A143440 and A144041

IN THE COURT OF APPEAL
OF THE STATE OF CALIFORNIA
FIRST APPELLATE DISTRICT, DIVISION ONE

B. C.,
Plaintiff and Respondent,

v.

CONTRA COSTA COUNTY,
Defendant and Appellant.

APPEAL FROM CONTRA COSTA COUNTY SUPERIOR COURT
STEVEN K. AUSTIN, JUDGE • CASE NO. MSC09-01786

APPLICATION FOR PERMISSION TO FILE BRIEF OF *AMICI CURIAE* CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA AND CALIFORNIA CHAMBER OF COMMERCE SUPPORTING APPELLANT

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APPLICATION FOR PERMISSION TO FILE AN *AMICI CURIAE* BRIEF

The Chamber of Commerce of the United States of America is the world's largest business federation. The Chamber boasts more than 300,000 members and represents the interests of more than three million companies and professional organizations of every size, in every sector, and from every region of the country.

The California Chamber of Commerce (CalChamber) is a non-profit business association with over 13,000 members, both individual and corporate, representing virtually every economic interest in the state of California. For over 100 years, CalChamber has been the voice of California business. Although CalChamber represents several of the largest corporations in California, seventy-five percent of its members have 100 or fewer employees. CalChamber acts on behalf of the business community to improve the state's economic and jobs climate by representing business on a broad range of legislative, regulatory, and legal issues.

To further their members' interests, the U.S. Chamber and CalChamber regularly file *amicus curiae* briefs in cases of concern to the business community.

This case is one of them. With some frequency, certain of the Chamber's members face lawsuits in which future medical expenses are a portion of the claimed damages. Those members have a strong interest in ensuring that damages awarded for future medical costs reflect market realities.

Unfortunately, the trial court below allowed a damage award divorced from market rates. It ruled that the plaintiff's damages for future medical expenses could be based on billed rates rather than the rates actually accepted by providers as full payment. In so ruling, the trial court ignored not only this Court's and the California Supreme Court's settled teaching that the amounts billed by medical providers do not reflect the market value of medical services but also a mountain of industry and government reports supporting that conclusion.

The goal in awarding future damages is to compensate for harm suffered. Awarding damages based on billed charges rather than the amount accepted as full payment does not compensate; it provides the plaintiff a windfall recovery—in some cases, many multiples of the damages that would make the plaintiff whole.

The message to companies facing lawsuits involving future medical expenses? Charge more to compensate for higher litigation costs. The message to other trial courts? Binding precedent is not so binding after all.

Neither of those messages is good for the public.[1]

[1] In accordance with California Rule of Court 8.520(f), the U.S. Chamber and CalChamber certify that no party or party's counsel authored this brief in whole or in part and that no person except the Chambers and their counsel funded the brief.

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INTRODUCTION

In *Howell v. Hamilton Meats and Provisions, Inc.*, 52 Cal. 4th 541, 564 (Cal. 2011), the California Supreme Court held that "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." Echoing *Howell*, this Court later explained that "the full amount billed by medical providers is not an accurate measure of the value of medical services" and "is not relevant to the determination of damages for future medical expenses." *Corenbaum v. Lampkin*, 215 Cal. App. 4th 1308, 1326, 1330 (Cal. Ct. App. 2013).

Yet despite California appellate courts' unambiguous statements prohibiting the use of billed charges to calculate damages for future medical expenses, the trial court below allowed Plaintiff B.C.'s expert to do just that: In the only expert testimony about damages that the jury heard, B.C.'s expert calculated damages for future medical expenses based on the amounts that medical providers *bill* for their services. B.C. Br. 31. Relying on that testimony, the jury awarded B.C. $9.577 million in damages—three times more than what would have been allowed had the jury been instructed to consider only what insurers and patients actually *pay* for the medical services that B.C. will need in the future. County's Br. 21. *Howell* and *Corenbaum* should have foreclosed that result.

That was not the trial court's only error. It also barred the County from introducing evidence of the amounts that B.C. would pay for the required medical services if he had health insurance. Appellant's Br. 40–41. The court did so based on a mistaken understanding of the collateral-source rule. That rule generally forbids a defendant from avoiding liability for damages by pointing to payments that an insurer made on the plaintiff's behalf for the same injuries. *Id.* at 41. But as the *Howell* Court explained, the "negotiated rate differential—the discount that medical providers offer the insurer—is not a benefit provided to the plaintiff in compensation for his or her injuries and therefore does not come within the [collateral source] rule." 52 Cal. 4th at 566. Indeed, today, contracted rates under healthcare plans are not "collateral" at all because, with some limited exceptions, federal law now requires everyone to have health insurance. *See* 26 U.S.C. § 5000A(a).

In many respects, then, the judgment below is inconsistent with *Howell* and *Corenbaum* and should be reversed. If left to stand, it will lead to an increase in phantom damages awards in cases involving future medical expenses.

ARGUMENT

I. BILLED AMOUNTS ARE NOT AN ACCURATE MEASURE OF ACTUAL DAMAGES.

The trial court got its evidentiary rulings on future medical damages doubly wrong: It admitted damages

projections based on the amounts that medical providers bill for services while excluding evidence of what medical providers actually accept as full payment. California law—consistent with the realities of the U.S. healthcare system—requires just the opposite: A trial court must exclude billed amounts (and expert testimony based on billed amounts) as "not relevant" to future medical damages. *Corenbaum*, 215 Cal. App. 4th at 1330–31 (citing *Howell*, 52 Cal. App. 4th at 560–62, 564). And it must admit evidence of the amounts that providers accept as full payment because those amounts are the "best indication" of the reasonable value of medical services. *Id.* at 1326 (citing *Howell*, 52 Cal. App. 4th at 562).

A. In opining about future medical expenses, B.C.'s damages expert impermissibly relied on billed amounts.

Reversing the judgment below is as simple as applying controlling precedent. Under California law, "the full amount billed for past medical services is not relevant to the amount of future medical expenses and is inadmissible for that purpose." *Corenbaum*, 215 Cal. App. 4th at 1331. And "any expert who testifies . . . with respect to the reasonable value of the future medical services . . . may not rely on the full amounts billed." *Id.* at 1332.

But that is precisely what Plaintiff B.C.'s damages expert, Jan Roughan, did. Roughan used Fair Health—a national database that provides information about providers' billed charges—to calculate the 80th percentile of the usual,

customary, and reasonable charges for future medical expenses in B.C.'s providers' zip codes. *See* B.C.'s Br. at 52 (Roughan relied on "the Usual, Customary and Reasonable (UCR) charge based on average charges in a particular zip code as set forth in a national database, Fair Health"). B.C. admits that "[t]he UCR is the average . . . 'billed' amount" (*id.*); Fair Health's database is an aggregation of billed amounts, not of amounts actually accepted as full payment. *See* Fair Health Consumer Cost Lookup, Estimated Charge, *available at* http://fairhealthconsumer.org/medical_cost.php (the Fair Health database calculates estimated charges based on what a "medical provider . . . may bill for the procedure").

By deriving her future-damages estimate from Fair Health, Roughan improperly relied on providers' billed amounts to estimate damages for future medical expenses.

B. Under California law, billed amounts are "not relevant" to future medical expenses.

California appellate courts have led the charge in aligning tort damages with modern medical economics. The trial court somehow missed that, resurrecting an outdated view of medical pricing and damages.

In *Howell*, the California Supreme Court explained that "[w]here the provider has, by prior agreement, accepted less than a billed amount as full payment, evidence of the full billed amount is not itself relevant on the issue of past medical expenses." 52 Cal. 4th at 567. The Court also noted

that a plaintiff who does not pay her provider's full bill may not recover that full bill as damages. *Id.* at 563.

Howell's reasoning reflects the "complexities of contemporary pricing and reimbursement patterns for medical providers." *Id.* at 560. Relying on several papers and articles, the *Howell* Court explained that "[h]ospital charge setting practices are complex and varied," and "[d]isparities between charges and costs have been growing over time." 52 Cal. 4th at 560 (citing Allen Dobson et al., *A Study of Hospital Charge Setting Practices* at v (Dec. 2005)). Fifty years ago, "there were no discounts . . . and everyone paid the same rates." *Id.* at 561. Today, "only uninsured, self-paying U.S. patients have been billed the full charges." *Id.* at 561 (citing Uwe E. Reinhardt, *The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy* 25 HEALTH AFFAIRS 57, 62 (2006)). In other words, almost nobody pays full billed charges anymore. *Id.*

Accordingly, "[b]ecause so many patients, insured, uninsured, and recipients under government health care programs, pay discounted rates," medical bills often do not reflect market prices. *Howell*, 52 Cal. 4th at 561 (citing Reinhardt, *Pricing of U.S. Hospital Services* at 63). "[P]rices for a given [medical] service can vary tremendously, sometimes by a factor of five or more, from hospital to hospital in California." *Id.* (citing Reinhardt, *Pricing of U.S. Hospital Services* at 58). In light of that, the *Howell* Court concluded that "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." "[I]t is not possible," the *Howell* Court concluded, "to say generally that providers' full bills represent the real value of their service." *Howell*, 52 Cal. 4th at 561.

And because the "pricing of medical services is highly complex," *Howell* explains, it makes more sense to look to negotiated rates—not full billed amounts—to assess the reasonable value of medical services. *Id.*; *accord Corenbaum*, 213 Cal. App. 4th at 1326 (identifying negotiated rates as "best indication" of reasonable value). Indeed, "[g]iven th[e] state of medical economics, how a market value other than that produced by negotiation between the insurer and the provider could be identified is unclear." *Howell*, 52 Cal. 4th at 562. How the trial court ignored *Howell*'s teaching on that score is equally unclear.

Howell involved *past* medical expenses, but the nature of modern medical pricing compelled this Court in *Corenbaum* to extend *Howell*'s reasoning to *future* medical expenses. The *Corenbaum* court held that the full amount billed "is not relevant to a determination of the reasonable value of future medical services" and "is inadmissible." *Corenbaum*, 215 Cal. App. 4th at 1331. That being so, experts testifying about the reasonable value of future medical services "may not rely on the full amounts billed." *Id.* at 1332. Full stop. Roughan should not have been allowed to testify about billed charges.

Many California decisions since *Howell* and *Corenbaum* have assiduously applied those decisions' reasoning, holding that testimony based on billed amounts is inadmissible to support a damages award for future medical expenses. *See Ochoa v. Dorado*, 228 Cal. App. 4th 120, 135 (Cal. Ct. App. 2014) (collecting cases). Those courts agree that any evidence "based on . . . standard charges" by a medical provider is "not an accurate measure of the value of medical services." *State Farm Mut. Auto. Ins. Co. v. Huff*, 216 Cal. App. 4th 1463, 1472 (Cal. Ct. App. 2013) (citing *Corenbaum*, 215 Cal. App. 4th at 1326); *accord Ochoa*, 228 Cal. App. 4th at 139 ("We therefore conclude that evidence of unpaid medical bills cannot support an award of damages for past medical expenses.").

Given controlling precedent and the realities of modern medical pricing, Roughan's testimony based on full billed amounts should have never seen the courtroom.

C. Consistent with California law, numerous other sources confirm that billed charges are not an accurate measure of the value of medical services.

California law is well within the mainstream on that score. Pricing and economic data show that most people do not pay the sticker price for medical services and that billed charges are not an accurate measure of future medical expenses.

There is no shortage of studies showing that billed medical charges far exceed the amounts accepted as full payment. *See, e.g.*, America's Health Insurance Plans (AHIP), *Charges Billed by*

Out-of-Network Providers: Implications for Affordability 5 (Sept. 2015) (using the Fair Health database, among other resources, the "study identified a pattern of average billed charges submitted by out-of-network providers that far exceeded Medicare reimbursement for the same service performed in the geographic area"); AHIP, *Survey of Charges Billed by Out-of-Network Providers: A Hidden Threat to Affordability* (Jan. 2013) (similar findings). Studies also show that billed charges often vary within the same region, with the highest rates often exceeding the lowest rates by large margins. AHIP, *Charges Billed by Out-of-Network Providers: Implications for Affordability* at 5, 8.

The upshot is that reversing the judgment below is not just a matter of following binding precedent (although it is certainly that). It is also a matter of aligning the law with economic reality. *See Covey v. Commercial Nat'l Bank of Peoria*, 960 F.2d 657, 660 (7th Cir. 1992) (Easterbrook, J.) (explaining that a proposed legal rule was "good economics and therefore good law"); Richard A. Posner, *Economic Analysis of Law* 25 (7th ed. 2007) (noting that "many areas of law bear the stamp of economic reasoning").

II. THE COLLATERAL-SOURCE RULE DOES NOT BAR A COURT OR JURY FROM CONSIDERING NEGOTIATED RATES IN DETERMINING FUTURE MEDICAL COSTS.

The trial court compounded its error by excluding the evidence that *Howell* says best indicates the reasonable value of medical services: actual payments. It did so based on a

misunderstanding of the collateral-source rule—a misreading that *Howell* and *Corenbaum* had already rejected.

Howell emphasized that evidence of contracted rates for medical services does not come within the collateral-source rule:

> In so holding, we in no way abrogate or modify the collateral source rule as it has been recognized in California; we merely conclude *the negotiated rate differential*—the discount that medical providers offer the insurer—is not a benefit provided to the plaintiff in compensation for his or her injuries and therefore *does not come within the rule.*

52 Cal. 4th at 566 (emphasis added); *see also id.* at 565 ("[W]e do not alter the collateral source rule as articulated in *Helfend* and the Restatement.").

Corenbaum then explained *Howell*'s implications for proof of future medical damages. *Corenbaum* interpreted *Howell* as concluding that negotiated rates are likely "the best indication of the reasonable value of the [medical] services." 215 Cal. App. 4th at 1326. That "best" evidence obviously is "admissible." *Id.* at 1327.

The collateral-source rule is not to the contrary. The rule precludes the fact-finder from offsetting a plaintiff's damages with amounts that an insurer paid on the plaintiff's behalf for the same injuries, but it "does not preclude evidence of *the amount* that a medical provider . . . accepted as full payment." *Corenbaum*, 215 Cal. App. 4th at 1326 (emphasis added).

Other States agree. The Indiana Supreme Court has held that "[t]he collateral source [rule] does not bar evidence of discounted amounts in order to determine the reasonable value of medical services." *Stanley v. Walker*, 906 N.E.2d 852, 858 (Ind. 2009). Likewise, the Ohio Supreme Court has held that the collateral-source rule does not bar evidence of discounts to medical bills because the discounts are not themselves amounts paid to the plaintiff. *Robinson v. Bates*, 857 N.E.2d 1195, 1200–01 (Ohio 2006). Recognizing "the current state of the health care pricing system" in which "a medical provider's billed charges do not equate to cost," those and other States permit defendants to "introduce the discounted amounts into evidence." *Stanley*, 906 N.E.2d at 858.

In 2016, that is the only reasonable approach. As the County has argued, the collateral-source rule (at least as articulated in the trial court) is an anachronism in the age of the Affordable Care Act. Health insurance is no longer a matter of providence or foresight on the plaintiff's part; it is a matter of governmental command. *See* 26 U.S.C. § 5000A(a) (requiring all individuals not specifically exempted to maintain "minimum essential [health insurance] coverage"); *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2580 (2012). Fifty years ago, there may have been a reasonable policy justification for barring evidence of a plaintiff's health insurance coverage. Today—with virtually everyone in the United States now required to have some form of health

insurance—there is not. *See Stayton v. Delaware Health Corp.*, 117 A.3d 521, 534–37 (Del. 2015) (Strine, C.J., concurring) (questioning the viability of the collateral-source rule "in an era where we are closer to achieving universal healthcare").

And evidence of negotiated rates will not provide a windfall for defendants. It will mean only that verdicts on future medical damages will accurately reflect a plaintiff's actual damages, not the starting point for negotiations between provider and insurer.

CONCLUSION

The Court should vacate the judgment below because (1) evidence based on billed rates is never admissible to prove future medical damages and (2) evidence based on negotiated rates is always admissible to prove future medical damages.

Respectfully submitted June 16, 2016.

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CERTIFICATE OF COMPLIANCE

According to Microsoft Word's built-in word-count software, this brief consists of 2,478 words.

Dated: June 16, 2016

David Venderbush

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 631 South Olive Street, Suite 600, Los Angeles, CA 90014.

On June 16, 2016 I served the foregoing document(s) described as: APPLICATION FOR PERMISSION TO FILE BRIEF OF AMIC CURIAE CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA AND CALIFORNIA CHAMBER OF COMMERCE SUPPORTING APPELLANT, and BRIEF OF AMICI CURIEA CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA AND CALIFORNIA CHAMBER OF COMMERCE SUPPORTING APPELLANT, on the interested parties in this action.

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