S179115

IN THE
SUPREME COURT OF CALIFORNIA

REBECCA HOWELL,

Plaintiff and Appellant

vs.

HAMILTON MEATS & PROVISIONS, INC.

Defendant and Respondent.

After A Decision By The Court of Appeal
Fourth Appellate District (Division One)
Case No. DO53620
(Superior Court Case GIN053925; The Hon. Adrienne Orfield)

REPLY BRIEF ON THE MERITS

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I.

INTRODUCTION

Plaintiff's opposition makes one thing clear: under any tortured scenario postured in the answer brief, the collateral source rule will no longer exist. The rule has been misconstrued and contorted to fit a dream holding for plaintiffs and their attorneys, while significantly hurting California consumers. Plaintiff's concern about third party negotiations and benefits has nothing to do with the collateral source rule and is a purposeful attempt to cloud a bright-line, longstanding rule: Insured plaintiffs are entitled to a windfall recovery of medical expenses that were paid on their behalf, not what was billed.

The collateral source rule as explained by this court in *Helfend v. Southern Cal. Rapid Transit Dist.* (1970) 2 Cal.3d 1, and in BLACK'S Law Dictionary, focuses on the plaintiff and "payment."[1] The new rule requested by plaintiff focuses on everyone but herself and on everything except the "payment" that was made on her behalf. Plaintiff's attempt to get more money because a hospital has more patients or one insurance company pays less than another for treatment, has nothing to do with

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[1] BLACK'S defines the rule as follows: "The doctrine that if an injured party receives *compensation* for its injuries from a source independent of the tortfeasor, the *payment* should not be deducted from the damages that the tortfeasor must pay. Insurance *proceeds* are the most common collateral source." (Emphasis added.)

"payment" as defined by this court or any reasonable interpretation of the word. The collateral source rule has always been focused on the plaintiff and "payments" made on her behalf. To attempt to construe otherwise is misleading and unfounded.

Plaintiff is so desperate to receive more than just a windfall, she admits the collateral source rule should not be followed. Plaintiff states "if a defendant believes a provider's charges are unreasonable..., the defendant can submit its evidence and have the trier of fact decide the question." (Answer brief, p. 18.) No, a defendant cannot introduce this evidence. The collateral source rule holds the exact opposite of what plaintiff proposes: defendants are prohibited from introducing evidence of what was paid by insurance carriers. While some defense *amicus* briefs may agree with plaintiff, that all evidence of the reasonableness of medical bills including insurance payments be presented to a jury, this too would be the end of the collateral source rule. Although it is tempting to have a jury do what it does whenever it evaluates damages – look at the evidence of what was paid – this is not the case with the collateral source rule. The collateral source rule, while admittedly providing a windfall to insured plaintiffs, is a valuable and just rule which must be protected.

HOWELL proposes a new rule that goes beyond the mark and blindly allows her and other plaintiffs to recover whatever gross amount is

simply "billed" for medical care. The proposal is absurd and mocks the very essence of our system of compensatory damages. "The logic behind the rule does not extend so far." *Rotolo Chevrolet v. Superior Court* (2003) 105 Cal.App.4th 242, 247 (holding *disability* pension benefits are *not* a collateral source where employee also may recover regular pension benefits). Although the collateral source rule "bends to the needs of equity and fairness," there is nothing equitable or fair about imposing the cost of HOWELL's super-windfall damages on defendants and policyholders state-wide. *Rotolo, supra,* 105 Cal.App.4th at 249, fn 8. Bending the rule to cover such superfluous, non-existent "damages" does not merely modify the rule, it breaks it.

II.

EVERYONE "BENEFITS" FROM PRECAUTIONARY ACTIONS TAKEN BY PLAINTIFFS

In her Answer Brief, HOWELL focused heavily on the supposed unfairness of defendants benefitting from the prudence and foresight of plaintiffs' retention of health insurance. Nonsense! Without objection, HAMILTON paid every penny to HOWELL which her medical insurer paid to her medical providers. HAMILTON received no "benefit."

As for the balance of the *non-collectible*, gross charges, no one ever owed the amounts. Defendants (and society in general) commonly benefit from the mitigation of damages by plaintiffs. In fact, it is the rule. *Green v. Smith* (1968) 261 Cal.App.2d 392, 396 (wrongdoer not required to compensate the injured party for damages which are avoidable by reasonable effort on the latter's part); CACI 3930 (Mitigation of Damages—Personal Injury). The beneficial result is the same for precautionary actions taken by a plaintiff before an accident occurs.

For example, a plaintiff's potential damages may be directly and significantly reduced as a result of a *plaintiff's purchase* of a vehicle with multiple airbags, anti-lock brakes, anti-rollover technology, collision-avoidance alerts, or a specially engineered frame that provides heightened collision protection to occupants. Though increasingly common in modern vehicles, these safety features are not free, nor always standard. Vehicles with optional safety features may cost thousands more than a comparable vehicle without them. Defendants play no role in purchasing the features for plaintiffs. Defendants play no role in their creation. However, personal injury litigation defendants (and society at large) benefit from their existence because plaintiffs' potential injuries are reduced or avoided altogether. Resulting settlements and verdicts are correspondingly reduced.

Despite the "benefit" operationally bestowed on defendants from a plaintiff's purchase of safety features, the law does not compel defendants to pay for injuries that *would have* occurred absent the safety items. Yet if plaintiff gets her way, that will be the result. The radical expansion of the collateral source rule will cost all individual and business defendants, liability insurers, and all policyholders in California billions of dollars in the process.

III.

PLAINTIFF'S MEDICAL INSURANCE PRECLUDED HER ALLEGED EXPOSURE TO THE GROSS BILLS

Had plaintiff not had health insurance, she *may* have been charged and pursued for the gross billed amount for medical services, also known as "chargemaster" rates.[2] However, medical insurance *was* in place when the underlying accident occurred and medical treatment administered. Thus, plaintiff was never exposed to liability for any portion of the gross chargemaster rates above the amount paid by her health insurer for the

[2] For purposes of this brief, the gross charges will be alternatively referred to as "chargemaster" rates. *Health & Safety Code* § 1339.51 refer to the same items as "charge description master" rates. Such rates are defined as a "uniform schedule of charges represented by the hospital as the *gross* billed charge for a given service or item, regardless of payer type." *Health & Safety Code* § 1339.51(b)(1) (emphasis added).

medical services. Plaintiff admits her medical "debts were satisfied" and nothing remains to be paid by her or her medical insurance carrier. (2 AA 345:1-3.)

Like an airbag or anti-rollover technology, the health insurance was already in place when the underlying tort occurred. In our society, benefits to one (e.g., reduced physical injuries, reduced medical treatment and expenses), benefit others (mitigated judgments for business and individual defendants, lower liability insurance premiums, lower societal costs). This is how society works. HOWELL would have it otherwise, extracting payment for non-existent medical charges at the expense of innocent policyholders and businesses state-wide.

The avoidance of greater personal injuries due to safety equipment is a real, tangible benefit. It would be perverse and illegal to exact payment from litigation defendants for speculative injuries that "might have been." It would be equally perverse to exact payment from personal injury litigation defendants for medical bills which have never been imposed, charged, nor pursued by *anyone, anywhere, at any time.*

A. The Healthcare Providers' Intake Forms Never Obligated HOWELL To Pay More Than Her Medical Insurer Paid

The two agreements HOWELL signed with Scripps Memorial Hospital ("Scripps") and CORE Orthopedics ("CORE") prior to her receipt of treatment never obligated her to pay more than what her medical insurer paid for the medical services. (2 AA pp. 368-370.) The documents are not the smoking gun plaintiff purports.

There is no dispute HOWELL had medical insurance in place at the time the Scripps and CORE documents were executed. Therefore, her alleged liability for the "usual and customary charges" referenced in the provider agreements never existed. This alone prevents HOWELL from claiming she was ever liable for the gross charges billed by the medical providers. Further examination of the agreements themselves also undermines HOWELL's claim of detriment for the total charges.

1. The Scripps Memorial Hospital Consent Form

The first referenced agreement was generated by Scripps and is dated October 30, 2006. (2 AA 368-369.) This agreement, which is actually a consent form, was executed and dated ten (10) months *after* HOWELL's first surgery at Scripps that occurred in January 2006, and only days before her second surgery, which occurred on November 3, 2006. (2 AA 292:17-

19.) In other words, the sole Scripps agreement produced by HOWELL appears related to her second surgery only. The form is irrelevant for other reasons.

First, the Scripps agreement is a consent form by which HOWELL merely consented to medical services. The first paragraph titled "Consent to Medical, Nursing, and Surgical Procedures" makes this clear. The next four paragraphs cover issues including "Relationship between Facilities and Physicians," "Graduate Medical Education/Research Procedures," "Release" of medical information, and "Medical Photography."

The sixth paragraph finally mentions "Financial Arrangement." There, HOWELL is purportedly "obligated to pay the Facility's usual and customary charges for [medical] services." There is no indication on this consent form or any other evidence submitted by HOWELL that the medical bills submitted by HOWELL reflect the "usual and customary charges." This defect also limits the supposed application of the consent form.

Second, the consent form was executed with HOWELL's health insurance in place. The insurer and Scripps were already operating pursuant to pre-existing agreements which set forth what amounts the insurer would pay, and Scripps would accept as payment in full, for future medical services.

Third, the seventh paragraph of the consent form purportedly obligates HOWELL to pay any "not paid" portion of the "usual and customary" charges not satisfied by "third party payers" or "insurance." (2 AA 368.) HOWELL *was never pursued for such amounts, if any*, due to the pre-existing agreements between HOWELL's insurer and Scripps. As plaintiff's counsel admits: "The bills were submitted to PacifiCare and the debts were satisfied pursuant to the contracts between Plaintiff and PacifiCare and between PacifiCare and the treatment providers." (2 AA 345:1-3.)

The perfunctory execution of the consent form by HOWELL prior to her *second* surgery did not alter or usurp the pre-existing contracts acknowledged by HOWELL. Plaintiff never incurred the gross chargemaster rates, regardless of the boilerplate language of the consent form.

2. The CORE Orthopedic "New Patient Information" Form

The second admission form referenced by HOWELL was issued by CORE and signed on March 30, 2006. (2 AA 370.) The "New Patient Information" form clearly identifies "Pacific Care PPO" as plaintiff's "insurance company". (*Id.*) The form acknowledges that certain insurers

pay certain fees for certain procedures and that HOWELL assigns all insurance benefits to CORE. Specifically, the form reads in part:

> Some companies pay fixed allowances for certain procedures, others pay a percentage of the charge. It is your responsibility to pay any co-insurance, or any other balance not paid for by your insurance. . . . I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medi-Care, private insurance, and other health plans to the provider.

Accordingly, HOWELL assigned all medical insurance benefits to CORE, *prior* to her receipt of medical services from CORE. Moreover, the only debt to which she agreed was any "balance not paid for" by her insurer. However, no balance remains due to CORE. (2 AA 307:3-12.) HOWELL also concedes this. (2 AA 345:1-3.)[3]

Though the CORE form purports to make HOWELL "financially responsible" for all charges "whether or not paid by said insurance," the statement is meaningless because no financial responsibility exists for

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[3] Statements made in a brief or oral argument by counsel "are reliable indications of a party's position on the facts as well as the law, and a reviewing court may make use of the statements therein as admissions against the party." *DeRose v. Carswell* (1987) 196 Cal.App.3d 1011, 1019, fn. 3 (case superseded by statute on other grounds). *See also, Browne v. Superior Court* (1940) 16 Cal.2d 593, 599 (Supreme Court relied upon statements by counsel at oral argument to show that the only proper ground for an action does not exist.).

charges paid and satisfied by an insurer of HOWELL. The statement also makes this intake form inherently inconsistent.

As with the Scripps consent form, the "New Patient Information" did not amend, modify, or usurp the pre-existing Pacificare medical insurance policy, nor the pre-existing contract between Pacificare and CORE. The form does not impose any additional financial obligations on HOWELL beyond what those pre-existing agreements and policy require. Therefore, it cannot operate to provide an additional damage award to HOWELL beyond that for which she was actually obligated. "*The primary object of an award of damages* in a civil action, and the fundamental principle on which it is based, are *just compensation* or indemnity for the loss or injury sustained by the complainant, *and no more* [citations]." *Mozzetti v. City of Brisbane* (1977) 67 Cal.App.3d 565, 576 (original emphasis).

3. The Admission Forms Do Not Provide for Recovery of Non-Incurred Bills

The foregoing consent and information forms did not require HOWELL to pay anything above what her medical insurer paid to satisfy the gross "list" prices billed by the healthcare providers, because no balance remained after payment by the insurer. Inflated charges that are never pursued or paid are not "detriment proximately caused" by the defendant's

conduct. *Civil Code* § 3333 ([T]he measure of damages...is the amount which will compensate for all the detriment proximately caused thereby". . .)

The excessive "detriment" plaintiff hopes to persuade this Court existed was merely theoretical, never actual. Medical expenses actually paid, or required to be paid, are economic damages. *Civil Code* § 1431.2(b)(1) (economic damages include "*objectively verifiable monetary losses*, including medical expenses...")(emphasis added); *Hanif v. Housing Authority* (1988) 200 Cal.App.3d 635, 641. The gross charges above and beyond the amount accepted as payment in full by Scripps and CORE do not represent "verifiable monetary losses" to HOWELL. In this instance, they do not even represent "verifiable monetary losses" to her insurer, PacifiCare, nor to her medical providers.

It is clear that recovery by HOWELL of such theoretical detriment could only qualify as one thing: profit to her and her counsel, not reimbursement or recompense. HOWELL owes nothing. She never owed anything for the excess above what PacifiCare paid in exchange for medical services. Thus, HOWELL is owed nothing for that excess by HAMILTON.

B. Defendant Always Disputed Whether HOWELL Incurred Detriment For The Gross Medical Bills

Defendant never withdrew its objection to the issue of the actual past medical bills recoverable by HOWELL. As shown, Defendant moved *in limine* to exclude evidence of the excess portion of bills that were not pursued by the healthcare providers or paid by Pacificare. (1 AA 73-107.) Though the *in limine* motion was denied, the trial court specifically advised the final past medical expense award would be determined "post trial." (1 RT 67:13-16.) Accordingly, Defendant made no further dispute of the gross bills at trial, *solely in reliance on the anticipated post-trial motion procedure to deduct the illegitimate amounts.*

Indeed, HOWELL's counsel suggested the issue be determined post-trial:

> **Mr. Basile [Howell's counsel]**: ...My proposal would be just agree to what the number for past medical bills, **and you guys can raise all the other arguments post trial**, like if the Court inquired.
>
> . . .
>
> **Mr. Tyson [Hamilton's counsel]**: So we're clear, I assume, it's the Court's position and ruling that the jury gets to see the entire medical bills and so there's no need for us to argue that they just see the reduced one?
>
> **The Court**: Correct.
>
> **Mr. Tyson**: You handle that at post-trial Hanif motion.

The Court: Correct.

(1 RT 67:13-16; 68:10-13, 27-28; 69:1-6 (emphasis added).)

In accordance with that pre-trial agreement between both parties and the trial court, the gross bills were submitted to the jury and Defendant filed its post-verdict *Hanif* motion. (1 AA 123-176.) Defendant has never retreated from its position that HOWELL is entitled to recover the actual amounts paid by her insurance carrier for medical treatment, nothing more.

IV.

HOWELL WAIVED OBJECTIONS TO THE EVIDENCE SUPPORTING THE ACTUAL PAID AMOUNTS

HOWELL asserts she filed evidentiary objections to the declarations of the billing personnel, which declarations explained the actual amount accepted as payment in full by Scripps and CORE. (See, Answer Brief, p. 8.) Defendants acknowledge such objections were submitted. However, they were not filed until three months *after* HOWELL filed her opposition to the *Hanif* motion and more than two months after the *Hanif* motion was heard. (1 AA 211; 2 AA 339-463; 3 AA 604-607; 5 RT 253:23-28.)

During the *Hanif* motion hearing, HOWELL acknowledged the discretion of the court to conclude the matter *after one hearing*, or a second

hearing *if* necessary. (5 RT 250:1-13.) HOWELL was not precluded from filing her objections with her opposition to the *Hanif* motion.

HOWELL also referred the trial court to "in kind benefits" and contracts between HOWELL and her medical insurer. (8 RT 293:17-294:3.) Although HOWELL referred and objected to the declarations and evidence submitted by HAMILTON in support of the *Hanif* motion, she failed to file written evidentiary objections until months after the hearing.

The evidentiary objections were deemed filed as of July 16, 2008. (3 AA 618.) Moreover, plaintiff's counsel "indicate[d] to the Court that a further hearing is not necessary and is requesting that his supplemental be filed and made a part of the record." (3 AA 618.)

The trial court entertained all of HOWELL'S arguments on the issue. (8 RT 308:10-323:20.) At the conclusion of the lengthy oral argument at the *Hanif* motion, HOWELL'S counsel expressed satisfaction with the matters submitted to the trial court:

> [Court]: Gentlemen, I think we have enough on the record unless you feel that something else needs to be in.
>
> [Mr. Rice for Howell]: I don't think so, Your Honor.
>
> . . .
>
> [Court]: I'll take the matter under submission and I will try to get you something as soon as I can.
>
> And again, depending on what I decide, then we'll determine what's next. If I feel that if I make a decision that warrants another hearing, then I'll schedule the hearing. **If I make a decision that just warrants a reduction of**

> **some type, the it will be *nunc pro tunc* to the time the judgment is filed.** [March 4.].
> . . .
> [Mr. Rice]: The only caveat is, we only briefed the substantive law issues. **But I think the argument sort of covered most of what would be in the paper anyway.**

(8 RT 334:18- 335:14; emphases added.)

Given HOWELL'S knowledge that the matter might be determined after only one hearing on May 19, 2008, and HOWELL'S counsel addressing evidentiary objections at the May 19 hearing, the written evidentiary objections filed by HOWELL on July 16, 2008 are untimely and waived. Accordingly, the evidentiary arguments posited by HOWELL at this stage should be ignored.

V.

INITIAL ARGUMENT

Plaintiff inaccurately describes Defendant's position. *First*, Defendant's argument is *not* with healthcare providers' billing rates and practices as plaintiff claims. Although billing rates vary widely, that issue is not for determination here.[4] Rather, the actual payments by medical

[4] Indeed, it is trial and appellate counsel for HOWELL, Michael Vallee, who has attacked charges by medical providers in San Diego County. In a recently published appellate decision, Mr. Vallee--who is also HOWELL's husband--asserted "chargemaster" medical fees billed

insurers to satisfy the gross bills accurately reflect the true value of the medical services provided to plaintiff.[5] No one forces the healthcare providers and medical insurers to enter such agreements. The arms-length negotiations and terms between those two parties are settled pursuant to market forces and what each party deems in its best interests. To ignore the negotiated rates is to ignore the true value of the services provided.

Second, the gross billed amounts were introduced to the jury by way of the denial of HAMILTON'S *in limine* motion and the trial court's call for a post-trial hearing to determine the actual value of the medical services based upon the amount paid by the medical insurer. HOWELL's argument that a jury could resolve the issue of reasonable medical care expenses "in the normal course" is false, because the evidentiary aspect of the collateral source rule precludes (much to plaintiff's delight) evidence of what her

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by Sharp Grossmont Hospital in San Diego County are "excessive, unreasonable, and unconscionable" and "rarely bear any relation to the hospital's costs for providing treatment and differ from the actual, lower charges assessed against the overwhelming majority of patients who participate in Medicare or private insurance programs." *Durell v. Sharp Healthcare* (2010) 183 Cal.App.4th 1350, 1356. (3 AA 566:1-3.)

[5] On this point, Defendant and Mr. Vallee (counsel for HOWELL) agree. In *Durell,* Mr. Vallee argued: "The gross chargemaster rates often form the *starting point* for negotiations between insurance companies and managed care organizations to determine reasonable, and significantly lower, reimbursement rates...." [Brief of Appellant, *Durell v. Sharp Healthcare,* p. 3.]

medical insurer paid to resolve the amounts billed by her medical providers. The amount paid to extinguish the bills is the most accurate indicator of the true value of the services, given its determination by arms-length negotiations between the providers and the insurers. Again, counsel for HOWELL agrees. (See fns.3 and 4, above.)

Third, HOWELL and plaintiffs do not merely seek a "windfall" by recovering amounts above and beyond what insurance carriers pay in total for the medical services. Plaintiffs in California already enjoy a windfall under the collateral source rule for all amounts *paid* by their insurers to satisfy medical bills. What plaintiff seeks here is a "super windfall" above and beyond what the collateral source rule provides. Such a "super windfall" has not previously been permitted in California and would represent new law.

Further, the argument that civil defendants are prohibited from garnering "the benefit of his victim's providence" is an empty proposition, for defendants garner benefits from plaintiffs' providence in purchasing safer vehicles, investing in safe-work practices, investing in fire sprinkler systems, and availing themselves of cutting-edge medical services. All of these reduce and mitigate damages that would otherwise be borne by plaintiffs, and ultimately defendants. The law has never imposed the burden on defendants to pay the difference between what plaintiffs could

have suffered had they not availed themselves of such items and what they actually suffered. Yet that is precisely what HOWELL seeks to impose on all defendants when it comes to non-existent medical bill liability.

Fourth, HOWELL was awarded $350,000 in *general* damages ($200,000 past and $150,000 future) as part of the verdict. (2 AA 219.) The general damages award has been paid in full by HAMILTON and compensates HOWELL for the associated pain, suffering, inconvenience and other burdens associated with her injuries. *Civil Code* §1431.2 (b)(2). In contrast, *medical expenses* are economic damages. *Civil Code* §1431.2 (b)(1). Dissatisfied with the jury's $350,000 *non-economic* damages award, HOWELL seeks to supplement it with an inflated *economic* damages award for imaginary past medical expenses that were never due nor owed by anyone. Blurring the lines between economic and non-economic damages and creating an imaginary element of damages premised on non-incurred medical expenses is not a legally sound method to provide a *super*-damages award to plaintiff.

Fifth, Defendant does not argue that only cash payments are protected by the collateral source rule. Certain exceptions exist, such as gratuitously conferred benefits, which Defendant recognizes and supports. *See, Rodriguez v. McDonnell Douglas Corp.* (1978) 87 Cal.App.3d 626, 662 and *Arambula v. Wells* (1999) 72 Cal.App.4th 1006 (promoting

"charity" by holding gratuitous cash payments to plaintiff by his family-owned business to cover lost wages during his recovery were a collateral source). Moreover, Restatement sections other than 920A have direct application to the circumstances presented here, such as Section 911. *See, Rest. Second of Torts*, § 911, com. h. This section acknowledges the recovery for donated services or gifts, which Defendant does not dispute.

Sixth, there is the general understanding that reduction of medical specials by the trial or appellate court to an amount actually paid by an insurer is generally done so under *Hanif* and/or *Nishihama.* In 1988, the Court of Appeal decided *Hanif v. Housing Authority of Yolo County* (1988) 200 Cal.App.3d 635, in which a medical specials award was reduced to conform to the actual amount paid by Medi-Cal to satisfy the plaintiff's medical bills. In 2001 the Court of Appeal decided *Nishihama v. City and County of San Francisco* (2001) 93 Cal.App.4th 298, in which the Court reduced a medical specials award to conform to the amount actually paid by the plaintiff's private medical insurer to satisfy the bills. Later in *Greer v. Buzgheia* (2006) 141 Cal.App.4th 1150, 1154, the Court of Appeal specifically described the procedure as the "*Hanif/Nishihama* reduction." The court in *Katiuzhinsky v. Perry* (2007) 152 Cal.App.4th 1288, 1296 referred to it as a "*Nishihama*-type reduction" and the court in *Olsen v. Reid*

(2009) 164 Cal.App.4th 255, 257, fn.2, called it "the purported *Hanif/Nishihama* rule."

Seventh, the gross chargemaster rates were never incurred by HOWELL, as discussed above and further below. Thus she is not entitled to recover the imaginary excess above what her insurance carrier paid for the medical services provided to her.

Eighth, a procedural "quagmire" is not imminent in the event this Court rules the chargemaster rates in excess of insurance carrier payments are not recoverable damages. Courts have handled the matter in the past in an orderly post-trial manner and can do so in the future. The Legislature even supports such a method to determine an appropriate medical specials award. *Gov. Code* § 985(b). However, consistency in the procedure pursuant to this Court's direction is welcomed by Defendant.

VI.

THE AMOUNT "PAID" FOR MEDICAL CARE IS THE RECOVERABLE "REASONABLE" VALUE

Plaintiff seeks to recover the gross "chargemaster" rates while ignoring the actual amounts paid by her health insurer to compensate the providers for their services. Plaintiff disregards the reality that, unless coerced, one only pays an amount for goods and services that is reasonable.

Closer examination of the *entire* quotations from the cases cited by plaintiff on this point reveal the utility of the actual amounts paid in the damages analysis.

Plaintiff cites *Townsend v. Keith* (1917) 34 Cal.App. 564 for the proposition that the actual amounts paid play no role in the "correct measure of damages." However, the entire relevant statement by the *Townsend* court reads as follows:

> While the correct measure of damage is the necessary and reasonable value of the services rendered, rather than the amount which may have been paid for such services, nevertheless, **the amount paid for the services is some evidence as to their reasonable value.** [At 565, emphasis added.]

Townsend makes it clear that the actual amount paid is, at least, some evidence of the reasonable value of the medical services. Of course, the case did not deal with payment by a medical insurer or chargemaster rates. Moreover, the defendant in *Townsend* did not even dispute the medical charges claimed by plaintiff, which amounted to a mere $200. *Id.* at 566.

However, *Hanif* specifically cited *Townsend* and held that "implicit" in *Townsend* and other cases on the issue of recoverable medical expenses "is the notion that a plaintiff is entitled to recover *up to, and no more than,* the actual amount expended or incurred for past medical services so long as

the amount is reasonable." *Hanif, supra,* 200 Cal.App.3d at 643. Two principles are made clear here. First, the actual amount paid is a ceiling, not a floor, for recoverable medical expense by a plaintiff. Second, use of the term "incurred" in this context refers to amounts actually due in the future, but not yet paid by the time plaintiff obtains judgment from the defendant.

Another case cited by plaintiff, *Gimbel v. Laramie* (1960) 181 Cal.App.2d 77, further proves the point advanced by Defendant here. In *Gimbel,* the judgment (determined without a jury) included an award for medical expenses and pharmaceutical costs *less* than what plaintiff's medical witnesses had testified were reasonable. *Id.* at 80. Thus, the purported amount paid by plaintiff for medical services--rather than a gross amount billed, of which there was no evidence—was not even fully awarded. The reduced award was affirmed on appeal. *Id.*

The plaintiff in *Gimbel* recovered nothing for the non-itemized "hospital bill." *Id.* at 81. The *Gimbel* court pointed out that the plaintiff/appellant "did not contend that the bill had been paid and thus was some evidence of the reasonableness of the charge." *Id.* at 81. In other words, had the plaintiff shown the bill was paid, that paid amount would have provided evidence "of the reasonableness of the charge." The same is

true here. The amount paid for medical services as payment in full provides all the evidence necessary of the reasonable, recoverable amount.

More importantly, the gross billed amount for medical services is not determinative of a medical expenses award. In *Dimmick v. Alvarez* (1961) 196 Cal.App.2d 211, 216, where the jury returned a verdict for less than the "medical expenses" submitted by the plaintiff, the appellate court held it is not necessary "that the amount of the award [for medical costs] equal the alleged medical expenses for it has long been held the rule that the costs alone of medical treatment and hospitalization do not govern the recovery of such expenses." Again, this case demonstrates the actual paid amount is a cap on recoverable medical expenses, not a floor.

An award to recoup medical expenses does not simply mirror the gross billed amount, as urged by plaintiff. There is more to the calculation. The actual amount paid by a medical insurer for the services is the result of analysis and arms-length negotiations between providers and insurers, thus providing an accurate picture of the "reasonable value" of the services. This is why the paid amount must be considered in order to determine a past medical expenses award. *Townsend v. Keith* (1917) 34 Cal.App. 564, 565.

VII.

THE PARTIES INVOLVED IN THE TRANSACTION ARE SATISFIED

Plaintiff ignores the fact her medical providers and medical insurer claim no defects in their negotiations and contracts. Their transactions related to the provision of medical services to plaintiff are satisfied and closed.

The reasonableness of the amount paid in satisfaction of the medical bills was pre-determined by the two parties most interested in the financial transaction: HOWELL'S medical providers (Scripps and CORE) and her medical insurer (PacifiCare). The providers are obviously satisfied with the arrangement and agreed the amounts paid were the reasonable value of the services rendered to HOWELL. The providers could have expressed their dissatisfaction by rejecting the payments tendered in exchange for the services. They did not do so. The payments were accepted as payment in full, books closed.

Alternatively, plaintiff's medical providers could have expressed dissatisfaction by pursuing her for the difference between the chargemaster rates and the amount accepted from her medical insurer. Plaintiff claims they had the right to do so. However, the medical providers specifically

denied the existence of any balance due after receipt of payment from PacifiCare. (2 AA 307:3-12; 345:1-3.)

Frankly, the satisfaction of the bills pursuant to the agreements reached between the providers and the insurer reveals the artificiality of the issue pressed by HOWELL. Only an artificial extension of the collateral source rule to extract supposed value from a non-valued item (the so-called negotiated rate differential) will satisfy plaintiff. Whether out of a desire to supplement her perceived inadequate general damages award in this action, or whether seen as a potential goldmine for attorneys' fees for the plaintiffs' bar, the so-called negotiated rate differential is of no consequence to the parties who actually arranged, determined, and operate under the medical bill payment system.

Also of no consequence is HOWELL's argument regarding alleged difficulty of evaluating future medical expenses if defendant's position is adopted. The jury awarded $150,000 for "future economic loss, including medical expenses." (1 AA 118.) Defendant has never disputed this portion of the award and has paid HOWELL in full. The future economic damages award simply has no bearing on this appeal.

VIII.

THE COLLATERAL SOURCE RULE IS PROTECTED BY DEFENDANT

Plaintiff misconstrues and radicalizes the collateral source rule to reach her end result. While *Helfend v. Southern Cal. Rapid Transit Dist.* (1970) 2 Cal.3d 1 ("*Helfend*") applies in general--and was scrupulously followed by defendant HAMILTON—its specifics have no application to the separate issue involved in this case.

Helfend did not address the precise issue presented in this case: whether plaintiff has the right to recover the difference between what PacifiCare paid and the gross "chargemaster" amount. Extinguishment of such amounts is contractual, not compensatory, and thus does not implicate the collateral source rule. *Helfend,* 2 Cal.3d at 6. What *Helfend* did address, and has been upheld by HAMILTON, is the reimbursement to plaintiff for amounts paid by her medical insurer to satisfy her medical bills. Anything beyond that is an attempt to recast *Helfend* as something it is not.

Helfend addressed "compensation" and "payment" by an insurance carrier on behalf of a plaintiff/insured as the measurement of the amount a defendant must still pay to a plaintiff. *Helfend,* 2 Cal.3d at 6. This Court's earlier holding in *Anheuser-Busch, Inc. v. Starley* (1946) 28 Cal.2d 347,

349, which plaintiff failed to address, also confirmed the focus on "payment" from a source independent of the defendant which remains due and payable by the defendant. This Court's ruling in *Peri v. Los Angeles Junction Railway Co.* (1943) 22 Cal.2d 111, 131 was also ignored by plaintiff. This omission is not surprising, given *Peri's* clarification that a sum *paid* to plaintiff by his insurance carrier while unable to work due to injury caused by the negligence of the defendant remains recoverable from the defendant.

Returning to *Helfend,* this Court held a defendant should not be able to avoid "payment of full compensation" merely because a plaintiff obtained insurance for himself. *Helfend, supra,* 2 Cal.3d at p. 10. Given the payment by HAMILTON to plaintiff for the *full amount paid* by HOWELL's insurer to Scripps and CORE for the medical services provided, where has HAMILTON avoided "payment of full compensation"? There is no deficit. HAMILTON has paid. HAMILTON has fully complied with the collateral source rule. Payment of anything more to plaintiff and her lawyers (by the way, none of which would go to the medical providers) amounts to super-damages, for which there is no

applicable authority. Other states find plaintiff's position unacceptable as well.[6]

The last point in *Helfend* is the absence of a "double recovery" by plaintiffs where an insurer has a right of reimbursement against a damage award. *Helfend, supra,* 2 Cal. 3d at 10. This point has no relevance to this action, for two reasons. First, HOWELL has provided no evidence her insurer, PacifiCare, has a right of reimbursement for the monies it paid in exchange for the medical services, or that it has ever notified her of an intent to seek reimbursement. Second, even if PacifiCare did hold a right to reimbursement from HOWELL, the only amount subject to reimbursement would be that actually paid by PacifiCare to Scripps and CORE, *not* the chargemaster rates above and beyond what PacifiCare paid. The issue of reimbursement is a non-issue in this case either factually or substantively. It provides no excuse to distort the collateral source rule as HOWELL seeks.

Do not be misled. Defendant has not mounted any "attack" on the collateral source rule. The rule was followed and satisfied to the maximum extent of California law. The fact plaintiff seeks to gather a billing

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[6] *See, Moorhead v. Crozer Chester Medical Center* (Pa. 2001) 564 Pa. 156, 163 ("damages are to be compensatory to the full extent of the injury sustained, but the award should be limited to compensation and compensation alone."); *Dyet v. McKinley* (2003) 139 Idaho 526; *Mills v. Fletcher* (Tex.App. 2007) 229 S.W.3d 768.

byproduct under the umbrella of the collateral source rule does negate the fact defendant fully complied with the rule.

A. Existing Statutory Limitations On The Collateral Source Rule Do Not Prevent This Court From Rejecting Plaintiff's Attempt To Expand The Judge-Made Rule

The collateral source rule was judicially-created in California. Accordingly, this Court can further define the scope of the rule and reject plaintiff's attempt to expand the rule beyond recognition.

For example, the judiciary has determined the collateral source rule is inapplicable in uninsured motorist benefits cases. *Waite v. Godfrey* (1980) 106 Cal.App.3d 760 (clarifying the limitations of *Helfend, supra,* as that decision "concedes the collateral source rule is unpopular in some jurisdictions and that it might not be appropriate in a myriad of possible situations.").

Following the lead of the statutory limitations on the collateral source rule, such as *Government Code* § 985 (public entity defendants) and *Civil Code* § 3333.1 (medical malpractice cases), this Court is well within its authority to put the brakes on the radical expansion of the collateral source rule proposed by plaintiff. The fear-mongering by plaintiff with predictions of "relegating those statutes to the judicial dustbin" is

unfounded, as the cases governed by those statutes would still be obligated to follow the statutory protocol.

B. *Government Code* § 985 Definition of "Collateral Source" Does Not Include the Excess Bills Sought by HOWELL

Government Code § 985 provides a "public entity" defendant the option to file a post-trial motion to reduce the verdict by the amount of the collateral source. The Legislature's definition of "collateral source payment" reveals its intended scope of what comprises a "collateral source." The statute defines "collateral source payments" as follows:

> Monetary *payments paid or obligated to be paid* for services or benefits provided to the plaintiff before trial. *Gov. Code* § 985(a)(1)(B)(emphasis added).

The unequivocal requirement of "payment" reveals the Legislature's intent that a collateral source can only be equal to, but not greater than, actual "payments" made on behalf of a plaintiff when definable costs are associated with collateral source benefits.[7]

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[7] *Gov. Code* § 985(a)(1)(A) also includes "the direct provision of services" to a plaintiff by "prepaid health maintenance organizations" as a collateral source. This alternative definition is irrelevant here for two reasons. First, such organizations typically do not bill an outside insurer for their services, so no defined "payments" are readily calculable. Second, HOWELL did not receive her medical care from a "health maintenance organization."

Actual "payments" have been paid in exchange for the medical services provided to HOWELL by Scripps and CORE. The "payments" made to Scripps and CORE for all services rendered were $37,619.97 (1 AA 125:4-21; 126:4-15; 132:17 -134:24; 136:18- 27.) These "payments" *are* the only collateral source "paid or obligated to be paid" in this case. The Legislature's express definition of "collateral source" in Section 985 does not include the difference between the gross billed amount and the "paid" amount for which no *payment* was made and no *obligation* exists.

C. *Civil Code* § 3333.1 Definition of "Collateral Source" Does Not Include the Excess Bills Sought by HOWELL

The Legislature defined a collateral source again in *Civil Code* § 3333.1(a) as an "amount payable" as governmental benefits under the Social Security Act, disability or workers' compensation act, disability or accident insurance, or any group or entity that "reimburse[s]" the "*cost* of medical, hospital, dental, or other health care services. . .." (Emphasis added.) Again, a collateral source boils down to an "amount payable" for the "cost" of the services provided. "When the Legislature has spoken, the court is not free to substitute its judgment as to the better policy." *City and County of San Francisco v. Sweet* (1995) 12 Cal.4th 105, 121.

The Legislature placed no conditions on the word "cost." The Legislature did not state the "amount payable" really means the amount above and beyond what is "payable," or above and beyond the actual "cost" of collateral benefits for which reimbursement was paid to the plaintiff. Nor did the Legislature embed the phrase "reasonable value" as the measure of the collateral benefits in place of the "amount payable" for such benefits. Despite this second consideration and opportunity to define the collateral source in California, our Legislature did not expand its meaning to cover the difference between gross bills generated by healthcare providers and the actual "amount payable" to satisfy the accounts. In sum, plaintiff can find no relief in the Legislature's definitions for her proposed radical expansion of the collateral source rule to items which never represented an "amount payable" and for which she never needed "reimbursement."

IX.

HANIF AND *NISHAHAMA* PRECLUDE THE NON-BILLS SOUGHT BY HOWELL FROM THE COLLATERAL SOURCE RULE

As set forth in Defendant's opening brief, *Hanif* is not alone in supporting Defendant's position. *Nishihama v. City and County of San Francisco* (2001) 93 Cal.Ap0p.4th 298 ("*Nishihama*") provided review of

Hanif and the proper application of its principles to cases in which private insurance pays a plaintiff's healthcare provider for services rendered.

The principles in *Hanif* are correct and are not limited merely because it involved Medi-Cal benefits. The fact Medi-Cal was the source of the payment in *Hanif* was not the determinative factor in its decision. Nor was *Hanif* "driven by the Medi-Cal statutes" as plaintiff argues. Rather, it was the *amount paid* in satisfaction of the medical bills--regardless if by Medi-Cal or some other provider--which led the *Hanif* court to conclude the maximum amount a plaintiff can recover for medical services is the amount "expended or incurred for past medical services," **even if that amount** "may have been less than the prevailing market rate." *Id.* at 641.

Hanif properly relied on *Rest. of Torts 2d*, §911. That section is directly on point, because it deals with damages recoverable when one sues for "expenditures made or liability incurred to third persons for services rendered." *Rest.of Torts* 2d, §911, com. h. That is precisely what plaintiff has done here!

Plaintiff sued HAMILTON to recover, among other things, expenditures or liability allegedly incurred to her medical providers for the services they rendered to her after the underlying accident. This is the only item of which the past medical damages award is comprised. (2 AA

178:4.) Pursuant to comment "h" of Section 911, if the "injured person paid less than the exchange rate, *he can recover no more than the amount paid*, except when the low rate was intended as a give to him." (Emphasis added.) HOWELL has never claimed the difference between the *amount paid* to her medical providers and the gross bills were intended as a "gift" to her. Accordingly, at least pursuant to this Restatement section, she is not entitled to more than the "amount paid" by her medical insurer for the services provided. The *Hanif* court correct to relied on this section of the *Restatement of Torts, 2d. Hanif, supra,* 200 Cal.App.3d at 643.

A. ***Restatement Second of Torts*, Section 920A Was Properly Applied in *Hanif***

Hanif specifically cited *Restatement Second of Torts,* § 920A in support of the application of the collateral source rule in that case. *Hanif,* 200 Cal.App.3d at 639-640. *Hanif* applied both *Helfend* and Section 920A to find the collateral source rule permitted the plaintiff to recover the full amount paid by Medi-Cal for all injury-related medical care and services. *Id.*

In the same manner, Section 920A applies to this case. HAMILTON satisfied the collateral source rule by reimbursing HOWELL for all amounts paid by her medical insurer for the injury-related medical care and

services. Section 920A calls for nothing more, and certainly not the imaginary "damages" sought by HOWELL for an amount never subject to "payment." Plaintiff strains the language of Section 920A to argue it somehow trumps the application of Section 911. However, Section 920A and the comments thereto are nothing more than an affirmation of the collateral source rule as currently understood in California, prior to the *Howell* decision. For example, comment "a" to Section 920A notes that "payments made" by other sources are known as "collateral-source benefits." Obviously, "payments" refer to a specific dollar amount paid from one to another.

Not finding relief in that language, plaintiff focuses instead on the phrase "benefits conferred" found in comment "a." "Benefits" first appears to be a broader term than "payments," as illustrated in the additional comments in "b." However, the comment notes "benefits" includes "insurance," "advantageous employment arrangements" and "gifts" as collateral sources. HAMILTON does not dispute these benefits as collateral sources. Insurance payments have always been the primary factor of a collateral source in California. Thus, its classification as a collateral source "benefit" under the comment to Section 920A is not controversial.

"Advantageous employment arrangements" and "gifts" are not as readily measureable as "payments." Notwithstanding, defendant agrees

that such matters are collateral sources and plaintiffs are entitled to recovery for same.

None of these comments change the fact that the difference between the chargemaster rates and the amounts accepted by HOWELL'S medical providers did not represent "harm" to HOWELL. Common sense and equity mandate that only benefits which cover "harm" should be recoverable as collateral sources. *Rotolo Chevrolet v. Superior Court* (2003) 105 Cal.App.4th 242, 248 ("[E]quity and common sense" employed by the court to find duplicative disability pension benefits were *not* a collateral source). The chargemaster rates, generated while HOWELL was covered by medical insurance and that were never pursued or collected at anytime, did not represent "harm" to plaintiff.

Finally, *Rest. of Torts, 2d* Section 924 does not change the above analysis. The lone comment to Section 924 addressed by HOWELL is that which pertains to *gratuitous* services. Once again, HAMILTON does not dispute that gratuitous medical or other services provided to a plaintiff are appropriately considered a collateral source. What plaintiff ignores is the main thrust of Section 924: the recovery of damages for a plaintiff for bodily harm is the "reasonable medical and other expenses." However, evidence of the reasonable expenses is the *actual amount paid* for the services, which acts as the ceiling on the recoverable amount, not the floor.

Townsend v. Keith (1917) 34 Cal.App. 564; *Hanif, supra,* 200 Cal.App.3d at 643.

B. *Nishihama* Correctly Held That The Recoverable Debt Is The Amount Accepted by the Medical Provider as Payment In Full

Nishihama, supra, stands for much more than the application of California's Hospital Lien Act. The case is in complete alignment with ours.

The most relevant portion of *Nishihama* is the fact the hospital there accepted payments by Blue Cross as payment in full for the medical services provided to the plaintiff. *Id.* at 306-307. Accordingly, no balance remained for the hospital to pursue against the patient/plaintiff, whether under the Hospital Lien Act ("HLA") or some other procedure. *Nishihama* complies with the later unanimous ruling of this Court in *Parnell v. Adventist Health System/West* (2005) 35 Cal.4th 595 (hospital's recovery under the HLA to the amount the hospital accepted from the plaintiff's health insurer). *Nishihama* is also completely in accord with *Civil Code* §§ 3281 and 3282 (defining "detriment" and "damages"), both statutes which HOWELL completely ignored in her Answer Brief.

The crux of the issue is this: there must be an "underlying debt" in order for a recovery of same to be possible. Here, as in *Nishihama* and

Parnell, the debt is equal to, and not greater than, the amount accepted by plaintiff's medical providers as full payment for the medical services rendered. Until the *Howell* decision in the lower court, no other case in California had ruled otherwise.

X.

FLORIDA LAW CITED BY HOWELL REVEALS GOOD PUBLIC POLICY FOR DISALLOWING RECOVERY OF IMAGINARY DAMAGES

The sound public policy behind the ruling in the Florida case of *Goble v. Frohman* (2005) 901 So.2d 830 applies here. Although the *Goble* court concluded the difference between a provider's gross charges and the cash payment was a collateral source, it did so because a Florida statute specifically precludes the recovery of collateral sources by plaintiffs. *Id.* at 832. Following sound public policy, the *Goble* court holding satisfied the **Florida Legislature's** "intent to reduce 'the litigation costs that arise when insurers are required to pay damages beyond what the injured party actually incurred.'" *Id.* at 832. The *Goble* court specifically approved a lower court's written opinion, which also stated "the allowance of a windfall would undermine the *legislative purpose* of controlling liability insurance

rates because 'insurers will be sure to pass the cost for these *phantom damages* on to Floridians.'" *Id.* (Emphases added.)[8]

The same public policy has been found by our Legislature in *Government Code* § 985 and *Civil Code* § 3333.1. Demanding payment of phantom damages harms everyone, except plaintiffs' lawyers. The excess amount sought by HOWELL is also a super windfall and "beyond what [she] actually incurred." *Goble, supra,* at 832.

XI.

FORTUITY ALWAYS PLAYS A ROLE DETERMINING THE AMOUNT OF DAMAGES IN PERSONAL INJURY CASES

Plaintiffs are found in a variety of circumstances. Some drive vehicles with a myriad of safety features, while others use barely operable seatbelts. Some receive care from the best doctors and medical technology, while others are treated by non-physicians at neighborhood clinics. Some plaintiffs get their vehicles repaired at the costliest facilities, while others have a friend slap Bondo® on their vehicle.

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[8] Interestingly, the "specially concurring" opinion in *Goble* recognized *Hanif* as the standard in California for limiting damages for medical expenses to those actually incurred by the plaintiff. *Id.* at 834. Other states with similar common law rules limiting damages for medical expenses to the discounted amounts were also cited, including Kansas, Louisiana, and Pennsylvania. *Id.* at 834.

Whatever the combination of facts, fortuitousness always plays a role in the damages for which a defendant may be ultimately liable. The fact one plaintiff's medical insurer pays a different amount for medical services, or that one medical provider's chargemaster rates differ from another provider's chargemaster rates, does not convert into a blanket rule that any given chargemaster rate equals the reasonable value of provided medical services. Fortuity is a fact in life and litigation. It does not preclude consideration of actual payments accepted by medical providers for medical services as the measurement of recoverable medical specials.

XII.

ALTERNATIVE RATE CONTRACTS ARE PRESUMED "FAIR AND REASONABLE"

The California Legislature mandates that alternative rate contracts be "fair and reasonable." *Health & Safety Code* §10133.5(b)(4). Permission to "negotiate and enter into contracts [by medical providers and health insurers] for alternative rates of payment" was authorized by the Legislature's amendment of *Insurance Code* §10133(b), (e). The purpose of alternative rate agreements was to "facilitate the development of PPO plans," such as the PacifiCare plan held by HOWELL. *Lori Rubinstein*

Physical Therapy, Inc. v. PTPN, Inc. (2007) 148 Cal.App.4th 1130, 1136-1137.[9]

Insurance Code §10133.5(b)(4) required that regulations be promulgated prior to January 1, 2004 to ensure "alternative rate" agreements "**shall be fair and reasonable.**" *Ins. Code* § 10133.5(b)(4). This requirement of fairness and reasonableness answers the question: Were the rates paid by PacifiCare to HOWELL'S medical providers "fair and reasonable," or stated differently, do they represent the "fair and reasonable" value of the services rendered? The resounding answer must be "yes." If it were not true, the contracting parties would not have entered such agreements.

To ensure fair bargaining power for medical providers when contracting with insurers, the Legislature enacted the "Health Care Providers' Bill of Rights" found in *Insurance Code* § 10133.6. Therein, the Legislature specifically prohibited itself from meddling in the determination of the "rate of payment" agreed to by the medical providers and insurers. *Insurance Code* § 10133.6(f) ("Nothing in this section shall

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[9] Each of the foregoing legislative requirements were enacted for the stated purpose of ensuring that Californians "receive high quality health care coverage in the most efficient and cost-effective manner possible." *Insurance Code* § 10133.6. This section reiterates this goal is furthered by "permitting negotiations for alternative rate contracts between purchasers and payers and both institutional and professional providers...."

be construed or applied as setting the rate of payment to be included in contracts between health insurers and health care providers."). This statute also requires an insurer to provide 45-days notice of a "material change" to the contractual payment rates and allows the provider to terminate the contract if the changes are not acceptable. *Insurance Code* § 10133.65(c). This law provides further evidence and assurance of free, open, arms-length negotiations between medical providers and health insurers.

Accordingly, HOWELL'S medical providers and her PPO insurer, PacifiCare, freely entered their alternative rate contracts without compulsion, or the imposition of payment rates by outside parties. HOWELL makes no claim the contracts are unfair, were coerced, or need modification. Neither do her medical providers or insurer. Thus, the "fair and reasonable" rate of payment to CORE and Scripps sets the fair value for the medical services administered to HOWELL. Any other purported consideration is pure conjecture and speculation.

The "chargemaster" rates are irrelevant. Neither Scripps nor CORE had any ability or right to pursue such rates against HOWELL due to the alternative rate contracts. The rates governing HOWELL'S medical care at Scripps and CORE were set prior to her admission to those facilities by the alternative rate contracts. No authority permits HOWELL to shred the

alternative rate contracts just so she and her lawyers can obtain a super-windfall from the balance of the irrelevant chargemaster rates.

XIII.

CASE LAW CITED BY HOWELL DOES NOT SUPPORT HER CLAIM SHE INCURRED THE BALANCE OF THE CHARGEMASTER RATES

The several cases cited by HOWELL to support of the argument she "incurred" the full chargemaster rates are not on point and should be disregarded. For example, *City and County of San Francisco v. Sweet* (1995) 12 Cal.4th 105 is a case about one thing: the recovery of attorney's fees. The case has no bearing on the issue of what HOWELL purportedly "incurred" here, for several reasons.

The two hospitals in *Sweet* were county hospitals, which were generated by county funds. *Sweet, supra,* 12 Cal.4th 105, 109. No alleged liability for chargemaster rates or other gross billed amounts were in issue. Indeed, this Court specifically noted the "discrepancies" in the various medical specials figures "are not in issue here." *Id.*

The only issue determined in *Sweet* was whether a county's lien for the cost of medical care against a plaintiff/patient's judgment is subject to equitable reduction for a portion of *attorney's fees* incurred by the injured

party in recovering damages from a third party defendant. *Sweet,* 12 Cal.4th at 108, 125. This Court concluded it is not. *Id.* at 125.

HOWELL'S reliance on *Appleman v. National-Ben Franklin Ins. Co. of Illinois* (1978) 84 Cal.App.3d 1012 is equally misplaced. *Appleman* involved an analysis of whether an insurance policy provision excluded indemnity for medical expenses the insured is "not required to pay." *Id.* at 1014. The case only generically mentions in dicta that a patient in a hospital incurs expenses for which he is liable to pay. *Id.* at 1015. It does *not* hold expenses above and beyond what a third party payor covers are incurred, or that recovery is permitted from a liable defendant for expenses above and beyond what is actually paid for the medical services. The *Appleman* case is not on point.

The holding in *Mercy Hospital & Medical Center v. Farmers Ins. Group of Cos.* (1997) 15 Cal.4th 213 is equally far afield of the issues in our case. The referenced "value" of the medical-emergency lien asserted by the hospital was $49,197.95. *Id.* at 216. No chargemaster rates or other purported billed amounts were raised or discussed in the opinion. There is no analysis of how the "value" of the lien was calculated. Perhaps most importantly, *Mercy Hospital* acknowledged the hospital could proceed against the patient for any balance of its "reasonable and necessary charges," though those charges were not defined. *Id.* at 227.

In stark contrast, there is no balance billing claimed or shown in our case. HOWELL has not, nor will be, pursued for any amount of the chargemaster rates or excess above what her medical insurer paid for the medical services. (1 AA 131-175; 2 AA 345:1-3.) If she *had* remained liable for such balance—like the patient in *Katiuzhinsky v. Perry* (2007) 152 Cal.App.4th 1288--HOWELL would have been permitted to recover the balance amount from HAMILTON. This feature of continuing liability was the "crucial" factor that distinguished *Katiuzshinsky* from *Hanif* and *Nishihama*. *Id.* at 1296. There is no similar continuing liability to HOWELL.

Finally, the case of *Prospect Medical Group, Inc. v. Northridge Emergency Group* (2009) 45 Cal.4th 497 provides no relief to HOWELL. The "narrow" issue decided by this Court in *Prospect Medical* was whether emergency room doctors can balance-bill patients for the difference between the bill submitted and the payment received from an HMO. *Id.* at 502. The case did *not* examine the reasonableness of chargemaster rates, or provide that plaintiff/patients could recover the difference between the gross charges and what their insurers paid. Interestingly, however, this Court acknowledged "the bill the doctors submit *may or may not be* the reasonable payment to which they are entitled." *Id.* at 508. Further, *Bell v. Blue Cross of California* (2005) 131 Cal.App.4th 211, 220 was cited by this

Court in *Prospect Medical* for its holding that "emergency room doctors do not have unfettered discretion to charge whatever they may choose for emergency services." *Prospect Medical,* 45 Cal.4th at 508.

Despite the foregoing rationale, HOWELL seeks to establish the opposite new gold standard: *any* bill or charge by medical providers must be considered the end of the "reasonable value" analysis and defendants must pay that amount. That has never been the law in California, nor should it be.

XIV.

CRIMINAL RESTITUTION CASES SUPPORT HAMILTON'S POSITION

The criminal restitution statute in California squarely provides that reimbursement for past medical expenses can be no more than the amount paid by a medical insurer of a crime victim. [10] Corresponding case law

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[10] *Penal Code* §1202.4(f) provides that crime victims in California shall receive restitution from convicted defendants for "economic loss" suffered "as a result of the defendant's conduct...." The "dollar amount" of the restitution must be "sufficient to *fully reimburse* the victim for every determined economic loss as the result of the defendant's criminal conduct," including "medical expenses." Section 1202.4(f)(3)(B) (emphasis added).

Welfare & Institutions Code §730.6(h), the corresponding statute for restitution to victims of crimes committed by minors, also requires the restitution be sufficient to "fully reimburse" the victim for all

unanimously supports this interpretation of the statute. *In re Anthony M.* (2007) 156 Cal.App.4th 1010; *People v. Bergin* (2009) 167 Cal.App.4th 1166; *People v. Millard* (2009) 175 Cal.App.4th 7.

In an attempt to misdirect this Court, HOWELL refers to *People v. Singleton* (1980) 112 Cal.App.3d 418. The case has nothing to do with the criminal-restitution statute. Instead, *Singleton* only deals with the propriety of that defendant's conviction.

Moreover, HAMILTON has never suggested the criminal-restitution statute is limited only to reimbursement for actual medical expenses. The statute also provides reimbursement for, among others, mental health counseling, lost wages or profits, noneconomic losses for psychological harm, and attorney's fees. *Penal Code* § 1202.4 (f)(3)(B), (C), (D), (F), (H).

HOWELL has provided no authority to refute the *In re Anthony M., Bergin,* and *Millard* cases, all of which set medical expenses reimbursement equal to the amount paid by health insurers of crime victims. The cited case of *People v. Birkett* (1999) 21 Cal.4th 226 only decided the narrow issue of whether a restitution order (under the prior 1994 statute) is payable to a crime victim *and* their insurer, where the insurer partially paid for the economic loss. *Id.* at 234. The case did not

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economic loss occasioned by the crime. Application of *Hanif* and *Nishihama, supra,* is consistent with these legislative requirements.

even address medical expenses, but rather, dealt only with property insurance for stolen and damaged vehicles. *Id.* at 229.

Further, *Birkett's* holding of "full restitution" for all "losses" is consistent with the newer cases cited above, because a crime victim, like any other medical patient, does not suffer "loss" for medical bills never pursued or charged by a medical provider. Finally, *Birkett's* acknowledgment of *Helfend, supra,* is of no consequence. *Helfend's* definition of the collateral source rule has been fully honored by HAMILTON due to the reimbursement to HOWELL for all monies paid by her medical insurer. *Birkett* adds nothing to the issue presently before this Court.

Criminal defendants in California are not required to pay restitution to their crime victims for past *medical expenses* in excess of what the victims' medical insurers pay for medical services rendered.[11] HAMILTON committed no crimes against HOWELL. Justice and equity demand HAMILTON not be forced to pay an imaginary damages award above and beyond what even the worst criminals are ordered to pay as restitution for their crimes.

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[11] HOWELL also cites *People v. Carbajal* (1995) 10 Cal.4th 1114 (vehicle property damage); *In re Brian S.* (1982) 130 Cal.App.3d 523 (vandalism and burglary damage); *People v. Baker* (2005) 126 Cal.App.4th 463 (cattle theft), and; *People v. Ortiz* (1997) 53 Cal.App.4th 791 (counterfeit cassette tapes). None of these cases dealt with restitution for past medical expenses.

XV.

PROCEDURAL ISSUES

HOWELL misses the point on the procedural aspects of this issue. First, the new trial motion and motion to vacate filed by HAMILTON were done so in response to the trial court's admitted error in entering judgment *prior* to HAMILTON being permitted to review the proposed judgment. The *Hanif* motion had also already been filed and was awaiting decision when the judgment was inadvertently entered. (8 RT 271:28- p. 272:3; 272:7-9, 13-20.) Regardless, the motions for new trial and to vacate the judgment were not granted by the trial court, so the issue is moot. (2 AA 551.)

A. Plaintiff Recommended And Consented To The Trial Court Procedure

As shown above, HOWELL encouraged and consented to the procedure the trial court followed in reaching its decision. The recommendation by HOWELL'S counsel for a post-trial hearing on the issue prohibits HOWELL from now claiming she was coerced into such procedure. (1 RT 67:13-16; 68:10-13, 27-28; 69:1-6 (emphasis added).)

Further, HOWELL praised the trial court for handling the matter "in a very rational way." (6 RT 259:25- 26.) During the *Hanif* motion

hearing on May 19, 2008, HOWELL'S counsel also stipulated to the trial court's proposal that it simply modify the judgment *nunc pro tunc* if HAMILTON prevailed on its motion.

Specifically, HOWELL'S husband-attorney (Mike Vallee) stated that was a "fair way to do it" and the procedure "makes sense." (8 RT 273:13-16.) HOWELL'S other attorney (John Rice) told the court "that's the proper way to do it" and agreed the trial court "certainly does have the power *nunc pro tunc* to revise the judgment back to the date that the judgment was first entered." (8 RT 273:13-16; 274:2-13.) HOWELL forfeited any objections to the procedural manner in which the trial court reached its decision. *In re S.B.* (2004) 32 Cal.4th 1287, 1293, fn. 2.

B. Other Case Law Affirms the Trial Court Procedure

Greer v. Buzgheia (2006) 141 Cal.App.4th 1150 confirmed a *trial court* can also make such modifications after trial. In *Greer,* the trial court denied defendant's motion *in limine* to preclude submission of the non-reduced medical bills, but "made it clear that if the jury rendered an award that was excessive under *Hanif/Nishihama*, it would consider a post-trial motion to reduce the recovery." *Id.* at 1157. The appellate court specifically affirmed a post-verdict motion would be an acceptable method to determine a *Hanif/Nishihama* reduction of the damages verdict, wherein

it held: "[T]he trial court did not abuse its discretion in allowing evidence of the reasonable cost of plaintiff's care while reserving the propriety of a *Hanif/Nishihama* reduction until after the verdict." *Greer,* 141 Cal.App.4th at 1157. The same procedure was followed here.

XVII

CONCLUSION

For the reasons set forth in HAMILTON's Opening Brief and above, the decision of the trial court should be affirmed and the *Howell* decision reversed.

Dated: July 26, 2010

Respectfully submitted,

TYSON & MENDES, LLP

By: _____

Robert F. Tyson
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Attorneys for Defendant/Respondent
HAMILTON MEATS & PROVISIONS, INC.

CERTIFICATE OF WORD COUNT

Pursuant to California Rules of Court, Rule 8.204(c)(1), I certify that this Opening Brief On The Merits contains 10,759 words, not including the table of contents and authorities, the caption page, or this Certificate page.

Dated: July 26, 2010

Mark T. Petersen, Esq.

LEXSEE 564 PA. 156

JAYNET A. MOORHEAD, ADMINISTRATRIX OF THE ESTATE OF CATHERINE B. BAXTER, DECEASED, Appellant v. CROZER CHESTER MEDICAL CENTER, Appellee

No. 184 M.D. Appeal Docket 1998

SUPREME COURT OF PENNSYLVANIA

564 Pa. 156; 765 A.2d 786; 2001 Pa. LEXIS 210

April 27, 1999, Argued
January 29, 2001, Decided

PRIOR HISTORY: [***1] Appeal from the Order and Opinion of the Superior Court at No. 261 PHL 1997, affirming the Judgment of the Court of Common Pleas of Delaware County on December 13, 1996, *No. 94-5637. 705 A.2d 452 (Pa. Super. 1997).*

This Opinion Substituted by the Court for Withdrawn Opinion of December 22, 2000, Previously Reported at: *2000 Pa. LEXIS 2992.*

DISPOSITION: Affirmed the order of the Superior Court, but on different grounds.

COUNSEL: FOR APPELLANT, Jaynet Moorhead: Joseph M. Fioravanti, Esquire.

FOR APPELLEE, Crozer Chester Medical Center: R. Bruce Morrison, Esquire, Daniel J. Sheery, Esquire.

JUDGES: MR. JUSTICE CAPPY. Mr. Justice Saylor did not participate in the consideration or decision of this matter. Mr. Justice Zappala concurs in the result. Mr. Justice Nigro files a dissenting opinion.

OPINION BY: CAPPY

OPINION

[*158]

[**787] **OPINION**

[1]

1 The opinion was reassigned to this author.

MR. JUSTICE CAPPY

The issue in this case concerns the appropriate measure of compensatory damages for past medical [***2] expenses. [*159] For the following reasons, we affirm the order of the Superior Court, although on different grounds. [2]

2 We may affirm the order of the court below if the result reached is correct without regard to the grounds relied upon by that court. *Pennsylvania Game Comm'n v. State Civil Service Comm'n (Toth), 561 Pa. 19, 747 A.2d 887, 888 n.1 (Pa. 2000)* (citations omitted).

Appellant's decedent Catherine Baxter ("Baxter") fell and injured herself while she was a patient at Appellee's facility. Appellee provided medical services to Baxter for the injuries she received. Subsequently, Baxter commenced a medical malpractice action against Appellee. Following Baxter's death, Appellant, as administratrix of Baxter's estate, was substituted as the plaintiff. As the case proceeded to trial, an issue arose as to the appropriate measure of compensatory damages for Baxter's past medical expenses. The court reserved that issue for itself and submitted the case to the jury, which returned a verdict in [***3] favor of Appellant, awarding $ 46,500 in non-economic damages including pain and suffering.

In an "Agreed Upon Statement of Facts Pursuant to *Pa.R.A.P. 1925*", the parties established the following facts with regard to the issue of compensation for past medical [**788] expenses: Baxter was covered by Medicare as well as a "Blue Cross 65" supplemental plan, for which she had paid premiums. R. 12a. The fair

and reasonable value of the medical services rendered to Baxter was $ 108,668.31. Id. The Medicare allowance for those services was $ 12,167.40. Id. Of the $ 12,167.40, eighty percent was paid by Medicare and twenty percent was paid by Blue Cross 65. Id. Appellee was a voluntary participant in the Medicare program and consequently accepted the $ 12,167.40 as payment in full for the medical services it rendered. Id. Appellee cannot obtain the difference of the cost of its services and the Medicare allowance (i.e. $ 96,500.91) from Appellant or from any other source. R. 12a-13a. Conversely, Appellant never was and never will be legally obligated to pay more than $ 12,167.40 for the medical services. R. 13a. Appellant contended that she was entitled to the full $ 108,668.31, [***4] while Appellee maintained that her recovery was limited to $ 12,167.40. R. 12a.

[*160] The trial court agreed with Appellee that Appellant was entitled to recover $ 12,167.40, the amount actually paid and accepted as full payment for the medical services rendered by Appellee. On appeal, a divided panel of the Superior Court affirmed, but on different grounds. Two judges, relying on *Kashner v. Geisinger, 432 Pa. Super. 361, 638 A.2d 980 (Pa. Super. 1994)*, determined that the reasonable value of the services was $ 108,668.31, but that Appellee was entitled to a setoff of $ 96,500.91 since Appellee, as tortfeasor, forgave that amount, thereby contributing that amount towards its liability. See *Restatement (Second) of Torts § 920A(1)*. [3] Since Appellee's liability for damages after the setoff was $ 12,167.40, the same amount awarded by the trial court, the Superior Court affirmed the trial court's judgment. One judge dissented, arguing that Appellee was not entitled to a setoff for forgiving the excess amount because Appellee was contractually bound to accept that amount and therefore made no contribution to Appellant that Appellant had not already received from Medicare. [***5]

3 *Section 920A*, entitled "Effect of Payments Made to Injured Party", provides:

> (1) A payment made by a tortfeasor or by a person acting for him to a person whom he has injured is credited against his tort liability, as are payments made by another who is, or believes he is, subject to the same tort liability.
>
> (2) Payments made to or benefits conferred on the injured party from other sources are not credited against the tortfeasor's liability, although they cover all or a part of the harm for which the tortfeasor is liable.

Appellant contends that Appellee is not entitled to a setoff because it was contractually bound to accept the Medicare allowance and therefore made no payment to Baxter; that a setoff presupposes an existing obligation of the plaintiff which in this case is non-existent; that the collateral source rule precludes Appellee from profiting from the Medicare benefits; and that the Superior Court's decision arbitrarily assigns second-class claimant status to senior citizens [***6] who provide for their retirement medical expenses. Appellee counters that the trial court correctly determined that the reasonable value [*161] of the services was the amount actually paid, and in the alternative, the Superior Court properly granted a setoff.

On appeal, conclusions of law are always subject to our review. *Fiore v. Fiore, 405 Pa. 303, 174 A.2d 858, 859 (Pa. 1961)*. As this issue involves a question of law, our scope of review is plenary. *Phillips v. A-Best Products Co., 542 Pa. 124, 665 A.2d 1167, 1170 (Pa. 1995)*. The issue we must resolve is this: is Appellant entitled to collect the additional amount of $ 96,500.91, or is her recovery limited to $ 12,167.40, the amount actually paid for the medical services? We find that consistent with principles of fair compensation, she is entitled to the amount actually paid.

[**789] Initially, we will address Appellant's contention that Appellee is bound by the "Agreed Upon Statement Pursuant to *Pa.R.A.P. 1925*," which indicates that the fair and reasonable value of the medical services is $ 108,668.31. R. 12a. "Parties may by stipulation resolve questions of fact or limit the issues, and, if the stipulations [***7] do not affect the jurisdiction of the court or the due order of the business and convenience of the court, they become the law of the case." *Parsonese v. Midland Nat'l Ins. Co., 550 Pa. 423, 706 A.2d 814, 815 (Pa. 1998)* (citations omitted). In this case, the statement was only as to facts (R.R. 11a), and this court's review of a legal issue cannot be supplanted by a stipulation. See *Pittsburgh Miracle Mile Town & Country Shopping Center v. Board of Property Assessment, etc. 417 Pa. 243, 209 A.2d 394 (Pa. 1965)* (stipulation as to fair market value is merely evidentiary expedient on appeal and does not change court's obligation to determine correctness of the assessment as a whole). It is clear that Appellee was not conceding that Appellant was entitled to the full $ 108,668.31; to the contrary, both parties agreed that Appellee contended that Appellant's recovery should be limited to $ 12,167.40. R.12a. The stipulation cannot preclude this court's evaluation of the legal issue regard-

ing the amount of damages to which Appellant is entitled.

[*162] Pennsylvania case law allows a plaintiff to recover the reasonable value of medical services. See, e.g., *Piwoz v. Iannacone, 406 Pa. 588, 178 A.2d 707 (Pa. 1962)*; [***8] *Fougeray v. Pflieger, 314 Pa. 65, 170 A. 257 (Pa. 1934)*. The controlling question in this case is whether the definition of "reasonable value" permits an injured party to recover from the tortfeasor damages in an amount greater than the amount that the plaintiff has actually paid or for which he or she has incurred liability. We find that the amount paid and accepted by Appellee as payment in full for the medical services is the amount Appellant is entitled to recover as compensatory damages.

"The expenses for which a plaintiff may recover must be such as have been actually paid, or such as, in the judgment of the jury, are reasonably necessary to be incurred." *Goodhart v. Penn. R.R. Co., 177 Pa. 1, 35 A. 191, 192 (Pa. 1896)*. Appellant concedes that pursuant to agreements with Medicare and Blue Cross, Appellee was contractually obligated to accept $ 12,167.40 as full payment for services rendered. When a plaintiff will continue to incur expenses for medical services, it is appropriate for the factfinder to determine the amount of damages which will compensate the plaintiff for those expenses that "are reasonably necessary to be incurred." Conversely, [***9] where, as here, the exact amount of expenses has been established by contract and those expenses have been satisfied, there is no longer any issue as to the amount of expenses for which the plaintiff will be liable. In the latter case, the injured party should be limited to recovering the amount paid for the medical services. See 25 Corpus Juris Secundum, Damages § 91(3) (1996 & Supp. 1999) ("Where the amount paid for medical services is in accordance with a contractual schedule of rates, recovery is limited to that amount although the reasonable value of the services in the absence of contract is higher") (footnote omitted).

This evaluation of the reasonable value of services is in accord with the *Restatement (Second) of Torts, § 911 comment h* (1977), which states: "When the plaintiff seeks to recover for expenditures made or liability incurred to third [*163] persons for services rendered, normally the amount recovered is the reasonable value of the services rather than the amount paid or charged. If, however, the injured person paid less than the exchange rate, he can recover no more than the amount paid, except when the low rate was intended as a gift to him." It also is consistent [***10] with the approach taken in other jurisdictions. [**790] See *Hanif v. Housing Authority of Yolo County, 200 Cal. App. 3d 635, 641, 246 Cal. Rptr. 192 (Cal. Ct. App. 1988)* (declining to award plaintiff amount in excess of the amount actually paid by Medi-Cal, and stating "when the evidence shows a sum certain to have been paid or incurred for past medical care and services, whether by the plaintiff or by an independent source, that sum certain is the most the plaintiff may recover for that care despite the fact it may have been less than the prevailing market rate."); *Bates v. Hogg, 22 Kan. App. 2d 702, 921 P.2d 249* (Kan. Ct. App.), rev. den., *260 Kan. 991 (1996)* (plaintiff properly prohibited from admitting evidence of market value of medical services; because of medical provider's contractual agreement, the amount allowed by Medicaid represented the customary charge under the circumstances). Given Appellee's contractual obligations, the trial court did not err in determining that Appellant was limited to recovering $ 12,167.40, the amount that was paid and accepted as payment in full for past medical expenses.

Awarding Appellant the additional [***11] amount of $ 96,500.91 would provide her with a windfall and would violate fundamental tenets of just compensation. It is a basic principle of tort law that "damages are to be compensatory to the full extent of the injury sustained, but the award should be limited to compensation and compensation alone." *Incollingo v. Ewing, 444 Pa. 263, 282 A.2d 206, 228, 444 Pa. 299 (Pa. 1971)* (citations omitted). Appellant never has, and never will, incur the $ 96,500.91 sum from Appellee as an expense. We discern no principled basis upon which to justify awarding that additional amount.

Our approach is consistent with theories of fair compensation reflected in Pennsylvania case law, such as the following: remedies seek to put the injured person in a position as nearly [*164] as possible equivalent to his or her position prior to the tort, *Trosky v. Civil Service Comm'n, City of Pittsburgh, 539 Pa. 356, 652 A.2d 813, 817 (Pa. 1995)*; evidence of damages cannot be presumed (*Maxwell v. Schaefer, 381 Pa. 13, 112 A.2d 69, 73 (Pa. 1955))* and must be reasonably precise in order to provide the jury with an adequate framework upon which to base a verdict, *Nakles v. Union Real Estate Co. of Pittsburgh, 415 Pa. 407, 204 A.2d 50, 52 (Pa. 1964)*; [***12] an injured party cannot recover twice for the same injury, on the theory that duplicative recovery results in unjust enrichment, *Rossi v. State Farm Auto. Ins. Co., 318 Pa. Super. 386, 465 A.2d 8, 10 (Pa. Super. 1983)*; the loss the injured person sustained should be compensated with the least burden to the wrongdoer, consistent with the idea of fair compensation to the person injured, *Incollingo, 282 A.2d at 228*; a plaintiff has a duty to mitigate damages, *Thompson v. De Long, 267 Pa. 212, 110 A. 251, 253 (Pa. 1920)*; and a defendant may show such facts in mitigation to preclude the plaintiff from obtaining full compensation for damages occasioned by himself or herself, see *Robison v. Rupert, 23 Pa. 523, 525 (Pa. 1854)*.

Additionally, we find that the collateral source rule is inapplicable to the additional amount of $ 96,500.91. The rule "provides that payments from a collateral source shall not diminish the damages otherwise recoverable from the wrongdoer. [Citation omitted]. The principle behind the collateral source rule is that it is better for the wronged plaintiff to receive a potential windfall that for a [***13] tortfeasor to be relieved of responsibility for the wrong." *Johnson v. Beane, 541 Pa. 449, 664 A.2d 96, 100 (Pa. 1995)*. Appellant relies upon comment b to the *Restatement (Second) of Torts § 920A*, which provides in pertinent part: "If the plaintiff was himself responsible for the benefit, as by maintaining his own insurance or by making advantageous employment arrangements, the law allows him to keep it for himself. If the benefit was a gift to the plaintiff from a third party or established for him by law, he should not be deprived of the advantage that it confers." Appellant also cites to comment c of that same section, which provides that [*165] Social Security benefits are the type of collateral benefits which cannot be subtracted from the plaintiff's recovery.

[**791] Clearly, Appellant is entitled to recover $ 12,167.40, the amount which was paid on her behalf by Medicare and Blue Cross, the collateral sources. See *Restatement (Second) of Torts § 920A(2)*, supra, note 2. But the essential point to recognize is that Appellee is not seeking to diminish Appellant's recovery by this amount. Rather, the issue is whether Appellant is entitled to collect the additional [***14] amount of $ 96,500.91 as an expense. Appellant did not pay $ 96,500.91, nor did Medicare or Blue Cross pay that amount on her behalf. The collateral source rule does not apply to the illusory "charge" of $ 96,500.91 since that amount was not paid by any collateral source. See *McAmis v. Wallace, 980 F. Supp. 181 (W.D. Va. 1997)* (collateral source rule did not require that plaintiff recover the amount of the Medicaid write-off since no one incurred the written-off amount); *Bates, supra* (collateral source rule did not apply to amount written off pursuant to Medicaid contract).

Accordingly, we affirm the order of the Superior Court, but on different grounds. [4]

4 Because of the Superior Court's reliance on *Kashner v. Geisinger, 432 Pa. Super. 361, 638 A.2d 980 (Pa. Super. 1994)*, the reasoning of that case warrants further commentary. In Kashner, the plaintiff was treated at Geisinger Medical Center (GMC) and Geisinger Clinic (the Clinic) by Dr. Arthur Colley. The plaintiff brought a medical malpractice action against all three providers; the Clinic and Dr. Colley each were found to be fifty percent negligent. While a portion of the plaintiff's medical bills were paid by the Department of Public Welfare (DPW), the remainder were "written off" by GMC and forgiven by the Clinic. The trial court limited the amount of medical expenses submitted to the jury to the amounts paid by DPW. The Superior Court reversed, finding that the trial court erred in preventing the plaintiff from proving medical expenses in excess of the amounts paid by DPW. The court determined that "the amount actually paid for medical services does not alone determine the reasonable value of those medical services. Nor does it limit the finder of fact in making such a determination." *638 A.2d at 983* (citations omitted).

In support of this proposition, the Kashner court summarized a holding in *Brown v. White, 202 Pa. 297, 51 A. 962 (Pa. 1902)* as "the damages entitled to plaintiff for medical expenses are determined by assessing what would reasonably compensate the physicians providing the services regardless of what the physicians had actually been paid." *638 A.2d at 983*. This interpretation in the context of this case is misleading. In Brown, the trial court held that the plaintiff was entitled to recover damages for expenses incurred for medical service rendered by her physicians, although there was no evidence showing the amount of money expended for the services, nor what the services were reasonably worth. In sustaining this allegation of error, the Brown court held that the plaintiff must "furnish the jury evidence from which they could determine what had been paid for such services, or such amounts as the services were reasonably worth." *51 A. at 965*.

Additionally, the Kashner court relied upon D. Dobbs, Handbook on the Law of Remedies, § 8.1 at 543 (1973) which stated: "The measure of recovery is not the cost of services . . . but their reasonable value. . . . Recovery does not depend on whether there is any bill at all, and the tortfeasor is liable for the value of medical services even if they are given without charge, since it is their value and not their cost that counts." A more recent version of that same treatise indicates in the very next sentence that: "It has been said, however, that if the provider of medical services charges less than their value without intending a gift, the plaintiff's recovery is limited to the liability incurred." D. Dobbs, Handbook on the Law of Remedies § 8.1(3) at 377 (1993) (footnote omitted). Thus, we do not find the quoted language in Kashner to be a complete or final authority on this issue.

Finally, the Kashner court relied on the *Restatement (Second) of Torts § 924, cmt. f* (1979) which states: "The value of medical services made necessary by the tort can ordinarily be recovered although they have created no liability or expense to the injured person, as when a physician donates his services (See *§ 920A*)." As noted above, we find another provision, *Restatement (Second) of Torts § 911, cmt. h*, which limits the tortfeasor's liability to the amount paid if it is "less than the exchange rate" unless "the low rate was intended as a gift to [the injured party]", to be more applicable to the instant case.

[*166] [***15] Mr. Justice Saylor did not participate in the consideration or decision of this matter.

Mr. Justice Zappala concurs in the result.

Mr. Justice Nigro files a dissenting opinion.

DISSENT BY: NIGRO

DISSENT

DISSENTING OPINION

[**792] **MR. JUSTICE NEGRO**

Because I cannot agree that the amount actually paid and accepted by Appellee ("Crozer") as payment in full for the medical services rendered ($ 12,167.40) is the amount Appellant's decedent ("Baxter") is entitled to recover as compensatory damages, I must respectfully dissent. Instead, I would affirm that portion of the Superior Court's decision in which it found that Baxter is entitled to the reasonable value of the medical services provided ($ 108,668.31).

[*167] As noted by the majority, the primary objective of a compensatory damage award is to provide just compensation for the injured party's loss, so that the injured party may be made whole, and be restored to a position as nearly as possible equivalent to her position prior to the tort. See, e.g., *Trosky v. Civil Serv. Comm'n., City of Pittsburgh, 539 Pa. 356, 652 A.2d 813 (1995)*; *Feingold v. Southeastern Pennsylvania Transp. Auth., 512 Pa. 567, 517 A.2d 1270 (1986)*. [***16] To that end, compensatory damages are imposed to shift the loss from a wholly innocent party to one who is at fault. *Esmond v. Liscio, 209 Pa. Super. 200, 213, 224 A.2d 793, 799-800 (1966)*. A personal injury plaintiff's recovery for past medical expenses made necessary by a tortfeasor's wrongdoing is limited to the reasonable value of the medical services provided. See *Kashner v. Geisinger Clinic, 432 Pa. Super. 361, 367-68, 638 A.2d 980, 983 (1994)*(discussing plaintiff's right to recover reasonable value of medical services made necessary by tortfeasor's wrongdoing and noting that trier of fact must look to a variety of factors in determining the reasonable value of the medical service provided); see also *Piwoz v. Iannacone, 406 Pa. 588, 178 A.2d 707 (1962)*: *Brown v. White, 202 Pa. 297, 312, 51 A. 962, 965 (1902)*: *Ratay v. Yu Chen Liu, 215 Pa. Super. 547, 260 A.2d 484 (1969)*; 1 SUMMARY OF PENNSYLVANIA JURISPRUDENCE 2D § 9:59 (West 1999).

Unlike the majority, I believe the circumstances in the instant case clearly indicate that Baxter is entitled to $ 108,668.31 in compensatory damages. In finding [***17] that Baxter is only entitled to $ 12,167.40 in compensatory damages, the majority makes much of the fact that Crozer was contractually obligated to accept that amount as payment in full. While that may be true, such reasoning fails to take into account the fact that if Baxter had not-been covered by Medicare and Blue Cross 65 or some other health insurance at the time of her fall at Crozer, she would have been personally responsible to Crozer as her medical provider for her entire medical bill of $ 108,668.31. Perhaps more importantly, the parties actually stipulated that $ 108,668.31 was the reasonable value of the [*168] medical services rendered to Baxter following her fall. [1] Thus, I agree with the Superior Court that Baxter is entitled to the reasonable value of the medical services provided to her by Crozer. [2]

1 It bears noting that Crozer could have litigated the reasonable value of the medical services it provided to Baxter in the trial court and could have argued to the trier of fact that the amount accepted as payment in full for such services from Medicare and Blue Cross 65 is the most accurate barometer for calculating the reasonable value of the medical services provided to Baxter. But Crozer forewent that opportunity, and instead opted to stipulate to the reasonable value of the services while arguing that: (1) Baxter's compensatory damages should be limited to the amount of the payment from Medicare and Blue Cross 65; and (2) it was entitled to a setoff in the amount of the difference between the reasonable value of the medical services provided and the amount accepted as payment in full from Medicare and Blue Cross 65.

[***18]

2 As the majority notes, however, the Superior Court also found that Crozer is entitled to a setoff in the amount of the difference between the reasonable value of the medical services provided ($ 108,668.31) and the amount accepted as payment in full ($ 12,167.40). I disagree with this finding. "It is only where the tortfeasor himself makes a payment towards his tort liability that the pay-

ment will have the effect of reducing his liability." *Kashner, 432 Pa. Super. at 368, 638 A.2d at 984*. No such payment in the form of free medical services or a voluntary relinquishment of a right to collect occurred in the instant case. Crozer was required, pursuant to its preexisting contract with the federal government to participate in the Medicare program, to provide the services in question for $ 12,167.40. In my view, Appellant should not be made to bear the cost of Crozer's agreement with the federal government, and Crozer should not be granted a setoff simply because it chose to become a Medicare provider and subsequently treated Baxter for the injuries she sustained due to Crozer's own negligence. See *RESTATEMENT (SECOND) OF TORTS § 920A(2)*(1979)("Benefits conferred on the injured party from other sources are not credited against the tortfeasor's liability, although they cover all or a part of the harm for which the tortfeasor is liable."). As noted by Judge Olszewski in his dissenting opinion below, "[Crozer] did not contribute anything to [Baxter] that [Baxter] had not already received from Medicare." *Moorhead v. Crozer Chester Med. Ctr., 705 A.2d 452, 456* (Olszewski, J., dissenting). Thus, I would reverse the decision of the Superior Court to the extent that it granted Crozer a setoff in the amount of the difference between the stipulated reasonable value of the medical services provided and the amount that Crozer accepted as payment in full for such services pursuant to its voluntary participation in the Medicare program.

[***19] [**793] In reaching a different conclusion, i.e., finding that Baxter is only entitled to $ 12,167.40 as compensatory damages, the majority determines that where the amount initially billed by a plaintiff's health care provider is greater than the amount [*169] eventually accepted by the provider as payment in full for its services, the plaintiff's compensatory damages for past medical expenses should be limited to the amount actually paid to the provider. By doing so, the majority carves out a broad exception to the established rule of law in this Commonwealth that personal injury plaintiffs are allowed to recover the reasonable value of the medical services made necessary by the wrongdoer's tortious conduct. Contrary to the majority's holding, it is the value, and not the ultimate cost, of medical services made necessary by the tortfeasor's negligence that determines the proper measure of compensatory damages for past medical expenses. See *Kashner, 432 Pa. Super. at 367-68, 638 A.2d at 983* (noting that while the amount actually paid for medical services is relevant to determining the reasonable value of those services, it is still the value of the services, and not the cost, [***20] on which recovery of compensatory damages for said services depends); see also *RESTATEMENT (SECOND) OF TORTS § 924 cmt. f* (1979) ("the value of medical services made necessary by a tort can ordinarily be recovered although they have created no liability or expense to the injured person"). [3]

3 I further note that the majority ignores the fact that the underlying bases for tort recovery of medical expenses and the payment of an insured's medical benefits are distinct. The basis for the former is liability -- an injured party is entitled to receive compensation, including the reasonable value of medical services, from a culpable tortfeasor. The basis for the latter is contractual -- health insurers are contractually obligated to pay medical benefits to, or on behalf of, their insureds. See Michael F. Flynn, *Private Medical Insurance and the Collateral Source Rule: A Good Bet?*, 22 U. TOL. L. REV. 39, 65 (1990). Likewise, medical providers are sometimes contractually obligated to accept as payment in full reimbursement from health insurers which is less than the reasonable value of the services actually provided to the insured. By concluding that the contractual obligations between an insured and his or her health insurer and a medical provider and that insurer diminish the insured's recovery of compensatory damages, the majority blurs the distinction between the bases for tort recovery of medical expenses and payment of an insured's medical benefits.

[***21] In addition, by creating this exception to the rule that injured plaintiffs are entitled to recover the reasonable value of their medical services made necessary by the wrongdoers tortious conduct, the majority seriously undermines the collateral source rule. This Court recently defined the collateral [*170] source rule and described the principle behind the rule in *Johnson v. Beane, 541 Pa. 449, 456, 664 A.2d 96, 100 (1995)*, where we stated:

> The collateral source rule provides that payments from a collateral source shall not diminish the damages otherwise recoverable [**794] from the wrongdoer. See, generally, *Beechwoods Flying Service, Inc. v. Al Hamilton Contracting Corp., 504 Pa. 618, 476 A.2d 350 (1984)*. The principle behind the collateral source rule is that it is better for the wronged plaintiff to receive a potential windfall than for a tortfeasor to be relieved of responsibility for the wrong.

By diminishing the amount of compensatory damages otherwise recoverable from a wrongdoer based on payments made to the wronged plaintiff by a collateral source, the new rule advanced by the majority clearly violates the collateral source rule. According [***22] to the majority, when a medical provider contracts with a third party payor to accept an amount less than the reasonable value of the medical services provided as payment in full, the purpose of compensatory damages is no longer served by permitting an injured plaintiff to recover the reasonable value of her past medical services made necessary by the medical provider's tortious conduct. The majority repeatedly notes that the actual medical expenses paid on behalf of Baxter by Medicare totaled $ 12,167.40, and contends that any further recovery against Crozer in the nature of compensatory damages for past medical expenses would constitute a windfall. Although the majority chooses to emphasize the $ 12,187.40 payment that Medicare and Blue Cross 65 made to Crozer on Baxter's behalf, that is not the proper focus. Rather, the collateral source rule prohibits the wrongdoer from diminishing the damages recoverable against it based on the payments, compensation, or benefits that a collateral source confers on a wronged plaintiff on account of her injury. See, e.g., *Hileman v. Pittsburgh and Lake Erie R.R. Co., 546 Pa. 433, 439, 685 A.2d 994, 997 (1996)*(collateral source [***23] rule prohibits defendants from introducing evidence that the plaintiff received compensation on account of his injury from a collateral source); *Beechwoods, 504 Pa. at 623,* [*171] *476 A.2d at 352* (collateral source rule was intended to avoid precluding obtainment of redress for injuries merely because coverage for the injury was provided by a collateral source, such as insurance). In the context of the instant case, then, the focus for collateral source purposes is on the payment, compensation, or benefit conferred on Baxter by Medicare and Blue Cross 65 when they fully covered her post-injury medical treatment at Crozer.

It can hardly be argued that the benefit conferred on Baxter by Medicare and Blue Cross 65 was equal only to $ 12,167.40, the amount allowed by Medicare and ultimately accepted as payment in full by Crozer. Instead, by fully covering Baxter's post-injury medical services, Medicare and Blue Cross 65 conferred a benefit on Baxter equal to the reasonable value of the medical services provided, which the parties stipulated to be $ 108,668.31. The collateral source rule dictates that Crozer cannot profit from the benefit that Baxter received from her health [***24] insurers, but that is exactly what the majority allows today. [4]

4 In support of its conclusion, the majority also claims that awarding Baxter the additional amount of $ 96,500.91 would violate the tenets of fair compensation. The majority claims that its conclusion is consistent with several theories: that damages cannot be presumed, that damages must be reasonably precise, that duplicative recovery results in unjust enrichment, that the injured person should be compensated with the least burden to the wrongdoer, and that a plaintiff has a duty to mitigate damages.

There were no presumed damages in this case. In fact, the parties stipulated to the exact amount of the medical expenses: $ 108,668.31. While it is true that an injured party cannot recover twice for one injury, under the collateral source rule, the tortfeasor is required to pay for all the harm he causes, even if this creates a double compensation for part of the plaintiff's injuries. *RESTATEMENT(SECOND) OF TORTS § 920A cmt. b.* Moreover, the principle behind the collateral source rule, that it is better for the wronged plaintiff to receive a windfall than for the tortfeasor to pay less than the damages he owes, specifically refutes the majority's contention. *Johnson v. Beane, 541 Pa. 449, 456, 664 A.2d 96, 100 (1995).*

Finally, the majority finds that the principle of damage mitigation applies in the instant case. For example, the majority cites *Robison v. Rupert, 23 Pa. 523 (1854)*, where this Court held that the plaintiff could not receive full compensation for damages caused when the defendant shot into a crowd of youths rioting outside his home. I fail to see how this rule of law applies to the instant case. Moreover, it stretches the bounds of relevance to analogize a patient injured by the negligence of a medical provider to the trespassing plaintiff in Robison, who was injured after provoking the defendant landowner.

[***25] [*172] [**795] In addition, the majority's reliance on Comment h to the *Restatement (Second) of Torts § 911* for the assessment of the reasonable value of medical services provided to Baxter is misplaced. While *Section 911* generally governs valuation, Comment h deals specifically with the measure of recovery for a plaintiff "who sues for the value of his services tortiously obtained by the defendant's fraud or duress, or for the value of services rendered in an attempt to mitigate damages." That provision is clearly not applicable to the instant case. The majority ignores *Section 920A*, which specifically explains the effects of benefits provided by collateral sources:

> [Collateral-source benefits] do not have the effect of reducing the recovery against the defendant. The injured party's net loss may have been reduced correspondingly, and to the extent that the defendant is required to pay the total amount there may be a double compensation for a part of the plaintiff's injury. But it is the position of the law that a benefit that is directed to the injured party should not be shifted so as to become a windfall for the tortfeasor. If the plaintiff was himself responsible for the benefit, [***26] as by maintaining his own insurance . . ., the law allows him to keep it for himself. If the benefit was . . . established for him by law, he should not be deprived of the benefit that it confers. The law does not differentiate between the nature of the benefits, so long as they did not come from the defendant or a person acting for him.

RESTATEMENT (SECOND) OF TORTS § 920A cmt. b.

Furthermore, although *Comment f to Section 924 of the Restatement (Second) of Torts* clearly states that the "value of medical services made necessary by the tort can ordinarily be recovered although they have created no liability or expense to the injured person," the majority inexplicably finds *Section 911* "to be more applicable to the instant case." Majority Opinion, at 9 n.4.

[*173] In my view, the decision of the majority improperly limits the recovery of medical expenses by creating an exception to tortfeasor liability. Although it is the tortfeasor's responsibility to compensate for all harm that he causes, and not just the net loss of the injured party, the majority exempts tortfeasors from liability for collateral benefits received by injured plaintiffs. Based on the above analysis, I would [***27] affirm that portion of the Superior Court opinion holding that Baxter is entitled to recover the reasonable value of the medical services ($ 108,668.31) provided to her by Crozer as compensatory damages. However, I cannot agree with the Superior Court's conclusion that Crozer is entitled to a setoff for the difference between the reasonable value of the medical services ($ 108,668.31) and the amount that Crozer accepted as payment in full pursuant to its voluntary participation in the Medicare program ($ 12,167.40). Accordingly, I would award Baxter additional compensatory damages in the amount of $ 96,500.91, which is the difference between the reasonable value of the medical services provided to Baxter and the amount of compensatory damages for past medical expenses awarded by the trial court.

LEXSEE 139 IDAHO 526

MARI ANN DYET, Plaintiff-Respondent-Cross Appellant, v. WILLIAM SHANE MC KINLEY, Defendant-Appellant-Cross Respondent.

Docket No. 28628, 2003 Opinion No. 126

SUPREME COURT OF IDAHO

139 Idaho 526*; *81 P.3d 1236*; *2003 Ida. LEXIS 182

December 4, 2003, Filed

SUBSEQUENT HISTORY: Released for Publication December 26, 2003. As Corrected March 1, 2004.

PRIOR HISTORY: [***1] Appeal from the District Court of the Seventh Judicial District of the State of Idaho, Bonneville County. Hon. Jon J. Shindurling, District Judge.

DISPOSITION: Affirmed.

COUNSEL: Cooper & Larsen, Pocatello, for appellant. Garry L. Cooper argued.

McBride & Roberts, Idaho Falls, for respondent. Michael R. McBride argued.

JUDGES: SCHROEDER, Justice Chief Justice TROUT, Justices KIDWELL, EISMANN and BURDICK CONCUR.

OPINION BY: SCHROEDER

OPINION

[**1237] [*527] SCHROEDER, Justice

This is a personal injury case arising out of an automobile collision. Mari Ann Dyet (Dyet) was a passenger in her own vehicle which was being driven by her daughter, Charlotte Hansen (Hansen). Shane McKinley (McKinley) was driving the other car involved in the collision. A jury awarded Dyet damages and both parties appeal. The primary issues on appeal are the admissibility of evidence of reductions in the charges for medical services due to Medicare "write downs," and the question of whether the award should be reduced by the amount Dyet received for underinsured motorist benefits from her own insurance company.

I. FACTUAL AND PROCEDURAL BACKGROUND

[***2] On October 27, 2000, Hansen and Dyet were traveling in the same car on a highway near Idaho Falls. McKinley was traveling the opposite direction on the same highway and attempted to make a left turn in front of Hansen and Dyet at an intersection. The cars collided and Hansen and Dyet sustained serious injuries. Dyet's right hip and left femur were fractured. Her injuries required multiple surgeries, including the insertion of a new right artificial hip, replacing an artificial hip that had been inserted in 1987. In spite of successful surgeries, she has some remaining impairments as a result of the injuries. The charges from the medical providers for Dyet's care totaled $ 89,367.71. However, because Dyet was a Medicare patient, the bill was mandatorily reduced by $ 67,655.22 to $ 21,712.49. Subsequently, Dyet [**1238] [*528] also received $ 75,000 in Underinsured Motorist Benefits from her own insurance company.

Dyet sued McKinley for damages arising from his alleged negligent driving. She filed a motion *in limine* requesting that all evidence be excluded at trial relevant to whether she was insured and relevant to whether she "received monies from *any* source such as Medicare, Medicaid, [***3] underinsured insurance, or private health insurance." The district court granted the motion *in limine*, allowing Dyet to introduce the charges for the medical services but not allowing any evidence during trial as to the amount she actually paid for the services or the write off required by Medicare. McKinley made an

offer of proof during trial showing that Dyet's medical bills were reduced by $ 67,655.22 due to Medicare regulations and federal law.

The jury returned a special verdict finding McKinley and Hansen, a non-party, both negligent and apportioning 88% of the fault to McKinley and 12% to Hansen. The jury awarded Dyet $ 400,000 in damages, which amount included $ 89,367.71 for medical expenses. The district court reduced the verdict by $ 48,000 for comparative negligence on the part of Hansen and by another $ 67,665.22 for the reduction in charges required by Medicare regulations and federal law, leaving a net judgment of $ 284,334.78. The district court refused to reduce the verdict by the $ 75,000 paid for underinsured motorist coverage. Both parties appeal. Dyet maintains the verdict should not have been reduced. McKinley maintains that he should have been allowed to [***4] offer evidence at trial of the actual amount paid for medical expenses and that the verdict should have been reduced by the $ 75,000 paid as underinsured motorists benefits.

II. THE DISTRICT COURT DID NOT ERR IN PROHIBITING MCKINLEY FROM OFFERING PROOF OF THE AMOUNTS ACTUALLY PAID TO DYET'S MEDICAL PROVIDERS

A. Standard of Review

The interpretation of a statute is an issue of law over which this Court exercises free review. *Idaho Fair Share v. Idaho Public Utilities Comm'n, 113 Idaho 959, 961-62, 751 P.2d 107, 109-10 (1988), overruled on other grounds by J.R. Simplot Co. v. Idaho State Tax Comm'n, 120 Idaho 849, 820 P.2d 1206 (1991)*. When interpreting a statute, the primary function of the Court is to determine and give effect to the legislative intent. *George W. Watkins Family v. Messenger, 118 Idaho 537, 539-40, 797 P.2d 1385, 1387-88 (1990)*. Such intent should be derived from a reading of the whole act at issue. *Id. at 539, 797 P.2d at 1387-88*. If the statutory language is unambiguous, "the clearly expressed intent of the legislative body must be given effect, and there is no occasion for a court [***5] to consider rules of statutory construction." *Payette River Property Owners Ass'n v. Board of Comm'rs of Valley County, 132 Idaho 551, 557, 976 P.2d 477, 483 (1999)*. The plain meaning of a statute will prevail unless clearly expressed legislative intent is contrary or plain meaning leads to absurd results . *George W. Watkins Family, 118 Idaho at 540, 797 P.2d at 1388*.

When a statute is ambiguous, the determination of the meaning of the statute and its application is also a matter of law over which this Court exercises free review. *Kelso & Irwin, P.A. v. State Insur. Fund, 134 Idaho 130, 134, 997 P.2d 591, 595 (2000)*; *J.R. Simplot Co. v. Western Heritage Ins. Co., 132 Idaho 582, 584, 977 P.2d 196, 198 (1999)*. If it is necessary for this Court to interpret a statute, the Court will attempt to ascertain legislative intent, and in construing a statute, may examine the language used, the reasonableness of the proposed interpretations, and the policy behind the statute. *Kelso & Irwin, P.A. at 134, 997 P.2d at 595*.

B. The district court correctly refused to allow McKinley to present evidence [*6] to the jury regarding the amounts actually paid to Dyet's medical providers.**

Idaho Code § 6-1606, entitled "Prohibiting double recoveries from collateral sources" states:

[**1239] [*529] In any action for personal injury or property damage, a judgment may be entered for the claimant only for damages which exceed amounts received by the claimant from collateral sources as compensation for the personal injury or property damage, whether from private, group or governmental sources, and whether contributory or noncontributory. For purposes of this section, collateral sources shall not include benefits paid under federal programs which by law must seek subrogation ... Evidence of payment by collateral sources is admissible to the court after the finder of fact has rendered an award. Such award shall be reduced by the court to the extent the award includes compensation for damages, which have been compensated independently from collateral sources.

The central issue in this case is whether or not Medicare write-offs are a collateral source under *I.C. § 6-1606* or, if not, if the write-offs should be treated the same as a collateral source.

[***7] *I.C. § 6-1606* is clearly a statute that was designed to prevent double recovery. In the Statement of Purpose accompanying House Bill 745, currently *I.C. § 6-1606*, the legislature stated that:

This bill would modify the collateral source rule of evidence in certain circumstances in which the court determines that a double payment will exist [sic] the court is given the authority to modify an award of damages so that the damages would be paid once but not twice.

Both parties argue that a Medicare write-off is not a collateral source under *I.C. § 6-1606*. However, this is the extent to which they agree. Dyet argues that the write-off amount falls into the non-collateral "federal benefits under which by law must seek subrogation" category, but that it should be inadmissible under *I.R.E. 403*, analogous to the existence of liability insurance. McKinley argues that the statute cannot be construed to include the write-off as a collateral source, and as such, should be admissible at trial. McKinley maintains that misstating the total amount paid for the medical expenses

artificially inflates the damages awarded [***8] by the jury.

The district court followed a rule adopted by many states with statutes similar to that of Idaho. Citing *Kastick v. U-Haul, 740 N.Y.S.2d 167, 292 A.D.2d 797 (2002)* and *Loncar v. Gray, 28 P.3d 928 (Alaska 2001)*, the district court stated that "these jurisdictions hold that while Medicare write-offs are technically not payments from a collateral source, plaintiffs may not recover the amount of the write-off from a tortfeasor because it was not an item of damages for which the plaintiff ever became obligated."

Neither the language of *I.C. § 6-1606* nor its Statement of Purpose specifically deal with write-offs, but the district court's reasoning is sound. By treating a Medicare write-off as a collateral source, the danger of prejudice contemplated in *I.R.E. 403* is avoided, and the jury will not be influenced by the existence of Medicare. At the same time, the policy of *I.C. § 6-1606* contained in both the statute and the legislative history to prevent a double payment for the damages is preserved. Although the write-off is not technically a collateral source, it is the type of windfall that [***9] *I.C. § 6-1606* was designed to prevent. As reasoned by the New York court in *Kastick*, "Although the write-off technically is not a payment from a collateral source within the meaning of [the collateral source statute], it is not an item of damages for which plaintiff may recover because plaintiff has incurred no liability therefore." *Id. 740 N.Y.S.2d at 169, 292 A.D.2d at 798.*

III.

THE DISTRICT COURT DID NOT ERR IN DENYING MCKINLEY'S MOTION FOR NEW TRIAL

A. Standard of Review

When reviewing a trial court's ruling on a motion for new trial, this Court applies an abuse of discretion standard. *State v. Davis, 127 Idaho 62, 896 P.2d 970 (1995).* A trial court has wide discretion to grant or refuse to grant a new trial, and on appeal this Court will not disturb that exercise of discretion absent a showing of manifest abuse. *State v. Olin, 103 Idaho 391, 648 P.2d 203 (1982).* In *State v. Hedger, 115 Idaho 598,* [*530] [**1240] *768 P.2d 1331 (1989)*, this Court set out the test for evaluating whether a trial court has abused its discretion:

(1) whether the lower court rightly perceived the [***10] issue as one of discretion; (2) whether the court acted within the outer boundaries of such discretion and consistently with any legal standards applicable to specific choices; and (3) whether the court reached its decision by an exercise of reason. *Id. at 600, 768 P.2d at 1333* quoting *Associates Northwest, Inc. v. Beets, 112 Idaho 603, 605, 733 P.2d 824, 826 (Ct.App.1987).*

I.R.C.P. 59(a) states that a new trial may be granted to all or any of the parties and on all or part of the issues in an action for any of the following reasons: ... (5) Excessive damages or inadequate damages, appearing to have been given under the influence of passion or prejudice.

(6) Insufficiency of the evidence to justify the verdict or other decision, or that it is against the law.

(7) Error in law, occurring at the trial.

B. The district court acted within its discretion in denying McKinley a new trial.

McKinley moved for a new trial, contending that the inadmissibility of the Medicare write-offs unfairly prejudiced him, speculating that the medical expenses presented to the jury undoubtedly inflated the general damages award given by the jury. The district [***11] court disagreed on the following grounds:

(1) Even if the decision to exclude the evidence of the write offs were in error, the use of a special verdict which separated the medical damages from other damage elements eliminated the potential harm to McKinley.

(2) There is nothing in the verdict that indicates that the jury used some multiple of the medical expenses to reach a general damage figure (although attorneys regularly do such to evaluate a case.) Rather, it appears to the [district court] that the jury reached a decision about a fair total award of damages, then subtracted out the special damages to reach the general damage award. Such a process actually favors McKinley as a result of the Court's remittitur herein.

The district court was aware that it was exercising discretion and laid out its legal analysis, its rationale, and the supporting evidence presented at trial very carefully. The district court acted within its discretion when it denied McKinley a new trial.

IV. THE DISTRICT COURT DID NOT ERR WHEN IT DENIED MCKINLEY'S POST- TRIAL MOTION TO REDUCE THE VERDICT BY THE $ 75,000 IN UNDERINSURED MOTORIST BENEFITS DYET RECEIVED FROM HER OWN INSURER

McKinley [***12] maintains that the district court erred when it denied his motion to reduce the verdict by the $ 75,000 that was paid Dyet in underinsured benefits by her own insurance company. *Idaho Code § 6-1606* provides that "collateral sources shall not include . . . benefits paid which are recoverable under subrogation rights under Idaho law or by contract." McKinley says

that the district court wrongly assumed that it does not matter if the benefit provider actually exercises its right to recover benefits, and wrongly assumed that it only matters that a subrogation right exists. McKinley asserts that Dyet has refused to reveal whether her insurer has exercised or waived insurance rights, and therefore the court cannot decide whether such benefits are collateral sources under the terms of the statute, maintaining that waived subrogation rights are inherently not "recoverable," and therefore should be considered collateral sources.

A. Standard of Review

The interpretation of a statute is an issue of law over which this Court exercises free review. *Idaho Fair Share v. Idaho Public Utilities Comm'n, 113 Idaho 959, 961-62, 751 P.2d 107, 109-10 (1988),* [***13] *overruled on other grounds by J.R. Simplot Co. v. Idaho State* [**1241] [*531] *Tax Comm'n, 120 Idaho 849, 820 P.2d 1206 (1991).*

B. The district court correctly deemed the $ 75,000 received from Hartford Insurance as a non-collateral source.

I.C. § 6-1606 states "collateral sources shall not include ... benefits paid which are *recoverable* under subrogation rights created under Idaho law or by contract." *I.C. § 6-1606* (emphasis added). The definition of "recoverable" is commonly accepted as capable of being recovered. FUNK & WAGNALLS NEW STANDARD DICTIONARY OF THE ENGLISH LANGUAGE 2066 (9th ed. 1935). The relevant legislative history indicates that the policy behind *I.C. § 6-1606* is to prevent the double payment of damages, not to prevent payment only in the absolute case that a third party exercises its contractual rights to recovery.

In an effort to prove the recoverability of the amounts received from Hartford Insurance, Dyet placed into evidence the relevant portions of the insurance contract relating to the subrogation rights of amounts paid:

Our Right to Recover Payment: A. If we make a [***14] payment under this policy and the person to or for whom payment was made has a right to recover damages from another we will be subrogated to that right. That person shall do:

1. Whatever is necessary to enable us to exercise our rights; and

2. Nothing after loss to prejudice them.

B. If we make a payment under this policy and the person to or for whom payment is made recovers damages from another, that person shall:

1. Hold in trust for us the proceeds of the recovery; and

2. Reimburse us to the extent of our payment.

The rule sought by McKinley is that Dyet's recovery be reduced by the $ 75,000 unless she can prove that Hartford has recovered or intends to recover the amount paid. This could result in the non-recovery of those damages by Dyet if the damages are reduced and Hartford subsequently seeks recovery. Whether or not Hartford seeks recovery from Dyet as it is entitled under the contract is a contractual matter between Dyet and Hartford. If damages are reduced and Hartford seeks recovery, Dyet would either have to reopen proceedings against McKinley or suffer incomplete recovery of damages. This would either violate Idaho's policy of finalizing litigation or result in [***15] injustice. For purposes of *I.C. § 6-1606* the operative fact is that the amount is recoverable.

V.

THE DISTRICT COURT DID NOT ENTER JUDGMENT CALLING FOR PRE- JUDGMENT INTEREST COMMENCING MAY 18, 2001 ON THE ENTIRE JUDGMENT

McKinley argues that the district court improperly awarded pre-judgment interest on the entire judgment from May 18, 2001, instead of just interest on the offer of settlement under *I.C. § 12-301(c).*

Dyet agrees with McKinley that pre-judgment interest should only be awarded on the $ 85,000 settlement and not the entire judgment. However, Dyet believes that the court awarded the proper interest. In its final judgment, the district court made reference to its prior order awarding pre-judgment interest only on the $ 85,000.

I.C. § 12-301 authorizes the prevailing party to recover over and above the judgment annual interest on the amount contained in the settlement offer, computed from the date the offer of settlement was served:

If the court finds that such claimant has recovered an amount equal to or greater than his offer of settlement, the court shall add to the judgment, [***16] annual interest on the amount contained in such offer, computed from the date that the offer of settlement was served and shall enter judgment accordingly.

In the matter of interest on offers of settlement the Idaho legislature enacted I.C. § 12- 301, which allows the court to add to the judgment annual interest on the amount [**1242] [*532] of an offer of settlement if a claimant recovers an amount equal to or greater than his or her offer settlement.

In the current case, the district court ruled that:

Dyet served upon McKinley an offer of settlement on May 18, 2001, in the amount of $ 85,000, which was not accepted by McKinley and this matter has now moved to judgment. The [district court] finds that Dyet has recovered an amount greater than her offer of settlement and therefore, Dyet is entitled to interest on the $ 85,000.00 settlement offer computed from May 18, 2001.

The district court rightly awarded interest to Dyet based on the unaccepted offer of settlement.

I.C. § 12-301 states, "for purposes of this section, 'annual interest' shall mean the rate specified in *I.C. § 28-22-104(2)*." *I.C. § 28-22-104* [***17] states:

The legal rate of interest on money due on the judgment of any competent court or tribunal shall be the rate of five percent (5%) plus the base rate at the time of entry of the judgment ... The payment of interest and principal on each judgment shall be calculated according to a three hundred sixty-five (365) day year.

The district court directed that interest be paid to Dyet on the amount of the settlement offer computed from the date of the offer of settlement, May 18, 2001, but does not calculate this amount payable to Dyet. Both parties agree that *I.C. § 12-301* only requires that interest be paid on the $ 85,000 settlement offer. This is a matter understood by both parties and the district court. No remand is necessary to accomplish the mathematical calculation.

VI. CONCLUSION

The judgment of the district court is affirmed. Both parties have prevailed in part. No costs or attorney fees are allowed.

Chief Justice TROUT, Justices KIDWELL, EISMANN and BURDICK **CONCUR**.

LEXSEE 229 S.W.3D 765

Alisa MILLS, Appellant v. Kevin FLETCHER, Appellee

No. 04-06-00345-CV

COURT OF APPEALS OF TEXAS, FOURTH DISTRICT, SAN ANTONIO

229 S.W.3d 765; 2007 Tex. App. LEXIS 3723

May 16, 2007, Delivered
May 16, 2007, Filed

SUBSEQUENT HISTORY: Released for Publication August 24, 2007.

PRIOR HISTORY: [**1] From the County Court at Law No. 2, Bexar County, Texas. Trial Court No. 296698. Honorable Irene Rios, Judge Presiding.

DISPOSITION: REVERSED AND REMANDED.

COUNSEL: For APPELLANT: David L. Plaut, Jeffrey C Glass, Hanna & Plaut, L.L.P., Austin, TX.

For APPELLEE: R. Craig Bettis, John N. Tyler, Tyler & Peery, San Antonio, TX.; William J. Boyce, Fulbright & Jaworski, L.L.P., Houston, TX.; Roger W. Hughes, Adams & Graham, L.L.P., Harlingen, TX.; Jay Harvey, Texas Trial Lawyers, Ass'n, Austin, TX.; Kirk L. Pittard, Durham & Pittard, LLP, Dallas, TX.; Jim M. Perdue, The Perdue Law Firm, L.L.P., Houston, TX.; Peter M. Kelly, Moore & Kelly, P.C., Houston, TX.

JUDGES: Opinion by: Karen Angelini, Justice. Dissenting opinion by: Catherine Stone, Justice. Sitting: Catherine Stone, Justice, Karen Angelini, Justice, Steven C. Hilbig, Justice (concurring in judgment only).

OPINION BY: Karen Angelini

OPINION

[*767] REVERSED AND REMANDED

This appeal arises from a personal injury lawsuit brought by Appellee Kevin Fletcher against Appellant Alisa Mills. At trial, the jury awarded Fletcher $ 1,551.00 in past medical expenses. On appeal, Mills argues that pursuant to *section 41.0105 of the Texas Civil Practice and Remedies Code*, the amount of Fletcher's award for past medical expenses should have been reduced because his medical providers accepted lesser amounts for their services from his health insurance company, thereby "writing off" the balance due from Fletcher. Because we agree that *section 41.0105* requires such a reduction, we reverse the trial court's judgment and remand the cause for entry of judgment consistent with this opinion.

DISCUSSION

Section 41.0105 of the Texas Civil Practice and Remedies Code [**2] , titled "Evidence Relating to Amount of Economic Damages," provides the following:

> In addition to any other limitation under law, *recovery of medical or health care expenses incurred is limited to the amount actually paid or incurred by or on behalf of the claimant.*

TEX. CIV. PRAC. & REM. CODE ANN. § 41.0105 (Vernon Supp. 2006) (emphasis added). Here, Mills argues that the "written-off" or adjusted amounts were neither actually paid nor *actually incurred* by or on behalf of Fletcher. As such, Mills argues that pursuant to *section 41.0105*, Fletcher was not entitled to recover the written-off amounts. [1] In response, Fletcher argues that he "incurred" the medical charges at the time of his doctor's visit and that any [*768] amounts later written off do not affect the charges that he "incurred."

1 We note that in response to Mills's issues on appeal, Fletcher argues that Mills's bill of exceptions at trial was insufficient to show that Fletcher will never be liable for the written-off amounts. We disagree. In her bill of exceptions, Mills introduced Defendant's Exhibits two 2 and 3. *See Mack Trucks, Inc. v. Tamez, 206 S.W.3d 572, 577 (Tex. 2006)* ("The purpose of a bill of exceptions is to allow a party to make a record for appellate review of matters that do not otherwise appear in the record, such as evidence that was excluded."). These exhibits were copies of bills from Fletcher's health care providers, showing the adjustments made and the resulting balance of "$ 0.00." We believe that these exhibits were sufficient. Zero means zero -- Fletcher no longer owes any money to his health care providers.

[**3] According to the Code Construction Act, when interpreting a statute, "[w]ords and phrases shall be read in context and construed according to the rules of grammar and common usage." *TEX. GOV'T CODE ANN § 311.011(a)* (Vernon 2005); *see Alex Sheshunoff Mgmt. Servs. L.P. v. Johnson, 209 S.W.3d 644, 651 (Tex. 2006)* ("Ordinarily, the truest manifestation of what legislators intended is what lawmakers enacted, the literal text they voted on."). Additionally, "[w]henever possible, we construe statutes as written, but where the enacted language is nebulous, we may cautiously consult legislative history to help divine legislative intent." *Alex Sheshunoff, 209 S.W.3d at 652*.

In support of her interpretation, Mills cites to definitions found in common dictionaries:

> Incur: To become liable or subject to; to bring down upon oneself (as in "incur expenses"). *Webster's Ninth New Collegiate Dictionary*, at 611 (1984).
>
> Incur: To acquire or come into (something usually undesirable); to sustain; to become liable or subject to as a result of one's actions; to bring upon oneself. *The American Heritage Dictionary of the* [**4] *English Language* (4th ed. online).
>
> Incur: To suffer or bring on oneself (a liability or expense). *Black's Law Dictionary* 782 (8th ed. 2004).

Thus, Mills argues that "the word incur, in legal parlance, means simply 'to become liable to pay.'" And, according to Mills, because the amounts were written off or adjusted by the medical providers, Fletcher will never have to pay the amounts written off.

Additionally, Mills emphasizes that pursuant to rules of grammar, the word "actually" modifies both "paid" and "incurred." As such, "actually incurred" must necessarily be a limitation on expenses "incurred." That is, if "incurred" is a big circle, "actually incurred" must necessarily refer to a smaller circle within that big circle. In contrast, Fletcher argues in his brief that "actually incurred" refers to those expenses that have been charged but not paid. We agree with Mills's interpretation.

Here, the statute uses the word "incurred" twice: "recovery of medical or health care expenses *incurred* is limited to the amount *actually paid or incurred* by or on behalf of the claimant." *TEX. CIV. PRAC. & REM. CODE ANN. § 41.0105* [**5] (Vernon Supp. 2006) (emphasis added). In referring to "incurred" the second time, the Legislature chose to modify "incurred" with the word "actually." As such, "incurred" must mean something different than "actually incurred." And, the word "actually" modifying "incurred," as well as the phrase "[i]n addition to any other *limitation* under law," shows an intent by the Legislature to limit expenses simply "incurred." Thus, in construing this statute, we believe that "medical or healthcare expenses incurred" refers to the "big circle" of medical or healthcare expenses incurred at the time of the initial visit with the healthcare provider, while, as applied to the facts presented here, "actually incurred" refers to the "smaller circle" of expenses incurred after an adjustment of the healthcare provider's bill.

In contrast, Fletcher's interpretation of "actually incurred" does not limit the phrase "incurred" in any manner. We, however, believe that by modifying "incurred" with the word "actually" the Legislature did intend to limit expenses "incurred."

[*769] We also note that both parties point to legislative history in support of their respective interpretations. Mills emphasizes that [**6] *section 41.0105* was part of House Bill 4's tort reform legislation, which was enacted "to bring more balance to the Texas civil justice system, reduce litigation costs, and address the role of litigation in society." House Comm. on State Affairs, Bill Analysis, Tex. H.B. 4, 78th Leg., R.S. (2003). [2] As such, Mills argues that we must construe *section 41.0105* with this general intent in mind.

2 This document is available at http://www.legis.state.tx.us/tlodocs/78R/analysis/pdf/HB00004S.pdf.

In support of his interpretation, Fletcher points to an exchange between Senators Hinojosa and Ratliff during the Senate's debate of House Bill 4, which he argues

shows that the person who drafted the bill intended that the word "incurred" be synonymous with the word "charged." Additionally, Fletcher emphasizes that, although earlier versions of the bill would have eliminated the collateral source rule, those versions were amended to delete this language. As such, Fletcher argues that we should not interpret *section 41.0105* [**7] to violate the collateral source rule. [3]

> 3 Our interpretation clearly does violate the collateral source rule. The theory behind the collateral source rule is that a wrongdoer should not have the benefit of insurance independently procured by the injured party, and to which the wrongdoer was not privy. *Brown v. Am. Transfer & Storage Co., 601 S.W.2d 931, 934 (Tex. 1980)*. Thus, "[t]he collateral source rule bars a wrongdoer from *offsetting his liability* by *insurance benefits independently procured by the injured party*." *Mid-Century Ins. Co. v. Kidd, 997 S.W.2d 265, 274 (Tex. 1999)* (emphasis added). Here, the insurance adjustments or amounts "written off" are a benefit that a patient receives only as a result of procuring healthcare insurance. And, pursuant to our interpretation of *section 41.0105*, Mills (the "wrongdoer") will have the benefit of those adjustments made as the result of *Fletcher* having paid premiums and carrying health insurance. The Legislature, however, has the power to enact a statute that abrogates the collateral source rule, and we believe that the plain language of *section 41.0105* shows the Legislature's intent to do so here.

[**8] However, given the plain meaning of *section 41.0105*'s language, we need not consider legislative history here. *See Alex Sheshunoff, 209 S.W.3d at 652* (explaining that only when the enacted language is "nebulous" should a court "cautiously consult legislative history to help divine legislative intent"). Indeed, the Texas Supreme Court has emphasized that if the "text is unambiguous, we must take the Legislature at its word and not rummage around in legislative minutiae." *Id. at 652 n.4*.

We, therefore, hold that *section 41.0105* limits a plaintiff from recovering medical or health care expenses that have been adjusted or "written off."

In his cross-point on appeal, Fletcher contends that if *section 41.0105* is construed to allow a defendant the right to offset charges that were written off by a medical provider because of its contract with a health insurance company, then *section 41.0105* is unconstitutional under the Texas Constitution.

First, Fletcher urges a violation of substantive due process. In making a substantive due process determination, we look at whether the statute has a reasonable relation to a proper legislative purpose, and whether [**9] it is arbitrary or discriminatory. *Garza-Vale v. Kwiecien, 796 S.W.2d 500, 505 (Tex. App.--San Antonio 1990, writ denied)*.

It is Fletcher's position that, if defendants are allowed to benefit from medical provider write-offs, then the statute's "sole [*770] purpose would be to discriminate against financially responsible injured parties by taking away their benefits or rights they acquired under their health insurance policy, and give that right or benefit to a wrongdoer, thus treating the financially responsible injured party differently than a financially irresponsible party." According to Fletcher, this will result in people either foregoing health insurance or not submitting their bills to their health insurance company for fear that the defendant will benefit from their health insurance coverage. And, argues Fletcher, this will result in a loss of medical care to injured parties and the nonpayment of medical bills. It does not seem likely, however, that the Legislature considered the possibility that people will risk not having their medical bills covered by insurance just to make sure that a defendant from whom they may recover will not benefit from their health insurance [**10] coverage. It is more likely that the Legislature's purpose was to develop a statutory scheme that would allow neither the injured plaintiff nor the responsible defendant to benefit from the medical provider's write-off. In the end, regardless of whether an injured plaintiff is covered by health insurance or whether some of his bills are written off because of contracts with health insurance carriers, the injured plaintiff will still be able to recover from the defendant the amount paid to his medical provider. Thus, the statute has a reasonable relation to a proper legislative purpose, and it is not arbitrary or discriminatory.

Second, Fletcher urges a violation of the open courts provision of the Texas Constitution. To establish an open courts violation, a litigant must show he has a cognizable common law cause of action that is being restricted and that the restriction is unreasonable or arbitrary when balanced against the purpose and basis of the statute. *Rose v. Doctors Hosp., 801 S.W.2d 841, 843 (Tex. 1990)*. Here, *section 41.0105* in no way restricts a common law cause of action. A plaintiff still has access to the courts to bring a common law cause of action [**11] against a negligent defendant for injuries sustained in an accident. By allowing the defendant an offset for a medical provider's write-off due to a contract with the plaintiff's insurance carrier, the Legislature has only limited the damages a plaintiff may recover. As stated above, the plaintiff will still be able to recover the amount paid to his

medical provider. We, therefore, find no open courts violation.

Lastly, Fletcher contends *section 41.0105* is unconstitutionally vague. Fletcher urges that because there is a dispute over the statute's meaning, it is necessarily vague and a violation of due process.

A statute is unconstitutionally vague if the persons regulated by it are exposed to risk or detriment without fair warning of the nature of the proscribed conduct. *Raitano v. Tex. Dep't of Pub. Safety, 860 S.W.2d 549, 551 (Tex. App.--Houston [1st Dist.] 1993, writ denied)*. We scrutinize civil statutes less severely than criminal statutes because the consequences of imprecision are not as severe. *Zaborac v. Tex. Dep't of Pub. Safety, 168 S.W.3d 222, 225 (Tex. App.--Fort Worth 2005, no pet.)*. A due process violation occurs only when conduct [**12] is stated in such vague terms that people of common intelligence must guess at what is required. *Raitano, 860 S.W.2d at 551.*

We do not find *section 41.0105* to be unconstitutionally vague. First, there is no conduct proscribed by *section 41.0105*. Second, the mere fact that the parties disagree as to its meaning does not mean we must necessarily guess at its meaning. We have interpreted the meaning of *section 41.0105* [*771] by applying rules of statutory construction and by considering the plain meaning of *section 41.0105*. Thus, Fletcher's constitutional challenges must fail.

CONCLUSION

Because *section 41.0105* prevents Fletcher from recovering amounts "written off" by a healthcare provider, we reverse and remand the cause for entry of judgment consistent with this opinion.

Karen Angelini, Justice

DISSENT BY: Catherine Stone

DISSENT

DISSENTING OPINION

This appeal pits the sweeping tort reform changes of HB4 against the long-standing collateral source rule. Because I believe the majority opinion sweeps a little more broadly than the Legislature intended, I respectfully dissent.

The language of the statute in question, *section 41.0105 of the Texas Civil Practice and Remedies Code* [**13] , is not a model of clarity, perhaps because it underwent numerous revisions before it was finalized. *See* Kirk L. Pittard, *Dead or Alive: The Collateral Source Rule After HB4*, THE ADVOCATE, Winter 2006, at 76, 76-77 (outlining the five versions of the statute that were considered before *section 41.0105* was enacted). Regardless of whether the statute is ambiguous, this Court is entitled to consider various factors as we attempt to discern the statute's meaning. The Code Construction Act informs us that when the Legislature enacts a statute, it is presumed that the entire statute is meant to be effective; a just and reasonable result is intended; feasible execution of the statute is contemplated; and public interest is favored over any private interest. *TEX. GOV'T CODE ANN. § 311.021* (Vernon 2005). I believe that the interpretation of *section 41.0105* advocated by Mills and adopted by the majority fails to support any of these presumed intended outcomes.

Effectiveness of Entire Statute

The interpretation of *section 41.0105* endorsed by the majority fails to give meaning to the term "incurred." One incurs a liability when one suffers or brings on oneself a [**14] liability or expense. *Black's Law Dictionary* 782 (8th ed. 2004). Medical charges are incurred at the time the services are rendered to the patient. *See Black v. American Bankers Ins. Co., 478 S.W.2d 434 (Tex. 1972)* (concluding that patient incurs hospital expenses at the time he enters the hospital and receives medical services); *American Indemnity Co. v. Olesijuk, 353 S.W.2d 71, 72-72 (Tex. Civ. App.-San Antonio 1961, writ dism'd)* (holding that insured incurred medical expenses when he entered hospital and received medical services). *Section 41.0105* provides that recoverable medical damages include "expenses incurred ... limited to the amount actually paid or incurred by or on behalf of the claimant." The statute does not redefine the term "incurred" and it sets forth no different point in time from which to determine what expenses have been incurred. As one commentator has noted, there can be reasonable and necessary medical expenses that are not paid, but that are nonetheless incurred, thus demonstrating that "the two words must mean different things." *See* Jim Perdue, Jr., *Maybe It Depends on What Your Definition of "Or" Is? A Holistic* [**15] *Approach to Texas Civil Practice and Remedies Code § 41.0105, The Collateral Source Rule, and Legislative History, 38 TEX. TECH. L. REV. 241, at 250 (2006).*

Just and Reasonable Result

Perhaps the most compelling reason to reject the reading of the statute adopted [*772] by the majority is that it does not produce a just or reasonable result. In a nutshell, the wrongdoer is rewarded by the injured party's foresight to obtain medical insurance. In many cases it will likely be the wrongdoer's liability insurance carrier that actually benefits from the injured party's foresight; but one thing is certain: insult is added to injury when the

injured party pays premiums for medical insurance coverage and then watches the benefits of that coverage lower the accountability of the tortfeasor for her negligent conduct. *Cf., Brown v. American Transfer & Storage Co., 601 S.W.2d 931, 934 (Tex. 1980)* (recognizing that collateral source rule justly deprives a wrongdoer of the benefit of insurance independently obtained by the injured claimant).

Feasible Execution of the Statute

The statutory interpretation advanced [**16] by the majority spawns some very practical questions that suggest difficulty, not feasibility, in execution of the statute. The majority opinion ultimately stands for the proposition that the statutory language "actually paid or incurred" means "actually paid or actually incurred as ultimately determined by the provisions of an insurance policy." Medical bills can take months to be generated by the providers, and even longer periods to be processed by insurance carriers. At what point does a court decide the bills have been incurred? What happens when there is a dispute regarding the amounts due or the extent of coverage? What if adjustments are made after litigation is initiated or concluded? The statute provides no answers to these questions; and here is why the statute is silent on these issues -- it was not intended to spawn these issues. There is simply no indication that the collateral source rule was eliminated by *section 41.0105*, thus there is no need for these questions to arise.

Public Interest vs. Private Interest

The public interests at stake here seem to be that (1) citizens should be responsible and purchase medical insurance to the extent they are financially [**17] able to do so; (2) responsible citizens should reap the full benefit of insurance coverage they have purchased; (3) tortfeasors should be held accountable for their actions; and (4) tortfeasors should not be fortuitous beneficiaries of an injured party's foresight to purchase medical insurance. The private interests at stake are not expressly set forth in this record. One can reasonably assume that in many cases the private interest will be that of liability insurance carriers seeking to minimize their expenses in resolving liability claims. Again, there is nothing in the statute indicating the Legislature sought to elevate private interests above public interests. All evidence is to the contrary. The laudable public benefit of the collateral source rule was continued by the Legislature when it rejected earlier proposed versions of *section 41.0105* that would have eliminated the collateral source rule.

I recognize that the meaning of *section 41.0105* is of great significance to many parties in this state, and that the majority decision was not reached lightly. However, because I believe the majority decision erroneously allows Alisa Mills to reap the benefits of Kevin Fletcher's decision [**18] to purchase health insurance, I respectfully dissent.

Catherine Stone, Justice

Rebecca Howell v. Hamilton Meats & Provisions, Inc., et al.
California Superior Court Case No.: S179115
Division One, Case Number: D053620
SDSC Case Number: GIN053925

PROOF OF SERVICE

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

On July 27, 2010, I caused to be served the following document(s):

REPLY BRIEF ON THE MERITS

on the interested parties in this action by:

__X__ BY MAIL: I further declare that I am readily familiar with the firm's business practice of collection and processing of correspondence for mailing with the United States Postal Service, and that the correspondence shall be deposited with the United States Postal Service this same day in the ordinary course of business pursuant to Code of Civil Procedure section 1013(a). I then sealed each envelope and, with postage thereon fully prepaid, placed each for deposit in the United States Postal Service, this same day, at my business address shown above, following ordinary business practices.

____ BY PERSONAL SERVICE: I placed a copy in a separate envelope addressed to each addressee as indicated below, and delivered to the person(s) identified below for personal service.

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I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed on July 27, 2010, at La Jolla, California.

Claudia Gonzalez

SERVICE LIST

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

California Superior Court Case No.: S179115

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