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Medical liens and the current status of *Howell*

A review of *Howell* and its progeny: their impact on valuing medical damages and negotiating hospital liens

Howell v. Hamilton Meats & Provisions, Inc. (2011) 52 Cal.4th 541

Rebecca Howell was insured with a Preferred Provider Organization (PPO) when she was seriously injured in a traffic collision caused by a Hamilton Meats employee. Ms. Howell incurred $189,978.63 in medical charges for her care, which were included by the jury in its damage verdict. Pursuant to a pre-injury contractual arrangement between Rebecca's providers and her PPO, $130,286.90 was "written off" for which Rebecca could not be held responsible for by her medical providers. The trial court granted a post-trial motion to reduce the judgment by the amount of the write-offs over the objection of plaintiff's counsel that such an action violated the collateral-source rule.

The California Supreme Court ruled that the collateral-source rule was inapplicable to the "written-off" amounts, since the plaintiff was never going to be responsible for the written-off charges. The Court held that those damages (the $130,286.90) were never recoverable tort damages in the first instance and, therefore, the collateral-source rule never came into play. The Court repeatedly stated that it was not abrogating the collateral-source rule in its holding and that the fact that insurance would pay a tort victim's medical damages should continue to be inadmissible under the collateral-source rule.

The Supreme Court in *Howell* created a two-prong analysis of a tort victim's ability to recover for past medical expenses. Under the first prong, recoverable past medical expenses will never exceed the "paid or owing" amounts. A tortfeasor will never be responsible for paying past medical charges for which the plaintiff will never have any liability because the provider, as of the time the services were provided, contractually agreed to accept less than its full and customary charges as payment in full.

The second prong of the *Howell* analysis limits the plaintiff's recovery for past medical expenses to those that are "reasonable." A plaintiff's recovery for past medical expenses will be limited to the amounts actually paid or owed or the reasonable value of the care provided, whichever is less. While it would be unusual for the amount actually paid to be attacked as being unreasonable, theoretically a defendant could argue that the medical expenses actually paid or owing after the write-offs are still unreasonable. The *Howell* case turned on the first prong of the analysis since Rebecca Howell was insured with a PPO that had a pre-service contractual arrangement with the provider for a reduction of customary charges. The Court did not address or apply the second prong of *Howell*. It also declined to address the issue of valuing future medical expenses or whether or not billed charges could be relevant to general damages.

The *Howell* court drew a distinction between pre-injury negotiated rates for medical care and the situation where the rates are negotiated after the medical services are provided, the medical provider writes off or discounts the amount of the bill, or where the plaintiff receives charitable care. (*Id.* at 559.) Therefore, Howell should have no application where the plaintiff initially incurs the provider's customary medical charges but later obtains the benefit of a reduction, write-off or waiver. (See *Smock v. State of California* (2006) 136 Cal.App.4th 883; *Arambula v. Wells* (1999) 72 Cal.App.4th 1006; *Hanif v. Housing Authority* (1988) 200 Cal.App.3d 635; *Rest. 2d, Torts*, Section 920(a), comment, pg. 515.) Under this scenario, plaintiff should be allowed to proceed on the "reasonable value" prong of *Howell*.

The holding of *Howell* was soon extended to apply in the third-party action where the plaintiff's medical bills were paid by Workers' Compensation. (*Sanchez v. Brooke* (2012) 204 Cal.App.4th 126.) The Court of Appeal also applied the *Howell* doctrine to the situation where the plaintiff's medical bills were paid by Medi-Cal or Medicare. (*Luttrell v. Island Pacific Supermarkets, Inc.* (2013) 215 Cal.App.4th 19.)

The undisputable holding of *Howell* at this point focuses upon the plaintiff's obligation to pay for her medical care at the time it is provided. If there is a pre-service contractual agreement between the medical provider and the payor of the services that the provider will accept a negotiated rate, plus any potential co-pay from the plaintiff as payment in full, then the plaintiff's tort damages for past medical expenses are limited to the contractually paid rate plus plaintiff's co-pay obligation, if any.

If the medical provider accepts as payment in full Workers' Compensation, Medi-Cal or Medicare which statutorily prohibits them from looking to the patient for any financial contribution for the medical care, then the plaintiff's entitlement to recover as tort damages past medical expenses is limited to what was paid by the Workers' Compensation carrier, Medi-Cal or Medicare.

Corenbaum v. Lampkin (2013) 215 Cal.App.4th 13011

Corenbaum addressed a couple of issues that were left unanswered by the *Howell* court. The court in *Corenbaum* held that since the total amount of the provider's medical charges not paid or owed is inadmissible as to past medical expenses, then those charges are also inadmissible with respect to plaintiff's general damages or to establishing the value of future medical care. (However, this position was recently questioned by the 4th District Court in *Bermudez v. Ciolek* (2015) 237 Cal.App.4th 1311, footnote 6.) The court provided no guidance as to how to

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establish the reasonable value of future medical care.

***State Farm Mutual Ins. Co. v. Huff* (2013) 216 Cal.App.4th 1463**

This action was an interpleader claim by a hospital whose lien of $34,320.86 had not been honored despite the patient's tort victory and recovery of a judgment including $232,708.80 in past medical damages. In proving up its lien claim, pursuant to the Hospital Lien Act (*Civ. Code,* § 3043.1-3045.6), the hospital authenticated the hospital bill with itemized charges, provided testimony that its billing people had established that the patient had no insurance and had not paid his bill and that adequate notice of the lien had been provided to State Farm pursuant to the Hospital Lien Act. The Court of Appeal found that the evidence was insufficient to support a judgment in favor of the hospital, since the hospital had not provided any evidence that its charges were "reasonable and necessary." The Court applied the *Howell* holding to a hospital seeking to enforce its lien. It had to establish that its charges were both necessary and reasonable.

***Bermudez v. Ciolek* (2015) 237 Cal.App.4th 1311**

On June 22, 2015, Division 3 of the 4th Appellate District filed this opinion certified for publication. Bermudez was uninsured and incurred over $460,000 in medical bills, all of which were on a lien. Plaintiff called two doctors who testified that most of the charges were "fair and reasonable." Plaintiff's neurosurgeon, who had performed his second back surgery on a lien, testified that the bills were "fair and reasonable and within community standards" for the surgery he performed. He also rendered opinions as to the cost of medical care that plaintiff would require in the future. Plaintiff's medical experts conceded that $46,175.41 of the medical charges were unreasonable or slightly excessive. The defense called their own doctor to render his opinions as to the reasonableness of medical expenses based upon his own practice, his knowledge of rates in his area of practice and the amounts he actually receives from insurance companies and cash patients. He testified that more than $47,000 of the billings were excessive. The jury awarded plaintiff $3,751,969 in damages, which

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included charges for all the medical care plaintiff had received, including the $46,175.41 in damages which plaintiff's own experts conceded was excessive and not reasonable.

On appeal, relying upon *Howell* and *Corenbaum*, Ciolek argued that a new trial on damages was required because plaintiff failed to meet his burden of proving that his claim for past and future medical damages was "reasonable, as measured by an exchange or market value." The Court of Appeal held that the "actually paid" prong of *Howell* was inapplicable since the plaintiff was uninsured and that the determination of recoverable medical damages turned on the "reasonable value" prong of *Howell*. (*Howell*, *supra*, 52 Cal.App.4th at pg. 555-556.) The Court then held that plaintiff met his burden of proof with expert witnesses as to the reasonable value of his past and future medical expenses. The Court noted that determination of the reasonable value of plaintiff's past medical expenses and future needed care is a jury question, just as it had been before *Howell*. It is up to the trial judge to determine what evidence the jury considers on the issues. The Court affirmed the judgment as modified, subtracting the $46,175.41 which plaintiff's experts conceded were unreasonable charges.

Probably the most significant aspect of the *Bermúdez* decision is footnote 6 which states:

> Of course, this case does not feature an insured plaintiff. But as a general matter, we express some reservations about *Corenbaum*, *supra*, 215 Cal.App.4th 1308, seemingly holding that the amount initially billed is per se inadmissible in cases of insured plaintiffs whose bills were paid in full for less than the initial billed amount. *Howell*, *supra*, 52 Cal.4th 541, and *Corenbaum* did not contemplate a battle over the reasonableness of the amount paid to settle the bill in full. Unless defendants stipulate to the reasonableness of the amount actually paid to settle in full the medical bill, it seems to us that, consistent with pre-*Howell* case law, evidence of the initial billed amount would be relevant to proving the reasonableness of the discounted amount that was actually paid.

This footnote provides powerful ammunition for future litigation where insurance paid a plaintiff's past medical expenses at a discounted rate. The footnote stands for the proposition that, if the defendant is not going to stipulate

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that the amount paid is reasonable and they want to litigate the issue further, then the full charges should be admissible to allow the plaintiff to support its position that the final paid amount is, in fact, reasonable, given the fact that it is a discount from the original bills. Pursuant to *Auto Equity Sales v. Superior Court* (1962) 57 Cal.2d 450, all trial courts are bound by all Court of Appeal opinions.

The *Bermudez* opinion is a significant and long-overdue opinion that addresses the measure of damages for both past and future medical care. Ever since *Howell* and then *Corenbaum*, the defense has argued that "reasonable value" must include some sort of a "market rate" blend of paid rates, including insurance, private pay, as well as government pay. The defense has also argued that this standard must be applied to future medical expenses, while throwing in arguments of the Affordable Care Act and other potential insurance providers. *Bermudez* flatly rejected this contention and held that it was appropriate for plaintiff to establish the reasonableness of past medical expenses, which were not paid by insurance, with expert witnesses testifying as to the reasonableness of charges without regard to the amounts actually paid by various payors. The Court held that the plaintiff could also present the anticipated costs of future medical care with experts without being bound to payments typically made by insurance companies or governmental entities.

Valera v. Birdi 2015 WL 877793 – An unpublished decision

On February 27, 2015, Division One of the Fourth Appellate District issued this unpublished decision. Requests for publication were denied and the California Supreme Court declined to accept review. Therefore, the decision is not citable. However, it is included here since it provides a good example of a logical argument for the application or non-application of *Howell*.

Gabriel Varela had spent 26 years in the Navy and had just been selected to serve as a commander of a Navy missile destroyer ship. He was riding his bicycle home from work at the Naval Base when the defendant drove through an intersection directly into Varela's path of travel. The jury awarded Varela $4,761,399 in damages, including $1,355,598 in future medical expenses. Varela waived any claim for past medical expenses.

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Throughout trial, Birdi's counsel persistently sought to introduce evidence that Varela could receive all his medical care through the Navy at no cost. The trial court consistently sustained the objections to such evidence, ruling that it would be a violation of the collateral-source rule. On appeal, Birdi sought a remittitur awarding Varela only one-third of the future medical care awarded by comparing the amounts billed and paid for past similar services.

The Court of Appeal reviewed California's long adherence to the collateral-source rule and that the *Howell* court explained that it was not abrogating or modifying the collateral-source rule in its decision. The Court upheld the exclusion of the Tri Care collateral source. The Court held that where medical experts testified as to future medical care costs based upon what providers typically charge rather than amounts typically received through insurance or other payments was appropriate and not made inadmissible with respect to evaluating future medical expenses pursuant to *Howell* or *Corenbaum*.

Conclusion and prediction – *Howell/Corenbaum*

Bermudez is an important decision that finally provides some clarity to the issue of the reasonable value of medical care for an uninsured plaintiff and as to the measure of future damages for all plaintiffs. Hopefully, this signals that the *Howell/Corenbaum* pendulum has truly reached its extreme and is now swinging back to a more reasonable evaluation of a plaintiff's past and future medical expenses.

I predict litigation will continue over the valuation of medical care provided through HMOs and defendants will continue to dispute plaintiff's valuation of future medical care without taking into account various sources of payment to medical providers, such as Medicare, Medi-Cal, insurance, etc. in order to arrive at a lower, average rate for the cost of services.

Hospital liens

Hospital liens are statutory pursuant to the Hospital Lien Act (HLA) found at California *Civil Code* sections 3045.1-3045.6. Pursuant to the HLA, a hospital that treats a patient who has been injured by a third-party tortfeasor may assert a lien against any judgment, settlement or compromise recovered by that patient from the tortfeasor in the amount of its "reasonable and necessary charges." (*Civ. Code,* § 3045.1.) Pursuant to the HLA, any hospital "which furnishes emergency

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