Case No. S179115

SUPREME COURT OF THE

STATE OF CALIFORNIA

REBECCA HOWELL

Plaintiff and Appellant

vs.

HAMILTON MEATS & PROVISIONS, INC.

Defendant and Respondent.

San Diego County Superior Court, Case No. GIN053925
Honorable Adrienne Orfield, Judge

APPLICATION OF THE ASSOCIATION OF SOUTHERN CALIFORNIA DEFENSE COUNSEL AND DRI—THE VOICE OF THE DEFENSE BAR TO FILE AMICI CURIAE BRIEF IN SUPPORT OF DEFENDANT AND RESPONDENT HAMILTON MEATS & PROVISIONS, INC.

PROPOSED AMICI CURIAE BRIEF ON BEHALF OF THE ASSOCIATION OF SOUTHERN CALIFORNIA DEFENSE COUNSEL AND DRI—THE VOICE OF THE DEFENSE BAR IN SUPPORT OF DEFENDANT AND RESPONDENT HAMILTON MEATS & PROVISIONS, INC.

GREINES, MARTIN, STEIN & RICHLAND LLP
Robert A. Olson (SBN 109374)
5900 Wilshire Boulevard, 12th Floor
Los Angeles, California 90036
Telephone: (310) 859-7811
Facsimile: (310) 276-5261
E-Mail: rolson@gmsr.com

Attorneys for Prospective Amici Curiae
ASSOCIATION OF SOUTHERN CALIFORNIA DEFENSE COUNSEL
and DRI—THE VOICE OF THE DEFENSE BAR

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TABLE OF CONTENTS

TABLE OF CONTENTS
(Continued)

TABLE OF AUTHORITIES

TABLE OF AUTHORITIES
(Continued)

TABLE OF AUTHORITIES
(Continued)

TABLE OF AUTHORITIES
(Continued)

Page

Other Authorities:

Case No. S179115

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Pursuant to California Rules of Court, rule 8.520(f), the Association of Southern California Defense Counsel (ASCDC) and DRI—the Voice of the Defense Bar (DRI) respectfully request leave to file an amicus brief supporting the position of respondent Hamilton Meats & Provisions, Inc.

ASCDC is the nation's largest and preeminent regional organization of lawyers who specialize in defending civil actions, comprised of approximately 1,400 attorneys in Southern and Central California. ASCDC is actively involved in assisting courts on issues of interest to its members. It has appeared as amicus curiae in numerous appellate cases. DRI—the

Voice of the Defense Bar is an international organization that includes more than 22,000 attorneys involved in the defense of civil litigation. DRI seeks to address issues germane to defense attorneys, promote the role of defense attorneys, improve the civil justice system and preserve the civil jury. DRI has long been a voice in the ongoing effort to make the civil justice system fairer, more efficient and—where issues of national interest are involved—more consistent. To promote these objectives, DRI participates as amicus curiae in cases such as this one that raise issues of importance to its members, their clients and the judicial system.

In addition to representation in appellate matters and comment on proposed Court Rules, ASCDC and DRI provide their members with professional fellowship, specialized continuing legal education, representation in legislative matters, and multifaceted support, including a forum for the exchange of information and ideas.

ASCDC and DRI 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 correct. The ASCDC has a continuing interest in this area having previously appeared as amicus in support of defendant Hamilton Meat & Provisions Co. in the Court of Appeal in this cases as well as letters supporting review both in this case and in *Greer v. Buzgheia* (2006) 141 Cal.App.4th 1150. DRI shares ASCDC's interest in having the law in this area be correct.

Counsel for ASCDC and DRI has reviewed the briefing in this matter and believes that ASCDC and DRI 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 and DRI.

This application is timely under California Rules of Court, rule 8.520(f)(1).

For all of these reasons, ASCDC and DRI respectfully request that it be granted leave to file the accompanying Amici Curiae Brief on Behalf of the Association of Southern California Defense Counsel and DRI—the Voice of the Defense Bar in Support of Defendant and Respondent Hamilton Meats & Provisions, Inc.

Dated: August 31, 2010

Respectfully submitted,

GREINES, MARTIN, STEIN & RICHLAND LLP
ROBERT A. OLSON

By: _____
Robert A. Olson

Attorneys for Prospective Amicus Curiae Association of Southern California Defense Counsel and DRI—the Voice of the Defense Bar

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INTRODUCTION

In seeking to obtain a windfall recovery for medical expenses that she never paid and never will pay, plaintiff jumps over the fundamental first step: the basic measure of compensatory damages. She distorts the collateral source rule as the fundamental measure of damages rather than seeing it for what it is: an exception to an offset. Her approach is unprecedented in California.

This amicus brief is premised upon and demonstrates four core propositions under California law:

(1) compensatory damages are limited to the amount *actually paid* by the plaintiff or on the plaintiff's behalf;

(2) compensatory damages are also limited to the *reasonable value of services*, even if a plaintiff pays more;

(3) To the extent not paid, the face amount of an bill is *inadmissible* to prove the reasonable value of the services billed; and,

(4) The face amount of a medical bill (especially an unpaid medical bill) is logically disconnected from an injured plaintiff's *noneconomic* harm and should not be admitted to prove the amount of such harm. This Court should disapprove contrary suggestions and holdings.

It is a truism that a plaintiff in a tort action should not be placed in a better position than if no injury had occurred. Yet, that is what plaintiff here seeks. Plaintiff seeks to use a tort injury as a profit making proposition. She seeks to do so by arbitraging the actual cost of medical services versus a "list" price that is rarely actually paid. The law does not allow such schemes. The collateral source rule upon which she relies has always been a rule limiting offsets to and deductions from otherwise recoverable damages. It has never been what plaintiff seeks to transform it into – a rule defining damages in the first instance and increasing damages beyond amounts actually paid.

In truth, this issue should never have arisen. It should not have arisen because plaintiffs should not be introducing irrelevant evidence of "prices" that were never paid, whether for medical services or for anything else. Under this Court's longstanding precedent (consistent with the majority rule in the country), the face amount of an unpaid bill is *inadmissible* as to the reasonable value of the services reflected therein. Inadmissible evidence cannot set the measure of damages. The Court of Appeal opinions that have approved admitting such evidence as a measure of *noneconomic* damages are ill-considered and should be disapproved. Plaintiff's evidence of illusory medical charges – charges never paid or to be paid by plaintiff nor anyone on her behalf – should never have been admitted in the first place.

ARGUMENT

I. A Plaintiff's Compensatory Recovery Is Limited To Amounts Actually Paid; Nothing In The Collateral Source Rule Governing Offsets Negates This Basic Rule Nor Suggests That A Plaintiff Can Recover More Than What In Fact Was Paid Or Will Be Paid To Treat The Plaintiff's Injuries.

A. The fundamental compensatory damage measure: A tort plaintiff may recover the amount necessary to restore a loss *not to exceed* the amount actually paid.

It is a fundamental precept of California law that "'[a] plaintiff in a tort action is not, in being awarded damages, to be placed in a better position than he would have been in had the wrongful act not been done. [Citations.]'" (*Safeco Ins. Co. v. J & D Painting* (1993) 17 Cal.App.4th 1199, 1202; accord *Metz v. Soares* (2006) 142 Cal.App.4th 1250, 1255; *Valdez v. Taylor Automobile Co.* (1954) 129 Cal.App.2d 810, 821-822; *Basin Oil Co. v. Baash-Ross Tool Co.* (1954) 125 Cal.App.2d 578, 605.) "*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.)

The established rule is that the amount *actually* paid is the measure of tort damages. Restatement Second, of Torts section 924 says that for "harm to the person" damages include "(c) reasonable medical and other expenses." A comment explains that "[t]he injured person is entitled to damages for all expenses and for the *value* of services reasonably made necessary by the harm." (*Id.* & com. f, pp. 523, 526, emphasis added.) Section 924 does not define "value." But, section 911 does. It defines "value" as the "exchange rate" or market rate of the service *not exceeding the amount actually paid*: "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 gift to him." (Rest.2d Torts, § 911, com. h, quoted in *Hanif v. Housing Authority* (1988) 200 Cal.App.3d 635, 643.) The amount actually paid, thus, defines the measure of "reasonable medical and other expenses." (*Ibid.*)

These general rules apply as much in the arena of medical expenses as in any other. (*Hanif v. Housing Authority*, *supra*, 200 Cal.App.3d at pp. 639-644 [Medi-Cal payments]; *Nishihama v. City and County of San Francisco* (2001) 93 Cal.App.4th 298, 308 [payments made by a private insurer].) "[A]n award of damages for past medical expenses in excess of what the medical care and services actually cost constitutes overcompensation." (*Hanif v. Housing Authority*, *supra*, 200 Cal.App.3d at p. 641.) "[W]hen 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 that it may have been less than the prevailing market rate." (*Ibid.*)

This Court specifically approved *Hanif* in *Olszewski v. Scripps Health* (2003) 30 Cal.4th 798, 827: "Because the provider may no longer assert a lien for the full cost of its services, the Medicaid beneficiary may only recover the amount payable under Medicaid as his or her medical expenses in an action against a third party tortfeasor. (See *Hanif v. Housing Authority*, *supra*, 200 Cal.App.3d at pp. 639-644 [where the provider has relinquished any claim to additional reimbursement, a Medicaid beneficiary may only recover the amount payable under the state Medicaid plan as medical expenses in a tort action].)" In doing so, it did not limit *Hanif*'s rationale to anything unique about publicly funded medical payments. (But see *Parnell v. Adventist Health System/West* (2005) 35 Cal.4th 595, 611, fn. 16 [leaving open collateral source issue in non-Medicaid context].) *Hanif*'s rationale – that the injured plaintiff has suffered no damage beyond the amount which a healthcare provider has accepted as payment in full – has nothing to do with the publicly-financed nature of the health coverage; it applies equally whether the plaintiff is publicly or privately insured. There is no reason to give to privately insured plaintiffs windfalls that are properly not recognized as to publicly insured individuals.

Put another way, only medical bill amounts *actually* paid are a "*detriment* proximately caused" by the defendant's conduct. (Civ. Code, § 3333, emphasis added.) A "detriment" is a "loss or harm suffered." (Civ. Code, § 3282.) Unpaid amounts are not "suffered;" they do not fall within

the statutory definition of recoverable damages. A detriment inherently means an *actual* loss or harm, not a theoretical one.

Plaintiff's claim here is not for any *actual* harm. It is not for any money paid to any healthcare provider or that will ever be paid to any healthcare provider or for any medical service. Rather, plaintiff seeks to create a new category of "virtual" tort economic damages, representing moneys never paid or to be paid to anyone but that simply represent a profit to be garnered by plaintiff and her attorneys. That is a pure windfall that California law has never recognized and should never recognize. Such "virtual" damages comport with no know measure of compensatory harm and, if recognized here, are not logically limited to medical expenses but could apply to any never paid amounts across a range of personal and property damage injuries.

B. The collateral source rule's limitation on offsets and deductions affords no basis to allow a plaintiff to recover more than actually paid.

Plaintiff claims that the "collateral source rule" dictates that a plaintiff may recover for illusory medical expenses – that is, medical expenses which are never owed, never paid, and will be never owed and never paid. That misconstrues that collateral source rule. That rule is not a fundamental measure of damages – it is a rule governing what offsets or credits might be taken against amounts a plaintiff "otherwise would collect from the tortfeasor." (*Helfend v. Southern Cal. Rapid Transit Dist.* (1970) 2 Cal.3d 1, 6.)

1. The collateral source rule bars *offsets*; it does not increase otherwise available damages.

The collateral source rule is a judicially defined doctrine about the *credits* or *deductions* that can or cannot be taken against damages actually incurred or suffered. "Simply stated, the rule is that 'if an injured party receives some compensation for his injuries from a source wholly independent of the tortfeasor, such payment should not be *deducted* from the damages which the plaintiff *would otherwise collect* from the tortfeasor.' (*Helfend* [*v. Southern Cal. Rapid Transit Dist.*, *supra*, 2 Cal.3d] at p. 6.)" (*Rotolo Chevrolet v. Superior Court* (2003) 105 Cal.App.4th 242, 245, emphasis added; see *Anheuser-Busch, Inc. v. Starley* (1946) 28 Cal.2d 347, 349 ["Where a person suffers personal injury or property damage by reason of the wrongful act of another, an action against the wrongdoer for the damages suffered is not precluded nor is the amount of damages *reduced* by the receipt by him of payment for his loss from a source wholly independent of the wrongdoer," emphasis added]; Rest. 2d Torts, § 920A(2), p. 513 ["Payments made to or benefits conferred on the injured party from other sources are not *credited against* the tortfeasor's liability, ..." emphasis added], *id.* coms. b & c, p. 514 [collateral source benefits "do not have the effect of *reducing* the recovery against the defendant" and "are not *subtracted from* the plaintiff's recovery," emphases added].) Plaintiff never comes to terms with this Court's definition in *Helfend* of the collateral source rule as a limit on *deductions* from amounts that might *otherwise* be collected.

The collateral source rule, thus, does *not* define the basic measure of damages – "the damages which the plaintiff would otherwise collect." Rather it limits *offsets* to those damages. Until the current controversy, no California case has applied the collateral source rule to *expand* compensatory damages beyond amounts, in fact, actually paid.

Nowhere does the collateral source rule allow a plaintiff to *inflate, increase, or add to* damages so that they exceed amounts actually paid, the amount that the plaintiff "would otherwise collect." The rule is an exception to a potential deduction from the amount actually paid. An exception to a deduction logically does not increase the amount recoverable in the first place. (See, e.g., *Hurley Construction Co. v. State Farm Fire & Casualty Co.* (1992) 10 Cal.App.4th 533, 540 ["an exception to a policy exclusion does not create coverage not otherwise available under the coverage clause"].)

No one here is attempting to *deduct* from plaintiff's damages a penny of what, in fact, was paid. That is what the collateral source rule prevents. There is no claim that the amount that the health insurer, in fact, paid should be deducted from plaintiff's otherwise proved damages. By its own terms the collateral source rule does not apply. Rather, plaintiff is advocating a *new* rule *increasing* her damages by amounts *not* paid and which never will be paid. The collateral source rule is *not* a rule defining or increasing recoverable damages in the first instance. Nothing in the formulation of the collateral source rule has ever suggested that the rule means that the plaintiff may recover *more* than "the plaintiff would otherwise collect," that

is, *more* than the actual charges paid by the plaintiff or paid on the plaintiff's behalf.

The collateral source rule does not alter the fact that compensatory damages are just that, compensatory. They are *not* to compensate, to redress, an expense actually incurred. They are *not* to "compensate" for hypothetical amounts that arguably *might* have been paid in other circumstances.[1]

This makes particular sense in the realm of medical expense payments. Despite the label applied, so-called "usual and customary" charges for medical care are neither usual nor customary. They are a list or retail price that few ever pay. (See Alderman, *Bargaining Down the Medical Bills* (Mar. 13, 2009) <http://www.nytimes.com/2009/03/14/health/14patient.html?_r=2&ref=business> [last viewed August 27, 2010].) "Akin to the manufacturer's suggested retail price on automobiles, hospital retail charges are inflated prices that don't reflect what they are actually paid. In fact, the differential is even greater for hospitals than for automobiles. Medicare and private insurers pay only a fraction of hospital charges." (Chris Middleton, Pac. Research Inst., Hospitals Are Just Playing the Medicare Game, Vol. 1 no. 12 Health Pol'y Prescriptions, Dec. 2002,

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[1] To the extent that the plaintiff argues that the collateral source rule operates to compensate her for attorney's fees she has to incur in this litigation, her argument faces two problems. First, no judicially adopted rule can contravene or evade the *statutory* mandate that parties are to bear their own attorney's fees. (Code Civ. Proc., § 1021.) Second, if plaintiffs are entitled to compensatory damages for their attorney's fees, as a matter of equal protection any such rule needs to apply across the board or to whole rational classes – not essentially randomly only to those who can present never-paid "list" or "MSRP" bills. Certainly, a rule that only the privately insured are entitled to attorney's fees would appear to be arbitrary.

available at <http://www.pacificresearch.org/publications/hospitals-are-just-playing-the-medicare-game> [last viewed August 27, 2010].)[2] A charge is not "usual," "customary," or even reasonable, just because a vendor labels it as such. To give but one example, a hotel's "best available rate," often is no such thing – there often are AAA, government, and senior discount rates that are less. Just because the hotel labels the rate "best available" does not mean that litigants are bound by that label.

The amount *actually* paid – by a government program, by a private insurer, by uninsured individuals – in fact, reflects the *actual* market rate charged. Health care providers are not forced to accept government program rates or health insurer rates. They do so as a result of voluntary, arm's length transactions. Medical expenses should be treated no differently than any other damages element.

The collateral source rule applies fully to amounts actually paid; that is, there is no *deduction* from or credit against the damages awarded for amounts, in fact, paid on the injured plaintiff's behalf by others. But it applies only to amounts actually paid.

2. The windfall plaintiff proposes is not necessary to further the collateral source rule's goals.

Providing a windfall recovery of amounts never paid or to be paid to any healthcare provider is not necessary to satisfy the collateral source rule's purposes. There is no doubt that the payment claimed is a windfall.

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[2] That is not to say that *if* the full face amount of a medical bill is paid, that amount is not reasonable. Whether it is or not would be a matter of proof, see section II, below.

In this case, plaintiff claims entitlement to recovering several *times* the amount that her health insurer paid, and the medical providers had previously agreed to accept, as payment in full. The collateral source rule operates to ensure that a plaintiff is not *penalized* by responsibly obtaining health insurance, insurance that covers not only tortiously caused injuries but a vast array of sickness, illness, and accident unrelated to any tort. It has never been intended to create, as here, a pure windfall for the sake of a windfall. The offset of a collateral source's actual payments puts the insured plaintiff in a worse position than the uninsured plaintiff. The insured plaintiff may owe a lien recovery to the insurer, a recovery not covered if actual medical expenses are deducted from the recovery. That is not the case with regard to "virtual" medical expenses that were never paid. They do not compensate for anything. They do not affect lien exposure. They are a complete windfall.

And, the tortfeasor does not avoid liability. The tortfeasor remains responsible for every penny of the amount that the medical providers have accepted as payment in full for their services. The situation is no different than if the tortfeasor had gone directly to the healthcare providers, asked them what they would accept as payment in full to treat the plaintiff, and paid them in advance to do so. In that circumstance, would plaintiff be entitled to recover the face amount of the bill and only offset the payments that the tortfeasor had made? Of course not. The result should be no different here.

Likewise, the windfall that plaintiff seeks is not necessary to offset medical insurers' subrogation rights. In retaining the collateral source rule

despite substantial criticism of that rule, this Court noted that often plaintiffs do not receive a double recovery because insurers have rights to subrogation or refund of benefits after a tort recovery by the insured. (*Helfend v. Southern Cal. Rapid Transit Dist.*, *supra*, 2 Cal.3d at p. 11.) But as subrogation is limited to amounts actually paid, there is no need to increase the plaintiff's recovery beyond amounts actually paid to protect that interest. And even where a health insurer is *fully* subrogated, under plaintiff's proffered formulation, plaintiffs *still* obtain as a complete windfall the difference between what the insurer paid and may recoup by subrogation and the never paid portion of the bill. Often (as in this case) that windfall will be several *times* any subrogated amount that the insurer might recoup. There is no justification – other than greed – for such a result, it simply increases the overall costs of the tort system.

Finally, plaintiff's profit-making approach is not required to encourage socially responsible insurance. There are ample incentives for maintaining health insurance coverage – most of which is provided not by individuals but by employers or governmental entities. Tortiously caused injuries are only one of the multitude of risks against which individuals purchase health insurance. Individuals purchase health insurance to protect against cuts, falls, illness, and disease (e.g., flu, cancer, diabetes) that have nothing to do with tortious injury more than they do to protect against the unlikely risk of tortiously caused harm. Indeed, with the enactment of the federal Health Care and Education Reconciliation Act of 2010 (Pub.L. No. 111-152 (Mar. 30, 2010) 124 Stat 1029), individuals and employers are

required to carry health insurance coverage. Thus, the collateral source rule is not needed as an incentive for such coverage.

And, health insurance premiums are but one of a multitude of steps that individuals take to forestall greater injury – from buying cars with additional air bags or other safety features to putting alarms or fire sprinklers in their homes. The law has never compensated for such preventive measures. Indeed, even under its classic formulation, the collateral source rule does not either. If an insurer pays a plaintiff's expenses in full and is subrogated to the plaintiff's recovery from the tortfeasor, the plaintiff nets out nothing and has not been "paid" for insurance premiums. (Cf. Gov. Code, § 985 [plaintiff compensated for collateral source premiums where collateral source payments deducted from judgment and collateral source payors barred from recovering from plaintiff].)

The collateral source rule affords no basis to award plaintiffs as damages sums that neither they nor anyone on their behalf has ever paid or assumed an obligation to pay and which neither they nor anyone on their behalf will ever pay or assume an obligation to pay.

C. The amount of an unpaid bill provides *no* cognizable measure of damages; the face amounts of unpaid bills are not even admissible in evidence.

Plaintiff posits that here medical expense damages are to be measured by the face amount of an *unpaid* and *never to be paid* bill. But this Court's longstanding precedent is that an unpaid bill or charge is

not evidence of anything – particularly not of the reasonable value of services rendered – and is *inadmissible* hearsay. "*Pacific Gas & E. Co. v. G. W. Thomas Drayage etc. [Co.]* (1968) 69 Cal.2d 33, set out applicable rules. '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.* [Citations.] If, however, a party testifies that he incurred or discharged a liability for repairs, any of these documents may be admitted for the limited purpose of corroborating his testimony [citations], and if the charges *were paid*, the testimony and documents are evidence that the charges were reasonable. [Citations.]' (*Id.* at pp. 42-43.)" (*Gorman v. Tassajara Development Corp.* (2009) 178 Cal.App.4th 44, 87, emphasis added.) In this, California aligns with the majority view. (2 Damages in Tort Actions (Matthew Bender 2009) § 9.03[2][a][ii] at p. 9-9.)

That makes sense. Goods and services are worth what people pay for them, not some hoped for price that a vendor may place on them. (See *Shaffer v. Superior Court* (1995) 33 Cal.App.4th 993, 1002-1003 [reasonableness of attorney's fees measured by *market rates*].) This is no different than trying to value a home; actual sale prices of comparable properties, not listing prices, are required. An unpaid bill or the unpaid portion of a bill – especially a "list price" bill as here – in this context is nothing more that a statement as to the amount that a person – here, a healthcare provider – would *like* to be paid. It is *not*, without more, evidence of the value of services rendered or that the unpaid amount is a reasonable additional amount for the services.

It is absurd for plaintiff to proffer as a measure of compensatory damages something – an unpaid portion of a bill – that is properly is not even admissible in evidence.[3]

D. A "discount" – especially a pre-arranged "discount" – from the face of a bill is not a payment.

1. The benefit of a negotiated bargain is not recoverable as an element of tort damage.

Plaintiff appears to hypothesize that a healthcare provider obtains a non-cash benefit, for which the plaintiff should be compensated, equivalent to the amount that the pre-negotiated full payment is less than a bill's face amount. Nonsense. It strains credulity to believe that healthcare providers would not prefer payment of a bill's face amount if they could obtain it. They would. They typically aren't paid that amount, not because they would rather some other form of compensation, but because others – health insurers, the government – have more market power and can and do demand a lower rate. Nor is the healthcare provider's acceptance as payment in full of a lesser amount an act of charity; it is what a willing seller of services is prepared to accept from the customers that it deals with the most. It is no different than a lawyer agreeing to charge a reduced rate to a repeat client.[4]

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[3] Plaintiff's proposed rule will lead to absurd situations. A health insurer may negotiate the same fees with two providers. But if the unpaid "face" amount of the bills differ, one plaintiff would recover more than the other even though the amount actually paid for the services rendered was identical.

[4] The exception to the "actually paid" compensatory damages (continued...)

There are, of course, all sorts of reasons why, across a range of industries, sellers discount their prices. These include competitive pressures, a desire for quick or cash payment, reduction of collection expenses, the prospect of repeat business from regular (or hoped to be regular) customers, personal relationships,[5] etc. (See Civ. Code, § 1748.1 [allowing retailers to discount prices for cash payment].) But a discounted price is not a payment. It has never been recognized as such in California. If the "discount" is considered a payment by the health insurer, then the health insurer arguably is entitled to recover the discount as a matter of subrogation either from the plaintiff's recovery or in a direct action against the tortfeasor. Yet, no case has ever suggested that a health insurer has a subrogated right to recover *unpaid* portions of a medical bill.

Discount pricing appears throughout the economy. One may get a discount by being a AAA or warehouse store (e.g., Costco) member. But

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[4] (...continued)
measure for a plaintiff who receives charity care is consistent with this analysis. First, an injured party who receives charity care may be contractually, morally, or ethically obligated to reimburse the value of that care to the extent that recovery from a third party is obtained. Second, in providing charity care a healthcare provider is acting on behalf of and for the benefit of the patient recipient. It is paying – with its services – on behalf of the injured party. That's not the case where the service provider is simply accepting a negotiated reduced rate. It is not reducing its rate as a charitable expenditure in kind to the patient. Rather, it is making a considered market decision as a seller of a service to accept a particular reduced price, not for the patient's benefit, but because that is what the market price for the service really is. And, as discussed in section II, even charity care is subject to a reasonable value-market rate cap.

[5] See "Casablanca" (1942) <http://www.godamongdirectors.com/scripts/casablanca.pdf [last accessed August 27, 2010] at p. 71 [merchant seeking to entice Ilsa to make a purchase while she chats with Rick: "Ah, for special friends of Rick's we have a special discount"].)

obtaining a AAA rate on hotel or auto repair expenses or a good deal on a replacement camera or computer is not an element of compensable tort damages. To the contrary, the longstanding rule has been that tort damages do *not* include benefit-of-the-bargain damages. A "tort does not support recovery of damages representing the lost benefit of a bargain. . . ." (*Aas v. Superior Court* (2000) 24 Cal.4th 627, 639.) Nor does it afford a plaintiff a means of capturing the value of a bargain obtained. Yet, in effect that is what plaintiff is seeking as tort damages. She is seeking to recover as *damages* from the negligent defendant the supposed benefit of her bargain with a third party – savings on medical expenses. (We say "supposed" because the amount of the "bargain" cannot be measured against some list price but only against a market-determined reasonable value of those services.) But benefit of the bargain is not a tort measure of damages.

Nor has the value of damages that the plaintiff *avoided* ever been the measure of tort recovery. A tort plaintiff may avoid greater injury or damage because she buys a car with airbags, wears a helmet while bicycling, or has a home alarm monitoring service. The law, though, has never allowed her to recover damages reflecting what her injury would have been had she not taken such preventive measures, even when those measures cost her some amount (the cost of airbags, the cost of a helmet, monthly monitoring fees). The health insurance premiums that the plaintiff pays (or are paid on her behalf) are no different than any other preventive measure. A defendant takes a plaintiff as it finds her, whether that be particularly prone to injury (the proverbial "eggshell" plaintiff) or particularly prudent in having taken steps to minimize injury.

2. The amount actually accepted as payment in full, not form language in an admissions document, determines price.

The plaintiff's signing of an admission form accepting responsibility for amounts billed does not change this. First, *all* patients, publicly and privately insured as well as uninsured sign this form. It cannot be a distinction for treating privately insured patients differently from publicly insured patients under *Hanif.*

Second, where a plaintiff is already insured by an entity that has a superseding agreement with the healthcare provider, the admission agreement has to be read in context with the prexisting insurer-healthcare provider agreement. (Civ. Code, § 1642 ["Several contracts relating to the same matters, between the same parties, and made as parts of substantially one transaction, are to be taken together"].) Where the patient is insured (whether privately or publicly), the admission agreement from the outset does not obligate the patient to pay the healthcare provider more than the previously agreed price negotiated between the medical insurer and the healthcare provider. The plaintiff/patient is not "released" from an obligation that he or she never undertook or owed. The situation is no different than if a law seminar is priced at $100, $20 for government attorneys. The government attorney's price is $20, not $100 with $80 "written off."

The idea that part of an obligation is "written off" is a complete misnomer. There is no greater obligation in the first place. That the healthcare provider "writes off," as an internal accounting practice, an

amount on its books that never reflected the applicable agreed-upon price does not change the reality of the situation: The agreed-upon price for the services rendered to the plaintiff, from the minute that the plaintiff walked (or was otherwise transported) in the door was pre-set between the plaintiff's health insurer and the healthcare provider.

That leaves a third scenario, where the plaintiff/patient initially agrees to pay some "full" billed amount and thereafter negotiates – either directly, for example by offering to settle the bill for an immediate cash payment, or through a collateral benefactor – a discount. That is *not* the situation where the plaintiff/patient is already insured and the insurer already has an agreement with the healthcare provider. But even the circumstance of a *later*, post-services discount agreement, the price actually paid should be the proper measure of damages. A plaintiff's "thrift" in negotiating a better price has *never* been viewed as a component of damages. The "detriment" that the plaintiff suffers remains the price actually paid. Any bargain or discount that the plaintiff has received is not a detriment, that is "loss or harm suffered." (Civ. Code, § 3282.)

E. The rule plaintiff proposes would create a conflict between the civil and criminal law.

Plaintiff's proposed rule would also create a discontinuity between civil and criminal law. In *People v. Millard* (2009) 175 Cal.App.4th 7, 27-28 and *People v. Bergin* (2008) 167 Cal.App.4th 1166, 1171, the Court of Appeal held that the amount of criminal restitution is limited to the amount actually accepted by the medical provider as payment in full and do not

permit a windfall to a victim in the form of the difference between some billed amount and that amount actually accepted as payment in full. The *Hanif* rule, thus, governs in the criminal realm. There is no reason that it should not govern in the civil realm as well.

If plaintiff's approach is adopted, illogical results inevitably will follow. For example, in a negligent security case, see, e.g., *Delgado v. Trax Bar & Grill* (2005) 36 Cal.4th 224, the actual assailant might be ordered to pay the full amount of actual medical bills as criminal restitution but the less culpable negligent landowner could then be civilly liable for several times that amount in "virtual" damages as the "rate differential" between the actual charges paid and the face amount of a bill.

There is no justification for such a divergence between criminal and civil law rules.

F. Plaintiff's proposed reworking of the collateral source rule would create undoubted and unwarranted windfalls across a broad range of cases.

Let there be no doubt, plaintiff proposes a radical, novel reshaping of both the fundamental measure of compensatory tort damages and the collateral source rule. Such a reinvention would have broad implications in a whole host of cases – driving up the cost of insurance and goods and services for the majority in order to provide windfalls to the few.

The logic of plaintiff's theory would appear to apply outside the medical expense context. When an insured driver's car is damaged does the driver get to recover and pocket the difference between the insurer's

negotiated body shop repair rate and what the body shop would charge to a walk-in customer? If a new car is totaled, does the plaintiff get to recover the full "manufacturer's suggested retail price" or only the amount an insurer actually pays to replace the vehicle through a fleet purchase arrangement or the amount that the plaintiff actually pays to buy a replacement vehicle through an auto club buying service? If a television is broken, does the plaintiff get to recover the "manufacturer's list price," even if the plaintiff buys a replacement for half that cost at a membership discount store? Does a plaintiff forced to stay in a hotel get to recover the difference between the AAA or AARP rate actually charged and a "rack" or "best available" rate? If, through the tort of another, an insured plaintiff has been required to defend a lawsuit, are its damages the Civil Code section 2860 rate that its independent counsel agreed to accept to keep the business or does the insured get to claim as damages the maximum hourly rate that counsel sometimes is able to exact from a private client, with the insured plaintiff pocketing that rate difference as a windfall litigation profit?

The answer is simple. Of course, that's not the way damages are measured in any of those circumstances. (See Rest.2d Torts, § 911, com. h, p. 476.) The difference between the expense actually incurred and some hypothetical price that in fact was never paid is not an element of damages. (*Ibid.*) Yet, these circumstances are conceptually no different than the medical expense scenario plaintiff presents.

The absurdity of the result that plaintiff's theory will achieve would be particularly great in medical malpractice cases. An integral part of the Medical Injury Compensation Reform Act (MICRA), Civil Code section

3333.1 was intended to reduce the expense of medical malpractice actions. It allows a defendant to introduce evidence of amounts *paid* by collateral sources on the plaintiff's behalf. At the same time, it allows the plaintiff to introduce evidence of amounts that the plaintiff paid in premiums for such insurance as an offset. The collateral source payors are barred from any subrogated or like recovery against the plaintiff.

Under plaintiff's proposed theory here, a plaintiff in a medical malpractice case could both offset collateral source payments by insurance premiums paid *and* receive as a windfall profit the difference between amounts actually paid and an irrelevant billed amount. At the same time, the plaintiff's health insurers receive nothing by way of subrogation for the amounts that they paid. The plaintiff thus pockets both premiums *and* the difference between the amount paid and the never-paid billed rate. There is *no* suggestion that the Legislature – which thought it was eliminating the collateral source rule in medical malpractice actions – contemplated that plaintiffs would receive windfall "collateral source" amounts while health insurers were deprived of their subrogation rights.

And, what if plaintiff's reinterpretation is the rule? What if this Court effects a sea change in the law and remakes the fundamental measure of compensatory damages as well as the collateral source rule, will that be a fair, just and good outcome? The result will be that plaintiffs will recover windfall "compensatory" damages that, in fact, are not compensation for anything that anyone has paid to someone else. Health care providers and insurers will not see any of that money, only plaintiffs and their lawyers will as a litigation profit. At the same time, the money will not come out of

nowhere. It will come from defendants and their insurers. The result will be that defendants will have to increase the prices that they charge to the public at large for goods and services that they sell and insurers will have to raise premiums charged to the public at large. Thus, the public at large will ultimately bear the burden of providing windfall profits to a select group – tort litigation plaintiffs. That's neither fair, just, nor good public policy.

The rule is and should remain that a plaintiff may not recover more as *compensatory* economic damages than has actually been paid or will be paid on her behalf. Nothing in the traditional collateral source rule – a rule which is an offset to a potential deduction – suggests otherwise. The law should not be radically reformulated to create an unjust result.

II. To The Extent That Compensatory Damages Are Not Limited To The Amount Actually Paid, They Cannot Exceed The Reasonable Value Of Services.

The standard for compensatory damages is the *reasonable* value of the loss not to exceed the amount which was actually paid. (Civ. Code, § 3359 ["Damages must, in all cases, be reasonable"]; *Melone v. Sierra Railway Co.* (1907) 151 Cal. 113, 115 ["the correct measure of damage . . . is . . . the necessary and *reasonable* value of such services as may have been rendered him," emphasis added]; *Ferguson v. Workers' Comp. Appeals Bd.* (1995) 33 Cal.App.4th 1613, 1625 [where general tort rather than workers compensation measure of damages applies, compensatory damages are "the *reasonable value* of necessary medical expenses thus far incurred and fairly certain to be incurred in the future," emphasis added]; *Bonner v. Workers'*

Comp. Appeals Bd. (1990) 225 Cal.App.3d 1023, 1037 [same].) "When the plaintiff seeks to recover for expenditures made or liability incurred to third persons for services rendered, normally the amount recovered is the reasonable value of the services rather than the amount paid or charged." (Rest. 2d Torts, § 911 com. h, p. 476; see *ibid.* [noting that a price paid that is *less than* the market rate is a cap on damages, even if less than reasonable value].) As just discussed, the amount actually paid does and should limit compensatory damages, even if less than reasonable value. (*Ibid.*) But "reasonable value" is equally a limit. Even as to an amount actually paid, a plaintiff cannot recover beyond the reasonable value of the service or repair.

Under a reasonable value approach, what would properly be admissible evidence? First and foremost, the amount that the healthcare provider accepted as payment in full in this particular instance would be a strongly persuasive milestone as to the reasonable value of the service. It is the market-driven value in the particular transaction. A party might also present evidence as to what amounts the healthcare provider typically accepts as payment in full. That provides a market measure of value. What is *not* evidence of reasonable value is an amount that a healthcare provider or any vendor *bills but does not collect. That* is not evidence of anything. (*Pacific Gas & E. v. G. .W. Thomas Drayage etc. Co.*, *supra*, 69 Cal.2d at pp. 42-43.) It cannot be the standard by which reasonable value is measured. That a vendor – any vendor – labels its charges reasonable, usual, "best

available," or customary does not make it so, rather what is reasonable is an issue of *proof*.[6]

Should this Court hold that a plaintiff's recovery is not limited to amounts actually paid, it should make clear that *reasonable value* of medical services, not the face amount of a bill, is the measure of damages.

Throughout California defendants have been told that unpaid medical bills are being introduced for the limited purpose of allowing the jury to better gauge general damages (as discussed below, we think even that limited use is improper) and that any excess above the amounts actually paid will be deducted after verdict. The defendant here was expressly told by the trial court that the existing procedure of allowing the full amount of bills to be admitted (a procedure that, as we discuss below, is flawed) and that any amount exceeding that actually paid would be deducted post-trial. (See Opening Br. at 6-7.) To allow plaintiff to then recover the face amount of the bills without any regard to the actual reasonable value of services, would be complete sandbagging. Plaintiff invited a post-trial deduction procedure. If the rules are to change, defendants should be afforded the opportunity to *to try* what either the amount actually paid or the reasonable value of services is. The lesser of those two amounts caps damages. But even if an actual damages cap does not apply, defendants must be allowed to *try* the reasonable value of services.

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[6] That an amount appearing on the face of a bill may be discounted in some circumstances does not necessarily render the amount unreasonable. What is reasonable is a matter of proof. The unpaid face amount of a bill is simply irrelevant.

In the present case, it appears that the plaintiff put on *no* admissible evidence of the reasonable *value* of medical services. She just presented medical billings in an amount that was *never* paid. She admitted from the outset that such amounts did not reflect what the agreed-upon payment would be. At a minimum, therefore, the defendant should be entitled to a retrial to address the reasonable value of medical services based on *admissible* evidence. More likely, there has been a failure of proof as to amounts above those actually paid. And, if for some reason a retrial is not permitted in this case, this Court should make clear that if actual payment is not a limitation, the standard remains *reasonable value*, not the face amount of an unpaid bill, and that *both* sides are free to present *admissible* evidence – both percipient and expert – on that issue.

III. Plaintiff Should Never Have Been Allowed To Introduce Evidence Of Her "List" Price Medical Bills In The First Place; *Greer v. Buzgheia* Is Wrongly Decided To The Extent That It Holds Admissible Unpaid Medical Bills To Prove A Plaintiff's Noneconomic Damages.

Once it is clear that speculative, hypothetical amounts that might have been but were not paid for services or property are not the measure of compensatory economic damage, then there should be no basis to admit evidence of such unpaid first offers in price negotiations. Plaintiff's evidence of such "virtual" medical charges should never have been admitted in the first place.

The *Hanif/Nishihama* line of cases is entirely correct in holding that a plaintiff may not recover as compensatory economic damages more than, in fact, was actually paid for medical services. Later cases, *Greer v. Buzgheia*, *supra*, 141 Cal.App.4th 1150, in particular, are wrong in holding that evidence of an never paid billed amount should be admissible for some other purpose, e.g., as relevant to the extent of injury. That rule should not be followed.

The seminal case was *Hanif v. Housing Authority*, *supra*, 200 Cal.App.3d 635. *Hanif* struck the amount of damages awarded that exceeded actual medical expense payments. *Hanif* did not address admissibility questions. It did not need to do so. It was a straight substantial evidence determination holding that, as a matter of law, a plaintiff may not recover as economic medical expense damages amounts, in fact, not paid and never to be paid. (*Id.* at pp. 639-641.)

Nishihama v. City and County of San Francisco, *supra*, 93 Cal.App.4th 298, followed *Hanif*. It was the first case in which the initial admissibility of unpaid bill amounts was raised. There a plaintiff was injured, falling as a result of an inadequately maintained manhole cover. The plaintiff presented evidence of some $17,000 in medical bills for which the provider had accepted $3,600 as payment in full from an insurer. *Nishihama* held that the plaintiff could not recover more than the $3,600 actually paid for the medical services. (*Id.* at p. 309.)

It then held that no *prejudicial* error resulted from introducing the full medical bills. (*Ibid.*) The defendant there had argued that the prejudice was that the bills might have led the jury to believe that plaintiff's injuries were

greater than they otherwise were. In rejecting that argument, *Nishihama* did not suggest that medical bills were admissible or relevant to the determination of the extent of the plaintiff's injuries, just that once admitted a "list" price rate was no less probative of the extent of injury than a reduced, negotiated, actually paid rate:

> We do not agree with the [defendant] City, however, that this error [in awarding as damages the amounts never paid] requires remand, because the jury somehow received a false impression of the extent of plaintiff's injuries by learning the usual rates charged to treat those injuries. There is no reason to assume that the usual rates provided a less accurate indicator of the extent of plaintiff's injuries than did the specially negotiated rates obtained by Blue Cross. Indeed, the opposite is more likely to be true.

(*Ibid.*)

Nishihama never addressed admissibility, its comments were limited to *prejudice*. *Nishihama* nowhere discussed *Pacific Gas & E. Co. v. G. W. Thomas Drayage etc. Co.*, *supra*, 69 Cal.2d at pp. 42-43, and its rule that unpaid bills are *not* admissible and are *not* evidence of the reasonable value of services. Nor did *Nishihama* discuss its basis for concluding that the face amount of a bill was a "usual" rate. As discussed above, that is a question of proof; just because a vendor – healthcare provider, lawyer, electronics retailer – labels a billed (and thereafter discounted) amount as "usual" or "reasonable" does not make it so.

Greer v. Buzgheia, *supra*, 141 Cal.App.4th at p. 1157, then went astray on the admissibility question. It converted *Nishihama*'s after-the-fact *prejudice* analysis – and *Hanif*'s non-ruling on the issue – into a prospective rule that medical bills and rates (presumably high, low, average, mean, median and everything in between) are admissible, at least within the trial court's discretion. *Greer* agreed with *Hanif* and *Nishihama* that such never-paid or payable bills are *not* evidence of actual amount of economic medical expense damage. (*Greer v. Buzgheia*, *supra*, 141 Cal.App.4th at p. 1157.)

It formulated a different theory as to admissibility. It took *Nishihama*'s statement that the admission of evidence there (whether erroneous or not) was not *prejudicial* and transformed it into a rule that never-payable bills were, at least potentially in a trial court's discretion, admissible. (*Ibid.*) It read *Nishihama* as suggesting such bills were relevant as "[s]uch evidence gives the jury a more complete picture of the extent of a plaintiff's injuries." (*Ibid.*) (*Greer* goes on to posit a complex and convoluted process whereby evidence of unpaid bill amounts is to be received and the defense is given the burden to obtain – as if excessive, unsupported damages is an affirmative defense – a special verdict form detailing the precise amount of economic medical damages awarded in order to reduce the verdict to the appropriate level. (*Id.* at pp. 1157-1159.) Under *Greer*'s theory, a passenger in a train or airplane accident might introduce evidence of the cost to repair the train or airplane (or of the cost of medical care to other victims) as indicative of the plaintiff's noneconomic injuries because it might give a more complete picture of the seriousness of the accident.

Greer got the admissibility issue dead wrong. There is no logical connection between the nature and extent of plaintiff's injuries and medical bills. Medical bills for someone killed instantly are minimal. It costs much less to amputate an arm or a hand than to reconstruct one back to functionality. Medical bills for a hard to diagnose but relatively minor inconvenience can be substantial. Medical bills may well vary from county to county and even within a county. And the face amount of bills may vary between providers even when the amount that they have agreed to accept as payment in full is the same. That does not mean that the nature and extent of injuries or their value in noneconomic terms varies by locale or healthcare provider. There simply is no logical connection between medical charges – especially the unpaid face amount of bills – and compensation for noneconomic injuries.

Evidence of an amount of medical bills that, in fact, are not payable simply is not relevant to any issue in a personal injury case and should not be considered. (See Evid. Code, § 350 [only relevant evidence admissible].) The pernicious effect of allowing the admission of such irrelevant evidence is well illustrated by *Hanif*, *Nishihama*, *Greer* and like cases. The result of the erroneous admission of such evidence is that there has to be further – under *Greer*, Byzantine – measures to identify and strike the nearly inevitable improper jury use of such evidence to inflate medical expense economic damage amounts.[7] In the process, the burden has been placed, improperly, on the defense (and defense counsel) to prove – and to obtain

[7] Of course, even if such evidence meets some bare standard of relevance – as discussed it does not – it can be excluded, as trial judges in some locales consistently rule, under Evidence Code section 352.

special verdict form jury findings on – what amounts were *not* paid. (*Greer v. Buzgheia*, *supra*, 141 Cal.App.4th at pp. 1157-1159.)

The solution is not to allow irrelevant, likely-to-mislead evidence in the first place, evidence which later requires attempts to filter out its improper effects. Rather, the solution is to limit the admission of medical expense evidence to that which comports with the proper standard for recovery – charges actually incurred and paid or payable.

The offhand remark in *Helfend v. Southern Cal. Rapid Transit Dist*, *supra*, that "the cost of medical care often provides both attorneys and juries in tort cases with an important measure for assessing the plaintiff's general damages" (2 Cal.3d at p. 11) is not to the contrary. *Helfend* was considering a bill that had been fully paid by a collateral source. It did not address or consider *unpaid* bill amounts. Nor did it address *Pacific Gas & Electric*. Indeed, the comment is dicta directed at a wholly different issue – whether a jury should be told that a plaintiff incurred no net medical bills by virtue of collateral source payments. Cases, and particularly dicta in cases, are not authority for propositions not considered. (E.g., *Johnson v. Bradley* (1992) 4 Cal.4th 389, 415.)

CONCLUSION

The fundamental measure of compensatory damages has not changed and should not change. A plaintiff is entitled to recover the *lesser* of the amount *actually paid* or the reasonable value – measured by market rates – of services. Evidence of unpaid billed charges that do not, in fact, reflect the amount actually accepted by the vendor as payment in full do not suffice to

prove a plaintiff's economic medical expense damages *and* have no place in being admitted in the personal injury litigation in the first place. To the extent that the amount actually paid does not cap compensatory damages, the standard must be the *reasonable value of services*, not a hoped-for amount billed but never paid and defendants must be afforded a full opportunity (including notice of the standard that must be met) to try that issue.

The Court of Appeal's judgment should be reversed. The trial court's judgment should be affirmed. *Greer v. Buzgheia*, *supra*, 141 Cal.App.4th 1150, should be disapproved to the extent that it allows the admission of unpaid medical bills as evidence of a plaintiff's noneconomic injuries.

Dated: August 31, 2010

Respectfully submitted,

GREINES, MARTIN, STEIN & RICHLAND LLP
ROBERT A. OLSON

By: _____
Robert A. Olson

Attorneys for Prospective Amicus Curiae
Association of Southern California Defense
Counsel and DRI—the Voice of the Defense Bar

CERTIFICATION

Pursuant to California Rules of Court, Rule 8.520, subdivision (c)(1), I certify that this **PROPOSED AMICI CURIAE BRIEF ON BEHALF OF THE ASSOCIATION OF SOUTHERN CALIFORNIA DEFENSE COUNSEL AND DRI—THE VOICE OF THE DEFENSE BAR IN SUPPORT OF DEFENDANT AND RESPONDENT HAMILTON MEATS & PROVISIONS, INC.**, contains **8,496** words, not including the tables of contents and authorities, the caption page, signature blocks, or this Certification page.

Dated: August 31, 2010

Robert A. Olson

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 August 31, 2010, I served the foregoing document described as **APPLICATION OF THE ASSOCIATION OF SOUTHERN CALIFORNIA DEFENSE COUNSEL AND DRI—THE VOICE OF THE DEFENSE BAR TO FILE AMICI CURIAE BRIEF IN SUPPORT OF DEFENDANT AND RESPONDENT HAMILTON MEATS & PROVISIONS, INC.** and **PROPOSED AMICI CURIAE BRIEF ON BEHALF OF THE ASSOCIATION OF SOUTHERN CALIFORNIA DEFENSE COUNSEL AND DRI—THE VOICE OF THE DEFENSE BAR IN SUPPORT OF DEFENDANT AND RESPONDENT HAMILTON MEATS & PROVISIONS, INC.** on the interested parties in this action by placing a true copy thereof enclosed in sealed envelopes addressed as follows:

PLEASE SEE ATTACHED SERVICE LIST

I caused such envelope to be deposited in the mail at Los Angeles, California. The envelope was mailed with postage thereon fully prepaid.

I am "readily familiar" with this office's practice of collection and processing correspondence for mailing. It is deposited with U.S. postal service on that same day 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 August 31, 2010 at Los Angeles, California.

I declare under penalty of perjury under the laws of the State of California that the above is true and correct.

ANITA F. COLE

HOWELL
v.
HAMILTON MEATS & PROVISIONS, INC.
[Case No. S179115]

J. Jude Basile
Basile Law Firm
1334 Chorro Street
San Luis Obispo, California 93401-4006
[Attorneys for plaintiff and appellant Rebecca Howell]

John J. Rice
Lafave & Rice
2333 First Avenue, Suite 201
San Diego, California 92101
[Attorneys for plaintiff and appellant Rebecca Howell]

Gary L. Simms
Law Office of Gary L. Simms
2050 Lyndell Terrace, Suite 240
Davis, California 95616-6206
[Attorneys for plaintiff and appellant Rebecca Howell]

Robert F. Tyson, Jr.
Mark T. Peterson
Tyson & Mendes
5661 La Jolla Boulevard
La Jolla, California 92037
[Attorneys for defendant and respondent Hamilton Meats & Provisions, Inc.]

Scott H.Z. Sumner
Hinton, Alfert & Sumner
1646 N. California Boulevard, Suite 600
Walnut Creek, California 94596-7456
[Attorneys for Amicus Committee of the Consumer Attorneys of California]

Joel K. Liberson
Liberson & Wolford LLP
660 Market Street, 5th Floor
San Francisco, California 94104
[Attorneys for Amicus Committee of the Consumer Attorneys of California]

Steven Suchil
American Insurance Association
915 "L" Street, Suite 1480
Sacramento, California 95814-3765
[Attorneys for Pub/Depublication Requestor American Insurance Association]

Eric B. Kunkel
Tharpe & Howell
15250 Ventura Boulevard, 9th Floor
Sherman Oaks, California 91403-3221
[Attorneys for Pub/Depublication California Capital Insurance Company]

Curtis A. Cole
Cole Pedroza LLP
200 S. Los Robles Avenue, Suite 300
Pasadena, California 91101-2483
[Attorneys for Amici Curiae California Medial Association, California Hospital Association and California Dental Association]

Vicki F. VanFleet
David B. Newdorf
Newdorf Legal
220 Montgomery Street, Suite 1850
San Francisco, California 94104
[Attorneys for Amicus Curiae League of California Cities]

Barbara A. Jones
AARP Foundation Litigation
200 S. Los Robles, Suite 400
Pasadena, California 91101
[Attorneys for Amicus Curiae AARP Foundation Litigation]

Dean Peter Petrulakis
McCormick Barstow LLP
1150 Ninth St., Suite 1200
Modesto, California 95354-0845
[Attorneys for Amicus Curiae CSAC Excess Insurance Authority]

Clerk to the
Hon. Adrienne Orfield
San Diego Superior Court
North County Division
325 South Melrose, Dept. 29
Vista, California 92081
[SDSC Case No. GIN053925]

Clerk
California Court of Appeal
Fourth District, Division One
750 B Street, Suite 300
San Diego, California 92101
[Court of Appeal Case No. D053620]