Superior Court* (1977) 74 Cal.App.3d 890, 896-900.

- Because the three-year outside limitations period for an adult is similar to the limitations period for a minor, cases involving a minor are pertinent and should be consulted. (See Section F(10), *post.*)

(2) **Cases holding the plaintiff’s action is not time-barred, or at least not time-barred as a matter of law.**

(a) ***Warren v. Schechter***
(1997) 57 Cal.App.4th 1189.

The defendant did not disclose to the plaintiff that severe osteoporosis was a risk of gastric surgery. Following the surgery, the plaintiff developed several other surgical complications that were disclosed. Subsequently, almost eight years after the surgery, the plaintiff fractured her back while turning over in bed. She sued, alleging failure to obtain informed consent. The three-year period did not begin to run until the plaintiff suffered an undisclosed surgical complication. (*Id.* at pp. 1201-1203.) The plaintiff “is entitled to recover not only for the undisclosed complications but also for the disclosed complications, because she would not have consented to any surgery had the true risk been disclosed, and therefore would not have suffered those complications either.” (*Id.* at

p. 1204.) Because the plaintiff cannot sue for a disclosed complication until an undisclosed complication occurs, the earlier occurrence of disclosed complications did not trigger the three-year period. (*Id.* at pp. 1204-1205.) Also, the jury reasonably concluded that the plaintiff first suffered appreciable harm from the failure to disclose the risk of metabolic bone disease when, eight years after the surgery, she broke her back—not when, three years after the surgery, another doctor told her she had a calcium deficiency. (*Id.* at pp. 1202-1203.)

- (b) ***Mason v. Marriage & Family Center***
(1991) 228 Cal.App.3d 537.

The defendant therapist initiated a sexual relationship with the plaintiff. Four years later, the plaintiff was suffering mental and emotional distress and began seeing a psychiatrist. A year after that, the plaintiff disclosed her sexual relationship with her former therapist to her psychiatrist, who informed her that the therapist's conduct was inappropriate and abusive. The plaintiff then sued. "[T]he record suggests Mason's injury did not occur at the time of the alleged sexual relations. Her description of delayed symptoms is consistent with the view of clinicians who have described the injury caused by patient-therapist sexual relations as 'post-traumatic stress.'" (*Id.* at pp. 543-544, emphasis deleted.)

- (c) ***Steingart v. White***
(1988) 198 Cal.App.3d 406.

The plaintiff noticed a lump in her breast. The defendant diagnosed the lump as a cyst and told the plaintiff not to be concerned. Two subsequent mammograms were negative. Three years after the plaintiff first noticed the lump, breast cancer was diagnosed. The plaintiff sued within one year of diagnosis. "[A]lthough Steingart knew about

the lump at the time White examined her, such a condition is not a clear indication of injury [S]he was told repeatedly the lump was non-threatening. [¶] Under these circumstances, we cannot equate Steingart's lump with injury. She suffered no injury until her cancer had been diagnosed." (*Id.* at p. 415.)

(d) **Other cases.**

Filosa, supra, 59 Cal.App.5th at pp. 734-740;
Bispo, supra, 82 Cal.App.3d at pp. 830-832.

- Because the three-year outside limitations period for an adult is similar to the limitations period for a minor, cases involving a minor are pertinent and should be consulted. (See Section F(10), *post.*)

9. The three-year “outside” limitations period can be tolled by MICRA’s tolling provisions, but not by non-MICRA tolling provisions.

(a) **Non-MICRA tolling provisions do not apply.**

“No tolling provision outside of MICRA can extend the three-year maximum time period that section 340.5 establishes.” (*Belton, supra*, 20 Cal.4th at p. 931.)

(b) **MICRA’s tolling provisions.**

(1) **Service of a 90-day notice of intent to sue during the last 90 days of the three-year limitations period.**

MICRA’s Code of Civil Procedure section 364, subdivision (d), allows tolling for 90 days when the plaintiff serves the required notice of intent to sue during the last 90 days of the three-year period. (*Russell, supra*, 15 Cal.4th at pp. 788-789.) The plaintiff has three years and 90 days in which to file suit. (*Id.* at pp. 788, 790.)

(2) Fraudulent concealment of the defendant's negligence.

Section 340.5 allows tolling of the three-year outside limitations period “upon proof of fraud . . . [or] intentional concealment.” The difference between “fraud” and “intentional concealment” in this setting is not clear. The case law usually combines these terms into “fraudulent concealment.” (E.g., *Bernson, supra*, 7 Cal.4th at p. 931 & fn. 3 [“The rule of fraudulent concealment is applicable whenever the defendant intentionally prevents the plaintiff from instituting suit”]; *Sanchez, supra*, 18 Cal.3d at p. 99 [“It has long been established that the defendant’s fraud in concealing a cause of action against him tolls the applicable statute of limitations”].)

The tolling is “only for that period during which the claim is undiscovered by plaintiff or until such time as plaintiff, by the exercise of reasonable diligence, should have discovered it. [Citations.] Notwithstanding a defendant’s continuing efforts to conceal, if plaintiff discovers the claim independently, the limitations period commences.” (*Sanchez, supra*, 18 Cal.3d at p. 99.) The plaintiff then has one year to file suit.

In *Brown, supra*, 32 Cal.3d 426, the Supreme Court held the defendant’s *post*-surgery affirmative misrepresentation about the nature of the surgery created a triable issue of fact as to whether the three-year outside limitations period was tolled. (*Id.* at pp. 429-431, 437-438; see *Young, supra*, 41 Cal.3d at p. 901; *Trantafello, supra*, 182 Cal.App.3d at p. 321.)

In *Trantafello*, the Court of Appeal held that, where the plaintiff’s cause of action was premised on the defendant’s failure to inform the plaintiff in advance that the surgical technique was innovative and entailed risks, the continued failure to disclose these facts after surgery did *not* constitute intentional concealment. “The trial court properly concluded that intentional concealment requires something more than a mere continuation of the prior nondisclosure.” (*Trantafello*,

supra, 182 Cal.App.3d at p. 321; accord, *Reyes, supra*, 197 Cal.App.3d at p. 595, fn. 4.) “Plaintiff did not show there was any issue as to an affirmative misrepresentation.” (*Trantafello*, at p. 321; see *McNall, supra*, 25 Cal.App.4th at p. 1311 [“The [fraud and intentional concealment] provisions for extending the three-year time bar require ‘affirmative acts by the health care provider rather than mere omission or exercise of poor judgment’ ”]; *Barber, supra*, 234 Cal.App.3d at p. 1084 [“There is absolutely no evidence that defendant made any effort to conceal pertinent facts”].)

- Because fraudulent concealment is a rule of general application, non-MICRA cases may be useful in applying section 340.5. For example, in *Mark K. v. Roman Catholic Archbishop* (1998) 67 Cal.App.4th 603, the Court of Appeal distinguished between concealment of a cause of action and concealment of evidence, ruling the statute of limitations was not tolled just because “a tortfeasor failed to disclose evidence that would demonstrate its liability in tort” (*Id.* at p. 613.)

(3) Presence of a medically inserted foreign body inadvertently left in the plaintiff’s body.

Section 340.5 allows tolling of the three-year outside limitations period “upon proof of . . . the presence of a foreign body, which has no therapeutic or diagnostic purpose or effect, in the person of the injured person.” “[T]he ‘foreign body’ exception in section 340.5 lifts the three-year outside limit entirely if a nontherapeutic ‘foreign body’ has been left inside a patient.” (*Ashworth, supra*, 206 Cal.App.3d at p. 1058.) “The Legislature meant tolling to continue until the patient discovers or through reasonable (including non-dangerous) diligence would have discovered the ‘foreign body’ itself and the role this ‘foreign body’ played in the patient’s suffering.” (*Id.* at p. 1064, emphasis omitted.) “A patient’s mere suspicion she was the victim of some sort of malpractice cannot start the statute running as to a cause of action

based on the presence of ‘foreign bodies.’ Only discovery of those particular foreign bodies and their causal relation to the patient’s injuries can start the clock.” (*Id.* at p. 1062.) Upon discovery, the patient “has one year to file her lawsuit against the practitioners responsible for leaving the ‘foreign body’ inside her.” (*Id.* at p. 1058.)

The foreign body rule only applies if the foreign body was medically inserted. (*Wallace v. Hibner* (1985) 171 Cal.App.3d 1042, 1047-1049 [refusing to apply the foreign body rule where the plaintiff stepped on a needle and the defendant inadvertently left a portion of the needle in the plaintiff’s foot after attempting to remove it].) The statutory requirement that the foreign body have “no therapeutic or diagnostic purpose or effect” is satisfied if the foreign body had a therapeutic purpose or effect when originally inserted, but was allowed to remain in place too long, e.g., sponges, needles, tubes. (*Ashworth, supra*, 206 Cal.App.3d at p. 1057.) Thus, the foreign body rule applies “where a foreign body is *inadvertently* left in the patient, such as a surgical sponge.” (*Trantafello, supra*, 182 Cal.App.3d at p. 319, original emphasis; see *id.* at p. 320 [refusing to apply the foreign body rule to an acrylic substance used to maintain a space between the vertebrae]; *Hills, supra*, 152 Cal.App.3d at pp. 763-765 [refusing to apply the foreign body rule to silicone injections for breast augmentation].)

In *Maier v. County of Alameda* (2014) 223 Cal.App.4th 1340, the Court of Appeal disagreed with the suggestion in *Trantafello* and *Hills* that the foreign body rule only applies to objects or substances inadvertently introduced into the body. “What distinguishes *Hills* and *Trantafello* is that in both cases the substances placed in the patient’s body for a therapeutic purpose were intended to remain there permanently and *for that reason* did not come within the statutory foreign body exception.” (*Id.* at p. 1351, original emphasis.) *Maier* held: “[I]tems temporarily placed in the body as part of a procedure and meant to be removed at a later time do come within” the foreign body rule. (*Id.* at p. 1352.)

10. An action brought by a minor who was less than six years old when appreciable harm was first suffered must be brought within three years after the harm or prior to the minor's eighth birthday, whichever is longer. If the minor was at least six years old when appreciable harm was first suffered, the action must be brought within three years after the harm.

(a) Section 340.5 says a minor's action accrues on the date of the "wrongful act"; nevertheless, the courts have held the action accrues on the date of "injury," just like it does for an adult.

Section 340.5 says: "Actions by a minor shall be commenced within three years from the date of the alleged wrongful act except that actions by a minor under the full age of six years shall be commenced within three years or prior to his eighth birthday whichever provides a longer period." Because of equal protection problems, the courts have construed the statute to replace "wrongful act" with "injury"; i.e., the limitations period begins to run when appreciable harm is first manifested. (*Arredondo, supra*, 131 Cal.App.4th at p. 618.)

(b) It is the minor's age on the date of injury, not on the date of filing, that counts.

The words "actions by a minor" and "actions by a minor under the full age of six years" in section 340.5 refer to the plaintiff's age on the date of the alleged injury, not the plaintiff's age on the date the action is filed. (*Steketee, supra*, 38 Cal.3d at pp. 52-53.)

(c) The one-year "discovery" limitations period in section 340.5 does not apply to a minor's action.

"The first two sentences [of section 340.5] create a one-year discovery limitation which may be more restrictive than the outside limit of three years. [Citation.] The third sentence, by contrast, makes clear that minors have the full three years—or until the eighth birthday, if this is later—to initiate action. Accordingly, . . . the one-year discovery limitation is applicable only to adults." (*Young, supra*, 41 Cal.3d at p. 897, fn. 10.)

(d) The common law delayed discovery rule does not apply to a minor's action.

Arredondo, supra, 131 Cal.App.4th at pp. 618-619 & fn. 4 (overruling *Torres, supra*, 209 Cal.App.3d at p. 335; *Photias, supra*, 45 Cal.App.4th at p. 1021; and (by implication) *Curtis T. v. County of Los Angeles* (2004) 123 Cal.App.4th 1405, 1417); see *Young, supra*, 41 Cal.3d at pp. 894-896 (disapproving *Kite, supra*, 142 Cal.App.3d at pp. 801-803).

(e) The six-year limitations period for prenatal injury specified in Code of Civil Procedure section 340.4 does not apply.

A minor's cause of action for prenatal injury is governed by section 340.5 rather than by Code of Civil Procedure section 340.4 (formerly Civil Code section 29). (*Young, supra*, 41 Cal.3d at p. 894.)

(f) Cases applying the minor's limitations period.

(1) *Aronson v. Superior Court*
(1987) 191 Cal.App.3d 294.

The plaintiff sustained brain injury at birth. His aunt sued on his behalf 14 years after his birth, alleging his parents failed or refused to sue. The suit was untimely. "Except in egregious situations calling for interference with legal custody, the parents, not the courts, make decisions for the minor. . . . Nowhere in the statute is there language authorizing special exceptions for the minor whose parents simply refuse to sue when, perhaps, some person would conclude they should." (*Id.* at p. 299.)

(2) *Tran v. Fountain Valley Community Hospital*
(1997) 51 Cal.App.4th 1464.

The suit was timely even though it was filed on, rather than prior to, the plaintiff's eighth birthday, where the last day for filing fell on Sunday and the complaint was filed on Monday.

(3) **Other cases.**

Young, supra, 41 Cal.3d at pp. 889-891, 901-902;
Donabedian v. Manzer (1986) 187 Cal.App.3d 1021;
Katz v. Children's Hosp. of Orange County (9th Cir.
1994) 28 F.3d 1520, 1533-1535.

11. The minor's limitations period can be tolled by MICRA's tolling provisions, but not by non-MICRA tolling provisions.

(a) Non-MICRA tolling provisions do not apply.

The general tolling provision for minors, Code of Civil Procedure section 352, subdivision (a), does not apply. (*Steketee, supra*, 38 Cal.3d at pp. 53-54, fn. 3.) Neither do any other non-MICRA tolling provisions. (*Belton, supra*, 20 Cal.4th at p. 931 [three-year outside limitations period for adults cannot be tolled by any provision outside MICRA]; *Young, supra*, 41 Cal.3d at pp. 897-898 [treating tolling for minors the same as tolling for adults].)

(b) MICRA's tolling provisions apply.

The tolling that occurs when a 90-day notice of intent to sue is served during the last 90 days of the limitations period applies to a minor. (*Newman, supra*, 54 Cal.App.4th 722.) The fraud, intentional concealment, and foreign body tolling provisions of section 340.5 also apply to a minor. (*Young, supra*, 41 Cal.3d at pp. 895-901, disapproving *Kite, supra*, 142 Cal.App.3d at pp. 801-803.) The parent/provider collusion tolling provision of section 340.5 is an additional tolling provision that applies to a minor. (*Young, supra*, at pp. 897-898.)

12. Litigation.

(a) Section 340.5 must be raised by demurrer or as an affirmative defense or both.

"[T]he statute of limitations is a personal privilege which ' . . . must be *affirmatively invoked in the lower court* by appropriate pleading . . . ' or else it 'is waived.' " (*Mysel v. Gross* (1977) 70

Cal.App.3d Supp. 10, 15, original emphasis; accord, *Martin v. Van Bergen* (2012) 209 Cal.App.4th 84, 91.)

(b) The defendant bears the burden of proving the limitations defense.

Section 340.5 is an affirmative defense. The defendant bears the burden of proving all the facts necessary to establish that the action was not timely filed. (*Samuels v. Mix* (1999) 22 Cal.4th 1, 7, 10-11; see *id.* at pp. 22-23 (dis. opn. of Baxter, J.).)

In *Charkhchian v. Logistics Solutions, LLC* (Aug. 23, 2019, B289896) 2019 WL 3986203 [nonpub. opn.], the Court of Appeal reversed a judgment of dismissal following a demurrer on MICRA statute of limitations grounds, holding that “the allegations of the complaint do not establish, as a matter of law, that defendant is a health care provider as that term is defined in section 340.5.” (*Id.* at p. *4.) The court noted that the defendant did not “expressly assert, much less affirmatively demonstrate, that it was a health care provider as that term is defined in section 340.5,” for example by “request[ing] judicial notice of documents showing that it was a licensed or certified health care provider.” (*Id.* at p. *2 & fn. 2.)

(c) Consider invoking the right to a bifurcated trial.

If the limitations defense does not prevail at the pretrial stage, defense counsel should consider invoking the right to a bifurcated trial (Code Civ. Proc., § 597.5) in order to try the limitations issue first. (See *Kelemen v. Superior Court* (1982) 136 Cal.App.3d 861 [bifurcation required under section 597.5 where statute of limitations is pleaded and motion for separate trial is made].)

(d) There is a right to a jury trial on the issue of the date of accrual of the plaintiff's cause of action.

Jefferson v. County of Kern (2002) 98 Cal.App.4th 606.

G. CODE OF CIVIL PROCEDURE SECTION 364: REQUIRING 90 DAYS' NOTICE OF INTENT TO SUE.

1. Text of section 364.

- (a) No action based upon the health care provider's professional negligence may be commenced unless the defendant has been given at least 90 days' prior notice of the intention to commence the action.
- (b) No particular form of notice is required, but it shall notify the defendant of the legal basis of the claim and the type of loss sustained, including with specificity the nature of the injuries suffered.
- (c) The notice may be served in the manner prescribed in Chapter 5 (commencing with Section 1010) of Title 14 of Part 2.
- (d) If the notice is served within 90 days of the expiration of the applicable statute of limitations, the time for the commencement of the action shall be extended 90 days from the service of the notice.
- (e) The provisions of this section shall not be applicable with respect to any defendant whose name is unknown to the plaintiff at the time of filing the complaint and who is identified therein by a fictitious name, as provided in Section 474.
- (f) For the purposes of this section:
 - (1) "Health care provider" means any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or licensed pursuant to the Osteopathic Initiative Act, or the Chiropractic Initiative Act, or licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code; and any clinic, health dispensary, or health facility, licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code. "Health care provider" includes the legal representatives of a health care provider;
 - (2) "Professional negligence" means negligent act or omission to act by a health care provider in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death, provided that such services are within the scope of

services for which the provider is licensed and which are not within any restriction imposed by the licensing agency or licensed hospital.

2. Text of related statute: Code of Civil Procedure section 365.

Failure to comply with this chapter [section 364] shall not invalidate any proceedings of any court of this state, nor shall it affect the jurisdiction of the court to render a judgment therein. However, failure to comply with such provisions by any attorney at law shall be grounds for professional discipline and the State Bar of California shall investigate and take appropriate action in any such cases brought to its attention.

3. Summary of sections 364 and 365.

An action for professional negligence is not supposed to be commenced until the plaintiff has given the defendant 90 days' notice of intent to sue. (§ 364, subd. (a).) Failure to comply, however, does not invalidate any court proceedings or affect the court's jurisdiction to render a judgment in a medical malpractice action; rather, the attorney who fails to comply is (theoretically) subject to professional discipline. (§ 365; *Woods v. Young* (1991) 53 Cal.3d 315, 324; *Phillips v. Desert Hospital Dist.* (1989) 49 Cal.3d 699, 708; *Davis v. Marin* (2000) 80 Cal.App.4th 380, 385, fn. 4; *Silver v. McNamee* (1999) 69 Cal.App.4th 269, 281-282; *Toigo v. Hayashida* (1980) 103 Cal.App.3d 267, 269 ["The provisions of section 365 . . . seemingly emasculate the substance of section 364"].)

When a notice of intent to sue is served within the last 90 days of the limitations period, the statute of limitations is tolled for 90 days. (See *Preferred Risk Mutual Ins. Co. v. Reiswig* (1999) 21 Cal.4th 208, 211-212; *Russell v. Stanford University Hospital* (1997) 15 Cal.4th 783; *Woods, supra*, 53 Cal.3d 315; *Newman v. Burnett* (1997) 54 Cal.App.4th 722; *Anson v. County of Merced* (1988) 202 Cal.App.3d 1195, 1204-1205, cited with approval in *Preferred Risk*, at pp. 214, 217-218.) If, however, the notice of intent to sue is inadequate because it does not comply or at least substantially comply with the requirements of section 364, subdivision (b), there probably is no tolling. (See Section G(7), *post.*) When a notice of intent to sue is served before the last 90 days of the limitations period, there is no tolling. (*Woods*, at pp. 325-327; *Bennett v. Shahhal* (1999) 75 Cal.App.4th 384, 390.)

4. Section 364 is constitutional.

Section 364, subdivision (d), tolls the statute of limitations for plaintiffs who serve a notice of intent to sue during the last 90 days of the limitations period, but not for plaintiffs who serve a notice of intent to sue before the last 90 days of the limitations period. (*Woods, supra*, 53 Cal.3d at pp. 325-327.) This distinction does not deny equal protection of the laws. (*Id.* at pp. 327-328.)

5. Other contexts in which section 364 may apply.

(a) Wrongful death action.

Section 364 applies in a wrongful death action as well as a personal injury action. (§ 364, subd. (f)(2); see *Yates v. Pollock* (1987) 194 Cal.App.3d 195, 198-199.)

(b) Action against public entity or employee.

In addition to filing a claim under the Tort Claims Act, the plaintiff must serve a section 364 notice of intent to sue. (*Wurts v. County of Fresno* (1996) 44 Cal.App.4th 380, cited with approval in *Preferred Risk, supra*, 21 Cal.4th at p. 218.) Unless the plaintiff intended that a claim under the Tort Claims Act also function as a section 364 notice of intent to sue, the claim cannot be deemed to also constitute the notice. (*Wurts*, at pp. 382, 388.)

On the other hand, a section 364 notice of intent to sue that “discloses the existence of a claim that if not paid or otherwise resolved will result in litigation, must be treated as a defective ‘claim’ activating the notice and defense-waiver provisions of the [Tort Claims Act].” (*Phillips, supra*, 49 Cal.3d at pp. 707-708; see *Watts v. Valley Medical Center* (1992) 8 Cal.App.4th 1050; *Mandjik v. Eden Township Hospital Dist.* (1992) 4 Cal.App.4th 1488, 1502-1503; *Wilson v. Tri-City Hospital Dist.* (1990) 221 Cal.App.3d 441.)

If a section 364 notice of intent to sue is served within the last 90 days of the Torts Claims Act limitations period, the limitations period is tolled for 90 days. (*Anson, supra*, 202 Cal.App.3d at pp. 1204-1205, cited with approval in *Preferred Risk, supra*, 21 Cal.4th at pp. 214, 217-218; see *Wurts, supra*,

44 Cal.App.4th at p. 385 & fn. 6; but see *Last Frontier Healthcare Dist. v. Superior Court* (2019) 33 Cal.App.5th 492, 494-495 [“giving notice of an intent to file a medical malpractice action under Code of Civil Procedure section 364 does not alter the jurisdictional deadlines underlying an application for relief from the Government Claims Act (Gov. Code, § 810 et seq.) requirement of presenting a timely claim to a public entity before bringing an action for damages against it” (fn. omitted)].)

(c) EMTALA action.

Section 364 does not apply. EMTALA preempts state procedural restrictions on medical malpractice claims. (*Power v. Arlington Hosp. Ass’n* (4th Cir. 1994) 42 F.3d 851, 865-866; see *Barris v. County of Los Angeles* (1999) 20 Cal.4th 101, 113 & fn. 7.)

(d) Elder abuse action.

Section 364 does not apply. (*Smith v. Ben Bennett, Inc.* (2005) 133 Cal.App.4th 1507, 1512, 1526.)

(e) Equitable indemnity action.

Section 364 applies. (*Preferred Risk, supra*, 21 Cal.4th 208.)

(f) Action under Federal Tort Claims Act.

Section 364 does not apply. (See *Jackson v. United States* (9th Cir. 1989) 881 F.2d 707, 712 [in an action under the FTCA, “issues not affecting the government’s substantive liability are determined solely by federal law”]; see also 28 U.S.C. § 2401 [setting statute of limitations for FTCA action]; *Bunnell v. Department of Corrections* (1998) 64 Cal.App.4th 1360, 1370 [“where Congress has expressly set a limitations period on a federal claim, . . . state tolling provisions . . . do not apply”].)

6. Statutory definitions.

(a) Definition of “health care provider.”

See *ante*, Section B(2).

(b) Definition of “based upon professional negligence.”

See *ante*, Section B(3).

7. The notice of intent to sue must specify the alleged injury.

No special form of notice is required; however, the defendant must be notified of “the legal basis of the claim and the type of loss sustained, including with specificity the nature of the injuries suffered.” (§ 364, subd. (b).) In *Kumari v. The Hospital Committee for the Livermore-Pleasanton Areas* (2017) 13 Cal.App.5th 306, the Court of Appeal held that a letter the patient sent to the hospital more than a year before filing suit constituted a notice of intent to sue: “Section 364, subdivision (b) does not require any ‘particular *form* of notice’ [citation]. What the statute requires is that the notice include ‘the legal basis of the claim and the type of loss sustained, including with specificity the nature of the injuries suffered.’ [Citation.] Kumari’s letter included this information. It listed the date of her injury and described the events giving rise to her ‘medical negligence’ claim. The letter also described the injury, the medical treatment Kumari was receiving for that injury, and the damages she allegedly sustained. Additionally, the letter requested \$240,000, and indicated Kumari would ‘move to the court after 20 days’ if she did not receive payment.” (*Id.* at p. 313.) Responding to the plaintiff’s argument that the letter was not a notice of intent to sue because she did not intend it to be, the Court of Appeal said: “Section 364 does not include a requirement that the notice affirmatively express an intention to comply with the statute.” (*Ibid.*) “Whether Kumari intended for her letter to be construed as a notice of intent to sue under section 364 is irrelevant. The relevant inquiry is whether Kumari’s letter disclosed to [the hospital] that she ‘had a claim against it which, if not satisfactorily resolved, would result in [her] filing a lawsuit.’ ” (*Id.* at p. 314, fn. 4.)

In *Anson, supra*, 202 Cal.App.3d 1195, the Court of Appeal held that a claim filed under the Tort Claims Act did not serve as a proper notice of intent to sue under section 364. The claim did not specify the type of injuries suffered and did not name the persons who allegedly caused the injuries. (*Id.* at p. 1204.) (Subsequently, in *Wurts, supra*, 44 Cal.App.4th 380, the same court that decided *Anson* went further and held that even a claim filed under the Tort Claims Act that contains all the information required by section 364 does not serve as a notice of intent to sue unless the plaintiff so intended. (*Id.* at p. 387 & fn. 7.))

In *Edwards v. Superior Court* (2001) 93 Cal.App.4th 172, the defendant performed reconstructive surgery on the plaintiff's breasts and nose. The notice of intent to sue referred to injury from the breast surgery but not the nose surgery. The plaintiff sought to amend her complaint to allege injury from the nose surgery. The Court of Appeal held that "failure [in the notice of intent to sue] to allege the specific factual basis of each cause of action does not prevent the plaintiff from alleging the cause in the lawsuit or from obtaining leave to amend the complaint to add any cause of action omitted from the section 364 notice." (*Id.* at p. 175.)

A plaintiff who serves notice of intent to sue and then discovers further or different injuries cannot toll the limitations period for 90 days by serving a second notice. (*Bennett, supra*, 75 Cal.App.4th at pp. 390-392; see *Kumari, supra*, 13 Cal.App.5th at p. 315.)

8. The notice of intent to sue must be served in a manner likely to result in actual notice to the defendant.

Derderian v. Dietrick (1997) 56 Cal.App.4th 892, 899 & fn. 7.

(a) Service of notice by mail, in strict compliance with statutory requirements, is effective immediately upon deposit in the mail, even if the defendant does not actually receive it.

Silver, supra, 69 Cal.App.4th at pp. 279-280, 283; see *id.* at pp. 280, 283 (the defendant bears the risk of failure of the mail).

- (b) **Service of notice by fax, without complying with the statutory requirement of an advance written agreement permitting service by fax, is effective if based on past experience that documents sent by fax were received by the person being served.**

Jones v. Catholic Healthcare West (2007) 147 Cal.App.4th 300, 309.

- (c) **Service of notice on a hospital is insufficient notice to a doctor if the plaintiff knows the doctor's identity.**

In *Godwin v. City of Bellflower* (1992) 5 Cal.App.4th 1625, notice of intent to sue was served on the hospital where the plaintiff was treated. The notice did not name the defendant doctors, who did not learn of the plaintiff's intent to sue them until they were served with the complaint. (*Id.* at p. 1628.) The Court of Appeal held the notice was insufficient: "[W]here . . . a plaintiff has actual knowledge of the identities of the treating physicians whom he intends to sue, section 364, subdivision (a) notice on the hospital, without naming the physicians, is insufficient notice to them" (*Id.* at p. 1632.)

In *Hanooka v. Pivko* (1994) 22 Cal.App.4th 1553, notice of intent to sue the defendant doctors was served on the hospital where the plaintiff was treated. The doctors did not learn of the plaintiff's intent to sue them until they were served with the complaint. (*Id.* at p. 1557.) The Court of Appeal held the notice was insufficient: "[A] plaintiff cannot rely on a hospital to forward section 364, subdivision (a) notices to individual physicians where . . . the plaintiff has knowledge of the identity and location of the physicians." (*Id.* at p. 1560, fn. omitted.)

See also *Silver, supra*, 69 Cal.App.4th at pages 283-285, discussing *Godwin* and *Hanooka*.

(d) Service of notice on a billing service with no direct connection to a doctor is insufficient notice to the doctor.

In *Derderian, supra*, 56 Cal.App.4th 892, notice of intent to sue was sent to the address on a bill that had no direct connection to the defendant doctor. The doctor did not learn of the plaintiff's intent to sue him until he was served with the complaint. (*Id.* at pp. 895-896, 899.) The Court of Appeal held the notice was insufficient. (*Id.* at p. 899.) The court pointed out that a doctor's address can easily be obtained from the Medical Board of California, and that other generally reliable sources exist. (*Id.* at p. 900.)

See also *Silver, supra*, 69 Cal.App.4th at pages 283-286, discussing *Derderian* and two related cases, *Godwin, supra*, 5 Cal.App.4th 1625, and *Hanooka, supra*, 22 Cal.App.4th 1553, discussed immediately above.

(e) Service of notice to doctor's registered address with the Medical Board is proper notice.

In *Selvidge v. Tang* (2018) 20 Cal.App.5th 1279, plaintiffs mailed a notice of intent to file a malpractice action against defendant doctor to his address of record with the Medical Board (an address belonging to a business that received mail on his behalf) before the one-year statute of limitations expired, and then filed suit 85 days after the limitations period expired. (*Id.* at p. 1282.) The trial court granted defendant's motion for summary judgment, ruling that the MICRA tolling statute (Code Civ. Proc., § 364) did not apply because, absent proof of actual notice, plaintiffs were required to serve the notice at the doctor's residence pursuant to Code of Civil Procedure section 1013, subdivision (a). (*Id.* at pp. 1282-1283.) The Court of Appeal reversed, holding that service at the address defendant provided to the Board was sufficient. (*Id.* at p. 1286.) The court explained that the test for proper notice of malpractice actions was whether plaintiffs took adequate steps to achieve actual notice. (*Ibid.*) Since it was reasonable to assume a physician would receive actual notice of documents mailed to an address the physician identified as one where he or she could reliably be contacted for professional purposes,

plaintiffs' service triggered the 90-day tolling period and their suit was therefore timely. (*Id.* at pp. 1284-1286.)

9. Notice of intent to sue need not be given to Doe defendants before amending the complaint to name them.

Section 364, subd. (e); *Camarillo v. Vaage* (2003) 105 Cal.App.4th 552, 561-571; *Davis v. Marin* (2000) 80 Cal.App.4th 380, 386; *Hazel v. Hewlett* (1988) 201 Cal.App.3d 1458, 1463-1464; *Grimm v. Thayer* (1987) 188 Cal.App.3d 866, 870-871, disapproved on another ground in *Woods, supra*, 53 Cal.3d at p. 328, fn. 4.

If the plaintiff improperly names a known health care provider as a Doe defendant, but gives notice of intent to sue that health care provider before the statute of limitations expires, the 90-day tolling provision of section 364 still applies. (*Davis, supra*, 80 Cal.App.4th at pp. 386-387; cf. *Nikkel v. Seasons Hospice and Palliative Care of California, LLC* (Feb. 13, 2020, G055180/G055225) 2020 WL 728311, at p. * 7 [nonpub. opn.] [affirming trial court's ruling that statute of limitations expired where plaintiff "did not amend her complaint to allege she had provided defendants the [section 364] notice of intent to sue, which constituted a new fact that had been absent from her" second amended complaint].)

10. The statute of limitations is tolled for 90 days when the notice of intent to sue is served within the last 90 days of the limitations period.

Section 364, subdivision (d), states: "If the notice is served within 90 days of the expiration of the applicable statute of limitations, the time for the commencement of the action shall be extended 90 days from the service of the notice." The appellate courts have construed this to mean the limitations period is *tolled* for 90 days:

- (a) ***Preferred Risk Mutual Ins. Co. v. Reiswig***
(1999) 21 Cal.4th 208.

"[S]ection 364, subdivision (d), which tolls for 90 days the limitations period for an action based upon a health care provider's professional negligence, applies to equitable indemnity actions based upon professional negligence and

governed by separate statutes of limitation, including [Code of Civil Procedure] section 340, subdivision (3).” (*Id.* at p. 218.)

- (b) ***Russell v. Stanford University Hospital***
(1997) 15 Cal.4th 783.

The three-year outside limitations period for an adult’s professional negligence action (see *ante*, Section F(8)) is tolled for 90 days when the notice of intent to sue is served during the last 90 days of the three-year period. Note: *Russell* disapproved a Court of Appeal decision. (*Id.* at p. 791, fn. 2.)

- (c) ***Woods v. Young***
(1991) 53 Cal.3d 315.

The one-year “discovery” limitations period for an adult’s professional negligence action (see *ante*, Section F(7)) is tolled for 90 days when the notice of intent to sue is served during the last 90 days of the one-year period. “Tolling may be analogized to a clock that is stopped and then restarted. Whatever period of time that remained when the clock is stopped is available when the clock is restarted, that is, when the tolling period has ended.” (*Id.* at p. 326, fn. 3.) In contrast, a plaintiff who serves the 90-day notice before the last 90 days of the one-year limitations period must file the complaint within the one-year period—there is no tolling. (*Id.* at pp. 325-327; see *Bennett, supra*, 75 Cal.App.4th at p. 390 [two notices were served, one before and one during the last 90 days; the second notice was a nullity].) Note: *Woods* disapproved six Court of Appeal decisions. (*Woods*, at p. 328, fn. 4.)

- (d) ***Newman v. Burnett***
(1997) 54 Cal.App.4th 722.

The three-year limitations period for a minor’s professional negligence action (see *ante*, Section F(10)) is tolled for 90 days when the notice of intent to sue is served during the last 90 days of the three-year period.

11. Impact on tolling of inadequate notice of intent to sue.

In *Jones v. Caillouette* (Oct. 31, 2011, G044382) 2011 WL 5146024 [nonpub. opn.], the notices of intent to sue did not comply or even substantially comply with the requirements of section 364, subdivision (b). The Court of Appeal held there was no tolling: “Plaintiffs’ inadequate notices are no different from failure to give notice, which would not toll the statute of limitations.” (*Id.* at p. *4.) “Under section 365, a trial court has jurisdiction over a medical malpractice action even if the plaintiff failed to provide notice under section 364. [Citation.] The relevant issue here is not jurisdiction, but whether an inadequate section 364 notice tolls the statute of limitations.” (*Id.* at p. *3.)

H. CODE OF CIVIL PROCEDURE SECTION 667.7: ALLOWING PERIODIC PAYMENT OF FUTURE DAMAGES.

1. Text of section 667.7.

(a) In any action for injury or damages against a provider of health care services, a superior court shall, at the request of either party, enter a judgment ordering that money damages or its equivalent for future damages of the judgment creditor be paid in whole or in part by periodic payments rather than by a lump-sum payment if the award equals or exceeds two hundred fifty thousand dollars (\$250,000) in future damages. In entering a judgment ordering the payment of future damages by periodic payments, the court shall make a specific finding as to the dollar amount of periodic payments which will compensate the judgment creditor for such future damages. As a condition to authorizing periodic payments of future damages, the court shall require the judgment debtor who is not adequately insured to post security adequate to assure full payment of such damages awarded by the judgment. Upon termination of periodic payments of future damages, the court shall order the return of this security, or so much as remains, to the judgment debtor.

(b)(1) The judgment ordering the payment of future damages by periodic payments shall specify the recipient or recipients of the payments, the dollar amount of the payments, the interval between payments, and the number of payments or the period of time over which payments shall be made. Such payments shall only be subject to modification in the event of the death of the judgment creditor.

(2) In the event that the court finds that the judgment debtor has exhibited a continuing pattern of failing to make the payments, as specified in paragraph (1), the court shall find the judgment debtor in contempt of court and, in addition to the required periodic payments, shall order the judgment debtor to pay the judgment creditor all damages caused by the failure to make such periodic payments, including court costs and attorney's fees.

(c) However, money damages awarded for loss of future earning shall not be reduced or payments terminated by reason of the death of the judgment creditor, but shall be paid to persons to whom the judgment creditor owed a duty of support, as provided by law, immediately prior to their death. In such cases the court which

rendered the original judgment, may, upon petition of any party in interest, modify the judgment to award and apportion the unpaid future damages in accordance with this subdivision.

(d) Following the occurrence or expiration of all obligations specified in the periodic payment judgment, any obligation of the judgment debtor to make further payments shall cease and any security given, pursuant to subdivision (a) shall revert to the judgment debtor.

(e) As used in this section:

(1) “Future damages” includes damages for future medical treatment, care or custody, loss of future earnings, loss of bodily function, or future pain and suffering of the judgment creditor.

(2) “Periodic payments” means the payment of money or delivery of other property to the judgment creditor at regular intervals.

(3) “Health care provider” means any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or licensed pursuant to the Osteopathic Initiative Act, or the Chiropractic Initiative Act, or licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code; and any clinic, health dispensary, or health facility, licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code. “Health care provider” includes the legal representatives of a health care provider.

(4) “Professional negligence” means a negligent act or omission to act by a health care provider in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death, provided that such services are within the scope of services for which the provider is licensed and which are not within any restriction imposed by the licensing agency or licensed hospital.

(f) It is the intent of the Legislature in enacting this section to authorize the entry of judgments in malpractice actions against health care providers which provide for the payment of future damages through periodic payments rather than lump-sum payments. By authorizing periodic payment judgments, it is the further intent of the Legislature that the courts will utilize such judgments to provide compensation sufficient to meet the needs of an

injured plaintiff and those persons who are dependent on the plaintiff for whatever period is necessary while eliminating the potential windfall from a lump-sum recovery which was intended to provide for the care of an injured plaintiff over an extended period who then dies shortly after the judgment is paid, leaving the balance of the judgment award to persons and purposes for which it was not intended. It is also the intent of the Legislature that all elements of the periodic payment program be specified with certainty in the judgment ordering such payments and that the judgment not be subject to modification at some future time which might alter the specifications of the original judgment.

2. Summary of section 667.7.

(a) Periodic payments are mandatory if requested.

When a medical malpractice action results in an award of future damages with a present value of \$250,000 or more, the trial court *must*, at the request of either party, enter a judgment providing that money for future damages be paid periodically rather than in one lump sum. (*Salgado v. County of Los Angeles* (1998) 19 Cal.4th 629, 639.) The judgment must specify the “recipient or recipients of the payments, the dollar amount of the payments, the interval between payments, and the number of payments or the period of time over which payments shall be made.” (§ 667.7, subd. (b)(1); *Hrimnak v. Watkins* (1995) 38 Cal.App.4th 964, 973-974.)

(b) The jury determines the gross amount of future damages. The trial court structures the periodic-payment schedule to match future losses with compensation as the losses occur.

Section 667.7 says almost nothing about how to convert a jury’s verdict into a periodic-payment judgment. The Supreme Court has explained the basic approach the trial courts must take: “‘When a party properly invokes section 667.7, “ . . . the [trial] court must fashion the periodic payments based on the *gross* amount of future damages.” [Citations.] This is because if a present value award is periodized, a plaintiff might not be fully compensated for his or her future losses; the judgment, in effect, would be discounted twice: first by reducing the gross amount to present value and second by deferring payment.’

(original emphasis.) The proper approach . . . is for the jury to determine the gross amount of future damages and for the court to structure a periodic payment schedule based on that amount.’ [Citation.] ‘In structuring a periodic payment schedule under section 667.7, a trial court is “guided by the evidence of future damages” introduced at trial. [Citations.] The fundamental goal in this respect is to attempt to match losses with compensation “to ensure that money paid to an injured plaintiff will in fact be available when the plaintiff incurs the anticipated expenses or losses in the future.” ’ ” (*Salgado, supra*, 19 Cal.4th at p. 639; see *id.* at p. 640 [“the fundamental goal is to match losses with compensation as the losses occur”].)

(c) Periodic payments usually end upon death.

Periodic payments are subject to modification only if the plaintiff dies. Upon death, payments designed to provide for the plaintiff’s own needs terminate. (§ 667.7, subds. (b)(1), (c) & (f); *Salgado, supra*, 19 Cal.4th at p. 638; *Western Steamship Lines, Inc. v. San Pedro Peninsula Hospital* (1994) 8 Cal.4th 100, 111-112; *American Bank & Trust Co. v. Community Hospital* (1984) 36 Cal.3d 359, 368, fn. 8, 373.) On the other hand, payments for loss of future earning capacity continue after the plaintiff’s death if the plaintiff owed a duty of support, as provided by law, immediately prior to dying and a party in interest petitions the court to modify the judgment. (§ 667.7, subd. (c); *American Bank & Trust Co., supra*, 36 Cal.3d at p. 368; *Hrimnak, supra*, 38 Cal.App.4th at pp. 979-980.)

(d) The defendant usually purchases an annuity to fund the periodic payments.

“[T]he manner in which the defendant complies with a judgment ordering periodic payments . . . is the defendant’s decision. For example, the defendant can fund the judgment itself simply by writing a check to the plaintiff each payment period, or it can purchase an annuity to fund the stream of payments ordered by the court.” (*Holt v. Regents of University of California* (1999) 73 Cal.App.4th 871, 879.) Usually, the defendant will purchase an annuity from a life insurance company.

(e) Purchasing an annuity does not entitle the defendant to an acknowledgment of satisfaction of judgment.

Paying the upfront cash in the judgment and purchasing an annuity to fund the periodic payments does not entitle the defendant to an acknowledgment of satisfaction of judgment. (*Holt, supra*, 73 Cal.App.4th at pp. 880-881.) The defendant can obtain an acknowledgment of satisfaction of judgment only by foregoing periodic payments and paying the present value of the future damages in one lump sum. (*Ibid.*)

3. Section 667.7 and annuities: how periodic payments save money.

The courts have recognized that the defendant may choose to purchase an annuity from a life insurance company to fund the periodic payments required by the judgment. (See *Salgado, supra*, 19 Cal.4th at p. 643, fn. 3; *Holt, supra*, 73 Cal.App.4th at pp. 879, 880-881.)

The cost of an annuity is impacted by prevailing interest rates on the date the annuity is purchased and projections of what interest rates will be in the future; the higher the interest rate, the lower the cost (see *Nguyen v. Los Angeles County Harbor/UCLA Medical Center* (1995) 40 Cal.App.4th 1433, 1453, fn. 13). Thus, periodic payments funded by an annuity save money in comparison to the jury's present value verdict if the interest rate used by the life insurance company to price the annuity is significantly higher than the interest rate used by the jury to calculate present value.

The cost of an annuity is also impacted by the nature of the plaintiff's injury and whether it reduces the plaintiff's life expectancy. As the Supreme Court has explained: "Even though the jury, based on the evidence presented at trial, concludes that the plaintiff has a fairly long life expectancy, life insurance companies, after reviewing the plaintiff's medical records and applying actuarial principles, frequently are willing to assume a shorter life expectancy and price an annuity accordingly." (*Salgado, supra*, 19 Cal.4th at p. 643, fn. 3.) A plaintiff whose life expectancy is less than normal in the eyes of a life insurance company receives a "substandard age rating." A substandard age rating is usually expressed in terms of a "rated age," e.g., a 20-year-old male quadriplegic may be given a rated age of, say,

55, which means the annuity will be priced the same as though he were a 55-year-old male without any medical complications.

In short, the periodic-payment statute saves money by *allowing the defendant to substitute a life insurance company's assessment of the plaintiff's life expectancy, and of future interest rates, for the jury's assessment of these factors*. If the life insurance company's assessment of the plaintiff's life expectancy is significantly shorter than the jury's, or if the life insurance company's assessment of future interest rates is significantly higher than the jury's, periodic payments funded by annuity will save money in comparison to the jury's present value verdict.

Of the two factors impacting the cost of an annuity—life expectancy and interest rates—the greatest savings, by far, occur in cases where the life insurance company's assessment of the plaintiff's life expectancy is significantly shorter than the jury's. Seldom will a difference in interest rates, alone, be significant enough to make a periodic-payment motion worthwhile.

4. **Section 667.7 is constitutional.**

The constitutionality of section 667.7 was upheld in *American Bank & Trust Co.*, *supra*, 36 Cal.3d 359. The Supreme Court held section 667.7 does not violate the constitutional guarantees of due process and equal protection of the law. The Court further held that, to protect the right to jury trial guaranteed by the California Constitution, article I, section 16, the jury must separately specify the amount of future damages in the verdict.

In *Salgado*, *supra*, 19 Cal.4th at page 649, the Supreme Court held “it is not a violation of the plaintiff's jury trial right for the court to submit only the issue of the gross amount of future economic damages to the jury, with the timing of periodic payments—and hence their present value—to be set by the court in the exercise of its sound discretion.” (See *Piedra v. Dugan* (2004) 123 Cal.App.4th 1483, 1493.)

5. Other contexts in which section 667.7 may apply.

(a) Wrongful death action.

Section 667.7 applies in a wrongful death action as well as a personal injury action. (§ 667.7, subd. (e)(4); see *Yates v. Pollock* (1987) 194 Cal.App.3d 195, 198-199.) Usually, however, there are no significant savings to be achieved by applying the statute in a wrongful death action. The periodic payments would be based on the heirs' period of need. (See *Francis v. Sauve* (1963) 222 Cal.App.2d 102, 120-121.) The heirs usually will not have the shortened life expectancies necessary to make periodic payments worthwhile. (See *ante*, Section H(3).)

(b) Action against public entity or employee.

A public entity may elect to proceed under section 667.7 rather than under the periodic-payment statute generally applicable to suits against public entities. (Gov. Code, § 984, subd. (c).) This is fortunate for public entities. Government Code section 984 requires interest on unpaid periodic payments, and the periodic payments do not terminate upon death. As a result, the statute is worthless.

(c) EMTALA action.

Section 667.7 should apply to an EMTALA action for failure to stabilize, but probably does not apply to an EMTALA action for failure to provide an appropriate medical screening examination. (See *ante*, Section B(3)(c)(3).)

(d) Elder abuse action.

It is unlikely that any of the MICRA statutes apply in an elder abuse action. (See *ante*, Section B(3)(c)(4).)

(e) Equitable indemnity action.

Other MICRA statutes apply in equitable indemnity actions. (See *ante*, Section B(3)(c)(2).) There is no apparent reason why section 667.7 should not apply as well.

(f) Action under Federal Tort Claims Act.

Section 667.7 should apply. (See *Taylor v. United States* (9th Cir. 1987) 821 F.2d 1428, 1430.)

6. Statutory definitions.

(a) Definition of “health care provider.”

See *ante*, Section B(2).

(b) Definition of “based upon professional negligence.”

See *ante*, Section B(3).

7. Impact of section 667.7 on settlement.

The reality of a periodic-payment judgment if the case goes to trial means the parties should give serious consideration to a structured settlement.

8. Impact of section 667.7 on the trial.

(a) Steps must be taken to preserve the right to a periodic-payment judgment.

(1) Invoke the right to a periodic-payment judgment in the answer to the complaint and in a trial brief.

Periodic *payments* must be based on the *gross* value, not the present value, of future damages. (*Salgado, supra*, 19 Cal.4th at pp. 639, 649; *Holt, supra*, 73 Cal.App.4th at p. 879.) It is the plaintiff's burden to present evidence of gross value. (*Hrimnak, supra*, 38 Cal.App.4th at p. 973.) Accordingly, the plaintiff is entitled to adequate notice of the defendant's intention to invoke the periodic-payment statute. (*Id.* at p. 972; *Gorman v. Leftwich* (1990) 218 Cal.App.3d 141, 152.) To assure adequate notice, the defendant should: (1) plead section 667.7 in the answer to the complaint, and (2) file a trial brief on periodic payments stating that, if the jury renders a significant verdict for future damages, the defendant

will invoke the right to periodic payments. (See *Hrimnak*, at p. 972; *Gorman*, at p. 152.)

(2) Request BAJI No. 16.01, the special verdict form for medical malpractice cases.

BAJI No. 16.01 separates damages into past and future; separates future damages into future lost earnings, future medical expenses, and future noneconomic losses; and asks the jury to specify the gross value, as well as, the present value of future lost earnings and future medical expenses. All of this is important.

The jury must be instructed to designate the portion of its verdict that is intended to compensate the plaintiff for future damages. (*Salgado, supra*, 19 Cal.4th at p. 639; *Fein v. Permanente Medical Group* (1985) 38 Cal.3d 137, 156; *American Bank & Trust Co., supra*, 36 Cal.3d at pp. 376-377; *Craven v. Crout* (1985) 163 Cal.App.3d 779, 784.) Absent designation by the jury of the amount of future damages, the trial court has no power to implement section 667.7. (*American Bank & Trust Co.*, at pp. 376-377; *Craven*, at p. 784.)

Also, “it would generally be wise to have the jury designate the portion of the future damage award which is intended to compensate the plaintiff for loss of future earnings . . . because section 667.7, subdivision (c) provides that damages for future earnings . . . must continue to be paid to a plaintiff’s dependents after the plaintiff’s death.” (*American Bank & Trust Co., supra*, 36 Cal.3d at p. 377, fn. 14.)

Since periodic payments must be based on the gross value of future damages (see *Salgado, supra*, 19 Cal.4th at p. 639), it is necessary to obtain a gross value determination by the jury. (*Hrimnak, supra*, 38 Cal.App.4th at pp. 976-979; but see *Salgado*, at pp. 647-648 [jury determination of gross value of future noneconomic damages not required for periodic payments].) Absent a jury determination of the gross value of future lost earnings or future medical expenses, periodic payments may still be permissible if the

plaintiff's economist testified about both the present value and gross value and there is a mechanical path from the jury's present value verdict to only one possible gross value.

A determination of present value must be made as well. Present value is used for attorney fees, prejudgment interest, and settlement setoff. Note that it is not essential to obtain a present value determination by the *jury*; the judge can determine present value during the postverdict periodic-payment proceedings. (*Salgado, supra*, 19 Cal.4th at p. 649; see *Piedra, supra*, 123 Cal.App.4th at pp. 1493, 1494.) Before suggesting, or agreeing with a suggestion by the plaintiff, that the judge determine present value, however, defense counsel should consider what method the judge will use to calculate present value. Unless the judge is willing to disclose what that method will be, and the method raises no concerns with the defense economist, it probably will be too risky to leave present value in the judge's hands.

CACI No. VF-500, the other special verdict form for medical malpractice cases, is inadequate. It does not require the jury to specify the present value as well as the gross value of future lost earnings and future medical damages.

(3) In a “lost years” case, request that BAJI No. 16.01 be amended with questions that apportion future lost earnings between the earnings subject to lump-sum payment and the earnings subject to periodic payments.

(a) Lost years earnings are not subject to periodic payments.

The jury is permitted to award damages for earning capacity that has been lost because the plaintiff's life expectancy has been shortened by the defendant's negligence. (*Fein, supra*, 38 Cal.3d at pp. 153-154.) With the exception discussed below, lost years earnings are not subject to periodic payments; the present value of

these earnings must be paid in one lump sum. (*Id.* at pp. 156-157.)

The exception is the portion of the plaintiff's lost years earnings that would likely be spent for the support of the plaintiff's dependents; this portion is subject to periodic payments. (*Fein, supra*, 38 Cal.3d at pp. 156-157.) But, for the same reason that periodic payments for lost support in a wrongful death case are unlikely to save money (see *ante*, Section H(5)(a)), periodic payments for lost support in a lost years case are unlikely to save money.

(b) Earnings during the plaintiff's remaining lifetime are subject to periodic payments. Apportionment is required.

The lost years rule only applies to earnings *after* the plaintiff dies. If there also is a claim for lost earning capacity *during* the plaintiff's lifetime, that part of the award is fully subject to periodic payments. (*Hurlbut v. Sonora Community Hospital* (1989) 207 Cal.App.3d 388, 406.) Therefore, the special verdict must apportion the damages for future lost earnings between these two categories.

In *Hurlbut*, the Court of Appeal held the defendant *waived* the right to periodic payment of damages for future lost earnings by failing to propose special findings separating earnings during the lost years from earnings during the plaintiff's remaining lifetime. The plaintiff, a minor, had a life expectancy to age 27.5. The court explained: "Rose Marie Hurlbut is entitled to lost earnings resulting from disability during her lifetime (i.e., from the age of 18 through 27.5 years) as well as lost years damages. The portion of the award stemming from disability rather than premature death would be subject to periodic payments under Code of Civil Procedure section 667.7. Although defendant here did secure

a special finding as to the amount of future lost earnings, no evidence was presented nor special findings sought on apportionment of the future lost earnings. The trial court, therefore, had no way to apportion the award between lost years and lifetime disability in order to structure an appropriate judgment for periodic payments.” (*Hurlbut, supra*, 207 Cal.App.3d at p. 406.)

(c) Request that BAJI No. 16.01 be amended so the jury can apportion.

In order to properly apportion future lost earnings between earnings during the plaintiff’s remaining lifetime and earnings during the plaintiff’s lost years, question 8 on BAJI No. 16.01 should be amended to read:

Question No. 8(a): What amount of damage, if any, do you find plaintiff will sustain during [his] [her] remaining life for the loss of future earnings that are caused by this negligence?

Answer: \$_____.

Question No. 8(b): What amount do you find to be the present cash value of the amount indicated in response to Question 8(a)?

Answer: \$_____.

Question No. 8(c): What is the present cash value of the amount of damage, if any, that you find plaintiff will sustain during the period after [his] [her] death for the loss of future earnings that are caused by this negligence?

Answer: \$_____.

(4) Immediately after the verdict, request a stay of entry of judgment.

In *Craven, supra*, 163 Cal.App.3d 779, the Court of Appeal ruled the trial court could not award periodic payments after a lump-sum judgment had been entered and the time for filing posttrial motions had expired. While *Craven* does not preclude asking for periodic payments via timely posttrial motions, the proper course to follow is: *immediately* after a verdict with future damages exceeding \$250,000 is rendered, ask the trial court to stay the clerk's entry of judgment on the verdict until a periodic-payment schedule has been formulated. (*Id.* at p. 784.) Absent a stay, the clerk is required to enter judgment on the verdict within 24 hours. (Code Civ. Proc., § 664.) Once a lump-sum judgment is entered, the right to periodic payments could be lost unless the circumstances fit into one of the recognized posttrial motions.

(b) Defense counsel should vigorously defend against both aspects of plaintiff's future economic damages claim: gross value and present value.

(1) A defense economist should be used on the issue of future inflation rates for gross value, and on the issue of future interest rates for present value.

(a) The need for a defense economist is much more apparent where periodic payments are concerned.

In the past, before periodic payments, when the jury determined only the present value, not the gross value, of future damages, the plaintiff's economist usually would use the relatively constant differential over time between inflation and interest rates to calculate present value. With the advent of periodic payments, however, it is necessary for the plaintiff's economist to use a particular inflation rate and a particular interest

rate; differentials over time will not work because the jury must find the gross value of future damages. While economists frequently agree on the differential over time between inflation and interest rates, they frequently do not agree when projecting specific future inflation and interest rates. The need for a defense economist to dispute the plaintiff's economist's testimony concerning future inflation and interest rates is much more apparent.

(b) The defense economist should scrutinize the plaintiff's economist's projection of future inflation.

If the plaintiff is seriously injured and will incur substantial medical expenses or lost earnings over a long period of time, inflation becomes a key—in many cases, *the* key—damages issue. For example, if the future medical expenses are \$100,000 per year for 50 years, the difference in gross value between, say, a 3 percent and a 5 percent inflation rate, is *millions* of dollars.

(c) The defense economist should scrutinize the plaintiff's economist's projection of future interest rates.

Although the gross value of future damages is “*the pivotal figure*” (*Holt, supra*, 73 Cal.App.4th at p. 880, original emphasis) in a periodic-payment case, present value is important as well. “The present value of the judgment is . . . ordinarily used to determine attorney fees. Additional uses of the present value figure include determining whether a prejudgment interest penalty is owed under Code of Civil Procedure section 998 and Civil Code section 3291, and in setting off a codefendant's settlement.” (*Salgado, supra*, 19 Cal.4th at p. 647, fn. 6.) The lower the present value, the lower the attorney fee and the less likely that substantial sums otherwise subject to periodic payments will have to be paid

as upfront cash to cover the fee. Also, the lower the present value, the lower any prejudgment interest penalty will be, and the greater the impact of any settlement setoff.

Arguably, if the defendant intends to fund the periodic payments by an annuity, the present value of the periodic payments should be measured by the cost of the annuity. (See *Nguyen, supra*, 40 Cal.App.4th at pp. 1451-1454.) That cost almost always will be lower than a jury's traditional present value verdict. (See *id.* at p. 1452.) But the courts have held the present value of periodic payments can be measured by a jury's present value verdict. (*Holt, supra*, 73 Cal.App.4th at p. 884; *Hrimnak, supra*, 38 Cal.App.4th at pp. 979-980.) This means it is important to use a defense economist to counter a projection of low future interest rates by the plaintiff's economist. The lower the interest rate, the higher the present value.

(2) A defense annuitist should be used on the issue of present value whenever a life insurance company's assessment of the plaintiff's life expectancy is likely to be significantly shorter than the jury's.

(a) Annuity testimony is like getting two bites at the apple on periodic payments.

This is true whether or not the plaintiff's economist's projection of future interest rates is unreasonable and needs to be challenged by the defense economist. If an annuitist testifies about the cost of funding the plaintiff's claimed future damages by annuity, and if the jury adopts the annuitist's number as its present value verdict, a periodic-payment motion will be unnecessary—the reduction in cost attributable to annuity funding of periodic payments already will have been achieved. If the jury does not adopt the annuitist's number, the same reduction in cost

should be achievable posttrial—by fashioning a periodic-payment judgment and funding it by annuity.

If the jury adopts the annuitist's number as its present value verdict, not only will a periodic-payment motion be unnecessary, but the resulting, lower present value will mean the attorney fee will be lower, any prejudgment interest penalty will be lower, and the impact of any settlement setoff will be greater. (See *ante*, Sections C(2), C(11)(b), & E(14).)

(b) Annuity testimony should be admitted.

The cost of purchasing an annuity from a life insurance company that will pay the periodic payments is the best measure of the present value of those payments. “The market price of the annuity, it is argued, is a more reliable ‘witness’ to value than the expert economists and doctors called by the parties because insurance companies, unlike the parties’ expert witnesses, survive by determining life expectancies and investing customers’ premiums. [Citation.] As one of the experts in this case acknowledged, by issuing an annuity policy the insurance company has ‘put its money where its mouth is.’ ” (Nguyen, *supra*, 40 Cal.App.4th at p. 1452; see *Hrimnak*, *supra*, 38 Cal.App.4th at p. 979 [“the cost of an annuity provides one measure of the present value of periodic payments”; “The cost of annuity approach is simple [citation]; it is also considered the most accurate”].)

Leading cases in other jurisdictions allowing evidence of the cost of an annuity to prove present value are *Cornejo v. State* (Wash.Ct.App. 1990) 788 P.2d 554, 559-563; *Southlake Limousine & Coach, Inc. v. Brock* (Ind.Ct.App. 1991) 578 N.E.2d 677, 682-685; and *Gallegos v. Dick Simon Trucking, Inc.* (Utah Ct.App. 2004) 110 P.3d 710, 714-715. In *Southlake*, the court said: “Annuities

are another way of calculating present value of damages.” (*Southlake*, at p. 682.) “A party should be permitted to question an expert regarding alternative means of formulating the present value of damages. One alternative method is an annuity. . . . Questioning regarding annuities and the cost of annuities is relevant to determining present value of damages.” (*Id.* at p. 684.) In *Cornejo*, the court said: “The cost of an annuity, which carries interest at a known rate, and which . . . may provide for yearly increases to account for expected inflation, is relevant evidence of the present value of future losses. The cost of an annuity thus is not a different, lesser amount [than present value], but is evidence to be considered by the jury in determining present value.” (*Cornejo*, at p. 562[.]) In *Gallegos*, the court said: “The admission of annuity evidence affords the jury the opportunity to understand the cost today of income for the future—that is, its present value.” (*Gallegos*, at p. 715.)

In *Scott v. United States* (9th Cir. 1989) 884 F.2d 1280, the Ninth Circuit held that the district court committed a reversible abuse of discretion when it excluded “testimony regarding the cost of purchasing a single premium annuity as a measure of the present value of [the plaintiff’s] economic losses.” (*Id.* at pp. 1287-1288.) “[T]he evidence is relevant to the present value determination.” (*Id.* at p. 1288.) See also *Bennett v. Hospital Corp. of America* (9th Cir., Aug. 14, 1990, No. 89-35059) 1990 WL 119096, at pages *1-*3 [nonpub. opn.].

For cases *disallowing* evidence of the cost of an annuity to prove present value, see *Garhart v. Columbia/Healthone, L.L.C.* (Colo. 2004) 95 P.3d 571, 589-590 and footnote 15, and cases cited.

(3) Steps should be taken to minimize jury confusion over the difference between gross value and present value.

(a) Confusion is likely.

If the jury decides to award a different amount for the gross value of future economic damages than either the plaintiff or the defendant espoused, there is a real danger of the jury being unable to calculate an appropriate present value to accompany its gross value determination. It is important for defense counsel to see to it that the jury has the information it needs to properly calculate present value.

(b) The CACI No. 3904B Present-Value Table B and Worksheet B may be helpful.

The BAJI present-value table (BAJI, appen. B) and the CACI No. 3904B Worksheet A and Table A can be used in cases where the future damages are a constant annual amount. In a periodic-payment case, however, most plaintiffs present evidence of inflation in order to increase the gross value of future damages, and may present evidence of discrete future expenses (e.g., future surgeries or other periodic treatments). This means the jury must calculate the present value of an amount that is not constant but increases annually and includes extraordinary expenses in some years. In these circumstances, the BAJI and CACI No. 3904B Table A are useless. Instead, counsel should consider using CACI No. 3904B Worksheet B and Table B, which may help the jury find the present value of future economic damages in these circumstances.

(c) Use proportions.

One possible solution to the gross value/present value problem is to ask the plaintiff's economist to explain, or to have the defense economist explain, that simple proportions work. For example, if the plaintiff's economist testifies to \$1 million in gross value with a present value of \$200,000, then, if the jury awards \$750,000 in gross value and agrees with the plaintiff's economist's approach to determining present value, the present value would be \$150,000. In other words, reduce present value to an amount that maintains the same proportion to gross value—in this example, a ratio of one-to-five.

(d) Another approach: have the jury render findings on the essential components of gross and present value, but have the court perform the calculations.

The parties could stipulate to altering BAJI No. 16.01 so the jury is instructed to answer the following questions for future care costs and future lost earning capacity: (1) What are the damages for the first year after trial? (2) What rate of inflation must be used to calculate the total damages? (3) For how many years must the damages be paid? (4) What interest rate must be used to calculate present value? Using these findings by the jury, the parties and the court can calculate gross and present value and avoid any possibility of mistake by the jury. (Note: This approach will not work if the future damages vary significantly from year to year for a reason other than inflation.)

- (c) If the plaintiff's life expectancy is disputed, defense counsel should request a special finding on this issue.**

Otherwise, the plaintiff's counsel will argue a long life expectancy to the jury to maximize the verdict for future care costs, then turn around and argue a short life expectancy to the trial judge to "frontload" the periodic payments. In other words, if the jury's verdict for future care costs is less than the plaintiff sought, and there is no special finding by the jury on life expectancy, the plaintiff will argue during the periodic-payment proceedings that the jury used the defendant's shorter life expectancy figure, but awarded the full annual amount of future care costs requested by the plaintiff. If the trial court goes along with the plaintiff's argument, the periodic payments will be larger and spread over a shorter period of time than would be the case if the jury used the plaintiff's longer life expectancy figure, but awarded less than the full annual amount of future care costs requested by the plaintiff. Avoid this potentially costly problem. *Unless the parties agree that the plaintiff's life expectancy is normal or near-normal, request a special finding on life expectancy.*

- (d) The existence of the periodic-payment statute should not be disclosed to the jury.**

The points previously made with regard to not disclosing the statutory limit on noneconomic damages to the jury apply equally here. (See *ante*, Section E(17)(b).) An instruction that future damages will be paid periodically and, except for loss of future earnings, will cease upon the plaintiff's death, is an abstractly correct statement of law, but it has no bearing on the jury's legitimate factfinding function. Like Civil Code section 3333.2, section 667.7 directly affects the final *judgment* in the case, but has no relevance to the jury's *verdict*. After the jury renders its verdict, it is the court's responsibility to periodize the judgment if so requested.

If life expectancy is a contested issue, the prejudice to the defendant if the jury finds out about the termination of payments upon the plaintiff's death is especially apparent. To advise the jury of termination of payments upon death is to deprive the defendant of a jury finding resolving the conflicting

evidence on life expectancy—the jury will simply award damages based on the longest possible life expectancy, reasoning that, if the plaintiff dies sooner, the periodic payments will stop anyway. But the defendant still has the right to forego periodic payments and “pay the judgment in a lump sum and obtain a satisfaction of judgment.” (*Holt, supra*, 73 Cal.App.4th at p. 878.) This right is meaningless if the verdict is larger than it otherwise would be because the jury was told about the periodic-payment procedure.

(e) If a lump-sum judgment is entered, request periodic payments in posttrial motions.

(1) Motion to vacate judgment.

If a lump-sum judgment is entered by the clerk before the trial court formulates a periodic-payment schedule, a motion should be made to vacate the judgment under Code of Civil Procedure section 663. Section 663 provides that a judgment may be vacated and another and different judgment entered where the “judgment . . . [is] not consistent with or not supported by the special verdict.” (§ 663, subd. (2).) If the special verdict awards more than \$250,000 in future damages, section 667.7 makes a periodic-payment judgment mandatory if requested. (*Salgado, supra*, 19 Cal.4th at p. 639.) Thus, a lump-sum judgment is not consistent with or supported by the special verdict.

(2) Motion to correct clerical error.

Where the court did not intend, by allowing its clerk to enter a lump-sum judgment, to deprive the defendant of the right to a periodic-payment judgment, the entry of a lump-sum judgment is quintessentially a clerical error. “A clerical error in a judgment is an inadvertent one made by the court which cannot reasonably be attributed to the exercise of judicial consideration or discretion.” (*Bowden v. Green* (1982) 128 Cal.App.3d 65, 71.) When the clerk entered the lump-sum judgment, the court had not exercised “judicial consideration or discretion” concerning the entry of a lump-sum as opposed to a periodic-payment judgment, i.e., the court

had not held the plaintiff was entitled to a lump-sum judgment. Accordingly, the court has inherent power, confirmed by statute (Code Civ. Proc., § 473, subd. (d)), to correct the clerical mistake made when the lump-sum judgment was entered prior to consideration of the issue of periodic payments.

In *Pettigrew v. Grand Rent-A-Car* (1984) 154 Cal.App.3d 204, 210-212, the original judgment entered against the owner of a vehicle was for \$150,000. But Vehicle Code section 17151, which was overlooked by the court and the parties, limited the liability of an owner to \$15,000. The owner moved to reduce the judgment from \$150,000 to \$15,000. The trial court so modified the judgment and the Court of Appeal affirmed: “It cannot be presumed that the court intended deliberately to render and enter a judgment which was contrary to law. Thus, there was an error in the judgment which was made inadvertently; it was a clerical error and could be corrected by the court under its statutory and inherent power so to do.” (*Id.* at p. 211.) If the inherent power to correct a judgment encompasses conforming the judgment to a statutory limit on liability, then it also encompasses conforming the judgment to a statutory requirement of periodic payments.

In *Orellana v. Mejia* (1988) 249 Cal.Rptr. 828, 830-833, there is an extensive discussion of clerical error as a basis for amending a lump-sum judgment to conform to the requirements of section 667.7. *Orellana* was *depublished* by the Supreme Court. Nevertheless, the Court of Appeal’s reasoning on this issue is persuasive and should be used (without citing the *Orellana* opinion).

(3) Section 473 motion.

If a lump-sum judgment was entered due to defense counsel’s failure to request a stay of entry of judgment, a motion for relief under Code of Civil Procedure section 473 probably will *not* succeed. Under section 473, an excusable mistake is one that “‘anyone [i.e., a non-lawyer] could have made.’” (*Zamora v. Clayborn*

Contracting Group, Inc. (2002) 28 Cal.4th 249, 258.) “The Legislature did not intend to eliminate attorney malpractice claims by providing an opportunity to correct all the professional mistakes an attorney might make in the course of litigating a case.” (*Garcia v. Hejmadi* (1997) 58 Cal.App.4th 674, 682.) “Counsel’s failure to discharge routine professional duties is not excusable” under section 473. (*Generale Bank Nederland v. Eyes of the Beholder Ltd.* (1998) 61 Cal.App.4th 1384, 1402.)

(4) Motion under section 667.7 itself.

Arguably, section 667.7 implicitly authorizes the trial court to enter a different judgment ordering periodic payments, so long as the request for periodic payments is made before the trial court loses jurisdiction over the case. The statement in *Craven, supra*, 163 Cal.App.3d at page 783, that “nothing in the language of section 667.7 authorizes a court to set aside one judgment awarding lump-sum damages and enter a different judgment ordering periodic payments,” should be read in light of the facts of *Craven*, where the defendant did not request periodic payments until “the action was no longer pending within the meaning of [Code of Civil Procedure] section 1049” (*id.* at p. 782, fn. omitted). When the action is still pending, section 667.7 should be read to implicitly confer such jurisdiction as is necessary to implement the statute.

9. Converting the verdict to a periodic-payment judgment.

(a) Determine whether the defendant has adequate medical malpractice insurance to be entitled to a periodic-payment judgment.

Section 667.7, subdivision (a), provides: “As a condition to authorizing periodic payments of future damages, the court shall require the judgment debtor *who is not adequately insured* to post security adequate to assure full payment of such damages awarded by the judgment.” (Emphasis added.) This provision effectively means that a defendant who is not

adequately insured may not be entitled to a periodic-payment judgment.

If the defendant has medical malpractice insurance, and if the policy limit exceeds the entire present value verdict (after capping noneconomic damages at the applicable statutory limit and applying any settlement setoff), the defendant should be considered adequately insured. But in *Leung v. Verdugo Hills Hospital* (Jan. 22, 2013, B204908) 2013 WL 221654 [nonpub. opn.], the Court of Appeal said: “In fashioning a periodic payment schedule, the gross amount of future damages is used, not [the] present value of the future damages. . . . Given that the periodic payment schedule sets the stream of future damages to be paid over time at gross value, the trial court was not unreasonable in considering the gross amount of that stream in determining whether the [defendant’s] insurance was ‘adequate,’ or whether the [defendant] should be required ‘to post security adequate to assure full payment of such damages awarded by the judgment.’ ” (*Id.* at p. *13.) The trial court required the defendant to post security in the form of an annuity purchased from an approved provider, payable to the defendant, sufficient to fund the periodic-payment portion of the judgment. The Court of Appeal approved that annuity as “adequate security under section 667.7, subdivision (a).” (*Ibid.*)

If the defendant has medical malpractice insurance, but the policy limit is *less* than the entire present value verdict (after capping noneconomic damages at the applicable statutory limit and applying any settlement setoff), the defendant still should be considered adequately insured if the policy limit is sufficient to pay the lump-sum portion of a periodic-payment judgment and fund the periodic-payment portion by purchasing an annuity. (The *Leung* case treats the purchase of an annuity as adequate security if the defendant is not adequately insured. The more straightforward approach would be to say that a defendant who can pay the lump-sum portion of the judgment and purchase an annuity to fund the periodic-payment portion is adequately insured in the first place.)

If the defendant’s medical malpractice insurance policy limit is insufficient to consider the defendant adequately insured, the defendant still should be entitled to periodic payments if the medical malpractice insurer represents to the court that it will

pay the cost of a periodic-payment judgment, whatever that cost may be. The malpractice insurer should be willing to make this representation if the policy limit has been opened during the handling of the claim. See *Hughes v. Pham* (Aug. 22, 2014, E052469) 2014 WL 4162364, at page *17 [nonpub. opn.]. The Court of Appeal directed the trial court to eliminate the requirement in the judgment that the defendant post adequate security, since the defendant had “submitted a declaration from his professional liability insurer which stated that the insurer accepted responsibility to pay the entire judgment, and that the insurer had assets exceeding \$1 billion.” (*Ibid.*)

(b) Submit a proposed periodic-payment judgment that is complete in every regard.

Periodic payments are complicated and trial judges are unlikely to be willing to fashion periodic-payment schedules on their own. It is defense counsel’s job to make the trial judge’s job as easy as possible. *The defendant should submit a complete proposed periodic-payment judgment with a supporting memorandum of points and authorities.* Anything less is toying with disaster—particularly if the plaintiff presents a complete proposed judgment and the defendant does not. Trial judges are busy people and may be inclined to take the path of least resistance. Do everything possible to ensure that path leads to proper implementation of the periodic-payment statute.

(c) Keep in mind the fundamental goal of periodic payments: to pay damages for future losses as those losses are incurred.

“The fundamental goal of the statute is ‘matching losses with compensation by helping to ensure that money paid to an injured plaintiff will in fact be available when the plaintiff incurs the anticipated expenses or losses in the future’ [citations], i.e., ‘affording a fair correlation between the sustaining of losses and the payment of damages’ [citations]. [¶] To satisfy this objective, the court will necessarily be guided by the evidence of the plaintiff’s future damages. [Citations.] A precise match between future losses and compensation is not required, but there must be evidence to uphold the court’s payment schedule.” (*Holt, supra*, 73 Cal.App.4th at p. 881.)

(d) Periodic payments for future economic losses should be spread over the full period of time the losses will be incurred. The payments should be progressive to account for inflation.

- (1) ***Deocampo v. Ahn***
(2002) 101 Cal.App.4th 758.

The trial court ordered that “the future medical damages found by the jury (\$9,312,335) were to be paid in *equal* monthly installments for a total period of 336 months (the period of plaintiff’s life expectancy) and the future lost earnings found by the jury (\$650,900) were to be paid in *equal* monthly installments over a total period of 240 months (the estimated remaining work life of a 45-year-old man).” (*Id.* at p. 769, original emphasis.)

The Court of Appeal set out the substance of the defendants’ argument on appeal against these periodic-payment schedules: “[The defendants] contend the trial court’s equal payment plan ‘deprived [them] of the time value of money [by] captur[ing] all of the inflationary impact and spread[ing] it equally over all years.’ In other words, they argue, this disproportionately assigned inflated dollars to the early years of plaintiff’s periodic award. They assert that ‘[t]his was contrary to what the jury assumed,’ although they do not explain how they know what the jury assumed. They argue that plaintiff will be overcompensated in the early years and under compensated in later years.” (*Deocampo, supra*, 101 Cal.App.4th at p. 783.)

The Court of Appeal rejected defendants’ argument: “[D]efendants have not *demonstrated* abuse of discretion. . . . [¶] ‘In structuring a periodic-payment schedule under section 667.7, a trial court is “guided by the evidence of future damages” introduced at trial. [Citations.]’ [Citation.] The trial court’s . . . minute order states that the court considered the evidence relating to plaintiff’s future medical needs and future loss of earnings when it made its periodic payment plan. The court noted ‘that the jury rejected a considerable portion

of Plaintiff's claimed future medical expenses,' [Footnote 20: 'Plaintiff had sought \$15 million in damages based largely on the testimony presented, concerning anticipated costs and inflation.'] and the court stated that when it considered the life care plan offered by plaintiff's expert and the testimony of all of the parties' medical experts, it found it appropriate to order equal payments for plaintiff's future medical expenses.

"At the hearing on the motions for section 667.7 payments, the trial court addressed defendants' concerns that the court was planning on ordering equal payments for plaintiff's future expenses. As it did in its minute order, the court observed that the jurors had rejected 'significant portions of the future medical expenses that were claimed by the plaintiff,' but the court said it '[didn't] know what portion that was. It could have been the escalations that were factored into it and the interest assumptions. It could have been the future medical expenses.' The court stated its belief that making equal payments 'was probably the safest way to ensure that if there are early surgeries at several hundred thousand dollars, [plaintiff] has enough money; and in the event there are expenses at the other end, he will still have enough money.'

"In addressing the issue of the equality of the payments for plaintiff's future lost wages, the court stated its belief that there was no conflict in the testimony of the parties' respective economists about those damages, and while perhaps the court could refigure the periodic payments to include an inflation factor, 'it is a relatively nominal amount to make a big issue out of.' The court observed it would be a difference over the 20 years of future lost wages payments of plus or minus \$50 to \$100 [per month].

"We have been presented with nothing that compels us to send this case back for a recomputation of the periodic payments. The trial court's reasoning for both the future expenses and the future lost wages is reasonable. Fashioning periodic payments is not an exact science. In *Holt* [], *supra*, 73 Cal.App.4th at page 883, the court

rejected equal periodic payments because there was evidence that the plaintiff's needs would be greater as time wore on." (*Deocampo, supra*, 101 Cal.App.4th at pp. 784-785, emphasis in original, fns. omitted.)

The Court of Appeal's reasoning in *Deocampo* leaves a lot to be desired. It is common knowledge that inflation is a fact of life. The difference between the \$15 million in future medical expenses that the plaintiff sought and the \$9,312,335 that the jury awarded cannot possibly be attributable to the jury rejecting evidence of inflation (as opposed to evidence of some of the plaintiff's claimed future medical expenses). In fashioning a periodic-payment schedule, the fundamental goal is to match losses with compensation as the losses occur. Since future medical expenses virtually *always* will increase over time as a result of inflation, periodic payments for future medical expenses virtually *always* should increase over time as well. The possibility of "early surgeries at several hundred thousand dollars" did not justify front-loaded periodic payments of \$332,583.39 *every* year.

As for the equal periodic payments for future lost earnings, it is obviously incorrect that the difference is only "plus or minus \$50 to \$100" per month between, on the one hand, equal payments of \$2,712.08 per month, and, on the other hand, payments that start lower and gradually increase over a period of *20 years*. There was no conceivable justification for the equal periodic payments for future lost earnings.

(2) ***Holt v. Regents of University of California***
(1999) 73 Cal.App.4th 871.

The jury awarded \$1,745,904 for future medical expenses and \$810,000 for future lost earnings (*id.* at pp. 875-876), which was less than the plaintiff sought (compare *id.* at p. 876 with *id.* at p. 880). After accounting for immediate rehabilitation expenses, attorney fees, and litigation expenses, the trial court ordered periodic payments as follows: 42 equal annual installments of \$29,367.75 for future medical expenses

and 20 equal annual installments of \$29,565 for future lost earnings. (*Id.* at p. 876.) The Court of Appeal held this was an abuse of discretion, explaining: “[The plaintiff] was 21½ years of age at the time of trial. The parties agree that at that time she had a remaining life expectancy of 59 years, i.e., to age 80, and that she will require medical and supportive care for the remainder of her life. . . . However, the court ordered future medical payments, starting at age 23, for only 42 years, i.e., to age 65. Periodic payments are not necessarily dependent on life expectancy when there is evidence supporting a lesser duration. . . . Here, however, the experts for both parties agreed that except for certain immediate rehabilitation expenses, [the plaintiff’s] medical needs would be constant and uniform throughout her life, and there is no evidence indicating why these expenses would be unnecessary for the last 15 years of her anticipated life expectancy. [The plaintiff] is unable to manage her own finances so as to be able to invest ‘front-loaded’ payments (i.e., payments that have greater spending value in the early years, before the impact of inflation) in order to insure the availability of medical costs in later years. Under these circumstances we agree with [the defendant] that the payment schedule must be restructured to provide medical and supportive care for [the plaintiff] throughout her life.” (*Id.* at pp. 881-882.)

“The 20-year duration for lost earnings also lacks evidentiary support. [The plaintiff] had a high school diploma and there was evidence that she would have obtained a bachelor’s degree absent her injuries, from which it is reasonable to infer a working life beginning at age 23, when the court ordered the lost earnings payments to commence. The jury was not asked to find the length of [the plaintiff’s] working life, and there is no evidence from either party that it would have been limited to 20 years. [The plaintiff’s] expert premised his analysis of her lost earnings on her working to age 65 [The defendant’s] expert . . . took into account a woman’s absence from work during child-rearing years, and showed a working life expectancy that ranged from 26.7 years with a high school diploma, to 28 years with a nontechnical bachelor’s degree. There is nothing in this

record to explain why [the plaintiff's] working life would be less than the minimum supported by the evidence. Although the trial court has considerable discretion in structuring a periodic payment schedule, that discretion must be exercised within evidentiary parameters." (*Holt, supra*, 73 Cal.App.4th at p. 882.)

"According to both parties' evidence, except for the expense of immediate rehabilitation and training, which the trial court ordered paid immediately, [the plaintiff's] medical and supportive needs will remain constant throughout her life, but the cost thereof will increase at least consistently with inflation. In addition, were it not for her disability her income would also rise during the course of her working life. . . . The issue on review is whether the trial court abused its discretion under these circumstances by ordering equal payments, which have greater spending power during [the plaintiff's] earlier years than later in life. . . . [¶] It is expected that [the plaintiff] will continue to reside with her parents, who will assume caretaking duties as long as possible, thereby minimizing [the plaintiff's] expenses during her earlier years. It is later in life when her parents can no longer care for her that [the plaintiff's] expenses will increase. [¶] '[T]he fundamental goal [of section 667.7] is to match losses with compensation as the losses occur.' [Citation.] The undisputed evidence here is that without progressive payments [the plaintiff] will not have sufficient funds available to her in the future to meet the increased cost of her medical needs. The purpose of the periodic payment statute—assurance that injured plaintiffs will have sufficient funds available to meet their future needs—will be thwarted unless inflation and salary increases are factored into the payment schedules." (*Holt, supra*, 73 Cal.App.4th at p. 883.)

- (3) ***Hrimnak v. Watkins***
(1995) 38 Cal.App.4th 964.

The Court of Appeal held the trial court abused its discretion by structuring periodic payments over 15 years without considering the evidence of when the plaintiff would sustain her losses:

“The trial court simply ordered Dr. Watkins to pay Emily’s future lost earnings in annual, equal installments . . . for a period of 15 years, beginning at the start of 1994. The problem, however, is that Emily was four years old at the time of trial in 1993; she would just be starting her working life when her periodic payments for future lost earnings would end. This schedule does not represent a fair correlation between ‘the sustaining of losses and the payment of damages.’ [Citation.]” (*Hrimnak, supra*, 38 Cal.App.4th at p. 975.)

“The trial court also did not fairly correlate the evidence of Emily’s future economic needs with their periodic payment. Emily presented undisputed testimony from her economist . . . that the present value of her future economic needs (based on life expectancy to 79) was as follows: [at this point in the opinion, a chart depicts seven categories of economic needs, four of which run to age 79]. [¶] . . . [¶] The trial court’s 15-year periodic-payment schedule does not fairly correlate these future economic needs with the evidence of when they will arise. . . . [A] precise match between future losses and compensation is not required. Nevertheless, to uphold the trial court’s periodic-payment schedule on appeal, there must be evidence to support it. . . . [Equal installments over the next 15 years] is an arbitrary determination rather than an evidentiary one. Accordingly, the trial court abused its discretion” (*Id.* at pp. 975-976.)

- (4) ***Atkins v. Strayhorn***
(1990) 223 Cal.App.3d 1380.

The trial court spread periodic payments for medical expenses over a period of four years even though the jury found the plaintiff had a six-year remaining life expectancy. The Court of Appeal held the trial court acted within its discretion: “The evidence showed Owren would need psychiatric care for a period of one and one-half to two and one-half years at an approximate cost of \$25,000 per year. The evidence also showed Owren presently needed a new prosthesis and wheelchair at a cost of \$4,319. The jury awarded \$51,600 for future medical expenses which, after reduction by Owren’s 45 percent comparative fault, left \$28,380 subject to periodic payments. Because the prosthesis and wheelchair are immediate needs and the psychiatric care is required for the first two years after trial, the record supports payment over a period substantially less than six years.” (*Id.* at pp. 1397-1398.)

According to the *Atkins* court: “In structuring a periodic payment schedule, a trial court is simply ‘guided,’ not bound, by the evidence of future damages introduced at trial.” (*Atkins, supra*, 223 Cal.App.3d at p. 1397.) This statement should not be read too literally. It offends the very notion of due process and a fair trial to suggest that any court can render a judgment *not* based on the evidence. The Court of Appeal in *Atkins* did not uphold the periodic-payment schedule without reciting the evidence in the record that supported the trial court’s “implicit[] finding Owren’s anticipated expenses and losses in the future would be incurred in a shorter period of time than his projected life expectancy as found by the jury.” (*Id.* at p. 1397.) The Court of Appeal also explained: “the [trial] court did not disagree with or disregard the jury’s finding as to Owren’s life expectancy”; rather, the trial court concluded the plaintiff would not suffer expenses and losses over his entire remaining life expectancy. (*Id.* at p. 1397, fn. 12.) In contrast, in a case where the evidence and verdict make it apparent the plaintiff’s damages *will* be suffered over the entire remaining life expectancy, the duration

of the periodic-payment schedule should match that life expectancy. (*Holt, supra*, 73 Cal.App.4th at pp. 881-882.)

In *Holt*, the Court of Appeal distinguished *Atkins* as follows: “[I]n [*Atkins*] the jury found the plaintiff had a life expectancy of six years, but the trial court did not abuse its discretion in ordering periodic payments over four years, given the evidence that the plaintiff would incur his particular medical care and equipment expenses in less than six years.” (*Holt, supra*, 73 Cal.App.4th at p. 882.)

- (e) **Never request periodic payment of damages for future noneconomic losses. Too much uncertainty exists. The periodic payments easily could end up costing more, not less, than the jury’s verdict.**

- (1) **Too much uncertainty exists regarding the total of the periodic payments.**

In *Salgado, supra*, 19 Cal.4th 629, the Supreme Court held (1) “the jury should be instructed expressly that they are to assume that an award of future [noneconomic] damages is a present value sum, i.e., they are to determine the amount in current dollars paid at the time of judgment that will compensate a plaintiff for future pain and suffering” (*id.* at pp. 646-647, emphasis omitted); (2) “the jury, in determining the amount that the plaintiff should be awarded now as compensation for pain and suffering, can properly be told to consider the time value of the award, but the trial court ‘should make it clear that the precise method appropriate for discounting awards for pecuniary losses need not be followed’ ” (*id.* at p. 647); (3) “[former] Civil Code section 3333.2 should be interpreted to provide a . . . limit of \$250,000 in current dollars at the time of judgment” (*id.* at p. 642); (4) “[i]f the award for future noneconomic damages is to be paid out periodically pursuant to Code of Civil Procedure section 667.7, the plaintiff is entitled to receive, over time, the equivalent of the immediate lump-sum award at the time of judgment, capped at \$250,000, i.e., *the amount that the capped award would have yielded if invested prudently at the time of*

judgment” (*id.* at p. 640, emphasis added; see *id.* at p. 635); and (5) “‘a trial court can consider the trial testimony and, if necessary, supplement that evidence with postverdict testimony in order to determine the gross [noneconomic] damages and in turn to fashion a schedule of periodic payments based thereon’” (*id.* at p. 648).

What exactly does all this mean? In particular, what is “the amount that the capped award would have yielded if invested prudently at the time of judgment”?

Dramatically different answers to this question are possible because so many variables exist.

(2) Too much uncertainty exists regarding the length of the periodic-payment schedule.

The correlation between the payment of damages for, and the sustaining of future noneconomic losses is less exact than for future economic losses. (See *Fein, supra*, 38 Cal.3d at p. 159 [referring to “the inherent difficulties in placing a monetary value on [noneconomic] losses” and “the fact that money damages are at best only imperfect compensation for such intangible injuries”].) This poses the danger that the trial court will fashion an unduly short periodic-payment schedule for noneconomic losses.

In *Atkins, supra*, 223 Cal.App.3d 1380, the plaintiff’s leg was amputated below the knee. The jury found the plaintiff’s life expectancy was six years, but the trial court spread periodic payments for noneconomic losses over only four years. The Court of Appeal held the trial court acted within its discretion: “Although no one can accurately predict whether pain and suffering will ever completely disappear, the trial court could reasonably assume Owren’s mental anguish would be favorably impacted by psychiatric care and thus, order payments over a period of four years.” (*Id.* at p. 1398.)

On the other hand, in *Salgado, supra*, 19 Cal.4th 629, where the plaintiff's arm was permanently injured at birth, the Supreme Court held the trial court acted within its discretion by ordering periodic payment of the future noneconomic damages over the plaintiff's entire life expectancy, which was 66.8 years. (*Id.* at p. 650.)

The length of the periodic-payment schedule is too unpredictable where future noneconomic damages are concerned.

(3) Avoid these potentially costly uncertainties. Use the future noneconomic damages as a source of upfront cash needed to pay the attorney fee and litigation expenses.

Every periodic-payment judgment must have enough upfront cash in it to pay the plaintiff's attorney fee and litigation expenses. (See *Salgado, supra*, 19 Cal.4th at p. 651; *Holt, supra*, 73 Cal.App.4th at p. 880.) Use the future noneconomic damages as the source for that upfront cash. (See *Salgado*, at pp. 640, fn. 2, 649 ["malpractice defendants and their insurers frequently stipulate to lump-sum payment of noneconomic damages upon entry of judgment"]; *Schiernbeck v. Haight* (1992) 7 Cal.App.4th 869, 881, fn. 9 ["Because of the difficulties associated with relating noneconomic damages to future pain and suffering the court should use the award of noneconomic damages as the source for the initial lump-sum payment to the plaintiff"].) Do not attempt to deal with the uncertainties discussed above, especially with the uncertainty regarding the total of the periodic payments under the *Salgado* case. *Do not request periodic payment of future noneconomic damages.* This advice holds true even in cases where not all the future noneconomic damages are consumed by the payment of attorney fees and litigation expenses. Pay *all* the future noneconomic damages as upfront cash in *every* case.

(f) Consider whether to forego the right to periodic payment of future lost earnings.

(1) The periodic payments may not end upon death.

Upon the plaintiff's death, periodic payments for future lost earnings will continue to be paid to persons to whom the plaintiff owed a duty of support, as provided by law, immediately before dying. (Code Civ. Proc., § 667.7, subd. (c).) In considering the likelihood that the plaintiff will owe a duty of support, keep in mind that a duty may exist in situations besides the usual one of parents supporting their children. Even if the plaintiff is a severely injured minor who, realistically, never will marry or have children, once the plaintiff becomes an adult, the plaintiff's parents could be owed a duty of support under certain circumstances. (See generally Fam. Code, § 4400; Pen. Code, § 270c; *People v. Heitzman* (1994) 9 Cal.4th 189, 210; *Swoap v. Superior Court* (1973) 10 Cal.3d 490, 502-504 [discussing adult child's duty to support parent]; *Gluckman v. Gaines* (1968) 266 Cal.App.2d 52, 53-55 [discussing "the many factors which a trial court must consider and weigh in determining whether, or to what extent, a child owes an obligation to support a parent"]; see also *Perry v. Medina* (1987) 192 Cal.App.3d 603, 608-610 [discussing meaning of "dependent parent" for purposes of wrongful death statute].)

(2) The uncertainty about whether periodic payments for future lost earnings will end upon death impacts the defendant's insurer's ability to close its claim file.

If the insurer wants to close its claim file, it should assume the periodic payments will continue after death, and it should purchase a guaranteed (as opposed to "life only") annuity. If the annuity is guaranteed, however, the reduction in cost due to age rating is lost (see *ante*, Section H(3)), which means the periodic payments are unlikely to save a significant amount of money. It may

make more sense to forego periodic payments for future lost earnings and pay the present value of these damages as upfront cash in the judgment.

If it is not essential to close the claim file, and if the defendant's insurer is willing to assume the risk that payments for future lost earnings may not end upon the plaintiff's death, a "life only" annuity can be purchased to take advantage of age rating. The annuity payments will stop when the plaintiff dies, however, so any payments owed thereafter because of a duty of support will have to be made by the defendant's insurer.

Alternatively, the annuity could be guaranteed but provide that, upon the plaintiff's death, unless a court order substitutes someone else as payee, the annuity payments will be made to the defendant's insurer.

(g) An ordered, step-by-step approach should be followed when converting the verdict to a periodic-payment judgment.

(1) Step one: reduce the noneconomic damages to the applicable statutory limit.

The verdict usually will include both past and future noneconomic damages. Retain as much of the past noneconomic damages as possible and eliminate the remaining noneconomic damages as necessary to bring the total down to the applicable statutory limit under Civil Code section 3333.2. (See *Salgado, supra*, 19 Cal.4th at pp. 635, 640, 646; *Fein, supra*, 38 Cal.3d at p. 156.)

(2) Step two: set off a settlement by a codefendant.

(a) Determine the present value of any portion of the settlement that was structured.

In *Franck v. Polaris E-Z Go Div. of Textron, Inc.* (1984) 157 Cal.App.3d 1107, 1120-1121, the Court of Appeal held that the setoff for the structured portion of a settlement is the present value of the payments due under the structure, and that present value is not necessarily the cost of the annuity. Subsequently, however, in *Nguyen, supra*, 40 Cal.App.4th at pages 1450-1454, and in *Schneider v. Kaiser Foundation Hospitals* (1989) 215 Cal.App.3d 1311, disapproved on other grounds in *Moncharsh v. Heily & Blase* (1992) 3 Cal.4th 1, 27-28—both cases in which there was no jury determination of present value—the courts held that the present value of structured or periodic payments is “normally best represented by the cost of the annuity purchased to fund the payments” (*Schneider*, at p. 1314). Thus, the cost of the annuity should be used as the present value of the structured portion of a settlement.

If the trial court refuses to use annuity cost, the defendant is entitled to a jury determination of the present value of the structure. (See *Syverson v. Heitmann* (1985) 171 Cal.App.3d 106, 110-111; *Albrecht v. Broughton* (1970) 6 Cal.App.3d 173, 177.) To avoid possible prejudice to one or both parties, the trial judge should bifurcate the present value issue for resolution by the jury after a verdict on liability and damages. This complication provides a practical reason for the trial court to use annuity cost: it simplifies the trial.

(b) Determine the impact of Proposition 51 on the setoff.

“ [E]ach defendant is solely responsible for its share of noneconomic damages under Civil Code section 1431.2 [Proposition 51]. Therefore, a nonsettling defendant *may not receive any setoff* . . . for the portion of a settlement by another defendant that is attributable to noneconomic damages.’ ” (*McComber v. Wells* (1999) 72 Cal.App.4th 512, 518, original emphasis.)

To determine what portion of the settlement is economic damages subject to setoff, apply the same percentages as the jury’s verdict. (*McComber, supra*, 72 Cal.App.4th at pp. 517-518.) Thus, if the verdict is 25 percent noneconomic and 75 percent economic damages, the settlement is considered 25 percent noneconomic and 75 percent economic damages. (This method is for a *preverdict* settlement, not a *postverdict* settlement. For the latter, the “ceiling” method is used. (*Torres v. Xomox Corp.* (1996) 49 Cal.App.4th 1, 40-42.))

(c) Subtract the cash portion of the setoff from the past economic damages in the verdict. Subtract any structured portion of the setoff from the present value of the future economic damages in the verdict.

Future economic damages are subject to periodic payments; past economic damages are not. The setoff must be allocated between these two categories of damages in order to determine how much of the verdict is subject to periodic payments. There are two possible approaches to allocation: (1) allocate the setoff to past and future economic damages in the same proportion as the jury’s verdict (proportional allocation), or (2) allocate the cash portion of the setoff to past economic damages first, and allocate any

structured portion of the settlement to future economic damages first (“like against like” allocation).

Proportional allocation has surface appeal, but is not the correct approach. Under the periodic-payment statute, the plaintiff is entitled to receive past economic damages, not future economic damages, in a lump sum. If the plaintiff already has received a lump-sum payment from a codefendant, that settlement should be applied first to past economic damages. Like should be credited against like. This is the approach that is consistent with the fundamental goal of matching losses with compensation as they occur. Effectuating this goal requires allocating in a manner that allows as much of the future economic damages as possible to be paid periodically so the plaintiff’s future needs can be met as they arise. (See *Deocampo, supra*, 101 Cal.App.4th at pp. 771-774.)

If the cash portion of the setoff exceeds the past economic damages, such that some of the setoff must be credited against the future economic damages, or if there is a structured portion of the settlement to set off against the future economic damages, it may be necessary to further allocate the setoff between future medicals and future lost earnings. Here, proportions can be used (since both future medicals and future lost earnings are subject to periodic payments). For example, if 75 percent of the future economic damages are medicals and 25 percent are lost earnings, then, after the setoff, 75 percent of the remaining future economic damages should be deemed future medicals and 25 percent should be deemed future lost earnings.

- (3) **Step three: calculate any prejudgment interest.**
- (a) **Decide whether the periodic-payment judgment is more favorable than the plaintiff's Code of Civil Procedure section 998 offer.**

Civil Code section 3291 provides: "If the plaintiff makes an offer pursuant to Section 998 of the Code of Civil Procedure which the defendant does not accept . . . and the plaintiff obtains a more favorable judgment, the judgment shall bear interest at the legal rate of 10 percent per annum calculated from the date of the plaintiff's first offer pursuant to Section 998 of the Code of Civil Procedure which is exceeded by the judgment, and interest shall accrue until the satisfaction of judgment." In *Atkins, supra*, 223 Cal.App.3d at pages 1398-1399, and *Hrimnak, supra*, 38 Cal.App.4th at pages 979-981, the Court of Appeal held that, when the judgment includes periodic payments, the present value equivalent of the judgment—i.e., the present value verdict after applying the applicable section 3333.2 cap on noneconomic damages and taking any settlement setoff—must be compared to the section 998 offer. If that present value exceeds the section 998 offer, prejudgment interest is owed. (See *Deocampo, supra*, 101 Cal.App.4th at p. 780 & fn. 17.)

- (b) **Calculate the prejudgment interest.**

In *Hrimnak, supra*, 38 Cal.App.4th at pages 979-981, the Court of Appeal held that Civil Code section 3291 prejudgment interest is calculated on the present value equivalent of a periodic-payment judgment. (Accord, *Steinfeld v. Foote-Goldman Proctologic Medical Group, Inc.* (1996) 50 Cal.App.4th 1542, 1551.) In other words, interest is calculated on the present value verdict—after applying the applicable section 3333.2 cap on noneconomic damages and taking

any settlement setoff—from the date of the section 998 offer to the date of entry of judgment. Once the periodic-payment judgment is entered, interest continues to accrue on the upfront cash, but interest does not accrue on the periodic payments until they become due. (*Deocampo, supra*, 101 Cal.App.4th at pp. 775-776; see also *id.* at pp. 780-782 [explaining how to calculate prejudgment interest when a codefendant settles after the section 998 offer but before the entry of judgment].)

(c) If the amount of prejudgment interest is specified in the judgment, make sure that postjudgment interest does not accrue on the prejudgment interest.

In a non-MICRA case involving prejudgment interest, the judgment simply states that interest accrues as of the date of the section 998 offer and continues to accrue *until* the judgment is satisfied. The amount of interest is not specified in the judgment because it increases daily until the judgment is satisfied. In a periodic-payment case, however, the prejudgment interest that accrues from the date of the section 998 offer to the date of entry of the periodic-payment judgment is sometimes specified in the judgment. If so, be sure the judgment makes it clear that postjudgment interest does not accrue on the prejudgment interest. (See *Deocampo, supra*, 101 Cal.App.4th at pp. 768-769, fn. 9; *Steinfeld v. Foote-Goldman Proctologic Medical Group, Inc.* (1997) 60 Cal.App.4th 13, 16, 23.)

(4) Step four: calculate the statutory maximum attorney fee, estimate the plaintiff's nonrecoverable costs, and allow for their payment.

(a) Calculate the attorney fee and estimate the nonrecoverable costs.

A periodic-payment judgment must include enough upfront cash to cover the plaintiff's attorney fee and nonrecoverable costs. (*Salgado, supra*, 19 Cal.4th at p. 651; *Holt, supra*, 73 Cal.App.4th at p. 880; *Nguyen, supra*, 40 Cal.App.4th at pp. 1444-1448.) This is not to say the judgment must or should specify the attorney fee and nonrecoverable costs. (See *Nguyen*, at p. 1442.) Rather, the judgment need only include enough upfront cash to cover these items owed by the plaintiff.

Business and Professions Code section 6146 sets forth the *maximum* contingency fee schedule:

- Pursuant to settlement and release of all claims before a complaint or demand for arbitration is filed: 25%
- Pursuant to settlement, arbitration, or judgment after a civil complaint or demand for arbitration is filed: 33%
- After trial or arbitration: above 33% at the court's discretion, upon motion establishing good cause.

(b) If there is a settlement setoff, take into account that some or all of the higher percentages on the sliding fee scale already have been paid.

Settlement-related documents often disclose the attorney fee and costs that were paid out of the settlement proceeds. Some or all of the higher fee percentages no doubt were paid. To calculate the

fee on the verdict remaining after setoff, treat the verdict as the “next” amount recovered and apply the appropriate fee percentage(s). For example, if the settlement was \$600,000 or more, all the higher fee percentages should have been paid out of the settlement, and the fee on the verdict remaining after the setoff should be limited to 15 percent.

If the actual attorney fee and costs paid out of the settlement are unknown by the defendant, assume the higher fee percentages were paid. This assumption will almost always be correct.

(c) Determine whether some of the damages subject to periodic payments must be paid as upfront cash to help cover the attorney fee and nonrecoverable costs.

“In some cases, the lump-sum recovery for past damages of various sorts [and any future damages for which the right to periodic payments has not been invoked] may provide a sufficient fund out of which to allocate the entire attorney fee award. In that instance, it would be unnecessary to allocate any portion of the periodic payment award to attorney fees.” (*Nguyen, supra*, 40 Cal.App.4th at p. 1447, fn. 9; see *id.* at pp. 1445-1446; see also *Deocampo, supra*, 101 Cal.App.4th at pp. 774-775.) In determining whether the judgment will have sufficient upfront cash to pay the attorney fee and nonrecoverable costs without using any of the damages subject to periodic payments, keep in mind that the plaintiff also needs enough upfront cash to pay any outstanding liens. (See *Salgado, supra*, 9 Cal.4th at p. 651; *Holt, supra*, 73 Cal.App.4th at p. 880; *Nguyen*, at pp. 1445-1446.) On the other hand, also keep in mind that, if prejudgment interest is owed, it can be used to help pay the attorney fee and nonrecoverable costs. (*Deocampo*, at p. 774.)

If some of the damages subject to periodic *payments* must be paid as upfront cash to help cover the attorney fee and nonrecoverable costs, and if the right to periodic payments has been invoked for future lost earnings as well as future care costs, the money for the fee and costs should be taken first from the damages for future lost earnings. The maximum possible amount of damages for future care costs should be subject to periodic payments so the plaintiff's care needs can be met as they arise.

(5) Step five: fashion a payment schedule.

Presumably, the periodic-payment schedule will be for future care costs, possibly future lost earnings (see *ante*, Section H(9)(f)), but not future noneconomic losses (see *ante*, Section H(9)(e)). The schedule must be based on the gross value verdict. (See *ante*, Section H(2)(b).)

(a) Work directly off the plaintiff's evidence of future damages.

Since the verdict is in the plaintiff's favor, the best approach is to work directly off the plaintiff's evidence. If the verdict adopts the plaintiff's economist's figures, the annual periodic payments should correspond to the annual amounts used by the plaintiff's economist.

If the verdict is less than the plaintiff sought, start with the annual amounts used by the plaintiff's economist and reduce them across-the-board by whatever percentage is necessary to bring down the total to the gross value verdict. For example, assume:

- (1) the plaintiff's rehabilitation witness testified the plaintiff needs \$50,000 per year, in today's dollars, to cover future care costs, (2) the plaintiff's economist testified the inflation rate for future care costs will be 5 percent per year, and (3) using \$50,000

per year increasing at 5 percent, the plaintiff's economist testified the gross value of future care costs over the plaintiff's remaining life expectancy is \$10,000,000. If the gross value verdict for future care costs is \$5,000,000, the annual payment schedule should be \$25,000 per year increasing at 5 percent. In other words, since the gross value verdict is 50 percent of the plaintiff's economist's gross value figure, the annual amounts should be 50 percent of the plaintiff's economist's annual amounts.

This basic approach works no matter how complex the plaintiff's claim for future damages is. For example, if the plaintiff's claim for future care costs is broken down into 10 categories of need with separate annual amounts and separate inflation rates for each category, prepare a chart depicting each annual amount for each category as well as the total annual amount for all 10 categories. If the verdict is less than the plaintiff sought, reduce each annual amount by the same percentage to bring down the total to the gross value verdict.

If the defendant had an economist testify at trial, and the verdict is less than or equal to the defense economist's figures, work directly off those figures in the same manner described above.

(b) If information is missing from the plaintiff's evidence, extrapolate.

For example, if: (1) the plaintiff's injuries are permanent and future care costs will be incurred for the plaintiff's remaining life expectancy of, say, 50 years, (2) no witness testified about the starting annual amount for future care costs, (3) the plaintiff's economist testified that inflation for future care costs will be 5 percent, (4) the plaintiff's economist testified that the gross value of future care costs is \$35,000,000, and (5) the

gross value verdict for future care costs is \$25,000,000, then the starting annual amount would be that amount which, when increased by 5 percent for 50 years, pays out a total of \$25,000,000. (To calculate this starting annual amount, it may be necessary to consult an economist or structured settlement broker. The answer is \$119,418.)

(c) Avoid level periodic payments.

Do not fashion an annual payment schedule simply by taking the jury's gross value verdict and dividing it by the number of years during which the future losses will be sustained. This approach results in level periodic payments, which are much more costly to fund by annuity than payments that begin lower and increase over time to compensate for inflation. Also, level payments are unrealistic; inflation is reality, so periodic-payment schedules virtually always should increase over time. Remember, the fundamental goal is to match losses with compensation as the losses occur. If the losses will gradually increase over time as a result of inflation, the periodic payments should gradually increase over time the same way. (See *ante*, Section H(9)(d).)

(6) Step six: adjust the payment schedule if the damages subject to periodic payments have been reduced because of a settlement setoff or because money was moved to upfront cash to help pay the attorney fee and nonrecoverable costs.

Calculate the percentage of the present value verdict for future losses that is not available to be converted to periodic payments. For example, if the present value verdict for future care costs is \$1,000,000, the setoff against future care costs is \$100,000, and \$150,000 of the verdict for future care costs must be used to help pay the attorney fee and nonrecoverable costs, then

25 percent of the present value verdict $([\$100,000 + \$150,000] \div \$1,000,000)$ is not available to be converted to periodic payments.

Next, reduce the annual amounts calculated in step five by the percentage of the present value verdict that is not available to be converted to periodic payments. In the example above, reduce by 25 percent each annual amount for future care costs calculated in step five.

For an example of this proportional approach to translating a reduction in present value to gross value, see *Hughes, supra*, 2014 WL 4162364, at page *10.

(7) Step seven: attach a schedule of annual amounts to the defendant's proposed judgment, but specify that the periodic payments are monthly.

For simplicity, the schedule attached to the defendant's proposed judgment should depict annual amounts. In the body of the judgment, however, specify that each annual amount is payable in 12 monthly increments. This is less expensive to fund by annuity than paying the entire annual amount at the beginning of the year. It also avoids putting all the money for the entire year in the plaintiff's hands at once, which could result in dissipation before the year is over.

(8) Step eight: specify the manner in which postjudgment interest accrues on the judgment. Periodic payments do not bear interest until they become due.

"Pursuant to section 667.7, *periodic payments* (i.e., the future damages portion of the jury's award) are not immediately payable under the . . . judgment. Therefore, interest will only accrue on each individual periodic payment *as that payment becomes due*. [Citation.] 'The purpose of section 667.7 payments is to provide compensation for losses that are to occur in the future. [Citation.] A plaintiff suffers no detriment if the future damages portion of the award is not paid when

judgment is entered because the injury for which the payment is intended to compensate has not yet occurred. By definition, therefore, a periodic payment due on some future date is not unpaid until that date. “Interest is only awardable to compensate for a delay in payment and compensation for future needs involves no such delay.” [Citation.]’ [Citation.] If each periodic payment is made by defendants in a timely manner, there will be no interest paid by defendants.” (*Deocampo, supra*, 101 Cal.App.4th at pp. 775-776, original emphasis.)

Accordingly, the judgment should specify that interest accrues on the upfront cash from the date of entry of judgment, and interest accrues on each periodic payment from the date each payment is due.

If the defendant appeals from the judgment and is unsuccessful, at the end of the appeal process the defendant should owe: (i) the lump-sum portion of the periodic-payment judgment, plus postjudgment interest on that amount, (ii) the periodic payments that came due during the appeal, and (iii) postjudgment interest on each of those periodic payments from the date each payment came due. The defendant should not owe postjudgment interest on the present value of the judgment. (See *Leung, supra*, 2014 WL 4807719, at pp. *5-*6.)

(h) A sample periodic-payment judgment.

After the opening paragraphs and recital of the jury’s verdict, the judgment should state:

Defendant [name] elected a periodic-payment judgment pursuant to Code of Civil Procedure section 667.7. The court, after reviewing the pleadings, memoranda, and other papers and documents on file herein, and hearing oral argument of counsel, orders as follows:

(1) Plaintiff [name] is entitled to judgment against defendant [name] as follows:

(a) A lump sum of \$_____ payable upon entry of judgment.

(b) Periodic payments according to the schedule[s] attached hereto. [The annual periodic payment for future care costs shall be payable in 12 monthly increments beginning on [date]. In the event plaintiff [name] dies before the last payment is made on [date], the periodic payments shall terminate upon [his] [her] death.] [The annual periodic payment for future lost earnings shall be payable in 12 monthly increments beginning on [date]. In the event plaintiff [name] dies before the last payment is made on [date], the periodic payments shall terminate upon [his] [her] death unless [he] [she] owes a duty of support, as provided by law, immediately prior to [his] [her] death and the judgment is modified in accordance with Code of Civil Procedure section 667.7, subdivision (c).]

[(c) Interest at the legal rate on [insert the lump-sum amount from a. above] from [insert the date of the verdict].]

or

[(c) Interest at the legal rate on [insert the total present value verdict (after applying plaintiff's comparative fault; the applicable Civil Code section 3333.2 cap on noneconomic damages; Proposition 51; and setoffs for settlements paid prior to the plaintiff's Code of Civil Procedure section 998 offer (settlements paid after the 998 offer alter the interest calculation—see *ante*, Section H(9)(g)(3)))] from [insert the date of plaintiff's Code of Civil Procedure section 998 offer] to the date of entry of judgment, and interest at the legal rate on [insert the lump-sum amount from a. above] from the date of entry of judgment.]

(d) Interest at the legal rate on each periodic payment from the date each periodic payment is due.

(2) Plaintiff [name] is awarded costs of suit against defendant [name] in the amount \$_____.

Wherefore, it is ordered that plaintiff [name] have and recover from defendant [name] in the manner and amounts set forth above.

— Attach the annual periodic-payment schedule[s] —

10. Bonding a periodic-payment judgment on appeal.

In *Leung v. Verdugo Hills Hospital* (2008) 168 Cal.App.4th 205, the trial court entered a periodic-payment judgment but calculated the amount of the appeal bond based on the jury's lump-sum, present-value verdict. In other words, the amount of the appeal bond was exactly the same as it would have been if the judgment were a lump sum without any periodic payments. The Court of Appeal held this was correct. "[T]he amount that would be due were the damages to be paid as a lump sum . . . is logically the amount of the money judgment for bonding under [Code of Civil Procedure] section 917.1. Requiring the lump sum judgment to be bonded is consistent with the purpose of section 917.1, in that it assures that the entire judgment will not become uncollectible if the judgment debtor becomes insolvent. [¶] . . . [S]ection 667.7 does not transform the present value of [the] judgment into a judgment of lesser value for purposes of calculating the amount of the required undertaking under section 917.1. Section 667.7 simply provides an alternative method, if future damages exceed \$50,000 [the threshold under former section 667.7], for ultimately paying those damages." (*Id.* at p. 213.) "Nothing in section 667.7 (nor in MICRA as a whole) suggests that the Legislature was concerned about health care providers or their insurers having to pay appeal bond premiums, or about their having to pledge assets for the relatively short time the appeal bond is necessary." (*Id.* at p. 216.)

In the past, some surety insurers have been unwilling to provide appeal bonds for periodic-payment judgments, fearful that they may end up having to pay all the periodic payments in the judgment. But *Leung* strongly suggests that, if the plaintiff enforces the appeal bond, the surety's obligation is to pay the lump-sum present value of the judgment, not the periodic payments. (*Leung, supra*, 168 Cal.App.4th at p. 217.)

11. The defendant is not entitled to an acknowledgment of satisfaction of judgment until the last periodic payment is made. This should not present a problem, however, because the case most likely will end in a structured settlement.

(a) Purchasing an annuity will not entitle the defendant to an acknowledgment of satisfaction of judgment.

In *Hrimnak, supra*, 38 Cal.App.4th at pages 981-982, the Court of Appeal held the only way to obtain acknowledgment of satisfaction of a periodic-payment judgment—before the last periodic payment is made, which may be decades after the judgment is entered—is to get the plaintiff's consent, even if an annuity has been purchased from a life insurance company to fund the periodic payments (which is almost always the case). The court said the periodic-payment statute “makes no reference to annuity funding or to satisfaction of judgment. We should not specify standards in this area without the benefit of legislative guidance.” (*Id.* at p. 981.) “If plaintiff wishes to accept an annuity as satisfaction of the judgment she may do so, but the law does not require her to agree to that. Defendants’ obligation is to pay the money, in the amounts and at the times that will be specified.” (*Id.* at p. 982; accord, *Salgado, supra*, 19 Cal.4th at p. 644, fn. 4; *Holt, supra*, 73 Cal.App.4th at pp. 880-881.)

(b) The inability to obtain an acknowledgment of satisfaction of judgment is not a reason to forego periodic payments.

The defendant may be concerned that entry of a periodic-payment judgment could disrupt the defendant's finances for as many years as it takes to pay the periodic payments. Defense counsel should explain that almost all periodic-payment judgments end up as structured settlements that fully resolve the defendant's liability. The periodic-payment judgment is just a necessary step along the way, intended to reduce the cost of settlement.

Defense counsel also should explain that, even in the unlikely event the case does not settle, the malpractice insurer, by purchasing an annuity to make the periodic payments, will provide an asset that offsets the defendant's liability. And, although the plaintiff can record a judgment lien on the defendant's real property (Code Civ. Proc., § 697.320, subd. (a)(2)), the lien is not enforceable so long as the periodic payments are made when due (*id.*, § 697.350, subd. (c)). Furthermore, Code of Civil Procedure section 724.220 provides a mechanism by which the defendant can prove to a prospective lender that all matured payments have been paid—by obtaining an acknowledgment of satisfaction of matured installments from the plaintiff. (But see *Hrimnak, supra*, 38 Cal.App.4th at pp. 983-984, fn. 1 (conc. opn. of Davis, J.) ["The [intricacies of the] statutory sections on judgment liens and partial satisfactions . . . may be difficult to convey in simple terms to a loan officer whose eyes are glazing over"].) If the plaintiff balks at providing an acknowledgment of satisfaction of matured installments, the defendant can obtain a court order that the matured installments have been satisfied, plus damages and attorney fees from the plaintiff. (Code Civ. Proc., §§ 724.210-724.260.) Finally, the fact that the plaintiff has recorded a judgment lien on the defendant's real property does not prevent the defendant from transferring the property free of the lien, provided the defendant obtains an acknowledgment of satisfaction of matured installments from the plaintiff. (Cal. Law Revision Com. com., 17 West's Ann. Code Civ. Proc. (2009 ed.) foll. § 724.220, p. 554; see Code Civ. Proc., § 697.400, subd. (b).)

(c) If the defendant objects to a periodic-payment judgment, defense counsel must forego periodic payments.

To avoid any possibility of a credit or lien problem, the defendant may demand that the periodic-payment statute not be invoked (provided there is sufficient insurance coverage to pay the present value of the verdict in one lump sum). If this demand is made, then defense counsel, whose primary duty is to the defendant, not to the malpractice insurer (*American Casualty Co. v. O'Flaherty* (1997) 57 Cal.App.4th 1070, 1076; *Purdy v. Pacific Automobile Ins. Co.* (1984) 157 Cal.App.3d 59, 76), has no choice but to forego periodic payments.

I. CODE OF CIVIL PROCEDURE SECTION 1295: ENCOURAGING AND FACILITATING ARBITRATION.

1. Text of section 1295.

a. Any contract for medical services which contains a provision for arbitration of any dispute as to professional negligence of a health care provider shall have such provision as the first article of the contract and shall be expressed in the following language: "It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration."

b. Immediately before the signature line provided for the individual contracting for the medical services must appear the following in at least 10-point bold red type:

"NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT."

c. Once signed, such a contract governs all subsequent open-book account transactions for medical services for which the contract was signed until or unless rescinded by written notice within 30 days of signature. Written notice of such rescission may be given by a guardian or conservator of the patient if the patient is incapacitated or a minor.

d. Where the contract is one for medical services to a minor, it shall not be subject to disaffirmance if signed by the minor's parent or legal guardian.

e. Such a contract is not a contract of adhesion, nor unconscionable nor otherwise improper, where it complies with subdivisions (a), (b) and (c) of this section.

f. Subdivisions (a), (b) and (c) shall not apply to any health care service plan contract offered by an organization registered pursuant to Article 2.5 (commencing with Section 12530) of Division 3 of Title 2 of the Government Code, or licensed pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 of Health and Safety Code, which contains an arbitration agreement if the plan complies with paragraph (10) of subdivision (a) of Section 1363 of the Health and Safety Code, or otherwise has a procedure for notifying prospective subscribers of the fact that the plan has an arbitration provision, and the plan contracts conform to subdivision [(i)] of Section 1373 of the Health and Safety Code.

g. For the purpose of this section:

(1) “Health care provider” means any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or licensed pursuant to the Osteopathic Initiative Act, or the Chiropractic Initiative Act, or licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code; and any clinic, health dispensary, or health facility, licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code. “Health care provider” includes the legal representatives of a health care provider;

(2) “Professional negligence” means a negligent act or omission to act by a health care provider in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death, provided that such services are within the scope of services for which the provider is licensed and which are not within any restriction imposed by the licensing agency or licensed hospital.

2. Summary of section 1295.

“In general, section 1295 insulates certain medical service contracts containing arbitration clauses against attack on grounds they are adhesive, unconscionable, or otherwise improper. In order to be so insulated, the contract must contain prominent notice, in statutory language, of the arbitration clause. Its purpose is to give people

signing such agreements the forewarning that they are relinquishing the right to a jury or court trial if a malpractice issue arises.” (*Dinong v. Superior Court* (1980) 102 Cal.App.3d 845, 849.)

An arbitration agreement that does not meet the form and content requirements of section 1295 is automatically unenforceable. (*Cox v. Bonni* (2018) 30 Cal.App.5th 287, 300; *Rosenfield v. Superior Court* (1983) 143 Cal.App.3d 198, 200.)

An *arbitration* agreement that meets the form and content requirements of section 1295 is not automatically enforceable. If, despite the prominent warning about relinquishing the right to a trial, the plaintiff can show that consent to arbitrate was unknowing, or, if the plaintiff can show that consent was involuntary, the arbitration agreement will not be enforced. (*Ramirez v. Superior Court* (1980) 103 Cal.App.3d 746, 756, fn. 3; see *Lopez v. Bartlett Care Center, LLC* (2019) 39 Cal.App.5th 311, 317-320 [trial court properly refused skilled nursing facility’s motion to compel arbitration where the arbitration agreement was executed by patient’s daughter who credibly denied she was authorized to execute it on the patient’s behalf].)

Section 1295 prescribes a 30-day “cooling off” period after the arbitration agreement is signed. This provision is preempted if the defendant’s medical practice bears on interstate commerce in a substantial way such that the Federal Arbitration Act applies. (*Scott v. Yoho* (2016) 248 Cal.App.4th 392, 401-402, 407.)

Section 1295 does not apply to a health care service plan (e.g., Kaiser) if the plan has an arbitration agreement that complies with governing statutes. (§ 1295, subd. (f); *Herbert v. Superior Court* (1985) 169 Cal.App.3d 718, 726-727 & fn. 4.)

A section 1295 arbitration agreement may include other provisions besides those specified in section 1295. (*Reigelsperger v. Siller* (2007) 40 Cal.4th 574, 579-580 [provision covering future transactions]; *Coon v. Nicola* (1993) 17 Cal.App.4th 1225, 1232 [retroactivity provision]; cf. *Saika v. Gold* (1996) 49 Cal.App.4th 1074 [trial de novo provision unenforceable]; see *Prewitt v. Omid* (Mar. 25, 2019, B280674) 2019 WL 1324399, at p. *8 [nonpub. opn.] [reversing trial court’s order denying petition to compel arbitration where parties “not only agreed to arbitrate medical malpractice disputes, as defined by section 1295, but also included language in the agreement”

covering “ ‘all claims’ that ‘arise out of or relate to treatment or service provided’ ”.) The general arbitration statutes (Code Civ. Proc., § 1281 et seq.) apply, except to the extent they conflict with section 1295. (*Coon*, at p. 1233.)

A section 1295 arbitration agreement governs: (1) intentional tort as well as professional negligence claims (*Baker v. Sadick* (1984) 162 Cal.App.3d 618, 622-626; *Herrera v. Superior Court* (1984) 158 Cal.App.3d 255, 259-262); (2) claims arising out of future medical services if the parties expect possible future transactions (*Cochran v. Rubens* (1996) 42 Cal.App.4th 481, 485; *Gross v. Recabaren* (1988) 206 Cal.App.3d 771, 778); and (3) claims by nonsignatories if an agency or similar relationship exists between the nonsignatory and one of the parties to the arbitration agreement (see *NORCAL Mutual Ins. Co. v. Newton* (2000) 84 Cal.App.4th 64, 72-76).

3. Section 1295 is constitutional.

Section 1295 does not violate the constitutional right to a jury trial, but the plaintiff must be permitted “to seek to show that he or she was coerced into signing or did not read the many waiver notices provided and did not realize that the agreement was an agreement to arbitrate.” (*Ramirez, supra*, 103 Cal.App.3d at p. 756, fn. omitted; but see *Baker v. Italian Maple Holdings, LLC* (2017) 13 Cal.App.5th 1152, 1162, fn. 6 [failure to read the arbitration clause is not a basis for avoiding it]; *Michaelis v. Schori* (1993) 20 Cal.App.4th 133, 138-139, fn. 4; *Coon, supra*, 17 Cal.App.4th at p. 1239; *Bolanos v. Khalatian* (1991) 231 Cal.App.3d 1586, 1590.)

Section 1295 does not deny equal protection by “distinguish[ing] between persons signing individual medical care contracts and those enrolling in group plans as to requirements for waiver of the fundamental right of trial by jury. It is well within the province of the Legislature to differentiate between the two situations and prescribe more stringent notice requirements for the former.” (*Dinong, supra*, 102 Cal.App.3d at pp. 852-853.)

Section 1295 does not violate the state constitutional right to a jury trial by “delegat[ing] the authority to consent to arbitration of medical malpractice claims arising from patients’ medical treatment to the patients themselves” (*Ruiz v. Podolsky* (2010) 50 Cal.4th 838, 853.) In *Ruiz*, the patient signed an arbitration agreement that specifically referred to “heirs” and provided for arbitration of

wrongful death claims. The Supreme Court held the agreement bound the patient's heirs, who were adult children, to arbitrate their wrongful death action. (*Id.* at p. 854.)

4. Statutory definitions.

(a) Definition of “health care provider.”

See *ante*, Section B(2).

(b) Definition of “based upon professional negligence.”

See *ante*, Section B(3).

5. Meaning of other statutory terms.

(a) “Any contract for medical services”

(§ 1295, subd. (a).) “[A]ny contract for health care (with the exception of certain licensed health care service plans (§ 1295, subd. (f)), whether written or oral, express or implied, is within the ambit of [section 1295].” (*Hilleary v. Garvin* (1987) 193 Cal.App.3d 322, 327; accord, *Hollister v. Benzl* (1999) 71 Cal.App.4th 582, 588, fn. 5.)

As noted in *Hilleary*, section 1295 does not apply to a health care service plan if the plan has an arbitration agreement that complies with governing statutes. (§ 1295, subd. (f); *Herbert, supra*, 169 Cal.App.3d at pp. 726-727 & fn. 4; *Dinong, supra*, 102 Cal.App.3d 845.) If, however, the plan refers the plaintiff to a doctor who is an independent contractor (as opposed to an agent or employee of the plan), and the medical services contract between the plaintiff and the doctor includes an arbitration agreement, that agreement prevails. (*Hollister, supra*, 71 Cal.App.4th 582.)

(b) “. . . any dispute as to medical malpractice”

(§ 1295, subd. (a).) A section 1295 arbitration agreement encompasses “any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered.”

Accordingly, intentional tort as well as professional negligence claims must be arbitrated. (*Titolo v. Cano* (2007) 157 Cal.App.4th 310, 314-315, 318-322; *Noble v. Superior Court* (1987) 191 Cal.App.3d 1189, 1192-1193; *Baker, supra* 162 Cal.App.3d at pp. 622-626; *Herrera, supra*, 158 Cal.App.3d at pp. 259-262; see *Victoria v. Superior Court* (1985) 40 Cal.3d 734, 746; see also *Souden v. Pacificare Life and Health Insurance Company* (Sept. 18, 2018, B278004) 2018 WL 4443119, at p. *4 [nonpub. opn.] [section 1295 does not apply to nonmedical malpractice wrongful death case].)

(c) “ . . . all subsequent open-book account transactions for medical services”

(§ 1295, subd. (c).) A section 1295 arbitration agreement “governs all subsequent open-book account transactions for medical services for which the contract was signed” These are the relevant cases:

In *Hilleary, supra*, 193 Cal.App.3d 322, the Court of Appeal reversed the trial court’s order denying the defendant’s petition to compel arbitration. The arbitration agreement signed by the plaintiff when she requested treatment for pregnancy also applied to followup surgery occurring three months later, after the plaintiff miscarried. “To impose upon a physician, during a continuous doctor-patient relationship, the extra burden of having to renew the arbitration agreement each time there is a variation in treatment or ailment would be impractical, and would frustrate the purpose of the statute, which is to facilitate, not emasculate, the arbitration process.” (*Id.* at p. 326.) “There is no evidence from which a reasonable person could conclude that the parties intended that the followup surgery for removal of the tumors would be severable from the treatment for the pregnancy.” (*Id.* at p. 327.)

In *Gross, supra*, 206 Cal.App.3d 771, the Court of Appeal reversed the trial court’s order denying the defendant’s petition to compel arbitration. The arbitration agreement signed at the time of the plaintiff’s first visit, during which minor surgeries were performed to excise a benign mole and a benign cyst on the plaintiff’s scalp, also applied to the plaintiff’s second visit 18 months later, during which radical surgery was performed to excise a cancerous nasal cyst. “[T]here was simply no

objective evidence from which a reasonable person could conclude either of the parties viewed their relationship as having terminated [after the first visit]. The mere fact that they did not anticipate Gross would return in the absence of further dermatological problems requiring the attention of an oncologist does not demonstrate otherwise. Obviously, Gross *hoped* additional treatment would not be necessary. When it was, however, he once again sought Dr. Fister's services. This was persuasive evidence of an ongoing relationship." (*Id.* at p. 778, original emphasis.)

In *Cochran, supra*, 42 Cal.App.4th 481, the Court of Appeal affirmed the trial court's order denying arbitration. The arbitration agreement signed at the time of the plaintiff's referral to the defendant specialist for an evaluation of pain in the plaintiff's ankle did not apply when the plaintiff was again referred to the defendant for the same problem three years later. "It is reasonable to infer from the fact Cochran chose not to return to Rubens for a recommended two week follow-up appointment after his first visit that Cochran had no expectation of future transactions with Rubens for medical services. The lack of such expectation on the part of both parties is evidenced by the fact they had no contact with each other between Cochran's 1990 and 1993 visits. The absence of an ongoing physician-patient relationship between Cochran and Rubens is further evidenced by the fact Cochran had such a relationship with his family physician and only saw Rubens when his family physician referred him to Rubens, as the trial court emphasized." (*Id.* at pp. 486-487.) "The present case is distinguishable from *Gross*[, *supra*, 206 Cal.App.3d 771]. . . . [T]here is sufficient objective evidence from which a reasonable person could conclude the parties here terminated their physician-patient relationship in 1990 without expectation of future transactions between them." (*Id.* at p. 488.)

- *Cochran* seems to turn on the fact that the plaintiff was referred to the specialist by another physician, whereas, in *Gross*, the plaintiff went to the specialist on his own. This should be a distinction without a difference. If anything, *Cochran* seems like the stronger case for compelling arbitration, because the second referral was for exactly the same medical problem as the first.

In *Reigelsperger, supra*, 40 Cal.4th 574, the Supreme Court observed: “In one sense, an *open-book account* is an account with one or more items unsettled. However, even if an account is technically settled, the parties may still have an open-book account, if they anticipate possible future transactions between them.” (*Id.* at p. 579, fn. 5, original emphasis.) The Supreme Court found it was unnecessary to decide whether the parties had an open-book account relationship. The arbitration agreement went beyond section 1295 and included a provision that said: “ ‘This agreement is intended to bind the patient and the health care provider . . . who now *or in the future* treat[s] the patient’ ” (*Id.* at p. 579, original emphasis.) The Supreme Court held this provision required arbitration of a medical malpractice claim arising from treatment for a different condition two years after the arbitration agreement was signed. (*Id.* at p. 576.)

(d) “ . . . until or unless rescinded by written notice within 30 days of signature.”

(§1295, subd. (c).) A section 1295 arbitration agreement “governs all subsequent open-book account transactions for medical services for which the contract was signed until or unless rescinded by written notice within 30 days of signature.” In *Rodriguez v. Superior Court* (2009) 176 Cal.App.4th 1461, the Court of Appeal said, “[the patient’s] death prior to the expiration of the 30-day period rendered it impossible to establish that an arbitration agreement exists that is enforceable under section 1295.” (*Id.* at p. 1469.) “Section 1295’s provision for a 30-day period in which a party could rescind the agreement should be interpreted as a strict and exclusive prerequisite for waive of a jury trial.” (*Id.* at p. 1470.)

Baker, supra, 13 Cal.App.5th 1152, disagreed with *Rodriguez*. “[T]he *Rodriguez* court suggests that section 1295, subdivision (c) creates a condition precedent to the enforcement of the terms of a medical services arbitration agreement contract—the condition precedent being the lapsing of the 30-day rescission period without either party rescinding. In our view, this interpretation of section 1295, subdivision (c) fails to adequately take into account the statutory language. Section 1295, subdivision (c) provides in relevant part: ‘*Once signed,*

such a contract governs . . . until or unless rescinded by written notice within 30 days of signature.’ [Citation.] The plain meaning of this provision is that a medical services [arbitration] agreement is effective upon execution by the parties and remains in effect until or unless a party rescinds within the 30-day period.” (*Id.* at p. 1164, original emphasis.) “Until the time of [the nursing home patient’s] death [10 days after signing the arbitration agreement], neither party had rescinded the agreements; the agreement therefore remained in effect and enforceable at the time of her death.” (*Id.* at p. 1165.)

6. An arbitration agreement that fails to comply with section 1295 is automatically unenforceable.

Rosenfield, supra, 143 Cal.App.3d at p. 200.

7. The substantial compliance doctrine applies.

“Where there is compliance as to all matters of substance[,] technical deviations are not to be given the stature of noncompliance. [Citation.] Substance prevails over form.” (*Baker, supra*, 13 Cal.App.5th at p. 1167, internal quotation marks omitted; see *Manning v. S&F Management Co. LLC* (July 16, 2018, B282385) 2018 WL 3424327, at p. *4 [nonpub. opn.] [“We agree the arbitration agreement was not ‘contained’ in the admission agreement but rather in a separate document devoted entirely to arbitration. Nevertheless, . . . there was substantial compliance with Code of Civil Procedure section 1295’s mandatory placement of the arbitration clause in the first provision of the admission agreement. The arbitration agreement itself has, as its first provision, the language required under section 1295, subdivision (a).” (Fn. omitted)].) “[I]t could be inequitable to deny effect to an arbitration provision because of an omission of an immaterial word or punctuation mark, or a slight variance in wording, if made inadvertently and without an intention to distract from the objectives of the statutory requirements.” (*Baker*, at pp. 1167-1168.) “The discrepancies identified by Plaintiffs are trivial . . . , and in no way undermine the fact that the agreements adequately emphasize—and reiterate, as required, in red, bold, capitalized print just above the signature lines—that the patient is waiving the right to a jury trial.” (*Id.* at p. 1168.)

8. An arbitration agreement that complies with section 1295 is not automatically enforceable. Consent to arbitrate must be knowing and voluntary.

“[W]e interpret [section 1295] as describing the *effect* of an [arbitration] agreement if one is found. However, no agreement exists unless the parties signing the document act voluntarily and are aware of the nature of the document and have turned their attention to its provisions or reasonably should have turned their attention to its provisions.” (*Ramirez, supra*, 103 Cal.App.3d at p. 756, fn. 3, original emphasis; see *Rodriguez, supra*, 176 Cal.App.4th at p. 1468; *Coon, supra*, 17 Cal.App.4th at pp. 1233-1234; see also *Engalla v. Permanente Medical Group, Inc.* (1997) 15 Cal.4th 951, 973-981 [arbitration agreement rescindable if fraudulently induced]; *Swain v. LaserAway Medical Group, Inc.* (2020) 57 Cal.App.5th 59, 75 [“Because section 1295, subdivision (e), is an exception to an otherwise applicable unconscionability defense, . . . the party relying on the exception[] has the burden to show it applies”].)

A section 1295 arbitration agreement is not adhesive, so “the general rule, that one who signs an agreement cannot avoid its terms on the ground that he failed to read it, is applicable.” (*Bolanos, supra*, 231 Cal.App.3d at p. 1590 [arbitration agreement enforced even though patient alleged she had limited ability to read, signed several documents at once, and received no explanation of the arbitration agreement]; see *Baker, supra*, 13 Cal.App.5th at p. 1162, fn. 6; *Michaelis, supra*, 20 Cal.App.4th at pp. 138-139, fn. 4; *Coon, supra*, 17 Cal.App.4th at p. 1239; see also *Caballero v. Premier Care Simi Valley LLC* (2021) 69 Cal.App.5th 512, 518-519 [claim that signer could not read English insufficient to invalidate arbitration agreement without evidence of fraud or that he alerted the defendants that he could not speak English, which would have shifted the burden to the defendants to explain the agreement].)

9. An arbitration agreement is unenforceable where the party executing it on behalf of the patient was not authorized to do so.

See *Holley v. Silverado Senior Living Management, Inc.* (2020) 53 Cal.App.5th 197 (temporary *conservators* cannot bind conservatee to arbitration agreement absent consent or lack-of-capacity ruling); *Lopez, supra*, 39 Cal.App.5th at pp. 318-320 (trial court had discretion to deny skilled nursing facility’s motion to compel

arbitration where the patient's daughter, who executed the arbitration agreement, credibly declared that her mother never authorized her to execute the agreement); *Valentine v. Plum Healthcare Group, LLC* (2019) 37 Cal.App.5th 1076 (patient's husband was not an authorized agent capable of binding wife to arbitration agreement he purported to sign on her behalf); *Hutcheson v. Eskaton FountainWood Lodge* (2017) 17 Cal.App.5th 937, 941 (residential care facility cannot enforce arbitration agreement executed by dementia care patient's sister, who was her attorney-in-fact for personal care matters, because it knew that the patient's niece was her health care power of attorney with priority authority to make health care decisions); see also *L.L. v. Orinda Care Center, LLC* (Dec. 1, 2021, A163601) 2021 WL 5822186, at pp. *1, *5, *7 [nonpub. opn.] (daughter's signing of the arbitration agreement when admitting her mother, who was "half unconscious" at the time, into care did not bind the mother because there was insufficient evidence of agency or ratification); *Phillips v. Villa Del Rey Manor, Inc.* (Feb. 27, 2019, C083116) 2019 WL 948741, at p. *1 [nonpub. opn.] (medical malpractice claim not subject to arbitration where son with legal, but not healthcare, power of attorney purported to execute the arbitration agreement on his mother's behalf).

10. A section 1295 arbitration agreement covers a claim by a nonsignatory if an agency or similar relationship exists between the nonsignatory and one of the parties to the arbitration agreement.

"A number of California cases have considered the question whether arbitration agreements may be enforced against parties who did not expressly agree to their terms. Many of these cases involve claims related to medical malpractice asserted by relatives of a patient who signed an arbitration agreement with the health care provider, and most of them hold the nonsignatories bound by the arbitration agreement." (*NORCAL Mutual Ins. Co.*, *supra*, 84 Cal.App.4th at p. 72; but see *Nida v. Chapman Care Center* (Apr. 28, 2020, G057211) 2020 WL 2029312, at p. *2 [nonpub. opn.] ["the general principal that an arbitration agreement complying with Code of Civil Procedure section 1295 binds nonsignatory heirs to arbitrate wrongful death claims does not apply" where, "although defendant moved to compel both plaintiffs to arbitrate all of their claims, including their wrongful death claims, it appealed only that portion of the court's order denying arbitration of [one plaintiff's] wrongful death claim"]

and therefore “the portion of the order denying the motion to compel arbitration of [the second plaintiff’s] wrongful death claim [was] final, and her wrongful death claim will be litigated in the superior court” (fn. omitted)].)

The case law on applying medical malpractice arbitration agreements to nonsignatories is collected in *Ruiz, supra*, 50 Cal.4th at pages 844-849; *NORCAL Mutual Ins. Co., supra*, 84 Cal.App.4th at pages 72-77; *County of Contra Costa v. Kaiser Foundation Health Plan, Inc.* (1996) 47 Cal.App.4th 237, 242-243; and *Keller Construction Co. v. Kashani* (1990) 220 Cal.App.3d 222, 225-226.

(a) The section 1295 cases holding that a nonsignatory must arbitrate.

Ruiz, supra, 50 Cal.4th at pages 841, 854 (heirs, including adult children, suing for wrongful death bound by arbitration agreement signed by patient, at least where agreement specifically referred to “heirs” and provided for arbitration of wrongful death and loss of consortium claims); *Mormile v. Sinclair* (1994) 21 Cal.App.4th 1508 (spouse suing for loss of consortium bound by arbitration agreement signed by patient); *Gross, supra*, 206 Cal.App.3d at pages 778-783 (same); see *Michaelis, supra*, 20 Cal.App.4th at pages 135, 139 (father of stillborn child bound by arbitration agreement signed by mother; associate of doctor bound by arbitration agreement signed by doctor); *Pietrelli v. Peacock* (1993) 13 Cal.App.4th 943 (child not yet conceived bound by arbitration agreement signed by mother); *Bolanos, supra*, 231 Cal.App.3d at page 1591 (child suing for perinatal injury, and father suing for negligent infliction of emotional distress, bound by arbitration agreement signed by mother). See also *L.L., supra*, 2021 WL 5822186, at pp. *7-*8 (distinguishing *Ruiz*; where patient’s arbitration agreement was found to be unenforceable because the plaintiff’s daughter signed it without her consent, the daughter’s individual claim was also not arbitrable despite the agreement having a valid clause requiring arbitration of family members’ claims); *Zakarian v. Bekov* (2002) 98 Cal.App.4th 316, 323 (plaintiffs could not resist arbitration on the ground that a willing third party did not sign the agreement, where the agreement provided for intervention or joinder of all parties relevant to a full and complete settlement of the dispute).

(b) The contrary, minority view.

In contrast to the above cases, *Baker v. Birnbaum* (1988) 202 Cal.App.3d 288, held that a spouse suing for loss of consortium was not bound by an arbitration agreement signed by the patient alone: “the policy favoring arbitration ‘does not extend to those who are not parties to an arbitration agreement or who have not authorized anyone to act for them in executing such an agreement.’” (*Id.* at p. 292, quoting *Rhodes v. California Hospital Medical Center* (1978) 76 Cal.App.3d 606, 609 [a pre-MICRA case].) “*Baker*, which has generally been ignored or questioned, constitutes a minority view, with its overly restrictive reading of the scope of arbitration agreements.” (*Mormile, supra*, 21 Cal.App.4th at p. 1514; see *NORCAL Mutual Ins. Co., supra*, 84 Cal.App.4th at pp. 74-75, fn. 9 [“*Rhodes* and *Baker* have been described as reflecting ‘a minority view . . .’]; *Pietrelli, supra*, 13 Cal.App.4th at p. 947, fn. 1 [*Rhodes* “is out of step with . . . the overwhelming weight of California authority”].)

In *Weeks v. Crow* (1980) 113 Cal.App.3d 350, the parents of a child who died two weeks after birth were not compelled to arbitrate their wrongful death claim because the arbitration agreement signed by the expectant mother failed to name the child as a patient.

“The omission of any reference to the child expresses an intention not to apply the agreement to malpractice claims arising out of medical services rendered to the child.” (*Weeks, supra*, 113 Cal.App.3d at p. 353.) *Weeks*’s narrow interpretation is avoidable; the arbitration agreement signed by the mother can specify that the expected child is covered as well. (See *Bolanos, supra*, 231 Cal.App.3d at p. 1591 [mother has authority to bind unborn child to arbitrate].)

In *Buckner v. Tamarin* (2002) 98 Cal.App.4th 140, the adult children of a patient who died following surgery were not compelled to arbitrate their wrongful death claim. “Generally speaking, one must be a party to an arbitration agreement to be bound by it. The strong public policy in favor of arbitration does not extend to those who are not parties to an arbitration agreement, and a party cannot be compelled to arbitrate a dispute that he has not agreed to resolve by arbitration.

[Citation.]’ [Citations.] Under three circumstances, however, someone can bind another person to a medical arbitration agreement without that other person’s consent. First, an agent can bind a principal. [Citation.] Second, spouses can bind each other. [Citations.] And, third, a parent can bind a minor child. [Citations.] One court recently summarized these exceptions as follows: “The common thread of all the above cases is the existence of an agency or similar relationship between the nonsignatory and one of the parties to the arbitration agreement. In the absence of such a relationship, courts have refused to hold nonsignatories to arbitration agreements. . . .’ [Citations.] [¶] Respondents do not fall into any of the foregoing categories. Their father entered into the arbitration agreement solely for his own medical care. He was not their agent, they were not married to him, and they were not minors. He therefore lacked the authority to waive their right to a jury trial of their claims.” (*Id.* at pp. 142-143.)

Buckner distinguished *Herbert*, *supra*, 169 Cal.App.3d 718, as a case in which “it was impractical . . . to let the adult children pursue their claims outside arbitration” “[b]ecause the widow and minor children were indubitably obligated to arbitrate their claim.” (*Buckner*, *supra*, 98 Cal.App.4th at p. 143.) “*Herbert*’s rationale is inapplicable here because respondents are not dividing their wrongful death claims between different forums.” (*Ibid.*)

In *Goliger v. AMS Properties, Inc.* (2004) 123 Cal.App.4th 374, an arbitration agreement signed by the patient’s adult child, not as “agent,” but as “responsible party”—meaning the adult child accepted financial responsibility for her mother’s nursing home bills—did not bind her mother to arbitrate her own medical malpractice claim. (*Id.* at pp. 376-377.) Neither was the adult child bound to arbitrate her wrongful death claim; signing as “responsible party” was not signing in a personal capacity. (*Id.* at pp. 377-378.)

In *Avila v. Southern California Specialty Care, Inc.* (2018) 20 Cal.App.5th 835, the Court of Appeal distinguished *Ruiz*, *supra*, 50 Cal.4th 838. In *Avila*, unlike in *Ruiz*, the “complaint include[d] allegations that could be categorized as professional negligence as well as elder abuse.” (*Avila*, at p. 843.) “[T]he complaint was pleaded as one for ‘negligence/willful

misconduct,’ elder abuse and neglect under the [Elder Abuse] Act, and wrongful death. The complaint allege[d] a ‘conscious and continued pattern of withholding the most basic care and services,’ which included a lack of monitoring, supervision, assistance, and other adequate care and services. It allege[d] the lack of availability of a physician, failure to provide properly trained staff and nursing, among other things.” (*Ibid.*) The court reasoned that plaintiffs “are essentially free to plead their case as they choose,” and they chose to plead a cause of action based on the Elder Abuse Act under which “neglect” refers “ “not to the substandard performance of medical services but, rather, to the ‘failure of those responsible for attending to the basic needs and comforts of elderly or dependent adults, regardless of their professional standing, to carry out their custodial obligation.’ [Citation.] Thus, the statutory definition of ‘neglect’ speaks not of the *undertaking* of medical services, but of the failure to *provide* medical care.” ’ ” (*Ibid.*) “The fact that [plaintiffs] could have also pleaded a claim for medical malpractice, had they wished to do so, is irrelevant.” (*Ibid.*) Accordingly, the Court of Appeal concluded that “the plaintiffs’ claim is not one within the ambit of section 1295, and therefore, *Ruiz*’s holding [did] not apply.” (*Ibid.*; accord, *Magyar v. Laurel Avenue, LLC* (Aug. 23, 2019, E070108) 2019 WL 3986201, at pp. *4-*7 [nonpub. opn.] [following *Avila* and holding that section 1295 is inapplicable were “[t]he primary basis for the wrongful death claim is neglect [within the meaning of the Elder Abuse Act], not professional negligence by a healthcare provider”]; *Perez v. P & M Health Care Holdings, Inc.* (Apr. 12, 2019, E069985) 2019 WL 1578360, at pp. *2-*3, [nonpub. opn.] [expressly following *Avila*]; see also *Souden, supra*, 2018 WL 4443119, at pp. *4-*5 [wrongful death claim by domestic partner (who did not execute the arbitration agreement) based on the defendant health insurer’s refusal to pay for lifesaving medical treatment was not subject to arbitration under *Ruiz* because Health and Safety Code section 1363.1, the statute governing health care service plan arbitration agreements, is materially different than section 1295]; *Daniels v. Sunrise Senior Living, Inc.* (2013) 212 Cal.App.4th 674, 684-685 [*Ruiz* is inapplicable to wrongful death and elder abuse claims against residential care facility that was not a MICRA facility governed by section 1295].)

- Although *Avila* was followed by the Court of Appeal decisions in *Magyar* and *Perez*, it seems out of step with decisions requiring courts to look past the form of the complaint and broadly apply MICRA and Code of Civil Procedure section 425.13 whenever the “gist” of the complaint alleges professional negligence by a healthcare provider. (See *Central Pathology Service Medical Clinic, Inc. v. Superior Court* (1992) 3 Cal.4th 181, 192 [“The allegations that identify the nature and cause of a plaintiff’s injury must be examined to determine whether each is directly related to the manner in which professional services were provided. . . . And, contrary to plaintiffs’ argument, section 425.13[, subdivision](a) applies regardless of whether the complaint purports to state a single cause of action for an intentional tort or also states a cause of action for professional negligence.”]; accord, *Holly v. Alta Newport Hospital, Inc.* (C.D.Cal., Apr. 10, 2020, No. 2:19-cv-07496-ODW (MRWx)) __ F.Supp.3d __ [2020 WL 1853308, at p. *4] [“ ‘[W]hen a cause of action is asserted against a health care provider on a legal theory other than medical malpractice, the courts must determine whether it is nevertheless based on the “professional negligence” of the health care provider so as to trigger MICRA,’ ” quoting *Smith v. Ben Bennett, Inc.* (2005) 133 Cal.App.4th 1507, 1514]; *Fruciano v. Regents of University of California* (N.D.Cal., Sept. 5, 2018, No. 18-cv-04452-JSC) 2018 WL 4219232, at p. *5 [nonpub. opn.]; see also *Larson v. UHS of Rancho Springs, Inc.* (2014) 230 Cal.App.4th 336, 352 [holding that MICRA applied because plaintiff’s intentional tort claims were actually based on professional negligence within the meaning of MICRA]; *Turner v. United States* (N.D.Cal., Feb. 26, 2019, No. 17-cv-02265-WHO) 2019 WL 935978, at p. *2 [nonpub. opn.] [“In order to determine if a plaintiff’s claims fall under MICRA, courts ask whether the claims flow or originate from a healthcare provider’s negligent act or omission”]; *ante*, Section B(3)(b)(1).)

(c) Analogous cases holding that a nonsignatory must arbitrate.

The cases involving arbitration clauses in health care service plan contracts compel nonsignatories to arbitrate. (See *Harris v. Superior Court* (1986) 188 Cal.App.3d 475 [arbitration agreement naming professional corporation bound doctor employed by corporation]; *Herbert, supra*, 169 Cal.App.3d 718 [arbitration agreement bound wife and children suing for wrongful death, even though not all children were members of plan]; *Wilson v. Kaiser Foundation Hospitals* (1983) 141 Cal.App.3d 891 [arbitration agreement bound child suing for prenatal injuries; child became a member of plan at birth]; *Hawkins v. Superior Court* (1979) 89 Cal.App.3d 413 [arbitration agreement bound wife suing for wrongful death, since she was a member of plan]; *Clay v. Permanente Med. Group, Inc.* (N.D.Cal. 2007) 540 F.Supp.2d 1101, 1110-1112 (following *Herbert*); see also *Drissi v. Kaiser Found. Hosps., Inc.* (N.D.Cal. 2008) 543 F.Supp.2d 1076, 1080-1081 (following *Herbert* and *Clay*).)

(d) Equitable indemnity claims are an exception.

In *County of Contra Costa, supra*, 47 Cal.App.4th 237, the Court of Appeal refused to compel arbitration of cross-complaints for equitable indemnity against Kaiser that arose out of a pedestrian-auto accident and subsequent medical treatment at a Kaiser hospital. The plaintiff pedestrian sued the county, its transit authority, the driver of the auto, and Kaiser, and the other defendants cross-complained against Kaiser. (*Id.* at pp. 239-240.) The Court of Appeal explained: “The present case is different from any other California case that has been cited by the parties. All nonsignatory arbitration cases are grounded in the authority of the signatory to contract for medical services on behalf of the nonsignatory—to bind the nonsignatory in some manner. In the instant case, there is no preexisting relationship between the cross-complainants and either [the plaintiff] or Kaiser that could support any implied authority for [the plaintiff] or Kaiser to bind any of the cross-complainants by their arbitration agreement.” (*Id.* at p. 243.)

11. A minor cannot disaffirm an arbitration agreement if the medical services contract was signed by a parent, or if the medical care related to pregnancy.

Under Code of Civil Procedure section 1295, subdivision (d), a minor cannot disaffirm an arbitration agreement that was signed by a parent. Under Family Code sections 6921 and 6925, a minor cannot disaffirm an arbitration agreement if the medical care related to pregnancy. (*Michaelis, supra*, 20 Cal.App.4th at p. 138 [construing the predecessor to sections 6921 and 6925].) Section 1295 does not override the Family Code sections; i.e., a minor cannot disaffirm an arbitration agreement if the medical care related to pregnancy, even if the agreement was not signed by a parent. (*Michaelis*, at pp. 136-139.)

12. Presumably, a section 1295 arbitration agreement will specify that MICRA applies. The agreement also should specify that an arbitrator's failure to apply MICRA is judicially reviewable as an act in excess of the arbitrator's powers.

Business and Professions Code section 6146 is expressly made applicable to arbitration. (§ 6146, subd. (a); see *Schneider v. Kaiser Foundation Hospitals* (1989) 215 Cal.App.3d 1311, 1317, fn. 3, disapproved on another ground in *Moncharsh v. Heily & Blase* (1992) 3 Cal.4th 1, 27-28.) The other MICRA statutes contain no express reference to arbitration. But every MICRA statute states that it applies in an “action” for injury against a health care provider based on professional negligence. (E.g., Civ. Code, § 3333.2, subd. (a) [“In any *action* for injury against a health care provider or health care institution based on professional negligence, the injured plaintiff shall be entitled to recover noneconomic losses . . . subject to the limitations in this section” (emphasis added)].) Arguably, the word “action” includes arbitration. (See *Nogueiro v. Kaiser Foundation Hospitals* (1988) 203 Cal.App.3d 1192, 1194 [noting the argument]; see also *Baker, supra*, 162 Cal.App.3d at pp. 627-628 [section 1295 arbitration is an “action” within the meaning of Civil Code section 3294, the punitive damages statute].)

Even if the MICRA statutes do not, by their own terms, apply to a section 1295 arbitration, the arbitration agreement itself almost certainly will specify that MICRA applies.

The real issue, then, is, what happens if an arbitrator fails to apply MICRA? In *Nogueiro, supra*, 203 Cal.App.3d 1192, the Court of Appeal held: “even if the arbitrator’s award resulted from an erroneous refusal to apply Civil Code section 3333.2, such error of law does not invalidate the award.” (*Id.* at p. 1196; but see *Baker, supra*, 162 Cal.App.3d at pp. 622, 626 [noting, without comment, that the trial court had “corrected” the arbitrator’s decision by reducing the award of noneconomic damages to [the applicable MICRA cap] under section 3333.2].)

One way to help ensure that arbitrators not only apply MICRA, but do so correctly, is to include in the arbitration agreement provisions stating that the arbitrators must apply MICRA, the arbitrators do not have the power to apply MICRA incorrectly, and the award can be vacated or corrected on appeal to a court of competent jurisdiction for any error by the arbitrators in applying MICRA. This follows from *Cable Connection, Inc. v. DIRECTV, Inc.* (2008) 44 Cal.4th 1334, where the arbitration agreement provided that “[t]he arbitrators shall not have the power to commit errors of law or legal reasoning, and the award may be vacated or corrected on appeal to a court of competent jurisdiction for any such error.’” (*Id.* at p. 1340.) The Supreme Court held that “[t]his contract provision is enforceable under state law” (*Ibid.*) “[T]o take themselves out of the general rule that the merits of the award are not subject to judicial review, the parties must clearly agree that legal errors are an excess of arbitral authority that is reviewable by the courts. Here, the parties expressly so agreed, depriving the arbitrators of the power to commit legal error. They also specifically provided for judicial review of such error.” (*Id.* at p. 1361, fn. omitted.) However, *Cable Connection* construes *California* law (the CAA) rather than federal law, so it does not control arbitration agreements that are governed by the FAA.

13. The law in other states.

See generally Annotation, Arbitration of Medical Malpractice Claims (1994) 24 A.L.R.5th 1.

**J. HEALTH AND SAFETY CODE SECTION 104340:
EXPRESSIONS OF SYMPATHY, BENEVOLENCE, OR FAULT
IN HEALTH CARE**

1. Text of section 104340.

(a) Statements, writings, or benevolent gestures expressing sympathy, regret, a general sense of benevolence, or suggesting, reflecting, or accepting fault relating to the pain, suffering, or death of a person, or to an adverse patient safety event or unexpected health care outcome, in relation to an act or omission to act in the provision of or failure to provide health care, and made to that person or the family or representative of that person prior to the filing of a lawsuit or demand for arbitration, shall be confidential, privileged, protected, not subject to subpoena, discovery, or disclosure, and shall not be used or admitted into evidence in any civil, administrative, regulatory, licensing, or disciplinary board, agency, or body action or proceeding, and shall not be used or admitted in relation to any sanction, penalty, or other liability, as evidence of an admission of liability or for any other purpose, and all such communications, whether verbal, electronic, in writing, or in any other form, shall also be entitled to the privileges and protections set forth in Sections 1119, 1152, 1157, and 1160 of the Evidence Code.

(b) For purposes of this section:

(1) “Adverse patient safety event or unexpected health care outcome” means any event or condition identified in Section 2216.3 of the Business and Professions Code, Section 1279.1, and any act or omission to act by a health care provider in the rendering of professional services resulting in, alleged to have resulted in, or with the potential to result in injury or death to one or more persons and that is not the result of knowingly or purposefully harmful action.

(2) “Benevolent gestures” means any action that conveys a sense of compassion or commiseration emanating from humane impulses.

(3) “Family” means the spouse, domestic partner, parent, grandparent, stepparent, child, guardian, stepchild, grandchild, sibling, half-sibling, adopted children of a parent, a spouse’s parent, and in-laws of an injured party.

2. Summary of section 104340.

Section 104340 was added to the Health and Safety Code by AB-35 in 2022. This section broadly protects expressions of sympathy, regret, or benevolence and acceptances of fault—as they relate to a person’s pain, suffering, or death, or an adverse patient safety event or unexpected health outcome—from “subpoena[s], discovery, or disclosure” and from use as evidence of an admission of liability. (§ 104340, subd. (a).) This protection applies where an expression or statement is made to a patient or their family member or representative *before* a lawsuit is filed or arbitration is demanded. (*Ibid.*) The expression or statement must relate to an act or omission to act related to the provision of health care resulting in harm that was *not* knowing or purposeful. (§ 104340, subd. (b)(1).) Thus, if injury or death results from a *knowing and purposeful* action, this protection does not apply.

Expressions and statements under this section are inadmissible in any civil, administrative, regulatory, licensing, or disciplinary proceedings and for purposes of sanctions, penalties, or other liability. (§ 104340, subd. (a).) The Assembly Committee on Judiciary indicated that this section’s protections are not intended to apply in criminal proceedings. (Assem. Com. on Judiciary, Analysis of Assem. Bill No. 35 (2021-2022 Reg. Sess.) May 7, 2022, p. 12.) The committee also noted that this section likely could not prohibit family members from *publicly disclosing* expressions or statements otherwise protected by this section. (Assem. Com. on Judiciary, Analysis of Assem. Bill No. 35 (2021-2022 Reg. Sess.) May 7, 2022, p. 11.)

Section 104340 also gives expressions under this section the protections of Evidence Code sections 1119 (inadmissibility of mediation communications), 1152 (inadmissibility of settlement communications), 1157 (inadmissibility of committee communications evaluating hospital care), and 1160 (inadmissibility of expressions of sympathy and benevolence made by person involved in an accident). (§ 104340, subd. (a).)

3. Statutory definitions.

As stated above, section 104340, subdivision (b), includes the following definitions:

- (1) “Adverse patient safety event or unexpected health care outcome” means any event or condition identified in Section 2216.3 of the Business and Professions Code, Section 1279.1, and any act or omission to act by a health care provider in the rendering of professional services resulting in, alleged to have resulted in, or with the potential to result in injury or death to one or more persons and that is not the result of knowingly or purposefully harmful action.
- (2) “Benevolent gestures” means any action that conveys a sense of compassion or commiseration emanating from humane impulses.
- (3) “Family” means the spouse, domestic partner, parent, grandparent, stepparent, child, guardian, stepchild, grandchild, sibling, half-sibling, adopted children of a parent, a spouse’s parent, and in-laws of an injured party.

APPENDIX A

TABLE OF FUTURE MICRA CAPS

The MICRA noneconomic damages caps applicable each year through 2034 for claims reported on or after January 1, 2023. (See Civ. Code, § 3333.2; *ante*, Section E.)

Year	Wrongful death cap	Personal injury cap
2023	\$500,000	\$350,000
2024	550,000	390,000
2025	600,000	430,000
2026	650,000	470,000
2027	700,000	510,000
2028	750,000	550,000
2029	800,000	590,000
2030	850,000	630,000
2031	900,000	670,000
2032	950,000	710,000
2033	1,000,000	750,000
2034+	+2.0% per year	+2.0% per year

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