Howell Two Years Later: Strategies for Responding to Attempts to Circumvent a Landmark Decision

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It has been more than two years since the California Supreme Court's seminal decision in *Howell v. Hamilton Meats & Provisions, Inc.* (2011) 52 Cal.4th 541 (*Howell*), which held that personal injury plaintiffs are limited to recovering the amounts actually paid for medical costs, not the inflated amount supposedly "billed" by their medical providers. In the two years since, the appellate courts have confirmed that *Howell* turned on general principles of universal application and should be applied broadly. Indeed, earlier this year, the Court of Appeal in *Dodd v. Cruz* (2014) 223 Cal.App.4th 933 recognized the defendant had a right to discovery regarding the machinations of plaintiff's counsel in seeking to circumvent *Howell* through the sale of medical liens. The purpose of this article is to update readers as to the status of *Howell*, and to discuss strategies for responding to attempts by the plaintiffs' bar to evade or limit *Howell* to its specific facts.

Howell – a recap.

In *Howell*, the Supreme Court held a plaintiff "may recover as economic damages *no more than the amounts paid* by the plaintiff or his or her insurer for the medical services received...." (*Howell, supra*, 52 Cal.4th at p. 566, emphasis added.) The court explained that, "[t]o be recoverable, a medical expense *must be both incurred and reasonable*." (*Id.* at p. 555, emphasis added.) "[I]f the plaintiff negotiates a discount and thereby receives services for less than might reasonably be charged, the plaintiff has not suffered a pecuniary loss or other detriment in the greater amount and therefore cannot recover damages for that amount." (*Ibid.*; see Civ. Code, §§ 3281 [damages are awarded to compensate for detriment suffered], 3282 [detriment is a loss or harm to person or property], 3283 [future damages also require detriment].)

Accordingly, when a health care provider has accepted as full payment an amount less than stated in that provider's bill, the plaintiff cannot recover for "the undiscounted sum stated in the provider's bill but never paid by or on behalf of the injured person ... for the simple reason that the injured plaintiff did not suffer any economic loss in that amount." (*Howell, supra*, 52 Cal.4th at p. 548.)

In reaching its holding, the Supreme Court explained that pricing for medical services is controlled by a highly complex market – one in which prices vary to a significant extent depending on the categories of payees and payors. (*Howell, supra*, 52 Cal.4th at pp. 561-562.) Some payors, such as private health insurers, are "well equipped to conduct sophisticated arm's-length price negotiations." (*Id.* at p. 562.) Other payors are guaranteed discounted rates by state law. (*Id.* at p. 561.) As a result, most patients, including those who are insured, uninsured, and recipients under government health care programs, pay steeply discounted rates. (*Id.* at pp. 561-562 & fn. 9.) As the court summarized: "Because so many patients, insured, uninsured, and recipients under government health care programs, pay discounted rates, hospital bills have been called 'insincere, in the sense that they would yield truly enormous profits if those prices were actually paid.' " (*Id.* at p. 561.)

Given these facts, the Supreme Court held the amount nominally "*billed*" for medical expenses does not reflect the value of the services provided: "it is not possible to say generally that providers' full bills represent the real value of their services, nor that the discounted payments they accept from private insurers are mere arbitrary reductions." (*Howell, supra*, 52 Cal.4th at p. 562.) Drawing any generalizations about the relationship between the cost of medical care and the amounts listed as the price for

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that care – "other than that the relationship is not always a close one – would be perilous." (*Ibid*.)

The Supreme Court thus held that "evidence of the full billed amount is not itself relevant on the issue of past medical expenses." (*Howell, supra*, 52 Cal.4th at p. 567.) By contrast, evidence of the amount actually *paid* for medical expenses *is* relevant and not barred by the collateral source rule. "[W]hen a medical care provider has ... accepted as full payment for the plaintiff's care an amount less than the provider's full bill, evidence of that amount is relevant to prove the plaintiff's damages for past medical expenses and, assuming it satisfies other rules of evidence, is admissible at trial." (*Ibid*.)

Corenbaum

In *Howell,* the Supreme Court did not address whether evidence of the "billed" amount for medical damages might be relevant on other issues, "such as noneconomic damages or future medical expenses." (*Howell, supra,* 52 Cal.4th at p. 567.) Those issues were decided by Division Three of the Second Appellate District in *Corenbaum v. Lampkin* (2013) 215 Cal. App.4th 1308 (*Corenbaum*).

Corenbaum dealt squarely with the issue of "admissibility in evidence of the full amount of an injured plaintiff's medical billings not only with respect to damages for past medical expenses, but also with respect to future medical expenses and noneconomic damages." (*Corenbaum*, *supra*, 215 Cal.App.4th at p. 1319.) *Corenbaum* held that because "the full amount billed is not an accurate measure of the value of medical services," the "full amount billed for past medical services is *not relevant* to a determination of the reasonable value of future medical services." (*Id*. at pp. 1330-1331, emphasis added.) For the same reasons, *Corenbaum* precluded expert witnesses from relying on the inflated "billed amounts" to support opinions regarding future medical expenses. Evidence of billed amounts "*cannot support an expert opinion on the reasonable value of future medical services*." (*Id*. at p. 1331, emphasis added.)

Corenbaum further concluded that the amount "billed" is also inadmissible to prove a plaintiff's noneconomic damages:

> [E]vidence of the full amount billed is not admissible for the purpose of providing plaintiff's counsel an argumentative construct to assist a jury in its difficult task of determining the amount of noneconomic damages and is inadmissible for the purpose of proving noneconomic damages.

(*Corenbaum, supra,* 215 Cal.App.4th at p. 1333.)

Corenbaum concluded in no uncertain terms: "evidence of the full amounts billed for [the plaintiffs'] medical care was not relevant to the amount of [the plaintiffs'] damages for *past medical expenses, future medical expenses or noneconomic damages*" (*Corenbaum, supra,* 215 Cal.App.4th at p. 1333, emphasis added.) Thus, under *Howell* and *Corenbaum,* a plaintiff's recovery of damages for future medical care is limited to the amount likely to be *paid* or incurred for that care, not the inflated amount listed on a hospital "bill" that no one is expected to actually pay, and a plaintiff cannot circumvent this rule by arguing that the billed amount is relevant to issues such as noneconomic loss.

Strategies for responding to attempts to circumvent *Howell* and *Corenbaum*

In light of *Howell* and *Corenbaum*, the amount "billed" by a medical provider is inadmissible to prove past or future medical damages, is inadmissible to support a claim for noneconomic damages, and cannot support an expert's opinion. It is simply inadmissible for any purpose. Nonetheless, plaintiffs' counsel have come up with novel arguments in an attempt to circumvent these clear rules. Following is a list of some of these arguments and possible responses.

The uninsured plaintiff: Plaintiffs frequently contend that *Howell* and *Corenbaum* turn on the existence of private insurance and that plaintiffs without insurance should, unlike insured plaintiffs, be able to rely upon the inflated amounts "billed" by medical providers. Not so. Whether or not insured, a plaintiff can recover only the amount *actually paid or incurred*. The contrary argument by plaintiffs should fail for three reasons.

First, the appellate courts have not limited *Howell* to its facts involving private insurance. Instead, the holding in *Howell* has been applied to plaintiffs with coverage under Medicare (*Luttrell v. Island Pacific Supermarkets, Inc.* (2013) 215 Cal.App.4th 196, 198) and the workers' compensation system (*Sanchez v. Brooke* (2012) 204 Cal. App.4th 126, 131). As the *Luttrell* Court of Appeal explained, any attempt to limit *Howell* to its facts "does not account for the fact that, whatever the *source* of the payments ... the end result is the same: [the plaintiff] has no liability for past medical services in excess of those payments, so he is not entitled to recover anything more than the payment amount." (*Luttrell*, at p. 206)

The most recent decision on this point is *Romine v. Johnson Controls, Inc.* (March 17, 2014, Case No. B239761) __ Cal.App.4th __ [2014 WL 1012960, at p. *__].) Although primarily addressing the issue of prejudice from the erroneous admission of evidence in a pre-*Howell* trial, the *Romine* Court of Appeal summarized the broad legal principles from *Howell* and *Corenbaum*: "[E]vidence of the full amount billed for a plaintiff's medical care is not relevant to damages for future medical care or noneconomic damages and its admission is error." (*Id*. at p. *__.) As correctly reflected in the *Romine* decision, the legal principle in these cases does not hinge on the existence of private insurance.

Instead, *Howell* and *Corenbaum* turn on the issues of detriment and reasonable value. As those courts recognized, damages require *actual detriment*. (Civ. Code, §§ 3281, 3282, 3283.) In the context of payments for medical expenses – past or future – this means the amounts *actually paid or incurred*, not the inflated amounts supposedly "billed" by medical providers. (*Howell, supra,* 52 Cal.4th at pp. 548, 567; *Corenbaum, supra,* 215 Cal.App.4th at pp. 1330-1332.)

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Due to the quirk of an odd industry practice, medical care billing is unlike that in other commercial contexts, where the word "bill" is generally understood to be a synonym for the word "invoice," and is taken as a demand for payment in the amount stated. Virtually no patient, whether insured or uninsured, actually incurs the full amount "billed" by a medical provider. (See *Howell, supra*, 52 Cal.4th at pp. 560-565; see *id*. at p. 561 ["Nor do the chargemaster rates ... necessarily represent the amount an uninsured patient will pay"]; see *Vencor Inc. v. National States Ins. Co.* (9th Cir. 2002) 303 F.3d 1024, 1029, fn. 9 [only a "small minority of patients" pay the full listed rate]; Nation, *Obscene Contracts: The Doctrine of Unconscionability and Hospital Billing of the Uninsured* (2005) 94 Ky. L.J. 101, 104 [labeling hospital charges as " 'regular,' 'full,' or 'list,' [is] misleading, because in fact they are actually paid by less than five percent of patients nationally"]; Ireland, *The Concept of Reasonable Value in Recovery of Medical Expenses in Personal Injury Torts* (2008) 14 J. Legal Econ. 87, 88 ["only a small fraction of persons receiving medical services actually pay original amounts billed for those services"]; see, e.g., *Luttrell v. Island Pacific Supermarkets, Inc.* (2013) 215 Cal.App.4th 196, 199 [$690,548 billed, but $138,082 accepted as full payment – a discount of 80 percent].)

Further, putting aside the question of how much is actually paid, a plaintiff may recover as damages "no more than the *reasonable value* of medical services received." (*Howell*, *supra*, 52 Cal.4th at p. 555.) Yet the "bills" issued by medical service providers (e.g., based on "chargemaster" schedules) do not reflect "reasonable value" because they grossly exceed what providers actually accept as full payment from insurers. (*Howell*, 52 Cal.4th at pp. 560-562]; *Corenbaum*, *supra*, 215 Cal.App.4th at p. 1326 ["the full amount billed by medical providers is not an accurate measure of the *value* of medical services"].)

Because the amount that medical providers include in their so-called bills is not incurred – even by noninsured patients – and does not reflect the value of the medical care, it should not be admissible and does not support a damages award.

***Future* medical expenses if the plaintiff is uninsured or *might* become uninsured:** Another variation of the argument to limit *Howell* and *Corenbaum* is that the plaintiff may not be insured in the future. All of the above arguments apply to defeat that claim.

Another argument based on federal law supports the defense argument as well. The Patient Protection and Affordable Care Act of 2010 (PPACA), also known as ObamaCare, now mandates that everyone obtain and maintain health insurance. (26 U.S.C. § 5000A(a) ["An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month"].) The PPACA requires that health insurance policies be offered on a guaranteed issue and guaranteed renewal basis. (42 U.S.C. §§ 300gg-1(a), 300gg-2(a).) The PPACA also prohibits health insurers from discriminating against prospective insureds on the basis of health status, including any preexisting condition. (42 U.S.C. § 300gg-3(a) [providing generally that "[a] group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion with respect to such plan or coverage"]; see generally *Nat. Fedn. of Indep. Business v. Sebelius* (2012) 567 U.S. __ [132 S.Ct. 2566, 2580, 183 L.Ed.2d 450] [describing the PPACA's provisions].)

Some might argue that patients could forgo their duty to buy health insurance, notwithstanding PPACA. But, by extension of the basic duty of mitigation (*Placer County Water Agency v. Hofman* (1985) 165 Cal.App.3d 890, 897; *Thrifty-Tel, Inc. v. Bezenek* (1996) 46 Cal.App.4th 1559, 1568), the plaintiff has an obligation to purchase medical insurance to obtain future medical treatment at negotiated rates. Because a plaintiff has the right and obligation to obtain such insurance under PPACA, the plaintiff cannot recover medical damages premised on a failure to obtain the insurance mandated by federal law. (For a full discussion of the implications of the PPACA on a plaintiff's right to recover economic damages, see H. Thomas Watson, Ripe For Litigation: Using the New Federal Healthcare Act to Limit Future Damages (Verdict Magazine 1st Quarter 2010) 39.)

The undocumented worker plaintiff: "A ha," says plaintiff's counsel, "my client is not only uninsured, but is also an undocumented worker and, thus, is not eligible under the PPACA for guaranteed-issue insurance coverage." Not so fast. Evidence of amounts that an expert claims will be "billed" in the future is no more relevant to showing the reasonable amount that would actually be paid for such a plaintiff' than it is to proving other patients' damages. The question is, what do providers actually accept as payment from such patients, and what will they accept in the future?

Moreover, if the plaintiff is subject to deportation, the future medical damages arguably should be calculated based on what the plaintiff would actually incur in the home country. Any recovery of future damages based on continued presence in this country would be preempted by federal immigration law. (See, e.g., *Hoffman Plastic Compounds, Inc. v. N.L.R.B.* (2002) 535 U.S. 137, 150-151 [claim for back pay foreclosed by federal immigration policy]; *Rodriguez v. Kline* (1986) 186 Cal.App.3d 1145, 1149 [an undocumented alien may only recover lost United States future earnings when he can "demonstrate to the court's satisfaction that he has taken steps that will correct his deportable condition"]; *Veliz v. Rental Service Corp. USA, Inc.* (M.D. Fla. 2003) 313 F.Supp.2d 1317, 1337 ["In sum, permitting an award predicated on wages that could not lawfully have been earned, and on a job obtained by utilizing fraudulent documents runs 'contrary to both the letter and spirit of the IRCA, whose salutory purpose it would simultaneously undermine'"]; *Hernandez-Cortez v. Hernandez* (D.Kan., Nov. 4, 2003, Civ.A. 01-1241-JTM) 2003 WL 22519678, at *6-7 [nonpub. opn.] [holding that federal immigration law preempts undocumented alien's state tort law claim for future earnings based on continued U.S. residence]; *Tarango v. State Indus. Ins. System* (Nev. 2001) 25 P.3d 175, 178-179 [holding that workers' compensation laws were preempted

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by federal immigration law to extent that state law afforded vocational rehabilitation benefits to undocumented alien].)

The medical lien scam: Another ploy to sidestep *Howell* and *Corenbaum* is to claim that the bill for medical services was sold to a third-party financing company (a factor) that is asserting a claim against the plaintiff for the full amount "billed." Fortunately, this tactic has been called into question by the recent Court of Appeal decision in *Dodd v. Cruz* (2014) 223 Cal.App.4th 933 (*Dodd*).

The facts in *Dodd* will bring a wry smile to any defense attorney's face. In *Dodd* the plaintiff was referred by his lawyer to a medical services provider. That provider, in turn, sold its account receivable to a factor, which coincidentally was owned in part by the plaintiff's attorney. The defendant subpoenaed documents to ascertain the amount the factor actually paid the medical provider for the lien. (*Id.* at p. 937.) The trial court granted the plaintiff's motion to quash the subpoena and sanctioned defense counsel $5,600. (*Id.* at p. 938.)

Defendant appealed and the Court of Appeal reversed the discovery ruling and the sanctions award. The Court of Appeal reaffirmed the rule that the amount "billed" by the medical provider (with no expectation of actual payment in that amount) is not the test: "The amount a health care provider bills a plaintiff for its medical services is not relevant to the amount of the plaintiff's economic damages for past medical services." (*Dodd*, *supra*, 223 Cal.App.4th at p. 941.) In contrast, the subpoena sought relevant information, i.e., what the medical provider actually accepted from the factor pursuant to their arrangement to discharge the medical provider's account receivable. (*Id.* at p. 942.) As the court noted, the defense expert could rely upon that figure in calculating the amount of the plaintiff's past medical expenses. (*Ibid.*)

Where we go from here

Howell and *Corenbaum* turn on general principles of universal application. In those cases, the billed amount was inadmissible because it was not incurred and did not reflect the reasonable value of the medical services. Despite attempts by the plaintiffs' bar to limit *Howell* and *Corenbaum* to their facts, the logic of those cases does not depend on the existence of insurance, the identity of the plaintiff, or the type of medical damages. Indeed, it would make no sense to apply the measure of damages inconsistently to some plaintiffs but not to others, or to apply a different measure for past medical damages than to future medical damages. Moreover, the PPACA dovetails with these cases by mandating health insurance and thus putting to rest any speculation that a plaintiff may lack insurance in the future. Using this logic and these authorities, attempts to circumvent *Howell* and *Corenbaum* should be cut off at the pass.

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