3d Civil No. C077975

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

THIRD APPELLATE DISTRICT

TARA FRISK,

Plaintiff and Respondent,

vs.

CATHERINE MARGARET COWAN,

Defendant and Appellant.

Appeal from the Amador County Superior Court
Case No. 10-CVC-06852
Honorable Arnold Rosenfield, Judge

APPLICATION OF THE ASSOCIATION OF SOUTHERN CALIFORNIA DEFENSE COUNSEL TO FILE AMICUS CURIAE BRIEF IN SUPPORT OF DEFENDANT/APPELLANT CATHERINE MARGARET COWAN

PROPOSED AMICUS CURIAE BRIEF ON BEHALF OF THE ASSOCIATION OF SOUTHERN CALIFORNIA DEFENSE COUNSEL IN SUPPORT OF DEFENDANT/APPELLANT CATHERINE MARGARET COWAN

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APPLICATION FOR LEAVE TO FILE AMICUS CURIAE BRIEF OF THE ASSOCIATION OF SOUTHERN CALIFORNIA DEFENSE COUNSEL

Pursuant to California Rules of Court rule 8.200(c)(1), the Association of Southern California Defense Counsel (ASCDC) respectfully requests leave to file an amicus brief supporting the position of Defendant and Appellant Catherine Margaret Cowan.

ASCDC is the nation's largest and most preeminent regional organization of lawyers who specialize in defending civil actions, comprised of approximately 1,100 attorneys in Southern and Central California. ASCDC is actively involved in assisting courts on issues of interest to its members and has appeared as amicus curiae in numerous appellate cases. In addition to representation in appellate matters and comment on proposed statutory changes, Court Rules and jury instructions, ASCDC provides its members with professional fellowship, specialized continuing legal education, and multifaceted support, including a forum for the exchange of information and ideas.

ASCDC members routinely represent clients in defending actions where medical expenses are being sought as economic damages. They have a direct interest that the law in this area be certain, practical, reasonably implemented, and correct. The ASCDC has been actively involved in issues regarding the admissibility and use of unpaid medical bills and liens as damages measures in personal injury actions. ASCDC appeared as amicus curiae in *Howell v. Hamilton Meats & Provisions, Inc.* (2011) 52 Cal.4th 541 (*Howell*), both in the Court of Appeal and in the Supreme

Court, including at oral argument. It also appeared as amicus curiae in *Corenbaum v. Lampkin* (2013) 215 Cal.App.4th 1308, a *Howell* case. It also has conducted numerous, well-attended seminars on the impact of *Howell*.

Counsel for ASCDC has reviewed the briefing in this matter and believes that ASCDC can provide an important broader perspective going beyond the facts of this particular case. No party has funded this amicus brief nor has any party drafted it. It is solely the work of counsel representing ASCDC.

The application is timely under rule 8.200(c)(1) of the California Rules of Court.

For all these reasons, ASCDC respectfully requests that it be granted leave to file the accompanying Amicus Curiae Brief of the Association of Southern California Defense Counsel in Support of Defendant and Appellant Catherine Margaret Cowan.

Dated: February 12, 2016

Respectfully submitted,

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AMICUS CURIAE BRIEF OF THE ASSOCIATION OF SOUTHERN CALIFORNIA DEFENSE COUNSEL IN SUPPORT OF DEFENDANT/APPELLANT CATHERINE MARGARET COWAN

In *Howell v. Hamilton Meats & Provisions, Inc.* (2011) 52 Cal.4th 541 (*Howell*), the California Supreme Court recognized what anyone who has ever received a medical bill already knows—the amounts "charged" for medical services are often a "sticker price" that no one actually pays. If you have insurance, the price drops substantially to a negotiated rate. And if you are uninsured, the price is often discounted even more.

Howell precludes a plaintiff from obtaining damages for medical expenses based on such inflated sticker prices. It sets forth a controlling, straight-forward damages standard that governs in *all* contexts—whether the plaintiff is insured or uninsured: Plaintiffs may recover *the lesser* of (a) the amount paid or incurred for medical services (or to be paid/incurred, as to future expenses), and (b) the reasonable value of the services. The *plaintiff* must prove *both* elements, not just the higher value. And "reasonable value" is not just some amorphous concept. *Howell* defines "reasonable value" as the reasonable *market* value of services. Evidence of "reasonableness" either abstractly or otherwise untethered to market value—amounts actually paid in arms' length transactions—does not suffice.

The plaintiffs' bar is doing everything conceivably possible to circumvent *Howell*'s constraints on higher damage recoveries (and higher contingency fees). Attorneys representing plaintiffs are instructing their clients to avoid using insurance and to avoid making payments, because

payments and insurance (including government programs such as Medi-Cal) limit recovery under *Howell*. They steer plaintiffs to doctors who perform services based on liens at inflated prices no one actually pays or to businesses that pay the doctors in exchange for an inflated receivables lien.[1] The attorneys then seek the entire inflated lien as damages, claiming the plaintiff technically (although not truly) is liable for the entire amount.

This case is no aberration. The plaintiff did not abandon her Medi-Cal treatment and end up at Creative Legal Funding by happenstance. This stratagem is occurring in personal injury cases across California.

This is not what *Howell* intended. It is not what *Howell* allows. The trial court here erred in not requiring the plaintiff to present evidence of the actual *market* value of her past and future medical services, and also in excluding the defendant from presenting relevant evidence that the *market* value was far below Creative Legal Funding's lien and its purported loan for future services.

Howell is the law of the land. Its damage-recovery limits must be followed.

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[1] For example, plaintiffs' lawyers advertise that injured accident victims should call them first before seeking medical attention so that the lawyers can refer them to "the best doctors," a euphemism for referral to doctors who will provide services on a lien, at an increased charge, so as to maximize the damages to be claimed at trial. (See, e.g., The Law Offices of Jacob Emrani <http://www.calljacob.com/testimonials> [testimonial of Michael G., Los Angeles: "They provided me with top physicians to handle my every need, at no out of pocket expense"], last accessed 2/12/2016.)

DISCUSSION

A. *Howell* And Its Progeny Require A Plaintiff To Prove The Reasonable *Market* Value Of Past And Future Medical Care.

1. *Howell*'s holding: In *all* cases, a plaintiff may only recover the *lesser* of the amount paid/incurred *and* the reasonable *market* value of services—not mere "charges."

Mere "charges" for medical care, even where customary, are an insufficient basis for damage recovery. The Supreme Court repeatedly recognized in *Howell* that so-called usual and customary "charges" for medical care do not reflect usual or customary *payments*. They are typically a list or stated price that virtually no payer of health services actually pays. (See *Howell*, *supra*, 52 Cal.4th at pp. 562 ["it is not possible to say generally that providers' full bills represent the real value of their services, nor that the discounted payments they accept from private insurers are mere arbitrary reductions"], 562, fn. 9 ["the 'custom' is to bill for medical services at chargemaster rates that are paid by relatively few patients and to discount those rates to varying degrees for various government insurance and individual payers . . . ."], 564 ["a medical care provider's billed price for particular services is not necessarily representative of either the cost of providing those services or their market value"].)[2]

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[2] See also *Howell*, *supra*, 52 Cal.4th at pp. 561 ("[b]ecause so many patients, insured, uninsured, and recipients under government health care (continued...)

The plaintiff bears a double burden of proof: Explicitly embracing the Restatement rule and applying it to medical services, *Howell* holds that a plaintiff trying to prove medical damages has a *double* burden of proof: "[A] personal injury plaintiff may recover *the lesser* of (a) the amount paid or incurred for medical services, and (b) the reasonable value of the services." (52 Cal.4th at p. 556, emphasis in original; see also *id.* at p. 555 ["a plaintiff may recover as economic damages *no more* than the reasonable value of the medical services received and is not entitled to recover the reasonable value if his or her actual loss was less," original emphasis, citations omitted], *ibid.* ["[t]o be recoverable, a medical expense must be both incurred *and* reasonable," original emphasis].)

Howell recognizes that "[t]he rule that a plaintiff's expenses, to be recoverable, must be both incurred *and* reasonable accords, as well, with our damages statutes. 'Damages must, in all cases, be reasonable . . . .' (Civ. Code, § 3359.)" (52 Cal.4th at p. 555, original emphasis.) *Howell* makes clear that the reasonableness requirement is a separate, independent limitation on recovery: "'"'[R]easonable value" is a term of limitation, not of aggrandizement.' [Citation.]" (*Id.* at p. 553.) "California decisions have

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[2] (...continued)
programs, pay discounted rates, hospital bills have been called 'insincere,' in the sense that they would yield truly enormous profits if those prices were actually paid'"), 562 ("making any broad generalization about the relationship between the value or cost of medical services and the amounts providers bill for them—other than that the relationship is not always a close one—would be perilous"), 560 (hospital cost setting "often produce[s] charges which may not relate systematically to costs"), 561 ("Nor do the chargemaster [face-of-the-bill] rates . . . necessarily represent the amount an uninsured patient will pay").

focused on 'reasonable value' in the context of *limiting* recovery to reasonable expenditures . . . ." (*Id*. at p. 555, original emphasis.)

Howell also makes clear that this two-pronged burden of proof governs *all* cases: "[T]he rule that medical expenses, to be recoverable, must be both incurred *and* reasonable [citations] applies equally to those with and without medical insurance." (52 Cal.4th at p. 559 fn. 6, original emphasis.)

Market value defines the "reasonable value" of medical services. *Howell* also holds that reasonable value must be determined based on *market* value. It adopts the Restatement Second of Torts standard: "[Restatement] [s]ection 911 articulates a rule, applicable to recovery of tort damages generally, that the value of property or services is ordinarily its *'exchange value,'* that is, *its market value* or the amount for which it could usually be exchanged." (52 Cal.4th at p. 556, emphasis added.) Thus, under *Howell*, the reasonable value is "the exchange value of medical services the injured plaintiff has been required to obtain." (*Id.* at p. 562.)

Restatement section 911 defines the controlling "exchange value"/"market value" measure as "the amount *paid* in *actual* transactions involving a similar subject matter." (Rest.2d Torts, § 911, subd. (2) & com. b, emphasis added; see *Howell*, *supra*, 52 Cal.4th at p. 556.) It makes no difference whether the amount at issue remains unpaid at the time of trial: The "exchange value" is not what was paid in the particular transaction, but rather is the "market value"—that is, "the amount of money for which the subject matter *could be* exchanged or procured if there is a

market continually resorted to by traders . . . ." (Rest.2d Tort, § 911, subd. (2), emphasis added.)

A reasonable value is *not* a price that a buyer negotiates expecting that someone else—such as a liable tortfeasor—will have to pay. Markets are defined by a willing buyer who in fact will be paying the price, and a willing seller who in fact will be providing the service and receiving the price, who mutually agree on a price—not sticker or list prices.[3] The reasonable value, thus, is "the 'going rate' for the services or the 'reasonable market value at the current market prices.' Reasonable market value, or fair market value, is the price that 'a willing buyer would pay to a willing seller, neither being under compulsion to buy or sell, and both having full knowledge of all pertinent facts.'" (*Children's Hospital Central California v. Blue Cross of California* (2014) 226 Cal.App.4th 1260, 1274, citations and internal quotation marks omitted.)

Howell rejects the notion that tortfeasors should pay more than others for the same services in the non-tort context. (*Howell*, *supra*, 52 Cal.4th at pp. 560-566 [rejecting "negotiated rate differential" damages construct and finding no windfall to tortfeasors in paying no more than price, in fact, paid].) There is no "regular" price and a "litigation" price. Tortfeasors (who have no choice in the providers who see the plaintiff) are

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[3] Thus, the exchange or market value of a hotel room is not the rate posted on the inside of the door, but the market price of the room at the time of rental. The exchange or market value of a new car is not the sticker price, but the price at which that model typically sells over a large run of sales transactions. The value of a lawyer's or other professional's time is not her "billing rate," or purported "charge" or "cost" of their time, but the amount clients actually pay for comparable services. (See *Shaffer v. Superior Court* (1995) 33 Cal.App.4th 993, 1002-1003 [reasonableness of attorney's fees measured by market, not billed, rates].)

liable for the *market* value of the service, not for whatever amount a provider might "charge" a particular plaintiff.[4]

2. *Corenbaum*, *Huff*, and *Ochoa*.

Although *Howell* involved an insurer's payment of past medical expenses, *Howell*'s incurred/reasonable market value standard applies universally. Post-*Howell* decisions have applied the standard in multiple contexts to reject attempts to recover medical expenses based solely on evidence of billed or charged amounts.

Corenbaum v. Lampkin (2013) 215 Cal.App.4th 1308 (*Corenbaum*) extended *Howell* to future, yet-to-be-paid medical expenses. It recognized that *Howell*'s analysis compels the conclusion that the full amount billed for past medical services is not relevant to determine the reasonable value of both past *and* future medical services, and that billed amounts cannot support an *expert's* testimony as to the reasonable value of future medical expenses. (215 Cal.App.4th at pp. 1330-1332.)

State Farm Mutual Automobile Ins. Co. v. Huff (2013) 216 Cal.App.4th 1463 (*Huff*), applied *Howell* to a medical-lien context.[5] Relying on *Howell* and *Corenbaum, Huff* held that a hospital asserting an

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[4] This is a standard tort limitation. The value of a car that is "totaled" or a television or computer that is destroyed is not its list price, a manufacturer's suggested retail price, or the purchase price at the most expensive store in town. It is what is *normally paid* for that product *in the marketplace*.

[5] *Huff* was decided under the Hospital Lien Act, which similarly limits hospital lien claims in tort cases to "reasonable and necessary" charges. (216 Cal.App.4th at p. 1468; see Civ. Code, §§ 3045.1, 3045.3.) Because *Huff* was an interpleader, the hospital was technically a defendant there. Effectively though, it was a plaintiff. (See 216 Cal.App.4th at p. 1470.)

unpaid lien for medical services could not prove the lien was reasonable simply by introducing a copy of the unpaid lien bill and having witnesses testify the amount reflected "standard charges"or "standard rates applicable to all patients." (216 Cal.App.4th at pp. 1467, 1472.) It held that evidence of "standard charges" and "full amount billed" is "not an accurate measure of the value of medical services" as many patients "'pay discounted rates" and standard rates vary tremendously. (*Id.* at pp. 1471-1472.)

Ochoa v. Dorado (2014) 228 Cal.App.4th 120 (*Ochoa*)—relying on *Howell*, *Corenbaum* and *Huff*—held that "evidence of unpaid medical bills cannot support an award of damages for past medical expenses," even where the medical providers may not have "previously agreed to accept a lesser amount" as in *Howell*. (*Id.* at pp. 135-136, 139.)

B. Under *Howell*, It Is The *Plaintiff's* Burden, Not The Defendant's, To Present Evidence Sufficient To Establish *Both* The Expenses Incurred (Or To Be Incurred) *And* The Reasonable Market Value.

Evidence Code section 500 directs that a plaintiff bears the burden of proving *every* element of her claim. (Evid. Code, § 500.) Thus, "as in any tort case, the plaintiff bears the burden of proving by a preponderance of evidence both the existence *and* the amount of damages proximately caused by the defendant's tortious acts or omissions." (*Cassim v. Allstate Ins. Co.* (2004) 33 Cal.4th 780, 813, emphasis added.)

The plaintiff's burden is to prove the *reasonable* measure of damages. (Civ. Code, § 3359 ["[d]amages must in all cases, be

reasonable . . . ."].) And the burden is to prove damages according to the controlling legal standard. (Cal. Law Revision Com. com., 29B pt. 1B West's Ann. Evid. Code (2011 ed.) foll. § 500, p. 309 ["The facts that must be shown to establish a cause of action or a defense are determined by the substantive law, not the law of evidence"]; *California Shoppers, Inc. v. Royal Globe Ins. Co.* (1985) 175 Cal.App.3d 1, 42 [no recovery without "proof by *competent evidence* of actual damages suffered," emphasis added].)

Howell provides the controlling legal standard in medical-expense cases. The *plaintiff* therefore has the burden to present evidence sufficient to prove *all* elements required by *Howell's* recovery standard—the *lesser* of the amount actually paid/incurred (or to be paid/incurred) *and* the reasonable market value of the past/future medical services.

A plaintiff cannot meet that burden by simply proving what is or may be the *greater* value.[6] Absent the requisite proof, the damages claim fails for a lack of sufficient evidence. (See, e.g., *Huff*, *supra*, 216 Cal.App.4th at pp. 1470-1471 [proof of bills' face amounts and mere testimony that amount was standard rate, without proving reasonable market value, failed to carry hospital's burden of proof in Hospital Lien Act case].)[7]

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[6] This is no different than in an auto accident case where the plaintiff may only recover the lesser of the cost of repair or pre-damaged depreciated value (cost to replace). If a fender is damaged, the plaintiff cannot just present evidence that the auto was worth $25,000 before the accident without proving the (likely substantially lesser) cost to repair. Nor can a plaintiff prove that accident repairs will cost $15,000 without proving the depreciated value of her twelve-year-old, 150,000 mile car.

[7] This is no different than a plaintiff having a burden of proving lost profits who proves only lost gross revenues—doing so is a failure of proof.

(continued...)

C. Plaintiffs Cannot Prove Reasonable Market Value Merely By Proffering Evidence—Expert Or Otherwise—That The Amount Of Unpaid Past Or Future Bills And Liens Reflect "Standard," "Customary" Or Abstractly "Reasonable" Charges Untethered To Actual Market Value.

Howell, *Corenbaum*, *Huff* and *Ochoa* demonstrate that generic testimony that the *charges* or *costs* listed in a bill or incorporated into a lien, or that form the basis for estimating future expenses, are "reasonable" is inadequate to meet the *Howell* standard. That is particularly true of a bill that is not due and payable, but merely reflects a lien on prospective recovery in litigation from a third-party (a tortfeasor) who has had no hand in negotiating the amount due. Such a bill is, at most, one party's unilateral assertion of what it hopes to recover from a nonparty to the transaction, a potentially liable tortfeasor, who had no role in setting the price.

Testimony untethered to exchange or market values—what is actually accepted as payment for services—is irrelevant. That's why *Huff* rejected as insufficient the hospital's claim that the statutory lien was reasonable because it was "based on standard rates applicable to all patients." (216 Cal.App.4th at pp. 1467, 1472.)

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[7] (...continued)
(E.g., *Kids' Universe v. In2Labs* (2002) 95 Cal.App.4th 870, 883-884 [evidence of gross revenue losses insufficient to bear burden; resulting in adverse summary judgment]; *Resort Video, Ltd. v. Laser Video, Inc.* (1995) 35 Cal.App.4th 1679, 1700-1701 [same re trial court granting new trial on damages]; *Jozovich v. Central California Berry Growers Assn.* (1960) 183 Cal.App.2d 216, 229-230 [failure to introduce evidence of net lost profits fatal to claim].)

Howell itself makes clear that "standard" charges are not proof of reasonableness. It rejects so-called "chargemaster" or listed rates as representing the reasonable value of medical services: "[M]aking any broad generalization about the relationship between the value or cost of medical services and the amounts providers bill for them—other than that the relationship is not always a close one—would be perilous." (*Howell*, *supra*, 52 Cal.4th at p. 562; see pp. 11-12 & fn. 2, *ante*.)

Longstanding Supreme Court authority also makes clear that an unpaid bill does *not* evidence reasonable market value. (*Pacific Gas & Elec. Co. v. G.W. Thomas Drayage & Rigging Co.* (1968) 69 Cal.2d 33, 42-43 (*Thomas Drayage*) ["Since invoices, bills, and receipts for repairs are hearsay, they are inadmissible independently to prove that liability for the repairs was incurred, that payment was made, or that the charges were reasonable"].) *Thomas Drayage* is binding Supreme Court precedent. (*Auto Equity Sales, Inc. v. Superior Court* (1962) 57 Cal.2d 450, 455.) *Howell* confirms the *Thomas Drayage* view: "[A] medical care provider's billed price for particular services is not necessarily representative of either the cost of providing those services *or their market value*." (52 Cal.4th at p. 564, emphasis added.)

The post-*Howell* cases likewise confirm that the amount of unpaid bills or charges cannot alone establish the reasonable value of services—that is, *market rates*. (*Corenbaum*, *supra*, 215 Cal.App.4th at p. 1326 ["the full amount billed by medical providers is not an accurate measure of the value of medical services"], 1327, fn. 8 [following *Thomas Drayage*]; *Huff*, *supra*, 216 Cal.App.4th at p. 1467, 1471-1472 [bill

reflecting "standard charges" not accurate measure of value]; *Ochoa*, *supra*, 228 Cal.App.4th at pp. 134-139 [unpaid bill does not show reasonable value].)

In deeming unpaid bills irrelevant to show the reasonable value of a service, California law accords with the majority view. (2 Damages in Tort Actions (Matthew Bender 2012) § 9.03[3][a][ii] 9-8 to 9-9.) An unpaid bill (or a lien in the amount of an unpaid bill) is at most an expression of the provider's hope as to how much it might receive or collect. It does not logically tend to prove the amount actually paid in arms' length negotiated market transactions—the measure of reasonable value.

That a vendor—any vendor—avers its *charges* are "reasonable" or "standard" in the community does not suffice; rather, the amount that is reasonable is determined by *actual payments tendered and accepted*. If a plaintiff's new car or computer was destroyed, no one could legitimately claim that an unpaid sticker price shows its value. So, too, a medical bill or charge cannot be "reasonable" in the abstract. It can only be reasonable when measured against *market* value—actual payment transactions in the marketplace.

For the same reason, an expert may not state abstractly what a "reasonable" charge or cost is. "'[E]xpert opinion is worth no more than the reasons upon which it rests.'" (*Jennings v. Palomar Pomerado Health Systems, Inc.* (2003) 114 Cal.App.4th 1108, 1117; accord, *Sargon Enterprises, Inc. v. University of Southern California* (2012) 55 Cal.4th 747, 770 ["'matter relied on must provide a reasonable basis for the particular opinion offered'"]; *Pacific Gas & Electric Co. v. Zuckerman*

(1987) 189 Cal.App.3d 1113, 1135-1136 [expert's approach not substantial evidence of fair market value where expert ignored more comparable transactions to formulate theory on remote transaction].)

Under *Howell*, experts must base "reasonable value" testimony on *market* transactions, *not* on customary "charges" in the community. (See *Corenbaum*, *supra,* 215 Cal.App.4th at pp. 1331-1332 [holding expert could not testify as to value of future medical expenses based on the full amount of unpaid bills].) To be relevant, an expert's testimony must be based *not* on what is *billed* in the marketplace, but on what is *paid*. An expert's testimony that the amount of a bill or lien reflects standard or customary "bills" or "charges" in the community does not address the controlling "reasonable value" standard, which is *market* value.

D. The Evidentiary Rulings In This Case Flout The Mandate Of *Howell* And Its Progeny.

The trial court's evidentiary rulings in this case contravene the *Howell* standard.

1. Plaintiff failed to show she actually "incurred" as medical expenses the amount of Creative Legal Funding's lien for past services and prospective loan for future services.

The Respondent's Brief brims with assertions that plaintiff was personally liable for the entire medical services lien Creative Legal Funding acquired regarding her past services and that there was a full recourse loan with Creative Legal Funding for future medical services. (E.g., RB 10-12, 25-26.)

Such assertions, even when proved, do not satisfy the burden of proof under *Howell* as they at most address what plaintiff purportedly *incurred* for medical service, not the separate required reasonable value inquiry. (See § D.2., below.) But even ignoring that latter prong, the assertion that plaintiff "incurred" these amounts is inherently suspect. It reflects a strategem attorneys are using to circumvent *Howell*, not reality.

Hospital and doctors' bills always state that the patient is personally liable for the full amount. But the reality, as *Howell* and its progeny recognize, is that the patient almost never pays that billed amount—the stated charges are almost always substantially discounted, whether the patient is insured or uninsured. The charges are a sticker price, not the real price, and that fact does not change when those charges become incorporated into a lien or used as a predicate for calculating future expenses. It is extremely easy for witnesses to state ipse dixit that a plaintiff is on the hook for an entire lien. Proving that reality-defying assertion is an altogether different matter.

Here, for example, Creative Legal Funding never presented any evidence that it has ever forced a plaintiff to pay the balance owed on a lien when a jury awards medical damages less than the lien amount. (See AOB 50-52.) Nor did plaintiff present any signed document indicating she would have to pay anything if the jury awarded medical damages but at less than the lien amount. (*Ibid.*)

The Respondent's Brief indicates that the closest plaintiff came to presenting such proof was one witness's testimony that plaintiff's agreement with Creative Legal Funding stated that "'I accept and

understand that such payment is not contingent on a settlement, judgment or verdict. If there is *no recovery*, the full balance owed to Creative Legal Funding , LLC, becomes due and is payable immediately regardless of the outcome of the case.'" (RB 26, emphasis added.) But even accepting that inadmissible hearsay, the "no recovery" language indicates the plaintiff would be liable only if there is *no* recovery whatsoever, not when the jury awards damages but determines the reasonable value is less than the lien's full amount.

Creative Legal Funding, by being able to choose which lawsuits to get involved in, can effectively ensure there always will be *some* recovery. The purported contract language does not say that if a jury awards medical damages less than the full amount of any lien or loan, the plaintiff must pay the balance. Nor is there even a hint of evidence that Creative Legal Funding could or would actually sue for the balance after a jury determines the full lien or loan amount is inflated and exceeds market value.

2. Regardless, the trial court erred in failing to require plaintiff to present proof of reasonable *market* value and instead letting her rely on testimony about standard or customary "charges," not actual, negotiated payments in the marketplace.

In any event, evidence that a plaintiff might technically be liable for the entire amount of a medical services lien or loan, at most addresses the amount "incurred" prong of the *Howell* standard. It does not address the separate required inquiry of whether any incurred amount exceeds the reasonable market value of the medical services. A plaintiff can only obtain

the *lesser* as damages. Again, there is no "regular" price for medical services and a "litigation" price. Plaintiffs cannot make defendants pay higher medical expenses based on customary "charges" that do not reflect actual *market* value. *Howell*'s market value standard requires pricing evidence based on arms' length market transactions.

Over the defendant's objections, the trial court did not require any such evidence in this case. Plaintiff's witnesses simply opined that the charges plaintiff was claiming for past and future services were "reasonable" without ever comparing or grounding the allegedly "reasonable" amounts to the *market value* typically paid in arms' length negotiations in the community. The witnesses relied solely on evidence of customary "charges," rather than customary *payments*. (See, e.g., RB 27 [plaintiff admitting that her expert witness used charges, rather than evidence of what would likely be paid in the marketplace]; AOB 6-24.) That's not enough to meet a plaintiff's burden of proof under *Howell*.

Just as a plaintiff cannot claim that an unpaid bill is reasonable merely by showing it reflects customary or standard charges, so too a plaintiff cannot claim that unpaid medical services liens or loans regarding future medical expenses are reasonable just because they reflect customary or standard charges. (E.g., *Corenbaum*, *supra,* 215 Cal.App.4th at pp. 1326, 1331-1332; *Huff*, *supra*, 216 Cal.App.4th at pp. 1467, 1471-1472.)

Plaintiff misses the point by citing *Bermudez v. Ciolek* (2015) 237 Cal.App.4th 1311 (*Bermudez*) for the principle that "an uninsured plaintiff who is personally liable for the full amount of the past medical expenses is not in the same market as insured healthcare recipients . . . ." (RB 44.)

Bermudez did not hold that an uninsured plaintiff seeking damages based upon an unpaid lien for past medical services or a loan for future medical services can properly establish "reasonable value" simply by showing the full amount reflects standard or customary charges. Instead, *Bermudez* correctly recognized that *Howell* endorsed a "market" or "exchange" value standard for determining reasonable value that governs both insureds *and* uninsureds, and that "unlike the amount paid pursuant to an insurer's negotiated rates, the amount *incurred* by an *uninsured* medical patient *is not sufficient evidence on its own* to prove the reasonable amount of medical damages." (237 Cal.App.4th at pp. 1329-1330, 1337, emphasis added.)[8]

Bermudez also recognized that "[i]n practical terms the measure of damages in insured plaintiff cases will likely be the amount paid to settle the claim in full," but "the measure of damages for uninsured plaintiffs who have not paid their medical bills will usually turn on *a wide-ranging inquiry* into the reasonable value of medical services provided, because uninsured plaintiffs will typically incur, standard, nondiscounted charges that will be challenged as unreasonable by defendants." (237 Cal.App.4th at pp. 1330-1331, emphasis added.) But the trial court here never required or allowed that "wide-ranging inquiry."

Not only did the trial court fail to require plaintiff's witnesses to tie or ground their comments about the "reasonableness" of past or future

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[8] Although *Bermudez* ultimately upheld the plaintiff's use of conclusory expert evidence, that holding rested on *waiver* principles. *Bermudez* found that the defendant waived its complaint that plaintiff's experts never sufficiently established "that their method of forming an opinion was linked to a market or exchange value of medical services" *by not objecting or otherwise raising the issue at trial*. (237 Cal.App.4th pp. 1339-1340.) That holding is irrelevant here.

medical expenses to market value—actual payments in the marketplace—it *excluded* defendant's evidence that the amount of the liens/charges did not reflect market value as they greatly exceeded the amounts insurers and government entities negotiate for such services in arms' length transactions. (See AOB 6-25, 46-48, 53-58.) The end result was that the jury determined "reasonable value" in a vacuum devoid of the evidence that *Howell* requires—evidence of *market* value.

3. The trial erred in excluding defendant's evidence of payments actually made in the marketplace.

The trial court's failure to require plaintiff to present evidence of market value meant plaintiff failed to meet her burden of proof under *Howell*. But the trial court also independently erred in excluding defendant's evidence of market value—testimony by defendant's expert establishing the average payments that insurers and government entities pay for the medical services at issue in this case.

Defendant's evidence was relevant. Health care providers are not forced to accept government program rates or heath insurer rates. They do so as a result of voluntary, arms' length transactions. Thus, the amounts actually paid by a private insurer or a government program (such as Medi-Cal) reflect the actual *market* rate charged, unlike the type of chargemaster list prices and standard charges plaintiff relied on at trial.

Howell specifically recognized that in seeking "the exchange value of medical services the injured plaintiff has been required to obtain ([citation]), looking to the negotiated prices providers accept from insurers *makes at least as much sense, and arguably more*, than relying on

chargemaster prices that are not the result of direct negotiation between buyer and seller." (52 Cal.4th at p. 562, emphasis added.) *Corenbaum* similarly recognized that discounted payments negotiated by health insurers "may be the best indication" of reasonable value. (*Corenbaum*, *supra*, 215 Cal.App.4th at p. 1326, emphasis added.) While such evidence is not necessarily dispositive when the plaintiff is uninsured, it is—as both *Howell* and *Corenbaum* recognize—irrefutably *relevant* to the reasonable value determination the jury must make. The evidence should have been admitted.

With respect to past medical expenses, for example, the jury heard evidence that Creative Legal Funding obtained a lien in the amount of approximately $103,342 in unpaid charges in exchange for paying only $26,000 total to the surgery facility and doctor. (RB 21.) The trial court, however, precluded the jury from hearing evidence that the average payment by insurers and government entities for these same procedures ranged from $22,800 to $28,400. (RB 23.)

A jury could conclude that the payments from Creative Legal Funding reflected a discount off market value that the surgery center and surgeon accepted based upon concerns about collecting from an uninsured plaintiff. (See *Uspenskaya v. Meline* (2015) 241 Cal.App.4th 996, 1003, 1007 (*Uspenskaya*; see § F, *post*.) But a jury could also reasonably conclude from defendant's evidence of actual payments negotiated in arms' length transactions that any such discount was *minimal*. Or it could reasonably conclude that the hospital and doctors negotiated a full market-value payment from Creative Legal Funding, and that Creative Legal

Funding was simply seeking to make a profit by using the lawsuit to arbitrage the difference between market value and inflated sticker prices. And a jury could generally conclude from such evidence that (a) the standard charges plaintiff relied on at trial were inflated, and (b) the reasonable value is far closer to what the hospital and doctor accepted from Creative Legal Funding than to those standard charges.

How to balance and reconcile all the competing information was the jury's call. But the trial court improperly precluded the jury from receiving all of the relevant information needed to make that call. Because of the trial court's erroneous evidentiary rulings, the requisite "wide-ranging inquiry" (*Bermudez*, *supra*, 237 Cal.App.4th at p. 1331) never occurred. Instead, the jury was asked to determine reasonable value based solely on evidence of customary "charges," not actual payments negotiated in arms length transactions. (See AOB 26, 57 [noting the "charges" for certain past and future surgeries and hospitalization totaled almost $421,000, while defendant's excluded evidence of actual marketplace payments supported a total of $61,000—a 7 to 1 ratio].)

E. The Trial Court's Reliance On *Katiuzhinsky* Was Misplaced.

The trial court predicated its evidentiary rulings—both in terms of the plaintiff's evidence it allowed and the defendant's evidence it excluded—on *Katiuzhinsky v. Perry* (2007) 152 Cal.App.4th 1288 (*Katiuzhinsky*), a *pre-Howell* decision. (RB 23.) That reliance was misplaced.

Plaintiff cites *Katiuzhinsky* for the principle that "[w]hen an injured plaintiff is not covered by private insurance or some type of governmental health program . . ., the plaintiff may be personally liable for the full amount," and "[i]n such cases, the full amount billed is relevant and admissible because the plaintiff has incurred and remains personally liable for the full billed amount." (RB 30-31.) It claims *Katiuzhinsky* establishes that "[t]he plaintiff may recover the full billed amount, so long as plaintiff presents evidence that amount is reasonable." (RB 31.) And it touts *Katiuzhinsky* and *Howell* as entirely consistent, claiming "*Howell* expressly distinguished its facts from those in *Katiuzhinksy*" (RB 37) and no appellate court has "felt it necessary to disapprove of or even disagree with the principles stated in *Katiuzhinsky*" (RB 46).

Wrong. Plaintiff's contentions disregard what *Howell* and its progeny actually hold. Plaintiff also ignores that *Katiuzhinsky* never addressed the "market value" standard or the problems with standard medical "charges" that *Howell* addresses.

Katiuzhinsky actually entailed two separate holdings: (1) that the amount paid by a third-party to purchase a provider's lien does not, as a matter of law, *cap* the plaintiff's recovery; and (2) that the amount of the unpaid bills was admissible and could be considered as evidence of the reasonable value of the services rendered. (152 Cal.App.4th at p. 1291.) The first holding has no bearing here. The defendant here never claimed any matter-of-law cap. The second holding is the basis for plaintiff's argument, and that holding is inconsistent with *Howell*.

Without citing *any* authority, *Katiuzhinsky* offered that "[p]laintiffs should have been permitted to present evidence of the amounts charged to and incurred by them, and to argue to the jury that these amounts represented the reasonable value of the medical services provided." (152 Cal.App.4th at p. 1298.) This language was arguably incorrect when decided, as it contradicts *Thomas Drayage*'s holding that an unpaid bill does *not* constitute evidence of the reasonable value of services. (*Thomas Drayage*, *supra*, 69 Cal.2d at pp. 42-43; p. 19, *ante*.) *Katiuzhinsky* does not mention *Thomas Drayage*.

But even if *Katiuzhinsky*'s language were correct when decided, *Howell*, *Corenbaum*, *Huff* and *Ochoa* subsequently rejected the idea that the face amount of medical bills or medical liens based on such bills—whether sold to a third party or not—can provide a basis for calculating reasonable value even if they reflect customary or standard "charges."

Howell adopted the Restatement standard that "reasonable value" means an *exchange or market value* and held that "it is not possible to say generally that providers' full bills represent the real value of their services." (52 Cal.4th at pp. 556, 562.)[9] *Corenbaum,* relying on *Howell*, likewise held that "the full amount billed by medical providers is not an accurate measure of the value of medical services." (215 Cal.App.4th at p. 1326.) *Huff*, too,

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[9] Plaintiff's emphasis on *Howell* "distinguishing" *Katiuzhinsky* is overstated. *Howell* merely noted that the insured *Howell* plaintiff had no personal liability for the provider's charges, unlike the *Katiuzhinsky* plaintiff. (52 Cal.4th at 557.) *Howell* did not discuss or analyze, let alone embrace, *Katiuzhinsky*'s holdings or reasoning. Nor did it even hint that *Howell*'s rules would *not* limit recovery in a *Katiuzhinsky*-type lien context. Instead, it explained that a plaintiff's dual incurred/reasonable value burden of proof *equally governs the uninsured*. (52 Cal.4th at p. 559, fn. 6.)

rejected unpaid "standard" or "customary" charges as a permissible measure of reasonable market value. (216 Cal.App.4th at p. 1471.)

And, *Ochoa* expressly disagreed with *Katiuzhinsky* on this very point: "We find the reasoning in . . . *Katiuzhinsky* . . . unpersuasive and decline to follow [that] opinion[] on this point. For the reasons stated in *Howell* . . . and *Corenbaum* . . . we conclude that an unpaid medical bill is not an accurate measure of the reasonable value of the services provided." (*Ochoa*, *supra*, 228 Cal.App.4th at p. 138.)

No issue was ever raised in *Katiuzhinsky* as to the reasonable value/exchange value limitation on damages—the standard subsequently adopted in *Howell*. In addition, *Katiuzhinsky* expressly declined to reach the relevance or impact of the fact that the health care provider sold its lien to a factor. (See 152 Cal.App.4th at p. 1298 ["Nothing in our decision should be taken to mean that evidence a health care provider subsequently sold its bill to MedFin is inadmissible. That issue is not before us and we do not address it."].) Cases do not stand for propositions not considered. (*In re Tobacco II Cases* (2009) 46 Cal.4th 298, 323.) *Katiuzhinsky*, thus, never actually dealt with the central issues involved in this appeal.

To the extent *Katiuzhinsky* is construed as holding that the amount of an unpaid medical bill (or the amount of an unpaid medical lien in the amount of the medical bills) suffices to prove the reasonable value of services rendered if based on customary charges (not payments), the decision would be contrary to *Howell*'s subsequently-pronounced market value standard. Even accepting the fiction that a plaintiff would ever truly be liable for the entire amount of such a lien, the lien amount at most would

establish an amount "incurred." It would not constitute the separate proof of reasonable *market* value that *Howell* requires.

F. *Uspenskya* Undermines, Not Supports, The Trial Court's Evidentiary Rulings.

Plaintiff also relies on *Uspenskaya*, *supra*, 241 Cal.App.4th 996, as supporting the trial court's evidentiary rulings. (RB 11, 32-34.) She accuses defendant Cowan of implicitly arguing that *Uspenskaya* must be overruled. (RB 46.)

Plaintiff gets the issue backwards. *Uspenskaya* can be read consistently with *Howell*. It actually shows that the trial court here *erred* in restricting the evidentiary presentation to the jury.

Exercising its discretion under Evidence Code section 352, the *Uspenskaya* trial court had excluded evidence of the amount that a third-party factor—MedFin—paid medical providers to acquire their medical services lien. (241 Cal.App.4th at p. 999.) The trial court "did *not* rule that the MedFin payments are categorically admissible evidence on the question of reasonable value of medical expenses," and instead correctly recognized "that the evidence *was* relevant to the question of reasonable value." (*Id.* at p. 1002, emphasis added.) But the trial court concluded that "without any evidence tending to show that MedFin payments represented a reasonable value of the treatment provided, evidence of those amounts was likely to confuse the jury and cause the jury to speculate." (*Ibid.*)

In upholding that discretionary ruling, the Court of Appeal concluded that "[t]he MedFin payments are relevant because they have a

tendency in reason to prove reasonable value," but that the probative value was minimal because there was no *additional* evidence "that those payments represented a reasonable value for the treatment" and thus evidence of the MedFin payments, *standing alone*, could confuse the jury. (241 Cal.App.4th at p. 1002, original emphasis.) The defendant sought "to admit the amount MedFin paid as her *only evidence* of the reasonable value of plaintiff's medical services." (*Id.* at p. 1004, emphasis added.)

The Court of Appeal recognized that the doctors may have sold the receivables to MedFin at a discount below actual market value because of concerns about collecting from an uninsured; thus, "MedFin's purchase price represents a reasonable approximation of the *collectability of the debt* rather than a reasonable approximation of the *value of the plaintiff's medical services*." (241 Cal.App.4th at p. 1003, emphasis added.) Since MedFin bought an asset "based on collectability factors, not necessarily the value of the services previously provided to plaintiff," something more than just the amount of MedFin's payments to the doctors is needed to establish reasonable value. (*Id.* at p. 1007.)

Recognizing that *Howell* "endorsed a 'market or exchange value'" and that *Bermudez* recognized this will require a "'wide-ranging inquiry'" for uninsureds who have not paid bills, the *Uspenskaya* court summed up its holding as follows: "As we see it, the inquiry into reasonable value for the medical services provided to an uninsured plaintiff *is not necessarily limited to the billed amounts* where a defendant seeks to introduce evidence that a lesser payment has been made to the provider by a factor such as MedFin. In such cases, the inquiry requires *some additional evidence*

showing a nexus between the amount paid by the factor and the reasonable value of the medical services." (241 Cal.App.4th at p. 1007, emphasis added.) Since "such evidence was not offered," the trial court "did not abuse its discretion when it excluded evidence of the MedFin payments." (*Ibid.*)

Here, in contrast, such additional evidence *was* offered—defendant's evidence of the amounts that insurers and government entities have negotiated in arms' length transactions for the medical services at issue—but the trial court excluded the evidence. The trial court, in essence, limited the reasonable value inquiry "to the billed amounts" incorporated in the lien, exactly what *Howell*, and now *Uspenskaya*, say courts cannot do.

CONCLUSION

Howell and its progeny hold that inflated medical provider charges cannot be the basis for a damages recovery. A plaintiff can only recover the *lesser* of the amount actually paid/incurred (or to be paid/incurred) *and* the reasonable *market* value of the medical services. Reasonable market value requires evidence of what people actually pay in the marketplace based upon arms' length negotiations, not just what was paid in any particular case or mere testimony about standard charges or list prices.

The trial court's evidentiary rulings in this case contravene *Howell*. If the judgment is upheld, this case will become a roadmap for plaintiffs' attorneys as to how to circumvent *Howell* and to obtain higher damage recoveries based upon inflated medical charges that do not represent market value and that virtually no one ever truly pays. *Howell* requires reversal.

Dated: February 12, 2016

Respectfully submitted,

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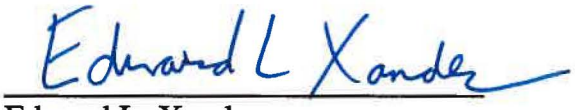
By: 
Edward L. Xanders

Attorneys for Prospective Amicus Curiae Association of Southern California Defense Counsel

CERTIFICATE OF COMPLIANCE

Pursuant to California Rules of Court, Rule 8.204(c), I certify that this **APPLICATION OF THE ASSOCIATION OF SOUTHERN CALIFORNIA DEFENSE COUNSEL TO FILE AMICUS CURIAE BRIEF IN SUPPORT OF DEFENDANT/APPELLANT CATHERINE MARGARET COWAN** and **PROPOSED AMICUS CURIAE BRIEF ON BEHALF OF THE ASSOCIATION OF SOUTHERN CALIFORNIA DEFENSE COUNSEL IN SUPPORT OF DEFENDANT/APPELLANT CATHERINE MARGARET COWAN** contains **7,354** words, not including the tables of contents and authorities, the caption page, or this Certification page.

Dated: February 12, 2016

Edward L Xanders

Edward L. Xanders

PROOF OF SERVICE

STATE OF CALIFORNIA, COUNTY OF LOS ANGELES

I am employed in the County of Los Angeles, State of California. I am over the age of 18 and not a party to the within action; my business address is 5900 Wilshire Boulevard, 12th Floor, Los Angeles, California 90036.

On February 12, 2016, I served the foregoing document described as: **APPLICATION OF THE ASSOCIATION OF SOUTHERN CALIFORNIA DEFENSE COUNSEL TO FILE AMICUS CURIAE BRIEF IN SUPPORT OF DEFENDANT/APPELLANT CATHERINE MARGARET COWAN** and **PROPOSED AMICUS CURIAE BRIEF ON BEHALF OF THE ASSOCIATION OF SOUTHERN CALIFORNIA DEFENSE COUNSEL IN SUPPORT OF DEFENDANT/APPELLANT CATHERINE MARGARET COWAN** on the parties in this action by serving:

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(X) BY MAIL: As follows: I am "readily familiar" with this firm's practice of collection and processing correspondence for mailing. Under that practice, it would be deposited with United States Postal Service on that same day with postage thereon fully prepaid at Los Angeles, California in the ordinary course of business. I am aware that on motion of party served, service is presumed invalid if postal cancellation date or postage meter date is more than 1 day after date of deposit for mailing in affidavit.

Executed on February 12, 2016, at Los Angeles, California.

(X) (State) I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Anita F. Cole

ANITA F. COLE