BY ROBERT H. WRIGHT AND STEVEN S. FLEISCHMAN

The Effect of *Howell* on Personal Injury Medical Cost Recovery

IN *HOWELL V. HAMILTON MEATS & PROVISIONS, INC.*, the California Supreme Court established that personal injury plaintiffs are limited to recovering the amounts actually paid for medical costs, not the amounts supposedly billed by their medical providers.[1] This decision is an example of how the law evolves to reflect a changing society. When doctors still made house calls, they billed for services at the rates they expected to be paid. *Howell* confronted the new financial reality that almost nobody pays the full amount billed by medical providers. A special report in *Time* magazine offered numerous examples of the gap between billed and paid amounts, such as a patient with "[c]harges for blood and lab tests [that] amounted to more than $15,000; with Medicare, they would have cost a few hundred dollars."[2] Indeed, government data reveals that "hospitals charge Medicare wildly differing amounts—sometimes 10 to 20 times what Medicare typically reimburses."[3]

In *Howell*, the supreme court held that a plaintiff may recover "no more than the amounts paid by the plaintiff or his or her insurer for the medical services received…."[4] The court explained that, "[t]o be recoverable, a medical expense must be…incurred."[5] "[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."[6]

Howell's holding is founded on longstanding damages principles. In 1872, the California Legislature decreed that tort damages require detriment.[7] As the *Howell* court summarized: "damages are awarded to compensate for detriment suffered" and "detriment is a loss or harm to person or property."[8] Accordingly, when a healthcare provider has accepted as full payment an amount less than stated in the 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."[9]

The amount incurred for medical care is not the only limit on recoverable medical damages: A plaintiff may recover the lesser of the amount actually paid for, or the reasonable value of, medical services. As the court stated in *Howell*: "To be recoverable, a medical expense must be both incurred *and* reasonable."[10] The *Howell* 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.[11] Some payors, such as private health insurers, are "well equipped to conduct sophisticated arm's-length price negotiations."[12] Other payors are guaranteed discounted rates by state law.[13] Consequently, most patients, including those who are insured, uninsured, and recipients under government healthcare programs, pay steeply discounted rates.[14] Indeed, as the facts of some published decisions reveal, a 5-to-1 ratio between amounts billed and amounts paid is not unusual.[15]

Due to these industry practices, medical care billing is unlike that in other commercial contexts in which the word "bill" is generally understood as a demand for payment in the amount stated. As the *Howell* court explained: "Because so many patients, insured, uninsured, and recipients under government healthcare 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.'"[16]

Given market realities, *Howell* held that the amount nominally billed for medical expenses does not reflect the value of the services provided. Thus, drawing any generalizations about the relationship between the cost of medical care and the amounts billed for that care "other than that the relationship is not always a close one—would be perilous."[17] Further, the court found that "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"; and "how a market value other than that produced by negotiation between the insurer and the provider could be identified is unclear."[18]

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Nevertheless, a recent court of appeal decision provides some hard numbers quantifying the discrepancy between what is billed and what is paid. In *Children's Hospital Central California v. Blue Cross*, the evidence at trial showed that, "in 2007 and 2008, less than five percent of the payors paid Hospital the full billed charges."[19] Stated differently, 19 out of 20 bills were paid at a discounted amount. Moreover, other sources examining the issue nationally have come up with similar numbers.[20]

As a result, the medical bills have little if any evidentiary value. Addressing the facts before it, the California Supreme Court held "evidence of the full billed amount is not itself relevant on the issue of past medical expenses."[21] 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."[22]

The principles of the collateral source rule remain intact because the plaintiff can still recover as damages the amount paid for med-

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ical expenses even if the plaintiff's insurance company made the payment. Since the plaintiff does not owe the higher amount that the medical providers have stated in their bills, but was never incurred, that higher amount "simply does not come within the rule."[23]

Corenbaum and *Romine*

The *Howell* court did not address whether evidence of the billed amount might be relevant to other issues not before that court, "such as noneconomic damages or future medical expenses."[24] These issues were decided by the court of appeal in *Corenbaum v. Lampkin*.[25] The *Corenbaum* court held that evidence of the billed amount is not relevant to these other issues for the same reasons that it is not relevant to the issue of past medical damages.

Applying *Howell*'s reasoning, *Corenbaum* began with the proposition that "the full amount billed is not an accurate measure of the value of medical services."[26] From that starting point, the court of appeal concluded that the billed amount "is not relevant to a determination of the reasonable value of future medical services."[27] For the same reasons, *Corenbaum* precluded expert witnesses from relying on the inflated billed amount" to support opinions regarding future medical expenses: evidence of billed amounts "cannot support an expert opinion on the reasonable value of future medical services."[28]

Corenbaum further concluded that the amount billed is inadmissible to prove a plaintiff's noneconomic damages. During trial, evidence of medical costs is often used as an argumentative construct to assist a jury in determining a plaintiff's noneconomic damages.[29] The *Corenbaum* court, however, held that evidence of the billed amount could not be used for that purpose and is generally "inadmissible for the purpose of proving noneconomic damages."[30]

Corenbaum determined that "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."[31] Thus, under *Howell* and *Corenbaum*, a plaintiff's evidentiary showing should be limited to the paid amount, not the inflated amount listed on a hospital bill, and the plaintiff's recoverable damages should be limited to the lesser of the amount paid or the reasonable amount.

Some have argued that *Howell* and *Corenbaum* turn on the existence of private insurance and that plaintiffs without insurance, unlike those with it, should be able to introduce evidence of the billed amounts. Courts have rejected this argument. The principles in *Howell* and *Corenbaum* have been applied to plaintiffs with coverage under Medicare and the workers' compensation system.[32] As one 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."[33]

A decision from earlier this year is informative. In *Romine v. Johnson Controls, Inc.*,[34] the court of appeal primarily addressed the issue of prejudice from the erroneous admission of evidence in a pre-*Howell* trial. However, the court of appeal summarized the broad legal principles from *Howell* and *Corenbaum*: "evidence 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."[35] The *Romine* court applied this rule without regard to the source of the payments. Indeed, the court noted only that the jury's award of past medical damages was properly reduced to "the amount that plaintiff's medical care providers accepted."[36] As understood by the *Romine* court, the legal principles from *Howell* and *Corenbaum* apply regardless of the payer's identity.

Uninsured Plaintiffs

Some have argued that *Howell* and *Corenbaum* do not apply to future medical expenses if the plaintiff is uninsured or might become uninsured. This argument raises interesting issues involving the interplay of the bar against speculative damages, the obligation to obtain insurance, and the duty to mitigate damages.

First, although damages need not be established with absolute certainty, they cannot be speculative. "Where the fact of damages is certain, the amount of damages need not be calculated with absolute certainty. The law requires only that some reasonable basis of computation of damages be used, and the damages may be computed even if the result reached is an approximation."[37] Nonetheless, while the bar is not set so high as to require absolute certainty, it is not set so low as to require only a possibility: "'damages which are speculative, remote, imaginary, contingent, or merely possible cannot serve as a legal basis for recovery.'"[38]

Second, the Patient Protection and Affordable Care Act of 2010 (PPACA), also known as Obamacare, now generally mandates that everyone obtain and maintain health insurance.[39] The PPACA requires that health insurance policies be offered on a guaranteed issue and guaranteed renewal basis.[40] The PPACA also prohibits health insurers from discriminating against prospective insureds on the basis of health status, including any preexisting condition: "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."[41]

Finally, a plaintiff has a duty to mitigate damages by taking reasonable steps to minimize the loss caused by a defendant's actions.[42] "A plaintiff cannot recover damages that would have been avoidable by his or her ordinary care and reasonable exertions [and] [i]ncreased loss due to the plaintiff's willfulness or negligence is the plaintiff's own burden."[43]

The interplay of these three legal principles could be significant. Although the courts have yet to directly confront the issue, the duty to mitigate damages might obligate a plaintiff to purchase medical insurance to obtain future medical treatment at negotiated rates. Because a plaintiff now has the right and obligation to obtain insurance under the PPACA, the plaintiff arguably cannot recover medical damages premised on a failure to obtain the insurance mandated by federal law. Any argument that the plaintiff may fail to comply with the PPACA would be impermissible speculation.

Gratuitous Medical Care

The *Howell* court observed that in other states the collateral source rule is often applied to gratuitous services and would allow a plaintiff to recover the value of donated medical care. However, the *Howell* court also observed that California law on this point was unclear.[44] Decades ago, in *Helfend v. Southern California Rapid Transit District*, the California Supreme Court suggested that the collateral source rule applied to unpaid services only when rendered "with the expectation of repayment out of any tort recovery."[45] But in *Arambula v. Wells*, the court of appeal declined to follow the *Helfend* dictum.[46] The *Arambula* court instead held the collateral source rule allowed recovery of "gratuitous payments…by family or friends to assist tort victims through difficult times."[47] The *Arambula* court reasoned that any other rule would conflict with the policy of encouraging charity.[48]

In *Howell*, the Supreme Court recognized the conflict between *Helfend* and *Arambula*, but left it to be resolved another day. The *Howell* court explained that the rationale for allowing recovery for gratuitous care—an incentive to charity—did not apply to the facts before it involving commercially negotiated price agreements between medical providers and health insurers.[49]

In *Sanchez v. Strickland*, the court of appeal dealt with this issue that had been left open in *Howell*.[50] The case involved personal injuries from an automobile accident. The medical provider billed $113,988.58, and Medicare paid $66,704, declining to pay $40,264.58.[51]

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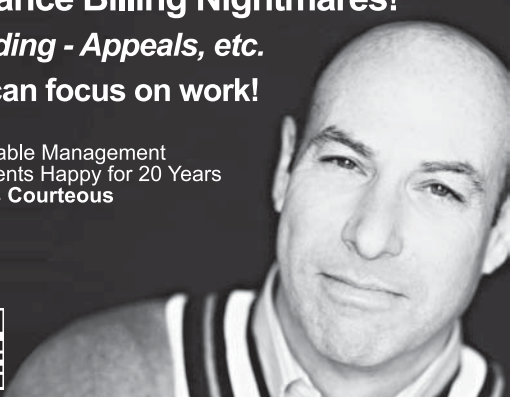

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This left a balance of $7,020. The decision did not fully explain the handling of this balance but quoted a declaration from a medical provider that the provider "'billed the remaining $7,020.00 to Medi-Cal, but wrote off that amount, as [the provider was] not contracted with Medi-Cal.'"[52]

While the *Sanchez* court discussed *Howell* and *Arambula,* it ignored the contrary dictum in *Helfend*. This court held that a plaintiff may recover damages for past medical expenses that have been written off so long as the medical provider has "(1) rendered medical services to a plaintiff, (2) issued a bill for those services, and (3) subsequently written off a portion of the bill gratuitously."[53] Thus, the court held the plaintiff could recover the $7,020 balance that had been "gratuitously" written off by the medical provider.[54]

Sanchez is perplexing because not every write-off is gratuitous. Indeed, *Howell* emphasized the distinction between write-offs made for commercial versus charitable purposes.[55] In *Sanchez*, the provider purportedly wrote off the $7,020 balance only because the provider lacked a Medi-Cal contract.[56] This seems a singularly commercial reason for writing off a medical bill, but perhaps facts before the *Sanchez* court—not apparent from the decision—showed otherwise.

Third-Party Financing

In *Dodd v. Cruz,* the court of appeal addressed the effect on recoverable medical damages when the bill for medical services is sold to a third-party financing company (a factor), which asserts a claim against the plaintiff for the full amount billed.[57] However, the California Supreme Court later ordered the *Dodd* opinion depublished, so the opinion can no longer be cited as authority in California state courts.[58]

The plaintiff in *Dodd* 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 that the factor actually paid the medical provider for the lien.[59] The trial court granted the plaintiff's motion to quash the subpoena and sanctioned defense counsel $5,600.[60]

The defendant appealed, and the court of appeal reversed both the discovery ruling and the sanctions award while reaffirming the rule that the amount billed by the medical provider (with no expectation of full payment) is not the test: "The amount a healthcare provider bills a plaintiff for its medical services is not relevant to the amount of the plaintiff's economic damages for past medical services."[61] Therefore, the subpoena sought information concerning what the medical provider actually accepted from the factor

pursuant to the arrangement to discharge the medical provider's account receivable.[62] As the court noted, the defense expert could rely on this figure in calculating the amount of the plaintiff's past medical expenses.[63] Further, discovery could establish that the arrangement was distinct from one in which the plaintiff remained fully liable for the medical provider's charges.[64]

Although the court of appeal's decision in *Dodd* can no longer be cited as authority, the court of appeal in another case reaffirmed *Dodd*'s discovery analysis in a decision that was filed in June of 2014. In *Children's Hospital*, the court of appeal held that Blue Cross should have been allowed to conduct discovery into the amounts paid by other parties for the hospital's medical services. The hospital argued that the discovery would disclose proprietary financial information and trade secrets. The court of appeal held that any such interests could be protected through the use of protective orders.[65]

As these decisions show, the change in law that the California Supreme Court began three years ago in *Howell* continues to reverberate through the appellate courts today. *Howell*'s recognition of fundamental market realities for medical pricing continues to necessitate corresponding changes across a range of medical damages issues, and those reverberations are likely to persist. ■

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[1] Howell v. Hamilton Meats & Provisions, Inc., 52 Cal. 4th 541, 566 (2011).
[2] Steven Brill, *Bitter Pill: Why Medical Bills Are Killing Us*, TIME, Mar. 4, 2013, at 10, 19.
[3] Barry Meier, Jo Craven McGinty & Julie Creswell, *Hospital Billing Varies Wildly, Government Data Shows*, N.Y. TIMES, May 8, 2013, at A1.
[4] Howell, 52 Cal. 4th at 566.
[5] *Id.* at 555.
[6] *Id.*
[7] CIV. CODE §§3281, 3283.
[8] Howell, 52 Cal. 4th at 548.
[9] *Id.*
[10] *Id.* at 555 (emphasis in original).
[11] *Id.* at 561-62.
[12] *Id.* at 562.
[13] *Id.* at 561.
[14] *Id.* at 561-62 & n.9.
[15] *See, e.g.*, Luttrell v. Island Pac. Supermarkets, Inc., 215 Cal. App. 4th 196, 199 (2013) ($138,082 accepted as full payment, despite a bill of $690,548.).
[16] Howell, 52 Cal. 4th at 561 (quoting Uwe E. Reinhardt, *The Pricing of U.S. Hospital Services: Chaos behind a Veil of Secrecy*, 25 HEALTH AFFAIRS 57, 63 (2006)).
[17] *Id.* at 562.
[18] *Id.*
[19] Children's Hosp. Cent. Cal. v. Blue Cross, 226 Cal. App. 4th 1260, 1268 (2014).
[20] George A. Nation III, *Obscene Contracts: The Doctrine of Unconscionability and Hospital Billing of the Uninsured*, 94 KY. L.J. 101, 104 (2005) (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.").
[21] Howell, 52 Cal. 4th at 567.
[22] *Id.*
[23] *Id.* at 565.
[24] *Id.* at 567.
[25] Corenbaum v. Lampkin, 215 Cal. App. 4th 1308 (2013).
[26] *Id.* at 1330.
[27] *Id.* at 1331.
[28] *Id.*
[29] Helfend v. S. Cal. Rapid Transit Dist., 2 Cal. 3d 1, 11 (1970) ("[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.").
[30] Corenbaum, 215 Cal. App. 4th at 1333.
[31] *Id.*
[32] Luttrell v. Island Pac. Supermarkets, Inc., 215 Cal. App. 4th 196, 198 (2013) (Medicare); Sanchez v. Brooke, 204 Cal. App. 4th 126, 131 (2012) (workers' compensation system).
[33] Luttrell, 215 Cal. App. 4th at 206 (emphasis in original).
[34] Romine v. Johnson Controls, Inc., 224 Cal. App. 4th 990 (2014).
[35] *Id.* at 1014.
[36] *Id.*
[37] GHK Assocs. v. Mayer Grp. Inc., 224 Cal. App. 3d 856, 873 (1990) (citations omitted) (emphasis in original).
[38] Piscitelli v. Friedenberg, 87 Cal. App. 4th 953, 989 (2001) (quoting Frustuck v. City of Fairfax, 212 Cal. App. 2d 345, 367-68 (1963).
[39] 26 U.S.C. §5000A(a) (2012) ("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.").
[40] 42 U.S.C. §§300gg-1(a), 300gg-2(a).
[41] 42 U.S.C. §300gg-3(a); *see generally* National Fed'n of Indep. Bus. v. Sebelius, 567 U.S. __, 132 S. Ct. 2566, 2580 (2012) (discussing the PPACA's provisions).
[42] *See* Placer County Water Agency v. Hofman, 165 Cal. App. 3d 890, 897 (1985).
[43] Mayes v. Sturdy N. Sales, Inc., 91 Cal. App. 3d 69, 85-86 (1979) (citations omitted); *accord*, Thrifty-Tel, Inc. v. Bezenek, 46 Cal. App. 4th 1559, 1568 (1996).
[44] Howell v. Hamilton Meats & Provisions, Inc., 52 Cal. 4th 541, 557-58 (2011).
[45] Helfend v. Southern Cal. Rapid Transit Dist., 2 Cal. 3d 1, 7 n.5 (1970).
[46] Arambula v. Wells, 72 Cal. App. 4th 1006, 1010 (1999).
[47] *Id.* at 1008.
[48] *Id.* at 1013.
[49] Howell, 52 Cal. 4th at 559.
[50] Sanchez v. Strickland, 200 Cal. App. 4th 758 (2011).
[51] *Id.* at 767.
[52] *Id.* (quoting declaration of Vibra Healthcare operations manager).
[53] *Id.* at 769.
[54] *Id.*
[55] *See* Howell v. Hamilton Meats & Provisions, Inc., 52 Cal. 4th 541, 558-59 (2011).
[56] Sanchez, 200 Cal. App. 4th at 767.
[57] Dodd v. Cruz, 167 Cal. Rptr. 3d 601 (2014).
[58] "A Supreme Court order to depublish 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." Cal. R. Ct. 8.1125(d).
[59] Dodd, 167 Cal. Rptr. at 603-04.
[60] *Id.* at 604.
[61] *Id.* at 606-07.
[62] *Id.* at 608.
[63] *Id.*
[64] *Cf.* Katiuzhinsky v. Perry, 152 Cal. App. 4th 1288, 1296 (2007).
[65] Children's Hosp. Cent. Cal. v. Blue Cross, 226 Cal. App. 4th 1260, 1277 (2014).

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