A143440 and A144041

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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

APPELLANT'S OPENING BRIEF

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TO BE FILED IN THE COURT OF APPEAL **APP-008**

COURT OF APPEAL, First APPELLATE DISTRICT, DIVISION One	Court of Appeal Case Number: A143440
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APPELLANT/PETITIONER Contra Costa County RESPONDENT / REAL PARTY IN INTEREST B.C.	

CERTIFICATE OF INTERESTED ENTITIES OR PERSONS

(Check one): ☒ INITIAL CERTIFICATE ☐ SUPPLEMENTAL CERTIFICATE

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1. This form is being submitted on behalf of the following party *(name)*: Contra Costa County

2. a. ☒ There are no interested entities or persons that must be listed in this certificate under rule 8.208.
   b. ☐ Interested entities or persons required to be listed under rule 8.208 are as follows:

Full name of interested entity or person	Nature of interest *(Explain):*
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The undersigned certifies that the above-listed persons or entities (corporations, partnerships, firms, or any other association, but not including government entities or their agencies) have either (1) an ownership interest of 10 percent or more in the party if it is an entity; or (2) a financial or other interest in the outcome of the proceeding that the justices should consider in determining whether to disqualify themselves, as defined in rule 8.208(e)(2).

Date: February 27, 2015

Robert H. Wright ▶ _____
(TYPE OR PRINT NAME) (SIGNATURE OF PARTY OR ATTORNEY)

TO BE FILED IN THE COURT OF APPEAL **APP-008**

COURT OF APPEAL, First APPELLATE DISTRICT, DIVISION One	Court of Appeal Case Number: A144041
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APPELLANT'S OPENING BRIEF

INTRODUCTION

This appeal raises novel issues regarding the admissibility of evidence in a medical malpractice action related to the plaintiff's access to health insurance pursuant to the Patient Protection and Affordable Care Act (ACA). It also raises issues concerning the evidence a jury may consider in calculating a future medical expense award, and whether such an award may be based upon billed rates greatly exceeding the amounts that will actually be accepted by healthcare providers as full payment for their services. The court below committed evidentiary and instructional errors on these points, leading to an excessive damages award. A new trial should therefore be ordered.

Background

This medical malpractice action was brought on behalf of a minor plaintiff who suffered a brain injury in utero during the period that his mother's pregnancy was being managed by a physician employed by Contra Costa County (County). Plaintiff alleged the physician should have delivered him prior to the time the injury occurred. The jury found in plaintiff's favor on negligence and causation. Liability is not challenged in this appeal.

At the time of trial, plaintiff was six years old and had been receiving free benefits for the disabled from the Regional Center and through the public school system. Although plaintiff's development has been delayed, he is a sociable and friendly child and is able to walk, run, feed himself with a fork and spoon, use playground equipment without assistance, and sleep unattended in his own room for the entire night.

Plaintiff was also enrolled in Medi-Cal and had incurred a total of about $56,000 in medical expenses (or less than $10,000 per year of his life to date).

In this lawsuit, however, plaintiff's life care planner projected that he would need nearly *$285 million* in future care expenses, with a present value of nearly *$29 million*. Her plan, however, did not take into account the free services plaintiff receives (and will continue to receive) from the Regional Center and school district. The plan also did not consider the substantially discounted rates Medi-Cal pays for medical care costs, or the reduced rates that are available through private insurance. Rather, plaintiff's life care

plan calculated costs based on the rates that the top 20 percent of healthcare providers bill for their services.

In contrast, the County's life care planner demonstrated that the billed rates are not what people actually pay for their medical care. She therefore created plans considering potential payment scenarios for plaintiff's future care, with the highest rate being the "private pay" level which is paid by the uninsured, followed next by discounted private insurance rates and, finally, at the most inexpensive end, the rates paid by Medi-Cal. She also factored into her analysis the free benefits plaintiff receives through the Regional Center and school district.

The court, however, ruled that the County could not introduce any evidence of private insurance rates that could be secured under the ACA, any evidence of Medi-Cal discounts, or any evidence concerning the free services plaintiff receives. Therefore, the County's life care planner was only allowed to testify about the "private pay" rate, which incorrectly assumes that the plaintiff will forgo insurance and voluntarily pay higher rates.

The court also ruled that plaintiff's life care planner could testify concerning the "billed" rates she used in calculating the expenses in her plan, and rejected a jury instruction proposed by the County that would have told the jury to limit any future medical damages award to the amounts that will be accepted as full payment.

As a result, the jury returned a future medical damages award of over $9.5 million—an amount nearly three times higher than the "private pay" plan the County estimated, and many factors

higher than what any expenses would be under private insurance or Medi-Cal.

Summary of argument

The trial court committed four categories of error.

First, the trial court barred evidence of future benefits available to plaintiff through the ACA. In 1975, in response to the "medical malpractice insurance crisis," the legislature enacted the Medical Injury Compensation Reform Act (MICRA). (*Western Steamship Lines, Inc. v. San Pedro Peninsula Hospital* (1994) 8 Cal.4th 100, 111-112.) One of the provisions enacted as part of this far-reaching reform was Civil Code section 3333.1,[1] which abrogated the common law collateral source rule in medical malpractice actions to allow the defendant to introduce evidence of "any amount payable as a benefit to the plaintiff" because of health insurance.

The trial court concluded, however, that section 3333.1 allows a defendant to introduce only the *past* benefits a plaintiff has received, and therefore the County could not submit evidence concerning future discounts plaintiff could receive through a private insurance policy under the ACA. But that conclusion conflicts with the terms of the statute and its goal of limiting recovery in medical malpractice actions. And although the court speculated that the ACA might be repealed, it was, and continues to be, the law and it guarantees access to health insurance regardless of any preexisting condition.

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[1] All further statutory references are to the Civil Code unless otherwise indicated.

Second, the court ruled that plaintiff's future medical expenses could be based upon billed rates rather than the much lower amounts accepted as full payment, and precluded the County from presenting evidence of the amounts providers will actually accept as payment. The court also rejected the County's proposed instruction on measuring "reasonable value" and allowed plaintiff's life care planner to present her care estimates based upon the inflated bills charged by the top 20 percent of providers in the country.

This conflicts with decisions such as *Howell v. Hamilton Meats & Provisions, Inc.* (2011) 52 Cal.4th 541 (*Howell*) and *Corenbaum v. Lampkin* (2013) 215 Cal.App.4th 1308 (*Corenbaum*) which recognize that the inflated amounts medical providers bill for their services bear no relationship to the "reasonable value" of those services, and that a plaintiff's past and future medical expense recovery must therefore be limited to the amounts that will actually be paid for the goods and services.

Third, the court erred by relying on the collateral source rule as a basis for excluding evidence concerning private insurance under the ACA. The collateral source rule is not an absolute exclusionary rule, and such evidence is admissible when it has substantial probative value to an issue. Here, the fact that the ACA guarantees access to insurance regardless of preexisting condition and mandates the purchase of insurance, and that private insurers pay substantially discounted rates for healthcare services, has substantial probative value in determining the reasonable value of future medical care. At a minimum, the County should have been

able to explain to the jury that much of plaintiff's future care will be paid for at significantly lower rates — without mentioning the ACA.

Finally, the court held that the County could not introduce evidence of the free Regional Center and educational benefits plaintiff receives through the Individuals with Disabilities and Education Act (IDEA) because these items were not identified in MICRA as exemptions from the collateral source rule. But these benefits are *not collateral sources*, so they are admissible regardless of MICRA. They are available to anyone with a qualifying disability as a result of law, not obtained through the recipient's prudence in procuring insurance. And since there is no requirement of reimbursement, barring evidence of these benefits results in a double recovery to the plaintiff.

The cumulative prejudicial impact of the court's errors is manifest in the jury's excessive verdict and an unjust judgment. A new trial should therefore be ordered.

STATEMENT OF THE CASE

A. Plaintiff suffers a hypoxic brain injury in utero after his twin dies.

This is an action to recover damages for obstetrical malpractice brought on behalf of the surviving twin of a Monochorionic-Diamniotic (MoDi) pregnancy—a condition whereby identical twins share a placenta, but have separate amniotic sacs. (1 RT 344-345; 5 RT 660-661.) Because the County does not

challenge the jury's findings on liability and proximate cause, we provide a limited overview of the liability facts and theories by way of background to the damages issues presented on appeal.

During her pregnancy, plaintiff's mother saw Dr. Teresa Madrigal, an employee with the health system for the County. (3 RT 329-330.) When plaintiff's mother reported for an appointment when she was 37 weeks and 6 days pregnant, only one fetal heart beat could be detected. (3 RT 397-398; 6 RT 969-970; 7 RT 1078-1080; see 6 RT 927; 7 RT 1097.) Plaintiff's mother was transferred to a hospital by ambulance, where the twins were delivered via caesarian section. (3 RT 400-401; 6 RT 986; 7 RT 1080-1081; 14 RT 2489-2490, 2497-2498.) Plaintiff's twin had died, and plaintiff had suffered a hypoxic brain injury. (7 RT 1139, 1144, 1164; 8 RT 1266-1269, 1370.)

Although plaintiff has mild cerebral palsy, he has made steady progress with motor development. (12 RT 2101-2102.) He has some developmental delay, but he is sociable, engaging, happy and playful; he is toilet trained, can walk, run, feed himself neatly with a fork and spoon, copy his name legibly, ride a bicycle with training wheels, use a swing and other playground equipment without assistance, play video games on his iPad, and sleep unattended in his own room throughout the night. (7 RT 1188-1189, 1195; 8 RT 1266-1267, 1285-1286, 1316-1321; 11 RT 1893-1895.) He will be able to feed, dress, and bathe himself. (8 RT 1302.)

B. At trial, the parties dispute the cause of plaintiff's injury, but the jury finds in plaintiff's favor.

It was undisputed that one twin died in utero because he had a "velamentous insertion" of his umbilical cord into the placenta which lacked the protective sheath of "Wharton's Jelly," and that his blood supply was restricted when his umbilical cord compressed. (8 RT 1364, 1365, 1385-1386.) It was also undisputed that once this twin's heart stopped beating, plaintiff's blood began to flow into his twin's body due to pressure differentials, which caused plaintiff to sustain a hypoxic brain injury in utero. (8 RT 1403-1404.)

The plaintiff's theory at trial was that he sustained this injury because Dr. Madrigal breached the applicable standard of care by failing to schedule his delivery to take place prior to 37 weeks' gestation. (9 RT 1529, 1569-1570; 13 RT 2227-2228, 2303-2305, 2316; see 3 RT 360.) Thus, plaintiff presented evidence that MoDi pregnancies generally create a potential risk of fetal death by this point and the shared placenta could allow the surviving fetus to lose blood to the deceased fetus. (9 RT 1479-1480; see 7 RT 1158.) Plaintiff also introduced evidence that Dr. Madrigal made multiple errors which increased the time it took to get his mother to a hospital for a caesarean section the day he was born, and that he could have been born without injury if Dr. Madrigal had reacted more quickly. (9 RT 1578-1585; 13 RT 2279-2285, 2287-2294; 15 RT 2619-2620, 2625-2626, 2632-2634.)

The County presented evidence that MoDi pregnancies do not need to be delivered before 38 weeks when no other risk factors are

present. (17 RT 3142-3146.) Furthermore, although it was ultimately determined that the twin died because he had a velamentous umbilical cord insertion that became constricted, that is not a recognized risk of a MoDi pregnancy and was not diagnosed in utero. (17 RT 3125-3126, 3128, 3141-3142.) Dr. Madrigal therefore had no reason to deliver the twins by 37 weeks, and did not breach the applicable standard of care by not scheduling the delivery prior to the death of the twin. (17 RT 3142-3146.) The County also presented evidence that after one twin died, the hypoxic injury to plaintiff happened within minutes, and well before plaintiff's mother arrived at Dr. Madrigal's office the day the twins were ultimately delivered. (17 RT 3127-3128, 3154-3160.) Thus, the County's position was that any delay by Dr. Madrigal was not the proximate cause of plaintiff's injury.

The jury disagreed and found in favor of plaintiff on both negligence and causation. (4 AA 780.)

C. Before trial, the court issues numerous rulings adverse to the County concerning plaintiff's future medical expense damages.

1. Plaintiff's life care plan does not account for Medi-Cal benefits, free Regional Center and public school services, or discounted healthcare costs available through insurance.

During discovery, plaintiff disclosed a "Life Care Plan" prepared by Jan Roughan, in which she provided her opinion regarding the care that plaintiff allegedly will need during the rest of his life, as well as the cost for each item. (3 AA 611-643.) In addition to medical services, Roughan's plan included items such as X-Box *and* Wii-U video game consoles, "Therapeutic Horseback Riding," "Rock Wall Climbing," "Restorative Neuromuscular Massage," "Aquatic/Water Safety," "Music Therapy," a "Standing Vibration Platform," and a "Cozy Comforter: Large," as well as private school tuition at the "STAR Academy," at an annual cost of $45,600. (3 AA 627, 628, 630, 632, 633.)

Roughan's plan did not account for the free services for the disabled that plaintiff receives (and will continue to receive) through the Regional Center and the public school system. (See 3 AA 611-643.)

Moreover, plaintiff was enrolled in Medi-Cal, and Roughan's life care plan contained over $150,000 in legal fees related to creating and managing a special needs trust to maintain plaintiff's

Medi-Cal eligibility in the future. (3 AA 500-501, 506, 548-550, 641.) Nevertheless, Roughan's plan did not account for the substantial savings plaintiff would accrue through the medical service discounts attributable to Medi-Cal. (3 AA 611-643; see 3 AA 551 [Medi-Cal rates not included because she does not know what they are and "they change all the time"].)

Likewise, the prices in Roughan's plan did not account for any negotiated healthcare discounts plaintiff would be able to obtain by procuring insurance through the ACA. (3 AA 611-643; see 3 AA 545 [noting that it's not her "usual custom and practice" to consider the ACA].)

Rather, Roughan explained that she calculated the future cost figures in the life care plan using a database of the "average current charge" for each item. (3 AA 498.) Thus, her plan was based on " 'retail' or 'full' charges" and the "Billed Charges Rather than Paid Charges for Future Medical Pricing." (*Ibid.*, emphasis omitted.) Indeed, she stated that she uses the "Usual Customary and Reasonable (UCR) charge at the 80th percentile through a subscription database service" to calculate costs—i.e., the amount that the most expensive 20 percent of providers charge for their services. (3 AA 498, 571.)

2. The County's life care planner prepares reports factoring in free Regional Center benefits, Medi-Cal rates, and "private pay" discounts.

By contrast, the County's life care planner, Linda Olzack, did not use amounts billed by healthcare providers in calculating future medical expenses because billed amounts "do not reflect what is actually paid by patients." (3 AA 571.) She identified the following ranking of rates, from high to low, for medical expenses: billed rates, rates paid by the uninsured (private pay), private insurance rates, and Medi-Cal rates. (*Ibid.*; see 3 AA 576-609.)

Olzack noted that plaintiff is a Medi-Cal recipient who planned to create a special needs trust to retain Medi-Cal eligibility, and this would "substantially reduc[e] the cost of his future medical care." (3 AA 572; accord, 1 AA 238-239.) She further noted that, if plaintiff did not establish a special needs trust to retain Medi-Cal eligibility, then he would be required under the ACA to obtain private insurance, which would meet his needs. (1 AA 239.) And plaintiff could even procure a private insurance policy *in addition* to Medi-Cal to further contain his future medical costs.[2] (*Ibid.*; see 3 AA 573.)

Olzack accordingly prepared life care plans reflecting plaintiff's future care costs under various scenarios, including one in which plaintiff would continue to be covered by Medi-Cal, one in which he would procure private insurance under the ACA, and one

[2] Notably, Olzack has been allowed to testify on these issues in at least three California cases. (1 AA 239.)

in which he would pay for expenses out of his own pocket ("private pay"). (3 AA 571, 572, 573, 576-609, 645-672.) Moreover, Olzack took into consideration the free benefits to which plaintiff was entitled from the Regional Center and school system. (3 AA 573-574, 576-609.)

The difference in the costs under the various scenarios was substantial, with Medi-Cal rates reflecting the greatest savings. (See 3 AA 576-609.) For example, one category of expenses alone reflected a more than 60 percent difference between the private pay and Medi-Cal rates. (3 AA 572.)

Considering the benefits available through the Regional Center and school system likewise resulted in significant savings for plaintiff's care. For example, for the cost of projected therapeutic modalities alone, plaintiff would pay a total of $93,950.10 under the private pay scenario but nothing by utilizing the benefits available from the Regional Center and school system. (3 AA 597-599.)

Olzack also prepared a report comparing the costs Roughan used in her plan with the Medi-Cal payment rate for the same goods and services, revealing that Roughan's costs were substantially higher. (3 AA 573, 674-704.) For example, the cost for a wide variety of physician visits listed in Roughan's plan were *four to six times higher* than the Medi-Cal rates. (Compare 3 AA 616-618 with 3 AA 679-682.)

3. Plaintiff argues that evidence of free services from the Regional Center, Medi-Cal benefits, and discounted insurance rates should be excluded.

Prior to trial, the parties filed multiple briefs addressing whether the court should allow the introduction of (a) evidence that plaintiff received benefits from Medi-Cal and free services for the disabled from the Regional Center and the school system, and (b) evidence that plaintiff might receive future benefits, including any possible future benefits he might obtain through private insurance under the ACA. (1 AA 37-67, 99-176, 196-239; 2 AA 242-324.)

Plaintiff argued that, although section 3333.1 of MICRA allows a medical malpractice defendant to introduce evidence of collateral source benefits received by plaintiff, Medi-Cal is exempt from the statute. (1 AA 38-43; 2 AA 243-248.) Plaintiff also asserted that the Regional Center and school system benefits were exempt as well. (1 AA 43-45; 2 AA 243-248.)

With respect to future medical benefits, plaintiff contended that MICRA's exemption to the collateral source rule applied only to past and not future costs, and so all future benefits were inadmissible collateral sources. (1 AA 48-54, 62-63; 2 AA 248-249.) Plaintiff argued that evidence concerning any discounts he might achieve through insurance under the ACA must be excluded for the additional reason that his ability to obtain those benefits is speculative, because the ACA might be repealed and because he could not obtain private insurance while he was on Medi-Cal. (1 AA 54, 62, 64-67; 2 AA 249-251.) And he asserted that Medi-Cal and

private insurance rates should not be used to calculate his future losses because their continued existence and rate stability were in question. (2 AA 251.)

4. The County disputes plaintiff's arguments.

On the other hand, the County argued that the free services plaintiff receives from the Regional Center and through special education are not collateral sources because they are free public benefits available to anyone with a qualifying disability and, as such, are admissible on the issue of plaintiff's future care costs. (1 AA 101-102.)

The County asserted that MICRA's provision allowing for the admission of collateral source benefits applies to both past *and* future benefits. (1 AA 107-109.) The County noted that a contrary rule would undercut MICRA's goal of limiting recovery in medical negligence cases in order to reduce the cost of malpractice insurance. (1 AA 109-111.)

The County also filed a declaration from Thomas J. Dawson, an expert on the ACA as well as regulatory and health care policy, who worked for the United States House of Representatives during the passage of the ACA and was directly involved in negotiating key provisions of the Act. (1 AA 222, 233-234.) Dawson explained that it is reasonably certain the plaintiff will have access to insurance in the future and identified stable and secure California insurance plans that would be available to plaintiff to meet many of his needs. (1 AA 226-230.) Dawson further explained that the plaintiff could

procure private insurance while maintaining Medicaid eligibility. (1 AA 230-233.) That is because disabled plaintiffs typically set up a special needs trust to ensure continuing Medi-Cal eligibility. Indeed Roughan included the costs associated with such a trust in her plan. (3 AA 501, 506, 548-550, 641.) Plaintiff can use funds in his special needs trust to purchase private health insurance, in which case private insurance would pay first, and Medi-Cal would only have a right to reimbursement from the corpus of the trust upon his death. Dawson similarly explained that California's longstanding public policy and statutory commitment to serving its disabled population was likely to remain unchanged, and therefore the availability of the concordant benefits (e.g., Medi-Cal, Regional Centers) was likely to continue. (1 AA 231-233.)

5. The trial court rules the County may not introduce evidence concerning the free Regional Center benefits plaintiff receives, Medi-Cal rates, or future insurance benefits available under the ACA.

After hearing argument on the briefing, the court ruled that (a) the County could not present evidence concerning the free benefits plaintiff will receive from the Regional Center and school system or the impact that will have on his future care costs because the court believed the benefits are not available for an offset under MICRA (1 RT 35, 41-42, 46); (b) the County could not introduce any evidence of Medi-Cal benefits because Medi-Cal benefits are not

included within MICRA's exemption to the collateral source rule (1 RT 28, 38, 47-48); and (c) the County could not present evidence of future benefits plaintiff could obtain by procuring insurance under the ACA because MICRA does not allow the admission of future benefits and because it was not "reasonably certain" that the ACA would continue to exist (1 RT 24, 47-49).

D. During trial, the court issues additional rulings adverse to the County concerning plaintiff's potential future medical expense recovery.

1. The court holds that plaintiff's future medical expenses may be based upon billed rates and that the County may not introduce evidence concerning discounted rates through Medi-Cal and private insurance.

During trial, the County sought clarification concerning the evidence the court would allow on the issue of plaintiff's future medical expenses. (2 AA 411-421.) Specifically, the County requested that the court clarify (a) whether the court intended by its prior ruling to allow plaintiff to introduce evidence of amounts billed for medical services (or plaintiff must instead limit his evidence to amounts health care providers will accept in the future as full payment); and (b) whether the County may introduce evidence regarding the range of discounted amounts healthcare

providers accept as full payment, without referencing the source of such payments. (2 AA 412.)

The County argued that, under *Howell* and *Corenbaum*, plaintiff is allowed to recover only the amounts his health care providers will accept as full payment, and inflated billed amounts (whether past or future) are irrelevant and inadmissible because they do not reflect the reasonable value of medical services. (2 AA 413-416.) The County noted that plaintiff's life care planner relied upon billed amounts in calculating the cost of plaintiff's future care, and those amounts greatly exceed the amounts that would be accepted as full payment and should therefore be excluded. (2 AA 413, 416-419.)

The County further noted that allowing it to introduce evidence concerning the range of discounted amounts healthcare providers accept as full payment (without referencing the source) would assist the jury in evaluating the reasonable value of plaintiff's future medical care, without violating the collateral source rule by disclosing any third party source of payment. (2 AA 413, 419-420.)

Plaintiff argued that the reasonable value of future medical care need not be based on paid amounts and that Roughan's life care plan was not based upon past billed amounts. (4 AA 713-714.)

The court ruled against the County on both points. First, the court held that plaintiff could use billed amounts as the basis for calculating his future medical expenses. (20 RT 3615 [stating that the life care planner "could do a survey of medical bills now, and then project into the future on that"]; see 20 RT 3615-3616

[granting the County a continuing objection to any testimony regarding the cost of plaintiff's future care based upon the amount that providers charge for their services].) Second, the court held that the County's life care planner could not explain that providers do not expect to be paid in full and will almost always expect to be paid less than their billed amounts, or what those amounts would be. (20 RT 3616-3620.)

2. The court allows plaintiff to introduce his life care plan based on billed rates, with a total present value of nearly $29 million. The County's life care plan totals about $3.3 million present value.

The parties stipulated that plaintiff's medical expenses up to the time of trial totaled $55,780.82—less than $10,000 a year for the six year old plaintiff. (25 RT 4755-4756.)

In accordance with the court's rulings, Roughan testified concerning the life care plan she created for plaintiff's future needs. (21 RT 3934-3981.) Based upon that plan, plaintiff's economist calculated the value of plaintiff's future care expenses at **$285 million** (with a present value of nearly $29 million). (22 RT 4232.) In contrast to the $10,000 plaintiff had incurred annually up to the time of trial, the life care plan calculated future care costs at over $365,000 per year. (5 AA 1047; 22 RT 4229 [daily care cost of more than $1,000].)

In light of the court's rulings, the County's life care planner Olzack could not testify concerning (a) the free benefits that plaintiff may receive from either the Regional Center or the local school district; (b) her opinion that plaintiff will have guaranteed access to insurance for life; (c) her opinion that plaintiff will always qualify for the lower rates negotiated between carriers and healthcare providers; or (d) the substantial savings in future medical services to which plaintiff was entitled as a result of these facts. (See 3 AA 571, 572, 573-574, 576-609, 645-705.)

Instead, Olzack's testimony was confined to "private pay" rates which are akin to the rates charged to uninsured individuals. (4 AA 571; 23 RT 4511-4540.) Using these rates and accepting plaintiff's claimed life expectancy, the County's economist testified that the present value of the future services identified in Olzack's plan totaled between $3,233,670 and $3,341,037. (24 RT 4610-4633; 4 AA 848G-848H.) These estimates would have been significantly lower if Olzack had been able to factor into her analysis the free benefits plaintiff receives from the Regional Center and the school system, or consider the discounted rates that would apply under Medi-Cal or a private insurance policy. (See 3 AA 571, 576-609.)

3. The court rejects the County's proposed instruction that plaintiff's future medical expenses must be limited to the amounts that will be accepted as full payment.

Consistent with the arguments it previously presented concerning the amount plaintiff may recover for future medical expenses (e.g., 2 AA 413-419), the County requested that the court instruct the jury that "[t]he damages awarded for future medical expenses cannot exceed the amount that is reasonably certain to be owed or paid to the plaintiff's healthcare providers in the future for that care." (4 AA 753.) The court rejected the instruction. (23 RT 4596-4597.)

E. The jury returns a verdict awarding plaintiff over $9.5 million in future medical expenses alone. Following post-trial motions, the County appeals.

The jury found in favor of plaintiff and awarded $9,577,000 as the total present value of plaintiff's future medical expenses. (4 AA 780.) This award was nearly three times the amount that the County's economist identified as the present value of plaintiff's future medical expenses at the "private pay" rate level (24 RT 4610-4633; 4 AA 848G-848H)—and many more times higher than the value of future care if private insurance or Medi-Cal rates had been used and the free Regional Center and school system benefits had been considered (see 3 AA 571, 576-609).

The County moved for a new trial, arguing that the court committed numerous evidentiary and instructional errors which resulted in an excessive damages award. (4 AA 801-804, 824-827, 834-843.)

The court denied a new trial (6 AA 1315), and the County appealed from the judgment and post-judgment orders awarding plaintiff costs and expert witness fees (4 AA 787-788; 6 AA 1322-1323).[3]

STATEMENT OF APPEALABILITY

The County appeals from the final judgment and post-judgment orders awarding prevailing party costs and expert witness fees, all of which are appealable. (Code Civ. Proc., § 904.1, subd. (a)(1), (2).)

[3] The County also moved for judgment notwithstanding the verdict and appealed from the order denying that motion. (4 AA 805-823; 6 AA 1322-1323.) However, the County does not challenge that ruling in this appeal.

LEGAL ARGUMENT

I. THE TRIAL COURT ERRED BY RULING THAT EVIDENCE REGARDING FUTURE ACA BENEFITS ARE NOT ADMISSIBLE UNDER SECTION 3333.1.

A. Section 3333.1 allows the introduction of evidence regarding future, as well as past, medical benefits.

Section 3333.1, subdivision (a) provides that a medical malpractice defendant

> may introduce evidence of any amount *payable* as a benefit to the plaintiff as a result of the personal injury pursuant to the United States Social Security Act, any state or federal income disability or worker's compensation act, any health, sickness or income-disability insurance, accident insurance that provides health benefits or income disability coverage, and any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or other health care services.

(Emphasis added.)

In return, the plaintiff may introduce evidence of any premiums they have paid to obtain that benefit. (§ 3333.1, subd. (a).) The jury is permitted to determine how the evidence should be considered in calculating a damages award. (*Barme v. Wood* (1984) 37 Cal.3d 174, 179, fn. 5 (*Barme*).) The Legislature's assumption, however, "was that the trier of fact would take the plaintiff's receipt of benefits into account by reducing damages." (*Hernandez v.*

California Hospital Medical Center (2000) 78 Cal.App.4th 498, 506 [noting that the statute does not preclude the recovery of medical expenses, but rather allows the jury to decide how to apply the evidence in calculating damages].)

Plaintiff argued, and the trial court agreed, that section 3333.1 does not allow the introduction of evidence regarding *future* health insurance benefits—only *past* benefits. (1 AA 47-55, 62-63; 2 AA 248-249; 1 RT 47-49.) This was error.[4]

A court's "primary task in interpreting a statute is to determine the Legislature's intent, giving effect to the law's purpose. [Citation.] [The court] consider[s] first the words of a statute, as the most reliable indicator of legislative intent. [Citation.] Words must be construed in context, and statutes must be harmonized, both internally and with each other, to the extent possible." (*Tuolumne Jobs & Small Business Alliance v. Superior Court* (2014) 59 Cal.4th 1029, 1037, internal quotation marks omitted.)

As recognized in *Anderson v. City of Los Angeles* (1973) 30 Cal.App.3d 219, 224:

> It is a cardinal rule, to be applied to the interpretation of particular words, phrases, or clauses in a statute . . . that the entire substance of the instrument or of that portion thereof which has relation to the subject under review should be looked to in order to determine the scope and purpose of the particular provision therein of

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[4] This court reviews a trial court's decision to exclude evidence for an abuse of discretion. (*Katiuzhinsky v. Perry* (2007) 152 Cal.App.4th 1288, 1293-1294.)

> which such words, phrases, or clauses form a part; and in order also to determine the particular intent of the framers of the instrument in that portion thereof wherein such words, phrases or clauses appear.

Nothing in the language of section 3333.1 limits a medical malpractice defendant's rights to the presentation of only *past* collateral source benefits. Indeed, by using the phrase "amount payable" instead of "amount paid," the statute contemplates that evidence of future benefits should be admissible as well.

Indeed, the Supreme Court has expressed agreement with the concept that available medical insurance can reduce a medical malpractice plaintiff's *future* medical costs. In *Fein v. Permanente Medical Group* (1995) 38 Cal.3d 137, 165, footnote 21, the plaintiff objected to a potential reduction in his future medical expense damages on the grounds that he might not be covered by insurance in the future. The Court swiftly rejected this argument, noting that under the terms of the judgment the defendant's liability for future medical expenses would only be reduced to the extent plaintiff received future collateral source benefits. (*Ibid*.)

Moreover, several federal decisions have held that section 3333.1 allows the admission of future insurance benefits. Most recently, in *Brewington v. United States* (C.D.Cal., July 24, 2015, No. CV 13-07672-DMG (CWx)) 2015 WL 4511296 [nonpub. opn.], the District Court specifically considered evidence of future health insurance benefits through the ACA in calculating the plaintiff's future life care plan needs. In particular, the court held that section 3333.1 applies to future benefits and that evidence concerning future benefits could be introduced at trial. (*Id.* at p. *6; accord,

Silong v. U.S. (E.D.Cal., Sept. 5, 2007, No. CV F 06-0474 LJO DLB) 2007 WL 2580543, at pp. *14-15 [nonpub. opn.] [noting that section 3333.1 entitled the government to seek an offset for those items of plaintiff's future medical care that would be covered by insurance]; *S.H. ex rel. Holt v. U.S.* (E.D.Cal., Oct. 30, 2014, No. 2:11-cv-01963-MCE-DAD) 2014 WL 5501005, at pp. *3-4 [nonpub. opn.] [assuming that, under section 3333.1, a trier of fact can consider future collateral source benefits and reduce a damages award accordingly].)

Moreover, as a matter of practice and policy, the distinction between past and future insurance benefits drawn by the trial court makes no sense. As a general rule, juries usually are not informed about a plaintiff's insurance coverage and defendants are not allowed to benefit from collateral source payments. However, in the context of medical malpractice actions, the Legislature determined that those rules are outweighed by the public's strong interest in containing medical malpractice liability. Section 3333.1 is part of MICRA which, as noted in *American Bank & Trust Co. v. Community Hospital* (1984) 36 Cal.3d 359, 371, was California's response to the medical malpractice insurance crisis that caused many physicians to either stop performing high risk procedures or terminate their practice in this state altogether. One of the noted causes of this crisis, which the Legislature sought to address, was the "a rapid 'liberalization' of tort doctrine in medical malpractice cases." (*Id.* at pp. 371-372; accord, *Barme*, *supra*, 37 Cal.3d at p. 179 [section 3333.1 "was intended to reduce the cost of medical malpractice insurance"]; see also *Chan v. Curran* (2015) 237

Cal.App.4th 601, 613, 618 [rejecting recent challenge to MICRA and noting that plaintiff "has not shown that the underlying circumstances that gave rise to the medical malpractice insurance problem that reached crisis proportions in the 1970's no longer exist"].)

In light of the goals of MICRA, it is illogical that a jury would be permitted to learn about and consider insurance as to *past* damages, but be barred from considering it for *future* damages. Indeed, given that future medical expenses frequently compose the largest part of a damages award (particularly in birth injury cases such as this), applying section 3333.1 to future awards is critical to furthering both the spirit and the letter of MICRA.

B. The ACA guarantees plaintiff access to health insurance in the future, and plaintiff must procure that insurance to mitigate his damages.

As justification for its decision to exclude evidence of future benefits, the court also asserted it was speculative to assume that the ACA would continue to exist in the future. (1 RT 47-49.) However, when deciding issues during litigation, courts must accept and apply the law as it currently exists, and may not speculate about how existing laws might change in the future. (See *District of Columbia Court of Appeals v. Feldman* (1983) 460 U.S. 462, 477 [103 S.Ct. 1303, 75 L.Ed.2d 206] ["A judicial inquiry investigates, declares and enforces liabilities as they stand on present or past facts and under laws supposed already to exist" (internal quotation

marks omitted)], quoting *Prentis v. Atlantic Coast Line Co.* (1908) 211 U.S. 210, 226 [295 S.Ct. 67, 53 L.Ed. 150]; see *Weldon v. Weldon* (Tex. App. 1998) 968 S.W.2d 515, 518 ["A trial judge rules on a statute that is *in effect at the time of the case* and is not in the position of predicting future changes by the legislature" (emphasis added)].) The potential future of the ACA was therefore irrelevant to the County's right to introduce evidence concerning future insurance benefits whose availability were, at the time of trial (and now), guaranteed by law.

Moreover, there is no reason to believe that plaintiff will not have guaranteed access to medical insurance in the future. The ACA, in its simplest terms, provides that all persons in the United States have health insurance regardless of their health or financial situation. It accomplishes this in a number of ways, including (1) providing for the creation of "health benefit exchanges" where individuals can obtain coverage; (2) setting "minimum essential coverage" standards for plans; (3) limiting the annual out-of-pocket medical expense that can be incurred; (4) requiring, under the so-called "individual mandate" that every "applicable individual" obtain minimum essential coverage or pay a penalty; and (5) enacting the "guaranteed issue" requirement and "community rating" requirement. (26 U.S.C. §§ 36B, 5000A; 42 U.S.C. §§ 300gg, 18001, 18022, 18031, 18091.)

Of particular relevance to this case, the guaranteed issue requirement provides that "each health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every employer and individual in the State that

applies for such coverage." (42 U.S.C. § 300gg-1(a).) Insurance companies are thereby barred from denying coverage to individuals with preexisting conditions. (42 U.S.C. §§ 300gg-3, 18001.) Moreover, under the community ratings requirement, insurance companies are prohibited from charging higher rates to individuals based on their medical history. (42 U.S.C. § 300gg). A health insurer also may not establish annual or lifetime limits on the dollar value for minimum essential benefits. (42 U.S.C. § 300gg-11.)

Under the ACA, all health plans offered in the individual and small group markets are required to cover essential health benefits (EHB), which include the following 10 benefit categories: (1) ambulatory patient services, (2) emergency services, (3) hospitalizations, (4) maternity and newborn care, (5) mental health and substance use disorder services including behavioral health treatment, (6) prescription drugs, (7) rehabilitative and habilitative services and devices, (8) laboratory services, (9) preventative and wellness services and chronic disease management, and (10) pediatric services, including oral and vision care. (26 U.S.C. § 18022.)

Although some have called for a repeal and replacement of the ACA with different laws, there has been no meaningful discussion of eliminating or changing the requirement that insurers must provide coverage irrespective of preexisting conditions. (See McDonough & Fletcher, *What Would Republicans Do Instead of the Affordable Care Act?* (Sept. 18, 2015) Health Affairs Blog <http://goo.gl/iyUU1K> [as of Oct. 7, 2015].) Indeed, since the insurance mandate took effect, 11.7 million individuals have

enrolled in the ACA marketplace and, as of March 2015, the United States Department of Health and Human Services reported that a total of 16.4 million have obtained coverage through the ACA. (Obamacare Facts, ObamaCare Enrollment Numbers <http://goo.gl/m1gMlp> [as of Oct. 7, 2015].) Thus, a repeal of the law requiring that coverage be offered regardless of preexisting condition would deprive many individuals of coverage upon which they have come to rely.

Furthermore, several developments since the trial demonstrate that the ACA is here to stay notwithstanding the political rhetoric against it. Although the Republicans took control over the Senate in January 2015 and now control the entire legislative branch, they have yet to repeal the ACA, and have acknowledged that they do not have sufficient votes to override a presidential veto. (Sullivan, *McConnell suggests Obamacare can't be repealed with 51 votes* (Oct. 28, 2014) The Hill <http://goo.gl/SwuJRc> [as of Oct. 7, 2015] ["'It would take 60 votes in the Senate, and no one thinks we're going to have 60 Republicans [after the election] and it would take a presidential signature, no one thinks we're going to get that"].) Furthermore, in June 2015, the United States Supreme Court rejected a challenge to the ACA in *King v. Burwell* (2015) 576 U.S. ____ [135 S.Ct. 2480, 192 L.Ed.2d 483], marking the second time that Court has upheld it. (See *National Federation of Independent Businesses v. Sebilius* (2012) 567 U.S. ____ [132 S.Ct. 2566, 183 L.Ed.2d 450].)

As such, despite the trial court's apparent belief that the ACA may not exist in the future, the fact remains that it has survived

every attack lodged at it, and continues in full force and effect. And as demonstrated there is no effort to eliminate the rule barring insurance companies from denying benefits on the basis of a preexisting condition. Thus, it is reasonably certain that the plaintiff will have access to insurance in the future.

In addition to his obligation under the ACA to have insurance, plaintiff is required to purchase insurance through the ACA based on his duty to mitigate his future damages. "The rule is of general and widespread application that one who has been injured either in his person or his property by the wrongful act . . . of another is under an obligatory duty to make a reasonable effort to minimize the damages liable to result from such injury." (*Placer County Water Agency v. Hofman* (1985) 165 Cal.App.3d 890, 897, internal quotation marks omitted, emphasis omitted.) Therefore, "a person injured by another's wrongful conduct will not be compensated for damages that the injured person could have avoided by reasonable effort or expenditure." (*State Dept. of Health Services v. Superior Court* (2003) 31 Cal.4th 1026, 1043; accord, *Rosenfeld v. Abraham Joshua Heschel Day School, Inc.* (2014) 226 Cal.App.4th 886, 900; *Mize-Kurzman v. Marin Community College Dist.* (2012) 202 Cal.App.4th 832, 870-871.)

Thus, plaintiff has not only the *right*, but the *obligation*, to maintain insurance in the years ahead to avoid increasing his annual costs from an average of $10,000 a year to an average of over $365,000 a year.

C. Plaintiff's enrollment in Medi-Cal does not prevent him from also obtaining private insurance that will further reduce his future health care expenses.

Plaintiff also argued that evidence of future health insurance under the ACA should be excluded because, as a Medi-Cal recipient, he is unable to enroll in an ACA policy. (1 AA 54, 62, 64-67; 2 AA 249-251.) Not so.

Individuals enrolled in government sponsored health insurance plans such as Medi-Cal may also procure healthcare coverage through another insurance plan or "third party." (See 42 C.F.R. § 433.138(a); see also 42 U.S.C. § 1396a(a)(25); *Matter of Jennings v. Commissioner, N.Y.S. Dept. of Social Servs.* (2010) 893 N.Y.S.2d 103 [71 A.D.3d 98, 105] [noting that funds from a special needs trust created for a child pursuant to 42 U.S.C. section 1396p in order to maintain Medicaid eligibility may be used to purchase private health insurance].)

Moreover, federal regulations require states to establish procedures for identifying other health insurers who may be liable third parties, and since Congress intended Medicaid to be the payer of last resort, if a beneficiary has another source of healthcare coverage, that coverage will pay before Medicaid. (See 42 C.F.R. § 433.138(a); see also 42 U.S.C. § 1396a(a)(25).) California similarly requires that other coverage be exhausted before Medi-Cal benefits are activated. (See Cal. Code Regs., tit. 22, § 50761 ["A beneficiary with other health care coverage is not entitled to receive health care benefits and services under the Medi-Cal schedule of benefits until

the other health care coverage available has been exhausted or denied for lack of service coverage"].) And Medi-Cal beneficiaries must report any entitlement to health care coverage at the time of application, and utilize other available health coverage before obtaining Medi-Cal benefits. (See Cal. Code Regs., tit. 22, § 50763, subd. (a)(1)-(3).) There would be no need for these provisions if Medi-Cal recipients were barred from procuring private insurance.

Thus, the fact that plaintiff is and will continue to be a Medi-Cal recipient does not prevent him from obtaining private health insurance through the ACA as well. There accordingly was no basis for excluding the County's evidence concerning the future benefits available through the ACA. The cumulative prejudice flowing from the court's erroneous ruling to the contrary, together with other errors, will be explained in section V below.

II. THE TRIAL COURT ERRED BY REFUSING TO INSTRUCT THE JURY THAT FUTURE MEDICAL DAMAGES MUST BE LIMITED TO AMOUNTS THAT WILL BE PAID AND PRECLUDING THE COUNTY'S LIFE CARE PLANNER FROM TESTIFYING TO THOSE AMOUNTS.

A. The appropriate measure of plaintiff's future medical expense damages is the amount that his providers will accept as full payment, not the inflated amounts reflected in their bills.

In *Howell*, *supra*, 52 Cal.4th at page 549, the jury based plaintiff's award for past medical costs on the amount she was billed by his providers, not the much lower amount the provider had accepted from plaintiff's insurance carrier as full payment. The defendant moved to reduce the award, arguing that plaintiff's loss was limited to the amount the provider had accepted as full payment.

The Supreme Court agreed with the defendant, holding that "[t]o be recoverable, a medical expense must be both *incurred and reasonable*." (*Howell*, *supra*, 52 Cal.4th at p. 555, emphasis added; accord, § 3359 ["Damages must, in all cases, be reasonable"].) The Court noted that, "if the plaintiff negotiates a discount and thereby receives services for less than might reasonably be charged, the plaintiff has not suffered a pecuniary loss or other detriment in the

greater amount and therefore cannot recover damages for that amount." (*Howell*, at p. 555.)

Therefore, "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." (*Howell*, *supra*, 52 Cal.4th at p. 556.) The amount actually incurred serves as a cap on a plaintiff's recovery; " '[r]easonable value' is a term of limitation, not of aggrandizement." (*Hanif v. Housing Authority* (1988) 200 Cal.App.3d 635, 641.)

The Supreme Court was very concerned by the fact 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." (*Howell*, *supra*, 52 Cal.4th at p. 564.) Indeed, as the Court noted, "[c]hargemaster prices for a given service can vary tremendously, sometimes by a factor of five or more, from hospital to hospital in California." (*Id*. at pp. 561-562.) Moreover, the Court recognized that because so many patients (insured, uninsured, and recipients of government health care programs) pay discounted rates, hospital bills are " 'insincere in the sense that they would yield truly enormous profits if those prices were actually paid.' " (*Id*. at p. 561; see, e.g., *Luttrell v. Island Pacific Supermarkets, Inc.* (2013) 215 Cal.App.4th 196, 199 [$690,548 billed, but $138,082 accepted as full payment—a discount of 80 percent]; *Nishihama v. City and County of San Francisco* (2001) 93 Cal.App.4th 298, 306-307, 309 [$17,168 in damages at billed rate reduced to $3,600 the hospital accepted as full payment—a discount of nearly 80 percent]; see also *Haygood v. De*

Escabedo (Tex. 2011) 356 S.W.3d 390, 393, fn. 17 (*Haygood*) ["a hospital's 'regular rates,' 'full charges,' or 'list prices' . . . are generally at least double and may be up to eight times what the hospital would accept as payment in full for the same services from Medicare, Medicaid, HMOs, or private insurers"]; *Daughters of Charity Health Services of Waco v. Linnstaedler* (Tex. 2007) 226 S.W.3d 409, 410, fn. 1 [the label for these charges, " 'regular,' 'full,' or 'list,' are misleading, because in fact *they are actually paid by less than five percent of patients* nationally" (emphasis added)].)

Rather, the "reasonable value" of medical services is the "going rate for the services" or the "reasonable market value at the current market prices." (*Children's Hospital Central California v. Blue Cross of California* (2014) 226 Cal.App.4th 1260, 1274, internal quotation marks omitted.) 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." (*Ibid*., internal quotation marks omitted; accord, *Alameda County Flood Control & Water Conservation Dist. v. Department of Water Resources* (2013) 213 Cal.App.4th 1163, 1174-1175, fn. 9.)

Ultimately, the *Howell* Court held 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." (*Howell*, *supra*, 52 Cal.4th at p. 567.)

Following the logic of *Howell*, courts have concluded that evidence of inflated medical bills is also irrelevant and inadmissible

with respect to noneconomic damages and any anticipated future medical expenses. (E.g., *Corenbaum*, *supra*, 215 Cal.App.4th at pp. 1331 ["the full amount billed for past medical services is not relevant to the amount of future medical expenses and is inadmissible for that purpose"], 1333 ["evidence of the full amount billed is not admissible for the purpose of providing plaintiff's counsel an argumentative construct to assist a jury in its difficult task of determining the amount of noneconomic damages and is inadmissible for the purpose of proving noneconomic damages"].)

The Court of Appeal in *Corenbaum* held that a plaintiff can recover as damages for future medical care only the amounts likely to be *paid* for that care. (*Corenbaum, supra*, 215 Cal.App.4th at p. 1331.) Therefore, the court held that expert witnesses cannot use inflated bills for past medical expenses as a basis for their opinions regarding the likely cost of future medical care. (*Ibid.*) "Because the full amount billed for past medical services provided to plaintiffs is not relevant to the value of those services, . . . the full amount billed for those past medical services can provide no reasonable basis for an expert opinion on the value of future medical services." (*Ibid.*) Evidence of the full billed amount accordingly "cannot support an expert opinion on the reasonable value of future medical services." (*Ibid.*)

The full billed amounts are not relevant to show future medical damages because the plaintiff will not incur a detriment based on those amounts. In *Howell*, the Supreme Court relied on the statutory requirement that detriment be shown for recoverable damages. Under section 3281, "damages are awarded to

compensate for detriment suffered." (*Howell*, *supra*, 52 Cal.4th at p. 548; § 3281 ["Every person who suffers detriment from the unlawful act or omission of another, may recover from the person in fault a compensation therefor in money, which is called damages"]; accord, § 3333 [standard measure of tort damages is "the amount which will compensate for all the *detriment* caused" (emphasis added)].) Plaintiffs do not incur a "detriment" for amounts they do not pay and will never be obligated to pay. (*Howell*, at p. 555.)

As *Corenbaum* recognized, this principle applies equally to damages for future medical care. (*Corenbaum*, *supra*, 215 Cal.App.4th at p. 1330; § 3283 [future damages may be awarded only "for *detriment* . . . certain to result in the future" (emphasis added)].)

Numerous cases have followed *Howell* and *Corenbaum* and have held that billed amounts are irrelevant to determine past or future medical expense damages. (E.g., *Ochoa v. Dorado* (2014) 228 Cal.App.4th 120, 135 ["the full amount billed for a plaintiff's medical care is not relevant to the determination of damages for past or future medical expenses, and therefore is inadmissible for those purposes, if the plaintiff's medical providers had agreed to accept a lesser amount as full payment for the services provided. . . the full amount billed for past medical services was not relevant to the reasonable value of the services provided"], 138-139 ["an unpaid medical bill is not an accurate measure of the reasonable value of the services provided"]; *Romine v. Johnson Controls, Inc.* (2014) 224 Cal.App.4th 990, 1014 [*Corenbaum* "held that evidence of the full amount billed for a plaintiff's medical care is not relevant to

damages for future medical care or noneconomic damages and its admission is error"]; *State Farm Mutual Automobile Ins. Co. v. Huff* (2013) 216 Cal.App.4th 1463, 1471 [" 'the full amount billed by medical providers is not an accurate measure of the value of medical services' "]; *Hill v. Novartis Pharmaceuticals Corp.* (E.D.Cal. 2013) 944 F.Supp.2d 943, 963 [following *Corenbaum* and applying its holding under the Federal Rules of Evidence]; *Pooshs v. Philip Morris USA, Inc.* (N.D.Cal., May 22, 2013, No. C 04-1221 PJH) 2013 WL 2253780, at p. *2 [nonpub. opn.] [under *Corenbaum*, "evidence of total amounts billed is not relevant to the value of future medical expenses"]; *Asanuma v. U.S.* (S.D.Cal., Mar. 28, 2014, No. 12CV908AJB (WMC)) 2014 WL 1286567, at p. *3, fn. 2 [nonpub. opn.] ["evidence of medical expenses that were not actually paid is irrelevant in determining future damages"].)

Therefore, a plaintiff's recovery for future medical expenses must be limited to those amounts that will be accepted as full payment by healthcare providers, and billed amounts are irrelevant to that calculation.[5]

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[5] In *Bermudez v. Ciolek* (2015) 237 Cal.App.4th 1311, 1335, the Court of Appeal held that billed amounts for an *uninsured* plaintiff may be introduced as part of the evidence to help determine "the reasonable value of services in the healthcare marketplace" because the plaintiff's "uninsured status meant that billed amounts were relevant to the amount he incurred (*unlike insured plaintiffs, who really only incur the lower amount negotiated by their insurer).*" (Emphasis added.) *Bermudez* is therefore inapposite here, where it is undisputed that plaintiff was and will continue to be insured under Medi-Cal.

B. The court erroneously refused to instruct the jury that future medical expenses cannot exceed the amounts that are reasonably certain to be accepted as full payment, excluded relevant evidence concerning those amounts, and permitted evidence concerning irrelevant billed rates.

In accordance with the principles outlined above, the County requested that the court instruct the jury that " '[t]he damages awarded for future medical expenses cannot exceed the amount that is reasonably certain to be owed or paid to the plaintiff's healthcare providers in the future for that care.' " (4 AA 753 [CACI No. 3903A, modified].) The court erroneously refused the instruction.[6] (23 RT 4596-4597.)

This error was compounded by the court's decisions (1) refusing to allow the County's life care planner Olzack to testify concerning the amounts that will be paid in the future for plaintiff's medical care and the fact that providers do not expect to be paid their "billed" amounts (1 RT 47-49; 20 RT 3616-3620); and (2) permitting plaintiff's life care planner Roughan to present evidence calculating plaintiff's future expenses based on charged rates rather than the steeply discounted amounts that would be

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[6] This court reviews de novo the question whether a trial court erroneously refused to instruct the jury on an applicable legal principle. (*Ford v. Polaris Industries, Inc.* (2006) 139 Cal.App.4th 755, 766.)

accepted as full payment (20 RT 3615; see *ante*, pp. 10-11, 19).[7] As explained in section V, these errors contributed to the excessive damages awarded by the jury.

III. THE TRIAL COURT ERRED BY CONCLUDING THAT THE COLLATERAL SOURCE RULE BARS EVIDENCE REGARDING THE ACA AND THE AMOUNTS ACCEPTED BY HEALTHCARE PROVIDERS.

A. The collateral source rule does not apply to evidence of negotiated rates or benefits available under the ACA.

Independent of section 3333.1, the trial court erred by relying on the collateral source rule to exclude evidence of the ACA and the amounts that healthcare providers typically accept as payment for their services. (See 1 RT 47-49.)

The common law collateral source rule states 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." (*Howell*, *supra*, 52 Cal.4th at p. 551, emphasis added.) As noted by the Supreme Court in *Helfend*

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[7] During trial, Roughan attempted to backpedal concerning the fact that her life care plan was based upon charge rates at the 80th percentile with a confusing assertion that the amount charged by the top 20 percent of the market is the same as the amount accepted as full payment by most providers. (See 21 RT 3977-3979, 4011-4013.) That assertion is illogical on its face.

v. Southern California Rapid Transit District (1970) 2 Cal.3d 1, 10 (*Helfend*):

> [t]he collateral source rule expresses a policy judgment in favor of encouraging citizens to purchase and maintain insurance for personal injuries and other eventualities, Courts consider insurance a form of investment, the benefits of which become payable without respect to any other possible source of funds. If we were to permit a tortfeasor to mitigate damages with payments from plaintiff's insurance, plaintiff would be in a position inferior to that of having bought no insurance, because his payment of premiums would have earned no benefit. Defendant should not be able to avoid payment of full compensation for the injury inflicted merely because the victim has had the foresight to provide himself with insurance.

Although section 3333.1 has largely abrogated that rule in medical malpractice actions, even before it was enacted the Supreme Court recognized that the collateral source rule is not an absolute rule of exclusion; rather, evidence of collateral source payments can be admitted under certain circumstances. Thus, in *Hrnjak v. Graymar, Inc.* (1971) 4 Cal.3d 725, 729, the Court stated that "[u]nlike evidence of a defendant's liability coverage, the admissibility of evidence of plaintiff's receipt of collateral insurance benefits is not governed by specific statutory exclusion." (Footnote omitted.) Such evidence is admissible upon a "persuasive showing" that it "is of *substantial probative value*." (*Id.* at p. 733, emphasis added; see *Lund v. San Joaquin Valley Railroad* (2003) 31 Cal.4th 1, 12; see also *Rotolo Chevrolet v. Superior Court* (2003) 105 Cal.App.4th 242, 249, fn. 8 ["The collateral source rule has never

been held to completely bar the introduction of evidence regarding other benefits . . . . [T]he rule bends to the needs of equity and fairness."].)

If the negotiated accepted amounts come within the collateral source rule at all (they do not pursuant to *Howell*, *supra*, 52 Cal.4th at page 564 [the "negotiated rate differential lies outside of the operation of the collateral source rule"]), they are clearly "of substantial probative value" in determining the reasonable value of medical services. Likewise, the ACA's guaranteed issue and renewal requirements are highly probative because they establish plaintiff's future right to obtain negotiated discounts, and thus are "of substantial probative value" in determining the reasonable value of plaintiff's medical services. As discussed above, these discounts are significant, and a huge discrepancy between amounts "billed" and amounts paid is not unusual. (See *Stayton v. Delaware Health Corporation* (Del. 2015) 117 A.3d 521, 530 (*Stayton*) ["The fact that the written off portion of Stayton's medical bills is thirteen times the amount paid gives us pause. It reflects . . . the way in which the realities of today's healthcare economy diverge from the traditional underpinnings of the collateral source rule."]; *Haygood*, *supra*, 356 S.W.3d at p. 393 [" '[f]ew patients today ever pay a hospital's full charges, due to the prevalence of Medicare, Medicaid, HMOs, and private insurers who pay discounted rates' "].)

Similarly, the fact that plaintiff will be a Medi-Cal recipient for the rest of his life is highly probative to evaluating his future medical expenses. California has a longstanding commitment to serving the needs of its disabled population, thus the services

presently available to plaintiff are likely to continue to be available to him in the future. (See *Association for Retarded Citizens v. Department of Developmental Services* (1985) 38 Cal.3d 384, 388-390 (*ARC*) [explaining that under the Lanterman Developmental Disabilities Act " '[t]he State of California accepts a responsibility for its developmentally disabled citizens and an obligation to them which it must discharge,' " and explaining the broad range of services provided].)

Accordingly, the County should have been able to introduce evidence concerning future discounted payment rates pursuant to the ACA or Medi-Cal, notwithstanding the collateral source rule. At a minimum, the County should have been allowed to discuss the negotiated rates that plaintiff will qualify without discussing the ACA and Medi-Cal and/or what plaintiff's healthcare providers–or other similar healthcare providers–customarily accept as full payment for medical services like those to be provided to plaintiff (without mentioning insurance or explaining why the plaintiff is entitled to pay this lesser amount).

Indeed, arms-length negotiations between a healthcare provider and an insurer, entered into before services are provided, regarding the value of the services are plainly a far better measure of reasonable value than amounts the provider unilaterally selects as its billed rates. (See *Howell*, *supra*, 52 Cal.4th at p. 562 [noting that, given the 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"]; *Smalley v. Baty* (2005) 128 Cal.App.4th 977, 984 [noting that it was an abuse of discretion

to exclude evidence that the plaintiff has paid his medical bill: "evidence that the bill was paid is evidence that the charge was reasonable" (emphasis omitted)].)

Allowing evidence concerning discounted rates without reference to the source of payment would be consistent with the approach taken in several other states. For example, in *Law v. Griffith* (2010) 457 Mass. 349, 360-361 [930 N.E.2d 126], the Supreme Judicial Court of Massachusetts held that although a defendant could not introduce evidence of the amount that was actually paid for plaintiff's care, he could show the *range* of payments that the providers accept for the types of services plaintiff received. The court reasoned that such evidence "would not undermine the collateral source rule . . . because it would not touch in any manner on whether, or in what amount, collateral third parties (whether a private insurance company [or Medi-Cal]) had paid." Similarly, the Montana Supreme Court held that defendants may present evidence of Medicare payment rates to attack the reasonableness of the plaintiff's medical bills for the same services as long as the defendants do not state that the plaintiff has Medicare. (*Meek v. Montana Eighth Judicial Dist. Court* (2015) 374 Mont. 150, 152-154 [349 P.3d 493].)

Therefore, since plaintiff is guaranteed to have some form of government and/or private insurance in the future, the trial court abused its discretion when it precluded the County from discussing the negotiated rates that providers are actually paid.

B. If the collateral source rule has any application in cases like this, the passage of the ACA requires re-examination of that rule.

Even if the collateral source rule had any bearing on plaintiff's future medical expenses, the passage of the ACA requires re-examination of that rule because the policies supporting the rule no longer apply. In *Helfend*, the Supreme Court discussed the policy reasons supporting the common law collateral source rule, noting that "a person who has invested years of insurance premiums to assure his medical care should receive the benefits of his thrift." (*Helfend*, *supra*, 2 Cal.3d at pp. 9-10.) However, as a result of the ACA, procuring health insurance for the care of an injured plaintiff is no longer a matter of a plaintiff's foresight, investment, or prudence. It is instead mandated by federal law. (26 U.S.C. § 5000A.)

The *Helfend* Court also reasoned that a "[d]efendant should not be able to avoid payment of full compensation for the injury inflicted merely because the victim has had the foresight to provide himself with insurance." (*Helfend*, *supra*, 2 Cal.3d at p. 10.) But the ACA seeks to control healthcare costs, in part, by spreading the costs through the mandate that everyone either purchase at least a "minimum essential coverage" plan or pay a penalty. Thus, under the ACA, *everyone* is supposed to buy insurance, which will subsidize the cost of healthcare services for those who have the greatest need for them—and who are not paying larger premiums to cover the higher costs associated with treating their preexisting

conditions. In light of these circumstances, the justification for the collateral source rule of preventing a "windfall" to tortfeasors no longer holds up because tortfeasors, like everyone else, have been and will continue to pay premiums that contribute to subsidizing the cost of caring for tort victims. In addition, the tortfeasor would not be avoiding payment of damages, but instead would be compensating the plaintiff based on what the plaintiff would actually be obligated to pay in the future.

Furthermore, the *Helfend* court noted that the underpinning for the collateral source rule is that the compensation be "from a source wholly independent of the tortfeasor." (*Helfend*, *supra*, 2 Cal.3d at p. 6.) But, here, since the plaintiff does not currently have private health insurance, any policy to be obtained in the future would come from funds paid by the County as a result of this litigation. The benefits plaintiff will obtain therefore will not be wholly independent of the tortfeasor, and they therefore do not implicate the common law collateral source rule.

Accordingly, none of the rationales for the collateral source rule apply in light of the ACA, and thus the rule cannot justify the trial court's decision to exclude evidence concerning the discounts that would be applied under a private policy procured under the ACA. (See *Stayton*, *supra*, 117 A.3d at pp. 534-537 (conc. opn. of Strine, C. J.) [[questioning the continued validity of the common law collateral source rule in the new era of near universal healthcare coverage].)

IV. THE TRIAL COURT ERRED BY EXCLUDING EVIDENCE REGARDING THE FREE SERVICES THAT PLAINTIFF IS ENTITLED TO RECEIVE FROM THE REGIONAL CENTER AND SCHOOL DISTRICT.

As noted above, the trial court precluded the County from introducing evidence concerning benefits plaintiff is entitled to receive at no cost from the Regional Center and public school system, and the impact that will have on his future care expenses. (1 RT 35, 41-46.) The court concluded that those benefits did not qualify as a collateral source admissible under section 3333.1. (*Ibid.*)

The services provided by the Regional Center and the school system are not specifically identified among the list of collateral sources admissible under section 3333.1, but they are admissible without regard to this section because they are not a collateral source in the first place. (*Washington by Washington v. Barnes Hosp.* (Mo. 1995) 897 S.W.2d 611, 619 [holding that the collateral source rule does not apply to "evidence of the availability of free public special education and therapies"]; *Florida Physician's Ins. Reciprocal v. Stanley* (Fla. 1984) 452 So.2d 514, 515-516 [holding that the collateral source rule does not apply to "evidence of free or low cost services from governmental or charitable agencies available to anyone with specific disabilities" and that such evidence is "admissible on the issue of future damages"].)

Rather, the Regional Centers were created by statute and provide free public benefits and services to anyone with a qualifying

disability. (*ARC*, *supra*, 38 Cal.3d at pp. 388-390; *Clemente v. Amundson* (1998) 60 Cal.App.4th 1094, 1097-1098; *Williams v. Macomber* (1990) 226 Cal.App.3d 225, 232.) Similarly, the public school system is required by federal and California law to provide everything needed for a free appropriate public education (20 U.S.C. § 1400 et seq.; Ed. Code, § 56000 et seq.), including, for example, physical, speech, and occupational therapy, in-school nursing, and placement in a public or private residential program (20 U.S.C. § 1401(9), (26), (29); Ed. Code, §§ 56000-56001, 56363; *Cedar Rapids Community School Dist. v. Garret F. ex rel. Charlene F.* (1999) 526 U.S. 66, 73-76 [119 S.Ct. 992, 143 L.Ed.2d 154]; *County of Los Angeles v. Smith* (1999) 74 Cal.App.4th 500, 512). There is no payment or reimbursement obligation for either. (20 U.S.C. § 1401(9), (29); Ed. Code, § 56040; Health & Saf. Code, § 123870, subd. (b).)

And none of the public policy justifications for the collateral source rule apply to these free benefits. The rule is designed, in part, to encourage citizens to purchase and maintain insurance for personal injuries. (*Helfend*, *supra*, 2 Cal.3d at pp. 9-10; see *People v. Birkett* (1999) 21 Cal.4th 226, 247, fn. 19.) But this goal has no bearing on the free benefits provided by the Regional Center and the public school system, since citizens are not required to purchase insurance to qualify for those benefits.

The collateral source rule is also promoted on the ground that "insurance policies increasingly provide for either subrogation or refund of benefits upon a tort recovery. . . . Hence, the plaintiff receives no double recovery." (*Helfend*, *supra*, 2 Cal.3d at pp. 10-

11.) Needless to say, there is no right to subrogation or right to reimbursement for these free services. Thus, applying the collateral source rule to free services provided by the Regional Center and the public school system *would result in a double recovery*.

Finally, the collateral source rule has been applied to promote private charitable assistance. (*Arambula v. Wells* (1999) 72 Cal.App.4th 1006, 1012. ["Why would a family member (or a stranger) freely give of his or her money or time if the wrongdoer would ultimately reap the benefit of such generosity?"].) Again, this policy consideration does not arise with public benefits provided by the Regional Center and the public school system, which are required by law.

Accordingly, the trial court abused its discretion by excluding evidence concerning the benefits plaintiff will receive from the Regional Center and local school district at no cost to him.

V. THE TRIAL COURT'S NUMEROUS ERRORS RESULTED IN AN EXCESSIVE DAMAGES AWARD.

As a result of the numerous errors outlined above, the jury in this case heard evidence concerning plaintiff's future medical care expenses that was completely divorced from the reality of the costs that will actually be incurred.

The jury learned nothing about the broad variety of free services which plaintiff receives and will continue to receive from the Regional Center and through the school district.

The jury received no evidence concerning the substantially discounted rates that have been and will continue to be applied for plaintiff's healthcare costs through Medi-Cal—rates that are generally four to six times *lower* than amounts paid by uninsured individuals. And the County was barred from offering evidence concerning the significant savings that would accrue through the purchase and use of a private insurance policy.

Instead, the jury learned only about the two *most expensive* possible rates for plaintiff's future care—the "private pay" rate applicable to those without insurance (which will not apply because plaintiff will always have some form of insurance), and the rates billed by the top 20 percent of healthcare providers (which cannot be recovered as a matter of California law). And the jury received no instruction on how it should reduce any future damages award to account for the fact that providers will accept much lower rates as full payment.

The combined impact of the trial court's errors was to enable a jury to hear a range of damages up $29 million in present value ($288 million in future value) and to return a verdict of $9,577,000—an amount nearly *three times* higher than the "private pay" rates which are themselves higher than the amounts that will actually be paid by Medi-Cal and/or private insurance. (*Ante*, pp. 19-20.) Moreover, this amount, which breaks down to nearly $130,000 a year for plaintiff's 74 year life expectancy, is *thirteen times* higher than the $10,000 per year in expenses that plaintiff had incurred to date. (*Ante*, p. 19.) Thus, the fact that the jury did not award the drastically exaggerated amount plaintiff sought does

not obviate the excessiveness of the amount that was awarded. Indeed, the fact the jury heard the exorbitant amounts was prejudicial to the defendants because the grossly inflated numbers created the erroneous impression that plaintiff's care would cost way more than any realistic estimate would suggest.

Had the jury been permitted to hear about the free benefits plaintiff receives and/or about the substantial discounts he will obtain through Medi-Cal and/or private insurance, there is a "reasonable chance" that the jury would have returned a significantly lower future medical expense award. (*College Hospital Inc. v. Superior Court* (1994) 8 Cal.4th 704, 715 [prejudice exists if there is "merely a reasonable chance, more than an abstract possibility," of a more favorable verdict absent the error (emphases omitted)].) The County is therefore entitled to a new trial.

CONCLUSION

For the foregoing reasons, it is respectfully submitted that this court should reverse the judgment and post-judgment orders awarding costs and expert witness fees, and remand this case for a new trial.

October 13, 2015

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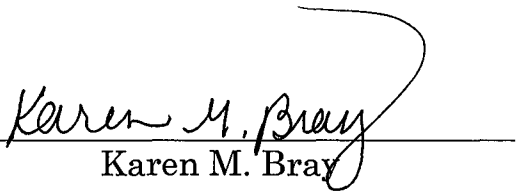
By: 
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CERTIFICATE OF WORD COUNT
(Cal. Rules of Court, rule 8.204(c)(1).)

The text of this brief consists of 12,199 words as counted by the Microsoft Word version 2010 word processing program used to generate the brief.

Dated: October 13, 2015

Karen M. Bray

ATTACHMENT

(Cal. Rules of Court, rule 8.1115(c))

2007 WL 2580543
United States District Court,
E.D. California.

Gina Melissa SILONG, et al., Plaintiffs,
v.
UNITED STATES of America, Defendant.

No. CV F 06-0474 LJO DLB. | Sept. 5, 2007.

Attorneys and Law Firms

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DECISION ON GOVERNMENT'S SUMMARY ADJUDICATION MOTION ON DAMAGES (Docs.51, 68.)

LAWRENCE J. O'NEILL, United States District Judge.

INTRODUCTION

***1** In this medical malpractice action addressing complications of the birth of minor plaintiff Paige Silong ("Paige"), defendant United States of America ("Government") seeks summary adjudication on all damage claims, except Paige's alleged general damages and future medical expenses after age 23.[1] The Government seeks to preclude damage claims of Paige's parents, Air Force Lieutenant Colonel Richard Silong ("Lt.Col.Silong") and Gina Melissa Silong ("Ms.Silong"). This Court considered the Government's summary adjudication motion on the record,[2] pursuant to Local Rule 78-230(h). For the reasons discussed below, this Court GRANTS in part and DENIES in part summary adjudication for the Government.

BACKGROUND

Paige's Birth

On March 5, 2001, Ms. Silong was eight weeks pregnant with Paige and began prenatal care at Lemoore Naval Hospital ("hospital"). On October 20, 2001 at 4:20 a.m., Ms. Silong arrived at the hospital's maternal infant unit in active labor. The delivery team encountered what the Government characterizes as an unpredicted shoulder dystocia that physically impeded Paige's normal descent through the birth canal. Shoulder dystocia results when the baby's shoulder becomes impacted or caught within the birthing canal after the baby's head is delivered to prevent full delivery of the baby. Dane Winkelman, M.D. ("Dr.Winkelman"), applied traction, pulling on Paige's head, to facilitate delivery, and Paige was delivered at 5:28 a.m. Lt. Col. Silong and Ms. Silong contend that excessive traction after shoulder dystocia is substandard care. Examination revealed weakness to Paige's left arm, consistent with injury to her brachial plexus, a network of nerves in the neck and armpit.

On October 21, 2001, Ms. Silong was discharged with Paige. Four weeks later, Lt. Col. Silong and Ms. Silong learned that Paige's brachial plexus condition may not resolve.

Improved Condition

Paige received therapy and showed muscle movement in her shoulder and hands by November 21, 2001. During 2002 and 2003, neurosurgical procedures were performed to Paige's brachial plexus nerves, including reconstructive and release procedures and a left posterior shoulder capsulodesis. Paige's left arm use and function improved, and she continued to receive therapy.

The Government describes Paige as a "vivacious five-year old" and points to deposition testimony of her school teacher that Paige is happy, easygoing, well-adjusted, typical, bright, articulate, loving and one of the better students. Paige's teacher notes that she has observed Paige jump rope, hang upside down from monkey bars, bounce a ball, hit a ball with a bat, run, play soccer, swing and climb a jungle gym.

Plaintiffs' Claims

Lt. Col. Silong and Ms. Silong proceed on their original complaint for themselves and Paige to pursue medical malpractice claims against the Government, pursuant to the Federal Tort Claims Act ("FTCA"), 28 U.S.C. §§ 2671-2680. Lt. Col. Silong and Ms. Silong allege that due to "failure to properly manage the pregnancy, labor and delivery, Paige Silong suffered a traumatic delivery which caused permanent and irreparable damage to her. Specifically, Paige Silong sustained permanent injury to her nerves, and the soft tissues of her left upper extremity, neck and shoulder."Lt. Col. Silong and Ms. Silong further allege that "Paige remains in a severely handicapped disabled condition that limits her daily active living."

***2** The complaint alleges Lt. Col. Silong and Ms. Silong's damages for past and future medical expenses for Paige and loss of parent-child consortium. For Paige, Lt. Col. Silong and Ms. Silong seek damages for:

1. Past and future mental anguish;
2. Past and future physical pain and suffering;
3. Past and future physical disfigurement;
4. Past and future permanent physical impairment;
5. Loss of earnings and earning capacity;
6. Past and future medical expenses;
7. Loss of enjoyment of life; and
8. Loss of parent-child consortium.

The Government seeks to preclude damages claims of Lt. Col. Silong, Ms. Silong and Paige (collectively "plaintiffs") (except Paige's alleged general damages and future medical expenses after age 23) on grounds that they are barred as a matter of law and by plaintiffs' inadequate discovery disclosures.

DISCUSSION

Summary Judgment/Adjudication Standards

F.R.Civ.P. 56(b) permits a party against whom a claim is asserted to seek "summary judgment in the party's favor upon all or any part thereof."Summary judgment/adjudication is appropriate when there exists no genuine issue as to any material fact and the moving party is entitled to judgment/adjudication as a matter of law. F.R.Civ.P. 56(e); *Matsushita Elec. Indus. v. Zenith Radio Corp.*, 475 U.S. 574, 587, 106 S.Ct. 1348, 1356, 89 L.Ed.2d 538 (1986); *T.W. Elec. Serv., Inc. v. Pacific Elec. Contractors Assn.*, 809 F.2d 626, 630 (9th Cir.1987). The purpose of summary judgment/adjudication is to "pierce the pleadings and assess the proof in order to see whether there is a genuine need for trial."*Matsushita Elec.*, 475 U.S. at 586, n. 11, 106 S.Ct. 1348, 89 L.Ed.2d 538; *International Union of Bricklayers v. Martin Jaska, Inc.*, 752 F.2d 1401, 1405 (9th Cir.1985).

On summary judgment/adjudication, a court must decide whether there is a "genuine issue as to any material fact," not weigh the evidence or determine the truth of contested matters. F.R.Civ.P. 56(c); *Covey v. Hollydale Mobilehome Estates*, 116 F.3d 830, 834 (9th Cir.1997); *see Adickes v. S.H. Kress & Co.*, 398 U.S. 144, 157, 90 S.Ct. 1598, 26 L.Ed.2d 142 (1970); *Poller v. Columbia Broadcast System*, 368 U.S. 464, 467, 82 S.Ct. 486, 7 L.Ed.2d 458 (1962); *Loehr v. Ventura County Community College Dist.*, 743 F.2d 1310, 1313 (9th Cir.1984). The evidence of the party opposing summary judgment/adjudication is to be believed and all reasonable inferences that may be drawn from the facts before the court must be drawn in favor of the opposing party. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 255, 106 S.Ct. 2505, 91 L.Ed.2d 202 (1986); *Matsushita*, 475 U.S. at 587, 106 S.Ct. 1348, 89 L.Ed.2d 538.The inquiry is "whether the evidence presents a sufficient disagreement to require submission to a jury or whether it is so one-sided that one party must prevail as a matter of law."*Anderson*, 477 U.S. at 251-252, 106 S.Ct. 2505, 91 L.Ed.2d 202.

To carry its burden of production on summary judgment/adjudication, a moving party "must either produce evidence negating an essential element of the nonmoving party's claim or defense or show that the nonmoving party does not have enough evidence of an essential element to carry its ultimate burden of persuasion at trial."*Nissan Fire & Marine Ins. Co. v. Fritz Companies, Inc.*, 210 F.3d 1099, 1102 (9th Cir.2000); *see High Tech Gays v. Defense Indus. Sec. Clearance Office*, 895 F.2d 563, 574 (9th Cir.1990)."[T]o carry its ultimate burden of persuasion on the motion, the moving party must persuade the court that there is no genuine issue of material fact."*Nissan Fire*, 210 F.3d at 1102;*see High Tech Gays*, 895 F.2d at 574."As to materiality, the

substantive law will identify which facts are material. Only disputes over facts that might affect the outcome of the suit under the governing law will properly preclude the entry of summary judgment."*Anderson,* 477 U.S. at 248, 106 S.Ct. 2505, 91 L.Ed.2d 202.

***3** "If a moving party fails to carry its initial burden of production, the nonmoving party has no obligation to produce anything, even if the nonmoving party would have the ultimate burden of persuasion at trial."*Nissan Fire,* 210 F.3d at 1102-1103;*See Adickes,* 398 U.S. at 160, 90 S.Ct. 1598, 26 L.Ed.2d 142."If, however, a moving party carries its burden of production, the nonmoving party must produce evidence to support its claim or defense."*Nissan Fire,* 210 F.3d at 1103;*see High Tech Gays,* 895 F.2d at 574."If the nonmoving party fails to produce enough evidence to create a genuine issue of material fact, the moving party wins the motion for summary judgment."*Nissan Fire,* 210 F.3d at 1103;*see Celotex Corp. v. Catrett,* 477 U.S. 317, 322, 106 S.Ct. 2548, 91 L.Ed.2d 265 (1986) ("Rule 56(c) mandates the entry of summary judgment, after adequate time for discovery and upon motion, against a party who fails to make the showing sufficient to establish the existence of an element essential to that party's case, and on which that party will bear the burden of proof at trial.") "But if the nonmoving party produces enough evidence to create a genuine issue of material fact, the nonmoving party defeats the motion."*Nissan Fire,* 210 F.3d at 1103;*see Celotex,* 477 U.S. at 322, 106 S.Ct. 2548, 91 L.Ed.2d 265."The amount of evidence necessary to raise a genuine issue of material fact is enough 'to require a jury or judge to resolve the parties' differing versions of the truth at trial.' " *Aydin Corp. v. Loral Corp.,* 718 F.2d 897, 902 (quoting *First Nat'l Bank v. Cities Service Co.,* 391 U.S. 253, 288-289, 88 S.Ct. 1575, 1592, 20 L.Ed.2d 569 (1968)). "The mere existence of a scintilla of evidence in support of the plaintiff's position will be insufficient." *Anderson,* 477 U.S. at 252, 106 S.Ct. 2505, 91 L.Ed.2d 202.

Under F.R.Civ.P. 56(c), a summary judgment/adjudication motion, interlocutory in character, may be rendered on the issue of liability alone."In cases that involve ... multiple causes of action, summary judgment may be proper as to some causes of action but not as to others, or as to some issues but not as to others, or as to some parties, but not as to others."*Barker v. Norman,* 651 F.2d 1107, 1123 (5th Cir.1981); *see also Robi v. Five Platters, Inc.,* 918 F.2d 1439 (9th Cir.1990); *Cheng v. Commissioner Internal Revenue Service,* 878 F.2d 306, 309 (9th Cir.1989). A court "may grant summary adjudication as to specific issues if it will narrow the issues for trial."*First Nat'l Ins. Co. v. F.D.I.C.,* 977 F.Supp. 1051, 1055 (S.D.Cal.1977).

As discussed below, this Court grants the Government's requested relief on plaintiffs' damages claims, except as to Paige's future earning capacity and a complete offset as to future medical expenses incurred up to age 23.

Governing Law

A district court applies the substantive law of the state where the negligent act or omission occurred in an FTCA action. *See Richards v. United States,* 369 U.S. 1, 11, 82 S.Ct. 585, 7 L.Ed.2d 492 (1962)."The extent of the government's [FTCA] liability is a matter of federal law (28 U.S.C. §§ 1346(b), 2674), albeit determined according to state standards."*Taylor v. United States,* 821 F.2d 1428, 1433 (9th Cir.1987). The Government points out that California substantive law applies to plaintiffs' damages claims given that "all activities," including Paige's prenatal care and birth, occurred in California but that federal law governs procedural matters.

Failure To Disclose Damages Computations

***4** The Government contends that plaintiffs' original and supplemental F.R.Civ.P. 26(a)(1) initial disclosures fail to include computations of alleged damages for loss of consortium, emotional distress and past medical expenses to bar such damages claims. As such, the Government argues that damages claims are limited to Paige's general damages and future medical expenses up to age 23.

F.R.Civ.P. 26(a)(1)(C) requires a party, "without awaiting a discovery request," to disclose "a computation of any category of damages claimed by the disclosing party, making available for inspection and copying as under Rule 34 the documents or other evidentiary material, not privileged or protected from disclosure, on which such computation is based, including materials bearing on the nature and extent of injuries suffered."Pursuant to F.R.Civ.P. 37(c)(1), a "party that without substantial justification fails to disclose information required by Rule 26(a)... is not, unless such failure is harmless, permitted to use as evidence at a trial, at a hearing, or on a motion any ... information not so disclosed."F.R.Civ.P. 37(c)(1)"gives teeth ... by forbidding the use at trial of any information required to be disclosed by Rule 26(a) that is not properly disclosed" and provides a "self-executing," "automatic" sanction as "a strong inducement for disclosure of

material."*Yeti By Molly Ltd. v. Deckers Outdoor Corp.*, 259 F.3d 1101, 1106 (9th Cir.2001) (quoting, in part, F.R.Civ.P. 37 Advisory Comm. Notes (1993)).

The Ninth Circuit Court of Appeals gives "particularly wide latitude to the district court's discretion to issue sanctions under Rule 37(c)(1)."*Yeti,* 259 F.3d at 1106.The Ninth Circuit has explained that "even absent a showing in the record of bad faith or willfulness, exclusion is an appropriate remedy for failing to fulfill the required disclosure requirements of Rule 26(a)."*Yeti,* 259 F.3d at 1106."The sanction of exclusion is thus automatic and mandatory unless the party to be sanctioned can show that its violation of Rule 26(a) was either justified or harmless."*Finley v. Marathon Oil Co.*, 75 F.3d 1225, 1230 (7th Cir.1996)."Implicit in Rule 37(c)(1) is that the burden is on the party facing sanctions to prove harmlessness."*Yeti,* 259 F.3d at 1107.Summary judgement may be imposed based on absence of evidence excluded for failure to comply with F.R.Civ.P. 26(a).*See Wong v. Regents of the Univ. of California,* 379 F.3d 1097, 1103 (9th Cir.2004).

The Government argues that plaintiffs' requisite F.R.Civ.P. 26(a) (1)(C) damages computations were limited to a $250,000 claim for Paige's general damages and reference to expert reports for future medical expenses and lost earnings. The Government faults plaintiffs' delay to July 6, 2007, four days prior to the discovery cutoff, to make such limited disclosures and absence of computation of damages for loss of consortium, emotional distress and past medical expenses. The Government continues that plaintiffs fail to demonstrate substantial justification for failure to disclose damages computations in that their attorneys specialize in FTCA cases throughout the United States. Based on plaintiffs' initial disclosures, the Government seeks to preclude Lt. Col. Silong and Ms. Silong's alleged damages (past and future medical expenses and loss of consortium) and Paige's alleged damages for past medical expenses and lost earning capacity.

***5** Plaintiffs do not oppose meaningfully the Government's absence of damages computation arguments as to Lt. Col. Silong and Ms. Silong's loss of consortium and emotional distress claims and Paige's past medical expenses.

Based on the absence of plaintiffs' sufficient F.R.Civ.P. 26(a) (1)(C) damages computations and for more specific reasons discussed below, this Court agrees with the Government to bar Lt. Col. Silong and Ms. Silong's loss of consortium and emotional distress damages claims and claims for Paige's past medical expenses and plaintiffs' out-of-pocket expenses for her care.

Loss Of Parent-Child Consortium

The Government argues that California law "disallows" claims for loss of parent-child consortium. The Government points to the California Supreme Court pronouncement in *Baxter v. Superior Court,* 19 Cal.3d 461, 463, 466, 138 Cal.Rptr. 315, 563 P.2d 871 (1977):

> In California, however, the parent's cause of action has not expanded beyond the ancient right to recover for loss of earnings and services of economic value. For the policy reasons stated in *Borer,* in particular the intangible nature of the injury and the danger of multiplication of claims and liability, we decline to enlarge the parent's cause of action to permit recovery for the loss of affection and society.
>
> ...
>
> ... We therefore conclude that a parent has no cause of action in negligence to recover damages for loss of filial consortium.

In *Foy v. Greenblott,* 141 Cal.App.3d 1, 7, 190 Cal.Rptr. 84 (1983), the California Court of Appeals explained:

> Losses of parental or filial consortium are not actionable. "[T]he inadequacy of monetary damages to make whole the loss suffered, considered in light of the social cost of paying such awards, constitutes a strong reason for refusing to recognize the asserted claim."(*Borer v. American Airlines, Inc.* (1977) 19 Cal.3d 441, 447 [138 Cal.Rptr. 302, 563 P.2d 858];*also see Baxter v. Superior Court* (1977) 19 Cal.3d 461 [138 Cal.Rptr. 315, 563 P.2d 871].)

More recently, the California Supreme Court reaffirmed:

> It is well established in this state that parents may not recover damages for loss of filial consortium. (*Baxter v. Superior Court* (1977) 19 Cal.3d 461 [138 Cal.Rptr. 315, 563 P.2d 871].) Reasons of public policy explain why such a cause of action is not recognized, including: "[t]he intangible character of the loss, which can never really be compensated by money damages; the difficulty of measuring damages; the dangers of double recovery of multiple claims and of extensive liability...."(*Id.* at p. 464, 138 Cal.Rptr. 315, 563 P.2d 871.)

Burgess v. Superior Court, 2 Cal.4th 1064, 1084, 9 Cal.Rptr.2d 615, 831 P.2d 1197 (1992) ("we hold that damages arising from loss of Joseph's affection, society,

companionship, love and disruption of Burgess's 'normal' routine of life to care for Joseph cannot be recovered by Burgess no matter how her claim for these damages is denominated."); *see Miller v. United States,* 803 F.Supp. 1120, 1124-1125 (E.D.Va.1992) (claim for "destruction of the normal loving relationship between parents and child ... is not viable because California does not allow recovery for loss of consortium between parent and child."); *Zavala v. Arce,* 58 Cal.App.4th 915, 937, 68 Cal.Rptr.2d 571 (1997) ("However, for public policy reasons parents in California may not recover for loss of filial consortium ... Zavala's recovery may not include damages for emotional distress arising from loss of her child's affection, society, companionship and love, or other similar loss of filial consortium.)

***6** Based on the above authorities, the Government seeks to bar Lt. Col. Silong and Ms. Silong's claims for "[l]oss of parent-child consortium, loss of companionship, love, nurturing, and affection."

The Government continues that despite the legal bar to Lt. Col. Silong and Ms. Silong's loss of consortium claims, the claims lack "basis in fact." The Government notes that Paige's shoulder injury "has not deprived her parents Paige's love, affection or companionship."The Government points to Lt. Col. Silong and Ms. Silong's deposition testimony that they have the same love and affection from Paige as from their 10-year-old son and that they have a caring, affectionate relationship with Paige that is not compromised by her shoulder condition. Lt. Col. Silong and Ms. Silong acknowledge that they spend more "quality" time with Paige because of her shoulder condition, Ms. Silong's decision not to return to work or hire a nanny, and Lt. Col. Silong's decision to transfer from the Navy to the Air Force to avoid 10-month aircraft carrier deployments. The Government contends that Lt. Col. Silong and Ms. Silong "have not suffered any loss of consortium, companionship, love, nurturing or affection."

Lt. Col. Silong and Ms. Silong agree that California law bars their loss of consortium claims and to dismissal of such claims. The Government is entitled to summary adjudication that Lt. Col. Silong and Ms. Silong are not entitled to recover on loss of consortium claims.

Lt. Col. Silong And Ms. Silong's Emotional Distress

The Government points out that plaintiffs' complaint does not allege a claim or prayer for Lt. Col. Silong or Ms. Silong's "emotional distress." The Government argues that since F.R.Civ.P. 8(a) requires "a demand for judgment for the relief the pleader seeks," a complaint "defines the scope of issues." The Government points to an absence of claims for Lt. Col. Silong and Ms. Silong's emotional distress and computation of such damages in their F.R.Civ.P. 26(a)(1) initial disclosures. The Government argues that the nature and extent of injuries must be disclosed, including amounts claimed for general damages (pain and suffering).*See City and County of San Francisco v. Tutor-Saliba Corp.,* 218 F.R.D. 219, 221 (N.D.Cal.2003).

The Government continues that Lt. Col. Silong and Ms. Silong's discovery and deposition responses fail to allege or support emotional distress or general damages claims. As noted by the Government, Lt. Col. Silong's interrogatory responses regarding damages raised objections, reiterated their complaint's allegations, and provided no meaningful information. The Government further points to the absence of produced documents to support a factual basis for Lt. Col. Silong and Ms. Silong's general damages. The Government notes that Lt. Col. Silong and Ms. Silong have not claimed fright, nervousness, grief, anxiety, mortification, shock, humiliation, indignity or physical pain from Paige's birth or brachial plexus injury.

***7** Lt. Col. Silong and Ms. Silong concede that they have not pled a claim for "emotional distress" damages and assert that "use of summary judgment for claims not part of this litigation is a misuse of the Court's time and resources."

Lt. Col. Silong and Ms. Silong are correct that they do not pursue a claim for "emotional distress' damages. This Court presumes that the Government addressed such claim out of an abundance of caution to clarify what damages claims Lt. Col. Silong and Ms. Silong pursued based on their discovery responses and objections. Although Lt. Col. Silong and Ms. Silong's emotional distress damages are not put in issue by their complaint to warrant summary adjudication, this Court nonetheless bars Lt. Col. Silong and Ms. Silong to pursue emotional distress damages.

Lt. Col. Silong's Negligence Claim

The Government contends the Lt. Col. Silong is unable to allege or establish that the Government breached a legal duty to him to support a negligence claim.

The negligence elements which a plaintiff must prove are:

(1) legal duty of care owed to plaintiff; (2) a breach of that duty; (3) a proximate causal connection between the negligent conduct and the resulting injury; and (4) actual loss or damage resulting from breach of the duty of care. *See Hanson v. Grode,* 76 Cal.App.4th 601, 606, 90 Cal.Rptr.2d 396 (1999); *see also Burgess v. Superior Court,* 2 Cal.4th 1064, 1072, 9 Cal.Rptr.2d 615, 831 P.2d 1197 (1992)."Whether a defendant owes a duty of care is a question of law. Its existence depends upon the foreseeability of the risk and a weighing of policy considerations for and against imposition of liability."*Burgess,* 2 Cal.4th at 1072, 9 Cal.Rptr.2d 615, 831 P.2d 1197.A duty of care arises when it is assumed by the defendant, imposed on the defendant as a matter of law, or arises out of a relationship between plaintiff and defendant. *Marlene F. v. Affiliated Psychiatric Medical Clinic, Inc.,* 48 Cal.3d 583, 590, 257 Cal.Rptr. 98, 770 P.2d 278 (1989).

The Government notes that plaintiffs' complaint fails "to specify what legal duty was owed to Lt. Col. Silong or that any breach of that duty occurred."The Government points out that the portion of the complaint entitled "Cause of Action Against the United States of America" fails to mention Lt. Col. Silong. The Government further notes the absence of allegations that Lt. Col. Silong had a physician-patient relationship with Dr. Winkelman or the hospital, that the Government assumed an applicable duty to Lt. Col. Silong, or that such duty was imposed by law.

The Government continues that Lt. Col. Silong fails to meet requirements for a bystander victim negligence claim. In *Burgess,* 2 Cal.4th at 1072-1073, 9 Cal.Rptr.2d 615, 831 P.2d 1197, the California Supreme Court contrasted "bystander" and "direct victim" cases:

> The distinction between the "bystander" and "direct victim" cases is found in the source of the duty owed by the defendant to the plaintiff. The "bystander" cases, commencing with *Dillon v. Legg* (1968) 68 Cal.2d 728 [69 Cal.Rptr. 72, 441 P.2d 912], and culminating in *Thing, supra,* 48 Cal.3d 644, 257 Cal.Rptr. 865, 771 P.2d 814, address "the question of duty in circumstances in which a plaintiff seeks to recover damages as a percipient witness to the injury of another."(*Christensen, supra,* 54 Cal.3d at p. 884, 2 Cal.Rptr.2d 79, 820 P.2d 181.)These cases "all arise in the context of physical injury or emotional distress caused by the negligent conduct of a defendant with whom the plaintiff had no preexisting relationship, and to whom the defendant had not previously assumed a duty of care beyond that owed to the public in general."(*Ibid.,* italics added.) In other words, bystander liability is premised upon a defendant's violation of a duty not to negligently cause emotional distress to people who observe conduct which causes harm to another.

***8** In *Thing v. La Chusa,* 48 Cal.3d 644, 647, 257 Cal.Rptr. 865, 771 P.2d 814 (1989), the California Supreme Court set limits to bystander liability:

> In the absence of physical injury or impact to the plaintiff himself, damages for emotional distress should be recoverable only if the plaintiff: (1) is closely related to the injury victim, (2) is present at the scene of the injury-producing event at the time it occurs and is then aware that it is causing injury to the victim and (3) as a result suffers emotional distress beyond that which would be anticipated in a disinterested witness.

Turning to a father's claim for injury to his child during prenatal care and birth, the California Supreme Court has observed that "the physician-patient relationship critical to a mother's cause of action is almost always absent in a father's claim. It, therefore, appears that a father must meet the criteria set forth in *Thing, supra,* 48 Cal.3d 644, 257 Cal.Rptr. 865, 771 P.2d 814. 48 Cal.3d 644, 257 Cal.Rptr. 865, 771 P.2d 814, if he is to state a viable claim."*Burgess,* 2 Cal.4th at 1078, n. 8, 9 Cal.Rptr.2d 615, 831 P.2d 1197.

The Government contends that Lt. Col. Silong is unable to meet *Thing* criteria given the absence of his bystander victim claim. The Government points to Lt. Col. Silong's deposition testimony that he was unaware of Paige's injury during birth. The Government concludes that Lt. Col. Silong lacked contemporaneous knowledge of alleged malpractice or injury and did not suffer requisite emotional distress for a bystander victim claim.

Lt. Col. Silong appears to concede that he did not pled a bystander victim and asserts that "use of summary judgment for claims not part of this litigation is a misuse of the Court's time and resources."Lt. Col. Silong appears to acknowledge he lacks legal grounds for a bystander victim claim.

A bystander victim claim is not apparent from the complaint. This Court presumes that the Government addressed such claim out of an abundance of caution to clarify what claims Lt. Col. Silong pursued based on his discovery responses and objections. Although a bystander victim claim for Lt. Col. Silong is not put in issue by the

complaint to warrant summary adjudication, this Court nonetheless bars Lt. Col. Silong to pursue a bystander victim claim.

Paige's Lost Earning Capacity Claim

The Government argues that Paige's shoulder injury should not decrease her life-long earnings. The Government contends that Paige's lost earning capacity claim fails because there is no dispute that Paige is able to perform 90 percent of jobs. The Government argues that "the test is not whether Paige can perform *all* jobs, but whether it is reasonably probable that her shoulder injury will cause her to sustain lost earnings in the future."(Italics in original.)

Plaintiffs argue that "the evidence conclusively establishes Paige Silong's diminished capacity to work due to her permanent arm injury."Plaintiffs respond that in the absence of dispute that Paige suffered a permanent injury, she may pursue a lost earning capacity claim.

Reasonable Certainty

***9** To support its position, the Government points to the following from *Walden v. United States,* 31 F.Supp.2d 1230, 1235 (S.D.Cal.1998):

> Plaintiff can only recover those elements that he can prove with reasonable certainty. "The burden of proof is upon the party claiming damage to prove that he has suffered damage and to prove the elements thereof with reasonable certainty."*Peters v. Lines,* 275 F.2d 919, 930 (9th Cir.1960). It follows that any claim by plaintiff for lost wages, medical expenses, and impaired future earning capacity must be supported by concrete evidence, not merely an optimistic forecast of loss divorced from plaintiff's past history substantiated by the facts. *See, Fleming v. American Export Isbrandtsen Lines, Inc.,* 318 F.Supp. 194 (S.D.N.Y.1970), aff'd451 F.2d 1329 (2nd Cir.1971).
>
> An award for lost or future earnings must be based on actual proof of the amount of impairment and not mere conjecture. *Oregon-Washington R.R. & Nav. Co. v. Branham,* 259 F. 555, 557 (9th Cir.1919); *Firth v. United States,* 554 F.2d 990 (9th Cir.1977). The base figure used to calculate future wage loss is the difference between what a person earned before the accident and what he would be able to earn upon returning to work, not necessarily in the same job.
>
> "[D]amages which are speculative, remote, imaginary, contingent, or merely possible cannot serve as a legal basis for recovery."*Frustuck v. City of Fairfax,* 212 Cal.App.2d 345, 367-368, 28 Cal.Rptr. 357 (1963).

The Government argues that plaintiffs do not meet their burden to establish reasonable certainty of future lost earning capacity for five-year-old Paige and that no reliable evidence demonstrates reasonable certainty that Paige will sustain future lost earnings. The Government points to the deposition testimony of plaintiffs' physician-life care plan expert Alex C. Willingham ("Dr.Willingham") that "I don't see any reason why the child could not as an adult pursue some type of work activity or vocational or self support perspective. There will be things she can't do, but that doesn't mean there won't be anything she can't do."

The Government points to the deposition testimony of its vocational rehabilitation expert Andrew Michael O'Brien that Paige will not suffer future lost earning capacity because:

> 1. Her physical impairment has mild functional limitations;
>
> 2. She reasonably should be able to participate in occupations consistent with her physical limitations to provide an equal or greater earning potential;
>
> 3. Her parents are college-educated to serve as a great predictor of future academic success;
>
> 4. Her left upper extremity limitations do "not preclude the lion's share of white-collar types of employment [which] can be easily accommodated and, again, would provide her with essentially the same earning potential as those which she's precluded from";
>
> 5. She will be able to perform a full-range of sedentary, light- and medium-level work;
>
> ***10** 6. She should not have a keyboarding impairment; and
>
> 7. She is not intellectually impaired.

The Government notes further factors to support no lost earning capacity:

> 1. The types of jobs precluded by shoulder injury are low paying and not performed typically by women;

2. Even without a college degree, Paige, as a woman, with reasonable probability would not seek jobs requiring significant bimanual overhead strength;

3. Paige lacks a mental or cognitive impairment; and

4. Lt. Col. Silong and Ms. Silong testified that they will support Paige's educational and vocational aspirations.

The Government concludes that Paige's inability to perform some jobs does not establish reasonable probability that her shoulder injury causes lost earning capacity.

Plaintiffs respond there is no dispute that Paige suffered a permanent disability. Plaintiffs point to the deposition testimony of Paige's treating surgeon Rahul Nath, M.D. ("Dr.Nath"): "She has a permanent injury to severe injury. She'll require lifelong management of that, including multiple surgeries and including lifelong physical therapy and other modalities, as well."Plaintiffs argue that the evidence creates material factual issues as to Paige's future earning capacity to defeat summary adjudication of the claim.

Plaintiffs point to an unpublished decision *Roberts Barrows v. Schneider National Carriers, Inc.,* 1998 U.S.App. Lexis 17536 (9th Cir.1998), where the Ninth Circuit Court of Appeals observed that "in the ordinary case, and as a general rule, evidence that a plaintiff sustained a permanent injury is sufficient to entitle him to submit to the jury the question whether there has been an impairment of his future earning capacity."(quoting *Tavenner v. Figini,* 273 Ore. 415, 541 P.2d 437, 438 (Or.1975)). Plaintiffs further point to an unpublished California district court decision *Simplicio v. United States,* 1991 U.S. Dis. Lexis 18081, *20 (N.D.Cal.1991), where the court noted that "[l]oss of earning power is an element of general damages that may be inferred from the nature of the injury, with or without proof of actual earnings or income either before or after the injury."(quoting *Hilliard v. A.H. Robins Co.,* 148 Cal.App.3d 374, 412, 196 Cal.Rptr. 117 (1983).

Plaintiffs note the deposition testimony of the Government's physical rehabilitation expert Joseph Capell, M.D. ("Dr.Capell"), examined Paige and estimates there are more than 1,000 jobs which Paige will be unable to perform. Dr. Capell testified:

> Well, my opinion is that in the future in spite of optimal treatment, Paige is going to continue to have some limitations in terms of her upper-left upper extremity function. And these limitations will be stated in vocational terms. A limitation from very heavy lifting using both arms at shoulder level and above or prolonged work with both arms, or hands in this case, at shoulder level or above. Those are the two preclusions.
>
> ***11** And those two preclusions do eliminate certain jobs that she probably would be able to do but not in a competitive fashion and shouldn't really be considered employment.

Plaintiffs further point to the deposition testimony of their physical rehabilitation expert Dr. Willingham that "there will be ... restrictions of some jobs that she will never be capable of."Plaintiffs conclude that Paige's permanent injury precludes certain jobs and no less than 10 percent of the job market.

Future lost earning capacity is not a precise science to render specific calculation. Imprecision is compounded in that Paige is five years old with no work history. There is no meaningful dispute that Paige suffered a permanent injury which she will carry through adulthood. The issue is not whether Paige will work. The issue is how and the extent to which her injury will impact her earning capacity. The parties' experts agree that Paige is foreclosed from no less than 10 percent of otherwise available work. That she would unlikely pursue the foreclosed jobs is a factor but not dispositive of the future earning capacity issue. Plaintiffs have raised a factual issue that Paige's future earning capacity is impaired. Their burden at trial is to prove the extent to entitle Paige to potential recovery for lost future earning capacity. Based on the evidence presented, this Court is not in a position at this point to foreclose Paige's future earning capacity claim.

Impairment Rating

The Government attributes plaintiffs to pursue $1 million lost earning capacity claim based on an "impairment rating" prepared by plaintiffs' life care planning expert Dr. Willingham. The Government attributes plaintiffs' economist to have multiplied the "whole body impairment rating" for Paige's shoulder injury by the number of years of her productive work life to render use of the impairment rating improper or unreliable.

Plaintiffs accuse the Government of mispresenting the "evidence on this issue" in that plaintiffs' economist testified that Paige's 10 percent impairment translated to a future lost earning capacity of $130,000-$280,000.

The Government contends that plaintiffs are unable to rely on a whole body impairment rating to support future lost earnings because:

> 1. There is a difference between physical impairment medically and impairment that affects ability to earn;
>
> 2. Plaintiffs' life care expert Dr. Willingham drafted the impairment rating and acknowledges that it is not intended to reflect specific claimed lost earning capacity;
>
> 3. The impairment rating's accuracy has not been confirmed given that it is based on an examination of Paige 2½ years ago;
>
> 4. Impairment ratings are used for workers' compensation for employed persons, not minors with no work history; and
>
> 5. California courts exclude workers' compensation information in civil cases.

The Government concludes that the impairment rating "cannot form the basis for a determination that it is reasonably certain that Paige will sustain any lost earnings."

***12** The Government characterizes impairment ratings as "merely tools used for determining workers compensation benefits" which cannot be used in a civil action to evidence lost earning capacity. The Government points to *Scalice v. Performance Cleaning Systems,* 50 Cal.App.4th 221,231-232, 57 Cal.Rptr.2d 711 (1996), where the California Court of Appeal explained:

> The difference in workers' compensation benefits and the economic damages ... stems from the fundamentally different nature of the workers' compensation system and the tort law system. The foundation of the workers' compensation system is the presumed compensation bargain, wherein the employer assumes liability for industrial injury or death without regard to fault and the employee is afforded relatively quick payment of benefits....
>
> ... Although some items of workers' compensation benefits resemble economic damages, others do not. The system is a substitute for bringing an action against an employer, and the benefits paid are akin to a compromise payment made to avoid litigation. Therefore, rather than attempting to fit the different components of worker's compensation benefits into specified items of out-of-pocket or more subjective losses, we view the benefits as the proceeds of a settlement imposed by the Legislature for claims arising out of and occurring in the course of employment.

See also Clemente v. State of California, 40 Cal.3d 202, 222, 219 Cal.Rptr. 445, 707 P.2d 818 (1985) ("courts have recognized the legal fiction of the 100 percent disability rating").

Plaintiffs do not meaningfully respond to the Government's impairment rating contentions. As such, this Court presumes plaintiffs do not rely on an impairment rating to oppose summary adjudication. In any event, this Court does not deny the Government summary adjudication on the future earning capacity claim based on plaintiffs' proposed impairment rating.

Past Medical Expenses

Plaintiffs' complaint alleges claims for past "medical, health care, and attendant care expenses."The Government contends such damages claims are barred based on plaintiffs' failure to disclose evidence on computation of such damages and supporting documents. The Government appears to focus on F.R.Civ.P. 26(a)(1)(C)'s requirement to provide damages computations with initial disclosures and plaintiffs' failure to produce such computations and documents to reflect past medical expenses in response to the Government's document requests. The Government notes that Lt. Col. Silong and Ms. Silong did not produce at their May 2007 depositions records of past medical expenses despite the Government's requests for the documents. The Government points to Lt. Col. Silong and Ms. Silong's deposition testimony that they paid out-of-pocket medical expenses and have records of expenses for which they have not searched.

"The power of the trial court to exclude exhibits and witnesses not disclosed in compliance with discovery and pretrial orders is essential" to judicial case management. *Sylla-Sawdon,* 47 F.3d at 284; *Admiral Theatre Corp. v. Douglas Theatre Co.,* 585 F.2d 877, 897-898 (8th Cir.1978). A party is prejudiced by its opponent's actions to impair ability to proceed to trial or to threaten to interfere with the case's rightful decision. *Adriana Int'l Corp. v. Thoeren,* 913 F.2d 1406, 1412 (9th Cir.1990); *Malone v. United States Postal Service,* 833 F.2d 128,131 (9th Cir.1987), *cert. denied sum nom Malone v. Frank,* 488 U.S. 819, 109 S.Ct. 59, 102 L.Ed.2d 37 (1988).

***13** F.R.Civ.P. 26(e)(2) addresses supplementation of

discovery responses and provides:

> A party is under a duty seasonably to amend a prior response to an interrogatory, request for production, or request for admission if the party learns that the response is in some material aspect incomplete or incorrect and if the additional or corrective information has not otherwise been made known to the other parties during the discovery process or in writing.

F.R.Civ.P. 26(g)(2) addresses the significance of an attorney's signature to discovery responses: "The signature of the attorney ... constitutes a certification that to the best of the signer's knowledge, information, and belief, formed after a reasonable inquiry, the ... response ... is: (A) consistent with these rules ..." Under F.R.Civ.P. 26(g)(3), sanctions may be imposed for an improper certification: "If without substantial justification a certification is made in violation of the rule, the court, upon motion or upon its own initiative, shall impose upon the person who made the certification, the party on whose behalf the ... response ... is made, or both, an appropriate sanction ..." Such sanction may preclude the violating party form introducing designated evidence. F.R.Civ.P. 37(b)(2)(B).

In *National Hockey League v. Metropolitan Hockey Club, Inc.*, 427 U.S. 639, 643, 96 S.Ct. 2778, 49 L.Ed.2d 747 (1976), the United States Supreme Court stressed that the most severe sanctions provided by the rules "must be available to the district court in appropriate cases, not merely to penalize those whose conduct may be deemed to warrant such a sanction, but to deter those who might be tempted to such conduct in the absence of such a deterrent."

Lt. Col. Silong and Ms. Silong note that they incurred "a small amount of out of pocket expenses" for Paige's injury but "could not quantify the amount and could not document what those amounts were."Plaintiffs note that TRICare[1] has covered Paige's past medical expenses. As such, plaintiffs note they "will not submit past medical expenses and out of pocket expenses as elements of damages at the time of trial and agree with their preclusion at trial."

Plaintiffs apparently fold on their claim for past medical expenses in that they agree not to present evidence on such expenses. In the absence of a dispute over past medical expenses, the Government is entitled to summary adjudication on plaintiffs' claim for past medical expenses.

Future Medical Expenses Offset

The Government asserts an affirmative defense of "offset for any and all collateral sources of indemnity to Plaintiffs."The Government seeks summary adjudication that it is entitled to an offset for Paige's future medical expenses because the Government will continue to fund the expenses under existing federal TRICare benefits until Paige reaches age 21, or age 23, if she attends college. The Government characterizes an award of future medical expenses as a windfall to plaintiffs in that the Government continues to pay for such expenses.

***14** The Government points to California Civil Code section 3333.1(a) ("section 3333.1(a)"), which provides in pertinent part:

> In the event the defendant so elects, in an action for personal injury against a health care provider based upon professional negligence, he may introduce evidence of any amount payable as a benefit to the plaintiff as a result of the personal injury pursuant to ... any health, sickness or income-disability insurance, accident insurance that provides health benefits or income-disability coverage, and any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or other health care services. Where the defendant elects to introduce such evidence, the plaintiff may introduce evidence of any amount which the plaintiff has paid or contributed to secure his right to any insurance benefits concerning which the defendant has introduced evidence.

In *Fein v. Permanente Medical Group*, 38 Cal.3d 137, 164-165, 211 Cal.Rptr. 368, 695 P.2d 665 (1985), the California Supreme Court explained application of California Civil Code section 3333.1(a):

> Under section 3333.1, subdivision (a), a medical malpractice defendant is permitted to introduce evidence of such collateral source benefits received by or payable to the plaintiff; when a defendant chooses to introduce such evidence, the plaintiff may introduce evidence of the amounts he has paid-in insurance premiums, for example-to secure the benefits. Although section 3333.1, subdivision (a)-as ultimately adopted-does not specify how the jury should use such evidence, the Legislature apparently assumed that in most cases the jury would set plaintiff's damages at a lower level because of its awareness of plaintiff's "net" collateral source benefits.

"Apparently, the Legislature's assumption was that the trier of fact would take the plaintiff's receipt of such benefits into account by reducing damages."*Barme v. Wood,* 37 Cal.3d 174, 179, 207 Cal.Rptr. 816, 689 P.2d 446 (1984).

In connection with an FTCA case, one district court has observed:

> In sum, the weight of authority clearly demonstrates that plaintiff is not entitled to recover any medical expenses already paid by the government. To award her such expenses would require the government to pay for the same services twice and allow the plaintiff a double recovery. The Federal Tort Claims Act is designed to compensate those wronged by the U.S. government in tort actions; it is not a reward system designed to provide windfalls to tort claimants.

Kornegay v. United States, 929 F.Supp. 219, 222 (E.D.Va.1996).

Plaintiffs argue that the Government has failed to offer evidence to support a "complete future offset." Plaintiffs argue that TRICare payment of past medical expenses does not entitle the Government to a blanket offset.Section 3333.1(a) does not preclude recovery of future medical expenses but "rather, it allows the jury to decide how to apply the evidence in calculation of damages. As such, the fact that all medical expenses may have been paid from a collateral source ... does not stand for the proposition that a plaintiff has suffered no recoverable damages ..."*Hernandez v. California Hospital Medical Center,* 78 Cal.App.4th 498, 505, 93 Cal.Rptr.2d 97(2000).

***15** Plaintiffs contend that the Government is not entitled to an offset because the Government's future medical insurance benefits expert, Tess Wolstenholme ("Ms.Wolstenholme"), lacks expertise on TRICare coverage[4] for Paige's future medical care. Ms. Wolstenholme is a health benefits advisor and beneficiary assistance counseling coordinator at Lemoore Naval Air Station and is responsible to coordinate insurance coverage for military personnel and their dependents. Plaintiffs argue that the Government cannot meet its summary adjudication burden in the absence of competent expert testimony on TRICare coverage for Paige's future medical care.

Plaintiffs point to F.R.Evid. 702, which provides:

> If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training or education, may testify thereto in the form of an opinion or otherwise, if (1) the testimony is based upon sufficient facts or data, (2) the testimony is the product of reliable principles and methods, and (3) the witness has applied the principles and methods of reliability to the facts of the case.

Plaintiff further point to *Kumho Tire Co., Ltd. v. Carmichael,* 526 U.S. 137, 141-142, 119 S.Ct. 1167, 143 L.Ed.2d 238 (1999), where the United States Supreme Court explained:

> We conclude that *Daubert*'s[5] general holding-setting forth the trial judge's general "gatekeeping" obligation-applies not only to testimony based on "scientific" knowledge, but also to testimony based on "technical" and "other specialized" knowledge. *See*Fed. Rule Evid. 702. We also conclude that a trial court may

> consider one or more of the more specific factors that Daubert mentioned when doing so will help determine that testimony's reliability. But, as the Court stated in Daubert, the test of reliability is "flexible," and Daubert's list of specific factors neither necessarily nor exclusively applies to all experts or in every case. Rather, the law grants a district court the same broad latitude when it decides how to determine reliability as it enjoys in respect to its ultimate reliability determination.

Plaintiffs point out that the Government relies on Ms. Wolstenholme to provide technical or other specialized knowledge but that her deposition testimony reveals "that her opinion substantially fails to meet the reliability test required for admission pursuant to F.R.E. 702 and *Kumho Tire.*"F.R.Evid. 702 establishes a standard of evidentiary reliability and requires a valid connection to the pertinent inquiry as a precondition to admissibility. *Kumho Tire,* 526 U.S. at 149, 119 S.Ct. 1167, 143 L.Ed.2d 238.Plaintiffs characterize the pertinent inquiry as whether "TRICare insurance will provide future coverage, if any, for Paige Silong's medical needs. Thus, the Court must determine whether Ms. Wolstenholme's testimony has a 'reliable basis in knowledge and experience of the discipline.' "

***16** Plaintiffs argue that Ms. Wolstenholme lacks requisite experience, training, education or specialized knowledge to provide reliable expert opinion on future TRICare coverage. Plaintiffs point to Ms. Wolstenholme's:

> 1. *Educational Background*-a two-year associates degree in office management from West Hills College;
>
> 2. *Current Work Experience*-"health benefits advisor" for two years during which she has acted as a liaison between military family members and TRICare personnel who have qualifications and authority to make TRICare coverage decisions. Ms. Wolstenholme lacks responsibility to approve or deny TRICare coverage and admitted that she is unqualified to offer an opinion about what is medically necessary for TRICare coverage approval;
>
> 3. *Past Work Experience*-secretarial, clerk and personal assistant; and
>
> 4. *Lack of Specialized Training*-No professional or specialized training on TRICare coverage or insurance coverage.

Plaintiffs further note that Ms. Wolstenholme conceded that she has not reviewed Paige's medical history to acknowledge that Ms. Wolstenholme is unfamiliar with Paige's past and future medical needs. Ms. Wolstenholme has not determined what Paige's future medical needs will be.

To address Ms. Wolstenholme's qualifications, the Government submits her declaration that she received "extensive informal and on-the-job training" on TRICare coverage and devotes 50 percent of her time to explain TRICare benefits to military families and 35 percent of her time to "working with the health care providers, case managers, TriCare representatives, families, and others regarding submittals, responding to questions, monitoring paperwork and requested activities, and to ensure that claims are properly submitted and paid and that medically necessary treatment is approved and received."Ms. Wolstenholme notes that prior to her deposition, she compiled information on Paige, including "requests for treatment, referrals and care, and all TriCare responses including dates of the response, whether it was approved or disapproved, and, if disapproved, the reason why." Ms. Wolstenholme concludes:

> My duties and responsibilities as a Health Care Advisor require me to know the terms and conditions of TriCare coverage, eligibility issues, what is and is not covered, the process for submittals and approvals, the transition from active military to retire, and everything health benefits related. As such, I am capable of offering qualified, reliable and relevant testimony about Silong's TriCare coverage at trial.

The Government further points to Ms. Wolstenholme's testimony that TRICare will cover Paige's "medically necessary" expenses. The Government asserts that questions as to Ms. Wolstenholme's qualifications go to the weight of her testimony, not its admissibility. In addition to Ms. Wolstenholme, the Government notes that it "relies on multiple sources to prove offsets including, without limitation, Plaintiffs' admissions, documentary evidence, confirmed payment of all past medical expenses, ongoing coverage, terms of future coverage if Lt. Col. Silong retires, and the deposition testimony of Lt. Com. Yoakley, Dr. Nath, and others."

***17** State and federal law provide the Government legal grounds to seek an offset. In other words, as a matter of law, the Government may seek an offset. The question

turns to evidence to support the offset. Plaintiffs take the position that the Government lacks competent offset evidence based on Ms. Wolstenholme's lack of qualifications. The evidence raises a question as to Ms. Wolstenholme's qualifications to opine on future TRICare coverage and the weight to give to her opinions. Ms. Wolstenholme is a two-year health benefits advisor and apparently not employed by TRICare. The Government claims it will produce evidence in addition to Ms. Wolstenholme but fails to detail such evidence. The parties do not identify specific future care for Paige. At this stage, this Court is left to examine the offset question in a vacuum in that if Ms. Wolstenholme is the Government's primary source of TRICare coverage opinion (and the Government has given this Court no meaningful grounds to believe otherwise), the Government lacks sufficient evidence for summary adjudication on the offset issue. With a factual dispute as to the competency of the Government's TRICare coverage evidence, the Government has not satisfied its summary adjudication burden regarding offset.

Moreover, this Court is unclear as to what the Government seeks. The Government notes that TRICare will provide medical benefits until Paige reaches age 21 or 23, if she attends college. The Government appears to seek a blanket offset for all of Paige's future medical expenses without consideration that she may not receive TRICare coverage after she reaches age 21 or 23. Such factor further prevents summary adjudication for the Government.

More fundamentally, as noted by plaintiffs, section 3333.1(a) does not preclude plaintiffs' recovery of future medical expenses. It allows this Court, as trier of fact, to determine how to apply future TRICare benefits to damages calculation. TRICare coverage for Paige's future medical expenses does not vitiate plaintiffs' claims for recoverable damages. TRICare coverage is a factor for this Court to consider.

As an alternative to an offset, the Government advocates establishment of a "trust" for future medical expenses under California Code of Civil Procedure section 667.7(a), which provides in pertinent part:

> In any action for injury or damages against a provider of health care services, a superior court shall, at the request of either party, enter a judgment ordering that money damages or its equivalent for future damages of the judgment creditor be paid in whole or in part by periodic payments rather than by a lump-sum payment if the award equals or exceeds fifty thousand dollars ($50,000) in future damages. In entering a judgment ordering the payment of future damages by periodic payments, the court shall make a specific finding as to the dollar amount of periodic payments which will compensate the judgment creditor for such future damages.

***18** California Code of Civil Procedure section 667.7 does not specify establishment of a trust. It provides for periodic payments of future medical expenses exceeding $50,000. Determination of the mechanism of future medical expenses is premature at this time.

Lastly, this Court clarifies that it is not ruling on plaintiffs' belated motion to exclude Ms. Wolstenholme's testimony. Since the Court addresses the Government's summary adjudication motion, trial exclusion of Ms. Wolstenholme's testimony is not before the Court and is an issue for another day. Furthermore, based on the above rulings, Lt. Col. Silong's sole remaining claim, if any, appears limited to Paige's future medical expenses which he may incur prior to Paige turning age 18, at which point Paige will be legally responsible for such expenses. This Court is unclear if Lt. Col. Silong pursues such a claim and requires Lt. Col. Silong to inform this Court in writing what, if any, damages claims Lt. Col. Silong pursues. If Lt. Col. Silong pursues no damages claims arising from Paige's medical care, this Court intends to dismiss him as a plaintiff.

CONCLUSION AND ORDER

For the reasons discussed below, this Court:

1. GRANTS the Government summary adjudication on Lt. Col. Silong and Ms. Silong's loss of consortium claims;

2. BARS Lt. Col. Silong and Ms. Silong to seek emotional distress damages;

3. BARS Lt. Col. Silong to pursue a bystander victim claim;

4. DENIES the Government summary adjudication on Paige's future lost earning capacity claim;

5. GRANTS the Government summary adjudication on plaintiffs' past medical expenses claim;

6. DENIES the Government summary adjudication that TRICare benefits offset Paige's future medical expenses in their entirety; and

7. ORDERS Lt. Col. Silong, no later than September 14, 2007, to file and serve his statement to identify what, if any, damages claims he pursues in light of this Court's rulings.

IT IS SO ORDERED.

All Citations

Not Reported in F.Supp.2d, 2007 WL 2580543, 69 Fed.R.Serv.3d 648

Footnotes

1 As will be discussed in greater detail below, the Government contends that Paige's future medical expenses will be covered by insurance until age 23, if she attends college as expected.

2 This Court carefully reviewed and considered all arguments, points and authorities, declarations, depositions, exhibits, statements of undisputed facts and responses thereto, objections and other papers filed by the parties. Omission of reference to an argument, document, paper or objection is not to be construed to the effect that this Court did not consider the argument, document, paper or objection. This Court thoroughly reviewed and considered the evidence it deemed admissible, material and appropriate for summary adjudication.

3 TRICare is the Department of Defense's worldwide health care program for active duty and retired service personnel and their families.

4 Plaintiffs filed a belated summary adjudication motion on the offset issue. Plaintiffs combined the summary adjudication motion with a motion to exclude Ms. Wolstenholme's testimony. This Court construes the combined motions as an opposition to the Government's summary adjudication motion on the offset issue.

5 *Daubert v. Merrell Dow Pharms., Inc.*, 509 U.S. 579, 113 S.Ct. 2786, 125 L.Ed.2d 469 (1993).

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United States District Court,
N.D. California.

Nikki POOSHS, Plaintiff,
v.
PHILLIP MORRIS USA, INC., et al., Defendants.

No. C 04–1221 PJH. | May 22, 2013.

Attorneys and Law Firms

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ORDER RE PRESENTATION OF MEDICAL EXPENSE DAMAGES

PHYLLIS J. HAMILTON, District Judge.

***1** On February 15, 2013, the court issued the Second Final Pretrial Order, which instructed the parties that evidence of past medical expenses "will be presented to the jury in accordance with *Howell v. Hamilton Meats & Provisions, Inc.*, 52 Cal.4th 541, 129 Cal.Rptr.3d 325, 257 P.3d 1130 (2011)." With regard to the reasonable value of future medical expenses, the court directed the parties to meet and confer regarding a procedure for presenting the evidence to the jury, and to submit either a stipulation, or two separate proposals. The parties did meet and confer, but were unable to reach any agreement, and thus each side presented a separate proposal, on April 17, 2013.

California's collateral source rule provides that in determining tort damages, "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. Souther Cal. Rapid Transit Dist.*, 2 Cal.3d 1, 6, 84 Cal.Rptr. 173, 465 P.2d 61 (1970). That is, a plaintiff's damage award may not be reduced to account for compensation the plaintiff received from sources independent of the tortfeasor as to amounts the plaintiff would otherwise collect from the tortfeasor. *Howell*, 52 Cal.4th at 548, 129 Cal.Rptr.3d 325, 257 P.3d 1130.

Thus, an injured plaintiff whose medical expenses are paid through private insurance may recover as economic damages no more than the amounts paid by the plaintiff or his or her insurer for the medical services received or still owing at the time of trial." *Id.* at 566, 129 Cal.Rptr.3d 325, 257 P.3d 1130.

> [W]hen a medical care provider has, by agreement with the plaintiff's private health care provider, accepted as full payment for the plaintiff's care an amount less than the provider's full bill, evidence of that amount is relevant to prove the plaintiff's damages for past medical expenses and, assuming it satisfies other rules of evidence, is admissible at trial.... Where 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.

Id. at 567, 129 Cal.Rptr.3d 325, 257 P.3d 1130. The *Howell* rule also applies when the medical payments are paid by Medicare (as opposed to private insurance).*See Luttrell v. Island Pacific Supermarkets, Inc.*, 215 Cal.App.4th 196, 205–08, 155 Cal.Rptr.3d 273 (2013).

Accordingly, in this case, while the February 15th order referred to evidence of past medical expenses presented "in accordance with *Howell,*" the clear intent of the order

was that the jury would be presented only with evidence of amounts actually paid (not the total amounts billed). Under *Howell,* amounts billed are irrelevant to past expenses because they greatly exceed the amounts plaintiff's medical providers accepted as payment in full. *See id.,* 52 Cal.4th at 567, 129 Cal.Rptr.3d 325, 257 P.3d 1130. Since plaintiff cannot recover the full amounts billed, evidence of those amounts is irrelevant.

It was because the court in *Howell* specifically did not address the relevancy or admissibility of evidence of the full billed amount with regard to future medical expenses (or, for that matter, on non-economic damages), that the parties were ordered to meet and confer with regard to how to handle presentation of evidence of future expenses. However, on April 30, 2013, after the parties had submitted their separate proposals, the California Court of Appeal issued the decision in *Corenbaum v. Lampkin,* — Cal.Rptr.3d ——, 2013 WL 1801996 (Apr. 30, 2013).

***2** In *Corenbaum,* the court first noted that under *Howell,* the full amount billed for the plaintiffs' medical care was not admissible for purposes of determining their damages for past medical expenses, where the medical providers had accepted lesser amounts as full payment pursuant to prior agreements with the insurers. *Id.,* 156 Cal.Rptr.3d 347, 2013 WL 1801996 at *8–9.

The court then addressed the question whether the *Howell* rule applies to damages for future medical expenses, and held that it does. The plaintiffs argued (as plaintiff does here) that the full amount billed for past medical expenses was relevant to the reasonable value of the medical expenses that the plaintiffs were reasonably certain to require in the future. The court noted that this argument "necessarily assumes that the full amount billed for past medical services is relevant to the value of those past medical services," an assumption that the court found was negated and precluded by *Howell. Id.* at *9, 129 Cal.Rptr.3d 325, 257 P.3d 1130.

Because the full amount billed is, under *Howell,* not relevant to the value of past medical services, the Court of Appeal reasoned that the full amount billed for past medical services cannot be relevant to the value of future medical services. *Id.* Thus, the court concluded, evidence of the full amount billed for past medical services cannot support an expert opinion on the reasonable value of future medical services, and, in addition, such evidence is not relevant to the amount of non-economic damages. *Id.* at *10, 129 Cal.Rptr.3d 325, 257 P.3d 1130.

Here, the parties' disagreement centers on whether medical bills themselves are admissible after *Howell,* which held that a plaintiff is entitled to recover only amounts actually paid. Plaintiff believes that bills remain relevant to past medical expenses, future medical expenses, and non-economic damages. Defendants, on the other hand, contend that the actual bills for medical services (which necessarily can only be for past medical services) are irrelevant and inadmissible.

With regard to past medical expenses, the court has already ruled that evidence of past medical expenses will be presented to the jury in accordance with *Howell* rule, which does not permit the introduction of evidence of total amounts billed when a medical provider has, by agreement with an insurer, accepted as full payment for the plaintiff's care an amount less than the provider's full bill. Accordingly, it is the order of the court that the parties shall stipulate to the amounts paid for past medical expenses.

With regard to future medical expenses and noneconomic damages, while the court in *Howell* "express[ed] no opinion" as to the relevance or admissibility of past medical bills, *see Howell,* 52 Cal.4th at 567, 129 Cal.Rptr.3d 325, 257 P.3d 1130, under *Corenbaum,* evidence of total amounts billed is not relevant to the value of future medical expenses or to noneconomic damages.

As plaintiff has not presented any proposal with regard to the presentation of future medical expenses, other than having plaintiff "introduce the bills directly," after which her expert, Dr. Horn, "will opine as to the reasonable value" of her future medical costs, it is not clear to the court how plaintiff intends to present evidence of future medical expenses to the jury at all, much less in light of *Corenbaum* and the court's ruling herein that past medical bills will not be admitted. Similarly, while plaintiff claims that past medical bills are relevant to noneconomic damages, her proposal fails to address any evidence of noneconomic damages apart from past medical bills, which may not be presented to the jury.

***3 IT IS SO ORDERED.**

All Citations

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United States District Court,
S.D. California.

Tak ASANUMA, Plaintiff,
v.
UNITED STATES of America; and Annette Vaipulu; and Does 1–100, Defendants.

Civil Case No. 12cv0908 AJB (WMC). | Signed March 28, 2014.

Attorneys and Law Firms

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Steve B. Chu, US Attorney's Office, San Diego, CA, for Defendants.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

ANTHONY J. BATTAGLIA, District Judge.

I.

The Action

***1** This is a negligence action under the Federal Tort Claims Act for the personal injuries suffered by Plaintiff Tak Asanuma on May 5, 2010. Plaintiff Tak Asanuma suffered injuries after he was involved in a collision while riding a bicycle. The pleadings which raise the issues are (1) Plaintiff's First Amended Complaint (ECF No. 7), and (2) Defendant's Answer (ECF No. 8).

II.

Jurisdiction and Venue

Federal jurisdiction is invoked under 28 U.S.C. § 1346(b)(1). Venue is proper because all conduct giving rise to the claims alleged in the complaint occurred in San Diego County.

III.

The Proceedings

Prior to trial, the Court excluded the proffered testimony of Dr. Lobatz on the issue of Plaintiff's comparative negligence due to his failure to wear a bicycle helmet at the time of the accident. The Court ruled, as better reflected in the transcript of the proceedings, that the testimony was excludable under Rule 702 and *Daubert* requirements. The testimony would have been unsupported by any accident reconstruction or details about the angles of impact, the force of impact, and the integrity of plaintiff's helmet, among other things.

The case proceeded to trial on February 24, 2014 and concluded on March 3, 2014. The issues tried were set out in the Final Pretrial Order in this case. (ECF No. 25). Following the trial, and upon review of the testimony and documentary evidence, the agreed facts, the arguments of counsel, and the relevant legal authorities, the Court now makes the following findings based on the credible evidence and their reasonable inferences to be drawn therefrom. These findings were made based upon a preponderance of the credible evidence. Causation was determined using the "substantial factor test" under California Law. *See, Mitchell v. Gonzales,* 54 Cal.3d 1041, 1 Cal.Rptr.2d 913, 819 P.2d 872 (Cal.1991); Restatement (Second) of Torts § 431. "A substantial factor in causing harm is a factor that a reasonable person would consider to have contributed to the harm."CACI 430.

Any finding of fact which is more appropriately a conclusion of law is to be deemed as such.

IV.

Findings of Fact

The following facts were admitted by the parties and are adopted by the Court as findings of fact.[1]

1. On May 5, 2010 Plaintiff Tak Asanuma was riding his bicycle on the 2100 block of Abbott Street in the City of San Diego, California.

2. Plaintiff was not wearing a bicycle helmet during this time.

3. Annette Vaipulu was a federal employee, as she was employed as a Census Bureau Crew Leader at this time by the United States.

4. Ms. Vaipulu was sitting inside a 1992 Toyota 4Runner that was parked on Abbot Street when she opened the driver's side rear door. Immediately thereafter Plaintiff collided with the open door. Plaintiff hit his head and suffered trauma.

5. Plaintiff was taken to UCSD medical center for treatment for his injuries.

6. Plaintiff had severe spinal stenosis and spondylosis prior to the accident of May 5, 2010.

***2** 7. Plaintiff had psychiatric issues which included bipolar disorder from an early age, prior to the May 5, 2010 accident.

8. Plaintiff has had frequent treatment from May 5, 2010 through the present time for injuries to several areas, including to his head, neck and back.

9. Plaintiff underwent surgery on his neck, a laminectomy, to treat his cervical stenosis on October 18, 2012.

10. Plaintiff was unemployed at the time of the accident, and had not been employed since prior to 2000.

11. Plaintiff was receiving Social Security Disability ("SSD") benefits at the time of the accident as a result of his psychiatric issues. Included in his SSD benefits was Medicare coverage for medical treatment.

12. According to Medicare records, the medical expenses paid to date by Medicare for Plaintiff's medical treatment is $30,959.16.

13. According to Medicare records, the amount paid for Plaintiff's surgery of October 18, 2012 was $9,554.33.

The Court further finds based on a preponderance of the credible evidence, the following:

14. Defendant, by and through its employee, Annette Vaipulu, was negligent in opening her car door and causing a collision with Plaintiff.

15. Plaintiff suffered injuries in the accident including: an intracranial hemorrhage, a fracture of the temporal bone, a fracture of the zygomatic arch, an inner ear injury with associated mild to moderate hearing loss, a sprain to the cervical spine, and a reactive/situational depression associated with these injuries. Plaintiff also suffered post traumatic headaches and dizziness.

16. Plaintiff did not suffer an occipital condyle fracture (alar ligament avulsion fracture) as a result of the accident.

17. Prior to the May 5, 2010 accident, Plaintiff suffered from spinal stenosis and spondylosis, which was being medically cared for through the University of California, San Diego ("UCSD") health system.

18. The progression of the Plaintiff's underlying spinal stenosis and spondylosis ultimately required a C3–C7 laminectomy to relieve spinal cord compression.

19. The May 5, 2010 accident, did not contribute, as a substantial factor to the cause of or need for the C3–C7 laminectomy.

20. Plaintiff would have required surgery to treat his spinal stenosis and spondylosis at some point, even if the May 5, 2010 accident had not occurred.

21. Plaintiff will require a fusion surgery for his neck at some unknown time in the future.

22. The need for a future fusion surgery is not caused by the accident in question.

23. The May 5, 2010 accident did not aggravate plaintiff's pre-existing bipolar disorder.

24. The May 5, 2010 accident, did cause plaintiff to suffer post traumatic reactive/situational depression as a result to the physical injuries suffered. This depression was significant during the eighteen months of vertigo, but following the resolution of the vertigo, any situational depression currently is accounted for on physical limitations not caused by

the accident.

*3 25. Plaintiff has been found totally disabled since 2000 by the Social Security Administration as a result of his psychiatric issues.

26. Plaintiff did not establish a reasonable probability that he would have returned to any type of work or gainful employment but for the accident. To the contrary, the evidence supports a finding that it would have been improbable for him to return to work based on his ten (10) year psychiatric disability. Other than vague testimony of a future goal, no details, plans, or prospects were described. As a result, no loss of employment, loss of earning capacity, or loss of future financial gain has been established.

27. No evidence was presented for the costs of future care related to the reactive/situational depression which has been subsumed in the ongoing care for his bipolar disorder.

IV.

Conclusions of Law

1. Defendant's employee, breached the ordinary duty of care, when she opened her car door into the oncoming path of Plaintiff; as a result, this negligence caused a collision and resultant injuries and damages to Plaintiff.

2. Plaintiff was not comparatively negligent in causing the accident and resultant injuries.

3. Plaintiff's damages are assessed at $21,404.53[2] for medical expenses to date.

4. Plaintiff failed to establish the cost of any future medical expenses for the injuries caused by the subject accident.

5. Plaintiff failed to establish any loss of income, earning capacity or prospective economic gain, and damages therefore.

6. The reasonable value of non-economic loss for pain and suffering to date is $250,000.

7. The reasonable value of future non-economic loss for pain and suffering to date is $100,000.

8. Plaintiff is entitled to a judgment against Defendant in the total amount of $371,404.53.

V.

Discussion

The accident of May 10, 2010 was caused by Defendant's employee opening her rear driver side door into on coming traffic, which resulted in a collision with Plaintiff who was riding his bicycle along Abbott Street, in Ocean Beach on that date. The Court finds that Defendant's employee was negligent for the subject collision. Upon impact with the vehicle door, Plaintiff crashed to the ground, striking his head. No evidence was admitted with regard to the forces of impact between Plaintiff and the ground.

Following the incident, Plaintiff was diagnosed, at UCSD Hospital, with having suffered a blunt head trauma and resulting right temporal fracture, a fracture of the zygomatic arch, an intracranial hemorrhage, with blood in the inner ear, a sensorineural hearing impairment, and trauma to the neck. A questionable alar ligament avulsion fracture was seen on diagnostic studies.

Plaintiff was treated conservatively following the accident. Ultimately, in October of 2012, Plaintiff had a laminectomy at the C3–C7 levels of his cervical spine to relieve the symptoms of cervical spinal cord compression. His psychological symptoms of depression worsened from his pre-existing state and ongoing psychological care was provided in conjunction with the care provided for his preaccident depression and bipolar personality disorder. The blunt trauma to the head and resulting traumatic brain injury resulted in symptoms including vertigo, daily headaches, dizziness and balance problems.

*4 There is no question that the closed head injury with the skull fracture, facial fracture and inner ear injury were caused by the accident. The attendant vertigo was also caused by the accident. The vertigo was destabilizing to Plaintiff's ability to function and took approximately eighteen (18) months to resolve. There is also no question that Plaintiff suffered a post accident depression associated with his injuries and reduced functions. This is distinguished from an exacerbation from a preexisting bipolar depression that plaintiff suffered from historically. This distinction will be discussed in more detail below.

The nature and extent of the injury to the cervical spine and the required care, including surgery, was the subject of competing testimony. The same can be said of the psychological injuries with psychiatric experts holding different views on the extent to which the pre-existing psychological state was exacerbated and for how long.

Plaintiff had a well documented pre-existing cervical spondylosis and chronic radiculopathy that was under doctor's care in the months before the accident. Dr. Weinstein found that a decompression of the cervical spine was warranted if the presence of myelopathy (injury to the spinal cord) were presented. Plaintiff's symptoms emanating from the cervical spine were considered radicular (emanating from a nerve root compression). Plaintiff also suffered from a bipolar psychological condition with associated depression, for ten (10) years or more that was managed by treating psychiatrists.

The Court concludes that Plaintiff had severe arthritis in his neck, with stenosis of the spinal canal that was producing symptoms due to cord compression. While these symptoms were considered to be radicular, and not a product of spinal cord compression, the testimony of the spine specialists makes it clear that the symptoms of spinal stenosis (myelopathy) will mimic or imitate nerve root compression. A careful review of Plaintiff's total medical history, except for a period of increased pain post accident, shows his condition was not otherwise exacerbated. Indeed, the evidence contraindicates a spinal column injury at the time of the accident.

To draw this conclusion, the Court carefully analyzed the medical records for the thirteen (13) years provided by counsel, (ten (10) years pre accident and three (3) years post accident). What is surprisingly lacking is any current medical assessment of Plaintiff's symptomology. Only the testimony of Plaintiff related his current status medically. The last medical reviews occurred in early 2013.

The record is clear that in early 2010 Plaintiff was suffering from symptoms associated with his spinal stenosis. The symptoms were radicular for the most part, indicating nerve root compression, and likely myelopathy (injury to the spinal chord). Over the years, low back pain and radicular pain into the buttocks was also noted. Multiple sites of radiculopathy would be suggestive of myelopathy related to spinal cord compression.

***5** While Plaintiff had symptoms related to his cervical spine as early as 2003, the period from 2008 through 2010 are the most meaningful on this issue of causation

On January 22, 2008, Plaintiff reported a problem of neck/trapezious pain on the left with radiation to the left hand for the past three weeks. (J2–431.) Physical therapy was offered but declined in favor of home stretching. In a follow-up on March 21, 2008, Plaintiff reported continued discomfort to his neck and upper back. He complained of some numbness and tingling of the hands as well as lower back pain with some radiation to the buttocks. There were periodic visits throughout the remainder of 2008 and 2009 with these general symptoms with the addition of bilateral shoulder pain and discomfort. Several of these are notable as they illuminate the issues with regard to causation. On June 2, 2008, Dr. Rosas notes that Plaintiff continues to be quite active and is able to surf for about an hour without too much problem in a non-related knee issue. However, Plaintiff noted concern about some tingling to his left hand that had been present for at least three months. (J2–439.)

In a subsequent therapy visit on June 23, 2008, Plaintiff noted that he had been surfing "more actively–45 min.–1.5 hours-day, no pain while surfing, but starts afterwards."Pain was described as achy and sharp radiating to the upper neck and anterior shoulder. The doctor's note for that visit states, "pain exacerbated by surfing, lifting; nothing makes better."(J2–441)

In a November 20, 2008 note, Dr. Willard writes, "New complaint of left arm numbness: Has baseline numbness in thumbs and fingers 2–4, attributed to nerve impingement at neck. Recently noted extensive left arm numbness-from shoulder to fingers-lasting fifteen minutes to 1 hour, occurring while paddling (pt avid surfer)." (J2–463.) While complaints of left arm symptoms was not new at this point, this may be a qualitative statement.

By December 8, 2008, bilateral shoulder pain was the subject of evaluation. The pain was described as occurring mostly "after he surfs, which he does almost on a daily basis."(J2–469.) A pattern is develops, showing that while the surfing activity was therapeutic for his psychological condition, it forms a logical reason for upper extremity and cervical symptoms.

Cervical related symptoms became a particular focus again on January 7, 2010, when Plaintiff again complained of numbness in the left arm starting in his shoulders and radiating to the fingers. Plaintiff advised the doctor that he was surfing almost on a daily basis, but he "has been having trouble with some tingling and numbness in his left upper extremity associated with neck discomfort ."(J2–509–512.) The diagnosis of cervical radiculopathy was discussed and x-rays of the cervical

spine confirmed pre-existing degenerative joint disease with possible encroachment of the left C6 region. An MRI was ordered. The MRI results were discussed with Plaintiff on February 5, 2010. (J2–513–515.) A surgical consult was ordered with Dr. Rojas noting that the patient "has fairly severe spinal stenosis." Dr. Weingarten did the surgical consult on March 19, 2010. (J2–518). The doctor confirmed Plaintiff's reports of a two year history of neck pain, with mild paresthesias of the left shoulder once the shoulder paresthesias began, Plaintiff also reported numbness of the lateral arm and radial forearm, and also the complaint of right hand numbness, particularly in the first three digits. Dr. Weingarten noted that the MRI showed multi level changes in the cervical spine that would "warrant decompression in the presence of any evidence of myelopathy."The symptoms were accounted for as nerve root related, however, in hindsight, these were equally likely related to spinal cord compression that was demonstrated on the January 2010 MRI. Physical therapy was recommended at that point.

***6** The therapy note of April 19, 2010 (J2–523 to 525) records Plaintiff's subjective complaints of neck and bilateral radicular symptoms down into both arms, hands and fingers along with constant tingling in the fingers. The accident then followed.

Of particular note with regard to the accident, was the questionable condylar fracture. This factor was significant to Plaintiff's orthopaedic expert, Dr. Tontz, who felt it was evidence of severe injury to the cervical spine. However, the evidence preponderates in favor of finding that the artifact found on the MRI was not an avulsion fracture, but rather an osteophyte resulting from the severe degenerative arthritis in the spine. As the defense expert indicated, the image of the body in the spinal column lacked the physical presentation of an avulsion fracture (with a jagged edge) and an injury of that type would have produced immediate and severe neurologic deficit and pain. It did not.

In a note dated May 6, 2010, the day after the accident, Plaintiff was neurologically intact on exam. (J2–529.) When Dr. Santman evaluated Plaintiff on May 8, 2010, for chief complaint of neck pain, Plaintiff noted that the radicular symptoms felt at the time of the accident had resolved to now simply a sore sensation in the left deltoid. (J2–530.) No numbness or tingling were described with regard to either upper extremity, and there was no bowel or bladder dysfunction. Additionally there was no loss of dexterity or fine motor skills (*Id.*)None of these would be consistent with cord compression caused by a frank injury to the spinal column at the time of the accident, or any exacerbation of the underlying spinal cord stenosis. The x-rays reviewed by Dr. Santman confirmed the pre-existing severe spondylosis throughout the cervical spine including a spontaneous fusion of a few of facet joints posteriorly. The small fleck of bone, discussed earlier, was noted. The continuation of the use of a hard cervical collar was recommended and future flexion/extension xrays of the cervical spine were anticipated in the weeks ahead. (J2–531.)

Dr. Santman did a follow-up on June 19, 2010. (J2–546 to 548). The doctor reported no change in handwriting or fine motor abilities and no evidence of neurologic deficit was noted. Cervical flexion/extension x-rays ordered on May 21, 2010, showed no pathologic motion according to the Plaintiff's orthopaedic expert.

By August 11, 2010, the physical therapist reported that Plaintiff had returned to surfing, but dizziness was a factor. (J2–563.) In a physical therapy note of August 31, 2010, the Lhermite's sign was first recorded. This occurred with the onset of numbness in both upper extremities and trunk with flexing neck to look down. Some ligamentous instability of the cervical spine was also noted. (J2–567.)

Dr. Rojas next evaluated the patient on August 31, 2010, noting the numbness to the mid-abdomen associated with flexion of the neck, but otherwise stating that no numbness or weakness of the upper extremities occurs unless he does a forced flexion of the neck. (J2–569.) On September 1, 2010, Dr. Rojas reviewed new x-rays which noted a loss of the normal cervical lordosis, minimal anterolisthesis of the C2 and C3 which does not change with motion, and a mild C4 on C5 rethrolisthesis which does not change on motion. A mild retrolisthesis of C5 on C6 reduces with flexion.

***7** Plaintiff's medical treatment continued, all the while focused in large part on the symptoms associated with the inner ear injury and its resultant vertigo. By October 20, 2010, the therapist was reporting improvement in the trunk tingling symptoms (J2–587) and on November 3, 2010, (J2–596) Plaintiff was able to return to surfing for 30 to 40 minutes and was encouraged to "tolerate surfing 60 minutes" along with continuing other forms of therapy.

Plaintiff's treatment continued into 2011, and remained predominated by issues associated with dizziness. Throughout this time, Plaintiff was using a cervical traction device. An MRI of July 11, 2012 is reported in the record (J2–834) as showing a slight progression of the multi-level degenerative changes of the cervical spine. This is now 29 months post accident, and an assessment of cervical stenosis with myelopathy was made. This

results in the multi-level laminectomy that was later performed.

The overall assessment of these records reveal that the immediate impact of the accident caused some immediate but short lived increase of the cervical spine symptoms, and that Plaintiff's medical needs and symptoms were predominated by the head and inner ear injuries. For well over two yeas, Plaintiff received conservative care that did not suggest any immediate onset of frank neurologic symptoms warranting surgery. The Court concludes that, at best, soft tissue injuries to the cervical spine were sustained in the accident but the development of a significant degree of myelopothy in 2012 was the result of the advancing degenerative changes that have been a feature in plaintiff's medical status for almost thirteen (13) years at that point. The onset of the pre-accident neurologic signs and symptoms appears associated with the active increase in the amount of surfing plaintiff was involved in. Clearly, the neck flexion and extension required in that activity was symptom inducing. It is notable that during the active treatment phase from May to August 2010, cervical spine related symptoms were less a factor, but when the surfing regimen picked up, pain and paresthesias returned. At this point, the cervical spine appears to be back to its pre-accident condition. Though vulnerable, it was Plaintiff's active lifestyle acting upon his long standing chronic cervical spine disease that precipitated the need for surgical intervention.

While the medical care for the multi-disciplinary treatment through the UCSD system in the amount of $21,404.83 was reasonable, necessary and compensable to plaintiff, the costs of the surgery are not. Plaintiff is entitled to recover the former sum.

Without establishing that the cervical surgery was legally caused by the subject accident, the postoperative cervical instability and kyophosis of the cervical spine which now warrants a cervical fusion, are similarly not compensable. Nor would any situational depression associated thereto.

Plaintiff did suffer, however, greatly with regard to the head injury, and the inner ear injury as a direct result of the accident. The Court places damages for the pain and suffering associated with those injuries to the present time in the amount of $250,000.00. Moving ahead, Plaintiff will continue to have hearing loss and the likelihood of some vestibular disturbance/dizziness on an intermittent basis far less limiting than the vertigo experienced immediately post accident, although the evidence was unclear in this regard. The costs of care of those items is less clear as there was a lack of evidence with regard to Plaintiff's current status and a lack of any testimony with regard to prognosis.

***8** The situational depression related to the accident is minimal at this point with the cervical symptoms dominating Plaintiff's life. In any event, ongoing psychological care is now based on treatment of the underlying and unaffected bipolar disorder. Assessing the information, however, the Court awards $100,000.00 for future pain and suffering associated with the injuries, predominately the right sided hearing loss, and the limitations they bring to this now sixty year old man.

CONCLUSION

Based on the foregoing, the Court finds in favor of the Plaintiff and against the Defendant United States of America, and awards Plaintiff damages in the amount of $371,404.83. The Clerk of Court is directed to enter judgment according to this order.

IT IS SO ORDERED.

All Citations

Slip Copy, 2014 WL 1286567

Footnotes

1 The facts are taken verbatim from the Parties' Proposed Pretrial Order, unedited, signed, and filed by the Court on September 30, 2013. (Doc. No. 25.)

2 While the medical expenses were billed at nearly ten (10) times this amount, the actual amount paid is the appropriate measure of damage.*Howell v. Hamilton Meats and Provisions, Inc.*, 52 Cal.4th 541, 129 Cal.Rptr.3d 325, 257 P.3d 1130 (Cal.2011). Additionally, evidence of medical expenses that were not actually paid is irrelevant in determining future damages or non-economic damages. *Hill v. Novartis Pharm. Corp.*, 944 F.Supp.2d 943 (E.D.Cal.2013).*Corenbaum v. Lampkin*, 215 Cal.App.4th 1308, 156 Cal.Rptr.3d 347 (Cal.2013).

2014 WL 5501005
Only the Westlaw citation is currently available.
United States District Court,
E.D. California.

S.H., a minor, by her guardian ad litem Chantal HOLT; William Kenneth Holt; and Chantal Holt, Plaintiffs,
v.
UNITED STATES of America, Defendant.

No. 2:11–cv–01963–MCE–DAD. | Signed Oct. 29, 2014. | Filed Oct. 30, 2014.

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Gregory T. Broderick, United States Attorney's Office, Sacramento, CA, for Defendant.

MEMORANDUM AND ORDER

MORRISON C. ENGLAND, JR., Chief Judge.

***1** Presently before the Court is Defendant United States of America's ("Defendant") Motion to Alter or Amend Judgment ("Motion") under Federal Rules of Civil Procedure 59 and 60. ECF Nos. 186, 190. For the following reasons, the Motion is GRANTED IN PART and DENIED IN PART.[1]

BACKGROUND[2]

In this case Plaintiffs sought relief under the Federal Tort Claims Act ("FTCA"), 28 U.S.C. § 1346, alleging that United States Air Force medical personnel committed medical malpractice. ECF No. 184 at 1. Specifically, Plaintiffs asserted that even though Air Force medical personnel provided care for, or were aware of Plaintiff Chantal Holt's two premature deliveries, and one miscarriage, they (1) failed to warn Chantal about the added dangers she faced during her then-current pregnancy with Plaintiff S.H., (2) failed to prepare Chantal for those dangers, and (3) failed to caution Chantal against traveling overseas to a facility that was not equipped to handle those dangers. *Id.* at 2. Plaintiffs asserted that this malpractice was the proximate cause of S.H.'s premature birth and resulting cerebral palsy. *Id.*

The Court[3] held a bench trial commencing on March 11, 2014. ECF No. 140. The trial concluded on March 20, 2014, and the matter was submitted pending the submission of post-trial briefs. ECF No. 153. The parties filed post-trial briefs on May 5, 2014. ECF Nos. 173 (Plaintiffs), 174 (Defendant). On July 2, 2014, the Court issued an Order resolving the case in Plaintiffs' favor. ECF No. 182. Judgment was entered on July 8, 2014. ECF No. 183. The same day, the Court entered an Amended Order, ECF No. 184; an Amended Judgment was entered the following day, ECF No. 185. In the Amended Order, the Court concluded that Dr. Stahlman, a military doctor acting within the scope of his duties, breached his duty of care to Chantal Holt by clearing her to travel overseas without investigating further her medical history of premature births and miscarriage, and without making any inquiry into whether the receiving base could handle her situation. ECF No. 184 at 61. The Court further found that Dr. Stahlman's negligence, and Chantal Holt's subsequent treatment at a base incapable of handling her situation, was the proximate cause of the injuries ultimately suffered by S.H. and her parents, Chantal Holt and William Kenneth Holt. *Id.*

The Court awarded Plaintiffs $10,409,700 in damages, as follows: (1) $814,028 for S.H.'s lost earnings; (2) $1,711,600 for Chantal Holt's costs of caring for S.H.; (3) $7,384,072 for the future costs of S.H.'s care; (4) $250,000 for S.H.'s noneconomic damages; and (5) $250,000 for Chantal Holt and William Kenneth Holts' pain and suffering. ECF No. 184 at 61–63.

On August 5, 2014, Defendant filed the instant Motion, ECF No. 186, which Plaintiffs opposed, ECF No. 187. Defendant filed a Reply on October 9, 2014. ECF No. 191. The Motion is based on two grounds. First, Defendant claims that the Court's Amended Order improperly awarded $7,384,072 for future medical costs without considering the future collateral benefits the United States is already providing and will continue to provide, as required by California Civil Code section 3333.1. ECF No. 186 at 1; ECF No. 186–1 at 2–5. Second, Defendant argues that the Amended Order improperly awarded Plaintiffs more than $8 million in future damages without permitting Defendant to make

periodic payments under California Code of Civil Procedure section 667.7(a).

STANDARD

***2** A motion for reconsideration is properly brought pursuant to either Federal Rule of Civil Procedure 59(e) or Rule 60(b).*Taylor v. Knapp,* 871 F.2d 803, 805 (9th Cir.1989). A motion for reconsideration is treated as a Rule 59(e) motion if filed within twenty-eight days of entry of judgment, but as a Rule 60(b) motion if filed more than twenty-eight days after judgment. *See Am. Ironworks & Erectors, Inc. v. N. Am. Constr. Corp.,* 248 F.3d 892, 898–99 (9th Cir.2001). Because this motion is seeking reconsideration of a final judgment and was timely filed, the Court will treat it as a Rule 59(e) motion.

A court should be loath to revisit its own decisions unless extraordinary circumstances show that its prior decision was clearly erroneous or would work a manifest injustice. *Christianson v. Colt Indus. Operating Corp.,* 486 U.S. 800, 817, 108 S.Ct. 2166, 100 L.Ed.2d 811 (1988). This principle is embodied in the law of the case doctrine, under which "a court is generally precluded from reconsidering an issue that has already been decided by the same court, or a higher court in the identical case."*United States v. Alexander,* 106 F.3d 874, 876 (9th Cir.1997) (quoting *Thomas v. Bible,* 983 F.2d 152, 154 (9th Cir.1993)). Nonetheless, in certain limited circumstances, a court has discretion to reconsider its prior decisions.

While Rule 59(e) permits a district court to reconsider and amend a previous order, "the rule offers an 'extraordinary remedy, to be used sparingly in the interests of finality and conservation of judicial resources.' " *Kona Enter., Inc. v. Estate of Bishop,* 229 F.3d 877, 890 (9th Cir.2000) (quoting 12 James William Moore, et al., *Moore's Federal Practice* § 59.30(4) (3d ed.2000)). Indeed, a district court should not grant a motion for reconsideration "absent highly unusual circumstances, unless the district court is presented with newly discovered evidence, committed clear error, or if there is an intervening change in the controlling law." *389 Orange St. Partners v. Arnold,* 179 F.3d 656, 665 (9th Cir.1999) (citing *Sch. Dist. No. 1J, Multnomah County, Or. v. ACandS, Inc.,* 5 F.3d 1255, 1263 (9th Cir.1993)). Mere dissatisfaction with the court's order, or belief that the court is wrong in its decision, is not grounds for relief under Rule 59(e).*Twentieth Century–Fox Film Corp. v. Dunnahoo,* 637 F.2d 1338, 1341 (9th Cir.1981).

Additionally, Local Rule 230(j) requires a party filing a motion for reconsideration to show the "new or different facts or circumstances claimed to exist which did not exist or were not shown upon such prior motion, or what other grounds exist for the motion."Finally, motions for relief from judgment pursuant to Rule 59(e) are addressed to the sound discretion of the district court. *Turner v. Burlington N. Santa Fe R.R.,* 338 F.3d 1058, 1063 (9th Cir.2003).

In order to succeed, a party making a motion for reconsideration pursuant to Rule 59(e) must "set forth facts or law of a strongly convincing nature to induce the court to reverse its prior decision."*Pritchen v. McEwen,* No. 1:10–cv–02008–JLT HC, 2011 WL 2115647, at *1 (E.D.Cal. May 27, 2011) (citing *Kern–Tulare Water Dist. v. City of Bakersfield,* 634 F.Supp. 656, 665 (E.D.Cal.1986), *aff'd in part and rev'd in part on other grounds,*828 F.2d 514 (9th Cir.1987)). A motion for reconsideration should not be used to raise arguments or present evidence for the first time when the arguments or evidence could reasonably have been raised earlier in the litigation. *389 Orange St. Partners,* 179 F.3d at 665.

***3** Furthermore, "courts avoid considering Rule 59(e) motions where the grounds for amendment are restricted to either repetitive contentions of matters which were before the court on its prior consideration or contentions which might have been raised prior to the challenged judgment."*Costello v. United States,* 765 F.Supp. 1003, 1009 (C.D.Cal.1991); *see also Taylor,* 871 F.2d at 805. This position stems from the district courts' "concerns for preserving dwindling resources and promoting judicial efficiency."*Costello,* 765 F.Supp. at 1009 (internal citations omitted).Rule 59(e) and motions for reconsideration are therefore not intended to "give an unhappy litigant one additional chance to sway the judge."*Frito–Lay of P.R., Inc. v. Canas,* 92 F.R.D. 384, 390 (D.P.R.1981) (quoting *Durkin v. Taylor,* 444 F.Supp. 226, 233 (N.D.Ohio 1967)).

ANALYSIS

A. California Civil Code § 3333.1

California Civil Code section 3333.1 provides in relevant part as follows:

> In the event the defendant so elects, in an action for personal injury against a health care provider based upon professional negligence, he may introduce evidence of any

> amount payable as a benefit to the plaintiff as a result of the personal injury pursuant to the United States Social Security Act, any state or federal income disability or worker's compensation act, any health, sickness or income-disability insurance, accident insurance that provides health benefits or income-disability coverage, and any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost or medical, hospital, dental, or other health care services. When the defendant elects to introduce such evidence, the plaintiff may introduce evidence of any amount which the plaintiff has paid or contributed to secure his right to any insurance benefits concerning which the defendant has introduced evidence.

Cal. Civ.Code § 3333.1(a). The California Supreme Court has explained the effect of the statute as follows: "Th[is] collateral source provision ... is one of the provisions of [the Medical Injury Compensation Reform Act of 1975] which was intended to reduce the cost of medical malpractice insurance.Section 3333.1, *subdivision (a*)... authorizes a defendant in a medical malpractice action to introduce evidence of a variety of 'collateral source' benefits-including health insurance, disability insurance or worker's compensation benefits. Apparently, the Legislature's assumption was that the trier of fact would take the plaintiff's receipt of such benefits into account by reducing damages."*Barme v. Wood,* 37 Cal.3d 174, 207 Cal.Rptr. 816, 689 P.2d 446, 449 (1984) (emphasis in original). Notably, "[e]arlier drafts ... required the trier of fact to deduct such collateral source benefits in computing damages, but-as enacted-subdivision (a) simply provides for the admission of evidence of such benefits, apparently leaving to the trier of fact the decision as to how such evidence should affect the assessment of damages."*Id.* n. 5. "Thus, section 3333.1 does not preclude recovery of such damages; rather, it allows the [trier of fact] to decide how to apply the evidence in calculation of damages."*Hernandez v. Cal. Hosp. Med. Ctr.,* 78 Cal.App.4th 498, 506, 93 Cal.Rptr.2d 97 (2000).

***4** Defendant contends that because section 3333.1 applies to FTCA cases, and Defendant pled section 3333.1 as an affirmative defense and introduced detailed evidence on the amount of benefits S.H. is expected to receive in the future from Defendant, the Court was required to consider the effect of section 3333.1 when awarding damages for S.H.'s future medical costs. ECF No. 186–1. Defendant does not argue that section 3333.1 requires an offset; rather, Defendant claims only that the statute requires consideration of an offset. ECF No. 186–1 at 3:3–11; ECF No. 191 at 3:14–25.

As an initial matter, although the Ninth Circuit has held that California Civil Code section 3333.2 applies to actions under the FTCA, *see Taylor v. United States,* 821 F.2d 1428, 1430 (9th Cir.1987), it is not clear that section 3333.1 does. *See Desart By and Through Desart v. United States,* 1989 WL 99253 at *3 (9th Cir.1989) (holding that a reduction of damages in an FTCA case was not an abuse of discretion "should section 3333.1 apply"). However, because Plaintiffs do not contest that section 3333.1 applies to this case and a determination of that issue will not affect the ultimate resolution of the Motion, the Court assumes without deciding that section 3333.1 applies in this case.

Plaintiffs do, however, contest Defendant's argument that section 3333.1 applies to future collateral source benefits. This question similarly does not appear to have a clear answer. Indeed, as recently as 2013, a California appellate court noted there were "good arguments" rebutting a defendant's interpretation that section 3333.1 applies to future collateral source benefits. *See Leung v. Verdugo Hills Hosp.,* 2013 WL 221654 at *4 (Cal.Ct.App. Jan.22, 2013); *but see Silong v. United States,* 2007 WL 2580543 at 13–18 (E.D.Cal. Sept.5, 2007) ("[California] and federal law provide the Government legal grounds to seek an offset for future costs."). Ultimately, the *Leung* court resolved that case without deciding whether section 3333.1 applies to future collateral source benefits. Because it will not affect the outcome of this case, the Court assumes without deciding that pursuant to section 3333.1 a trier of fact can consider future collateral source benefits and reduce a damages award accordingly.

The Court will also assume without deciding that because Defendant raised collateral source offset as an affirmative defense,[4] ECF No. 18 at 5:28–6:3, and questioned witnesses regarding the extent of benefits Defendant will provide S.H. going forward, the Court was required to address section 3333.1 in the Amended Order. Defendant's Motion is GRANTED on this point only and the Court will consider the application of section 3333.1 to this case.

Defendant argues that S.H. will be provided medical care and skilled nursing care for the rest of her life, and that

S.H.'s actual out-of-pocket costs will be no more than $4,599 per year under the Air Force's TriCare for Life ("TriCare") program. ECF Nos. 186, 191. The Court exercises its discretion under section 3333.1 and finds that Defendant is not entitled to an offset from the future medical costs awarded by the Amended Order. Defendant did not designate or call an expert witness to testify as to what level of care Defendant would provide S.H. in the future or the value of that care. Moreover, it appears that Defendant did not introduce into evidence a summary of any plan that would cover S.H. in the future or a schedule of benefits under any such plan. Rather, Defendant presented limited lay witness testimony about TriCare. And even this testimony from Lt. Col. Carol Copeland, who testified at her deposition that at the time she did not speak to TriCare issues at all, was inconclusive and speculative on the issues of S.H .'s eligibility for continued health care coverage at Defendant's expense and the level of that coverage.

***5** For instance, Lt. Col. Copeland testified that she "[didn't] claim to have special expertise in TriCare," ECF No. 169 at 585:16, that it was only her "impression" that S.H. would qualify for TriCare, ECF No. 169 at 582:7–10, that she "[couldn't] say that TriCare would cover everything, because all healthcare policies have specific provider networks or facilities that they have made arrangements with," ECF No. 169 at 582:15–17, that "it would be important for [Plaintiffs] to consult with a TriCare benefits advisor" to determine co-pays and other out-of-pocket expenses, ECF No. 169 at 583:12–13, that TriCare "benefits might change" "[s]imilar to all other health insurance plans," ECF No. 169 at 583:16–18, 24–25, and that she didn't "know the details about the TriCare benefit and [S.H.'s] specific situation," ECF No. 169 at 585:6–7. In fact, Lt. Col. Copeland's knowledge on TriCare apparently stems only from navigating the different TriCare plans and options for her dependent parents' "particular situation." ECF No. 169 at 583:16–21. Neither does the testimony from Plaintiffs William Kenneth Holt or Chantal Holt demonstrate S.H.'s eligibility for continued care at Defendant's expense or the level of that care.

In sum, Defendant had an opportunity to present compelling evidence of future collateral benefits S.H. would receive, yet failed to designate or call an expert to testify to this point, submit compelling documentary evidence, or even argue the issue in its post-trial brief. On this record, the Court declines under section 3333.1 to offset any potential future collateral benefits S.H. may receive and the Motion is DENIED on this point.

B. California Code of Civil Procedure § 667.7(a)

California Code of Civil Procedure section 667.7(a) states in relevant part:

> In any action for injury or damages against a provider of health care services, a superior court shall, at the request of either party, enter a judgment ordering that money damages or its equivalent for future damages of the judgment creditor be paid in whole or in part by periodic payments rather than by a lump-sum payment if the award equals or exceeds fifty thousand dollars ($50,000) in future damages. In entering a judgment ordering the payment of future damages by periodic payments, the court shall make a specific finding as to the dollar amount of periodic payments which will compensate the judgment creditor for such future damages. As a condition to authorizing periodic payments of future damages, the court shall require the judgment debtor who is not adequately insured to post security adequate to assure full payment of such damages awarded by the judgment. Upon termination of periodic payments of future damages, the court shall order the return of this security, or so much as it remains, to the judgment debtor.

Cal.Code Civ. Pro. § 667.7(a). California courts have interpreted section 667.7(a) as providing generally that when a plaintiff in a medical malpractice action is awarded $50,000 or more in future damages, the trial court, *upon a timely request,* shall enter a judgment providing for the periodic payment of those damages. *Hrimnak v. Watkins,* 38 Cal.App.4th 964, 971–72, 45 Cal.Rptr.2d 514 (1995).

***6** Defendant argues that its request for periodic payments of the future damages awarded S.H. was timely, and requests that the Court set an evidentiary hearing to receive testimony from Plaintiff's trial expert, Jennifer McNulty. ECF No. 186–1 at 5–6. Specifically, Defendant contends that by raising periodic payments as an affirmative defense in its Answer, ECF No. 18 at 6:11–3, and asking questions of Ms. McNulty, constituted a

timely request. Conversely, Plaintiff argues that Defendant's request to make periodic payments of future damages is untimely, and that in any event Defendant should not be given another bite at the apple through an additional hearing. ECF No. 187 at 12–15. Plaintiff notes that Defendant did not specifically request that the Court make periodic payments at any time prior to the instant Motion, and failed to raise the issue in its trial brief, post-trial brief, or its proposed findings of fact and conclusions of law. Moreover, Plaintiff points out that Defendant never designated its own witness to testify to the gross value of damages in the event S.H. was in fact awarded damages for future medical costs.[5]

The Court finds that Defendant's request for periodic payments was untimely.*Hrimnak* is instructive. In *Hrimnak,* the court found that the defendant timely requested the application of section 667.7 where he raised it in his answer, during pretrial hearings, and immediately after the jury returned its verdict. 38 Cal.App.4th at 973, 45 Cal.Rptr.2d 514. Here, although Defendant raised the statute as an affirmative defense, Defendant took no further steps to apprise the Court of its request for periodic payments.

The Court also finds that section 667.7 does not permit the Court to replace the current lump sum judgment with a periodic payment schedule. In *Craven v. Crout,* 163 Cal.App.3d 779, 783, 209 Cal.Rptr. 649 (1985), the court found that "nothing in the language of section 667.7 authorizes a court to set aside one judgment awarding lump-sum damages and enter a different judgment ordering periodic payments. On the contrary, the only references in that statute to modification of a judgment are those authorizing or prohibiting modification of the periodic payment judgment itself."Importantly, the *Craven* court found that such modification was not allowed even though generally California courts retained jurisdiction to entertain a motion for a new trial, a motion for a judgment notwithstanding the verdict, and a motion to vacate a judgment and enter a different judgment based on an incorrect or erroneous legal basis or a judgment not consistent with or not supported by the special verdict. *Id.* at 782–83, 209 Cal.Rptr. 649. Accordingly, Defendant's Motion is DENIED on this point.

CONCLUSION

For the foregoing reasons, Defendant's Rule 59(e) Motion, ECF Nos. 186, 190, is GRANTED only to the extent the Court exercises its discretion under California Civil Code section 3333.1. The remainder of the Motion is DENIED.

IT IS SO ORDERED.

All Citations

Slip Copy, 2014 WL 5501005

Footnotes

1 Because oral argument would not be of material assistance, the Court ordered this matter submitted on the briefs. E.D. Cal. Local R. 230(g). ECF No. 192.

2 Because the parties are familiar with the background of this case, this section recites only a general overview of the facts, some of which are taken verbatim from the Court's July 8, 2014, Amended Order, ECF No. 184.

3 Prior to his retirement, this matter was assigned to Senior District Judge Lawrence K. Karlton. On August 28, 2014, the matter was reassigned to the undersigned. ECF No. 189.

4 The Court notes that Defendant neither cited to section 3333.1 nor argued for an offset from any future medical costs the Court could have awarded S.H. in its post-trial brief. ECF No. 174.

5 Indeed, in the Motion Defendant appears to rely solely on Ms. McNulty's understanding that evidence regarding periodic payments would be introduced after an award was given.

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Only the Westlaw citation is currently available.
United States District Court,
C.D. California.

Stephan Brewington, Plaintiff,
v.
United States of America, Defendant.

Case No. CV 13–07672–DMG (CWx) | Signed July 24, 2015

Attorneys and Law Firms

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FINDINGS OF FACT AND CONCLUSIONS OF LAW

DOLLY M. GEE, UNITED STATES DISTRICT JUDGE

***1** This matter is before the Court following a bench trial which took place on June 30, 2015 through July 2, 2015. John F. DeNove, Diane M. Corwin, and Alicia S. Curran appeared on behalf of Plaintiff Stephan Brewington. Garrett Coyle and Julie Zatz appeared on behalf of Defendant United States of America.

Having carefully reviewed the evidence and the arguments of counsel, as presented at trial and in their written submissions, the Court makes the following findings of fact and conclusions of law pursuant to Rule 52 of the Federal Rules of Civil Procedure.

I.

FINDINGS OF FACT

On August 12, 2011, Stephan Brewington went to the Department of Veteran Affairs Greater Los Angeles hospital (the "VA") for treatment of a branch retinal vein occlusion that affected the vision in his left eye. The prescribed treatment was an injection into his left eye of Avastin, a drug used to treat conditions like macular edema. (Final PreTrial Conference Order ("PTO") 5a, b [Doc. # 45].) Instead of injecting Avastin, the VA injected Mr. Brewington's left eye with Velcade, a chemotherapy drug, causing irreversible blindness in Mr. Brewington's left eye. (PTO 5c, d.) There was no evidence presented as to any approved or medically indicated intraocular use of Velcade. To the contrary, whether directly or indirectly, Velcade caused serious injury to Mr. Brewington, including blindness in the left eye, mild chemical meningitis, left hemisensory deficits, chronic daily headache of a migrainous nature, rebound headaches, neuropathic orbital pain syndrome, depression, and anxiety. (Trial Declaration of H. Ronald Fisk, M.D. ("Fisk Decl.") ¶ 8 [Doc. # 56]; Trial Declaration of Raghu C. Murthy, M.D. ("Murthy Decl.") ¶¶ 14–15 [Doc. # 50].)

Mr. Brewington maintains 20/20 vision in his right eye. (PTO 5g.) At the time of the Velcade injection, Mr. Brewington was 42 years of age. (PTO 5h.)

The Velcade injection initially caused significant ocular inflammation in Mr. Brewington's left eye. Ocular inflammation can cause pain in the inflamed area as well as around the eye. This inflammation triggered Mr. Brewington's orbital pain and migraine-type headache. (Trial Declaration of Pradeep Prasad, M.D. ("Prasad Decl.") ¶ 8 [Doc. # 53].) By at least March 12, 2013, however, the ocular inflammation was fully resolved. (Prasad Decl. ¶ 8; Defendant's Exhibit 101 at 724–25.) The results of an October 14, 2011 MRI of Mr. Brewington's left orbit showed resolution of the globe enhancement, no abnormal orbital enhancement, normal appearance of the optic nerve, and resolution of prior swelling of the soft tissues of the eyelid. (Prasad Decl. ¶ 9; Defendant's Exhibit 101 at 44.) These results, as well as Dr. Prasad's examination of Mr. Brewington's left eye, confirmed the absence of objective signs of orbital inflammation. (Prasad Decl. ¶ 9.) Thus, a little after a month following the Velcade injection, signs of the inflammation associated with the injection had abated. (*Id.*) Nonetheless, Mr. Brewington reported that he continued to experience pain around his left eye radiating to the back of his head. (*Id.*)

A. *Treatment Since the Injury*

*2 Since the injection, Mr. Brewington has continued to receive treatment at the VA. (PTO 5e.) He has seen medical providers in a variety of specialties, including neurology, ophthalmology, pain management, and psychiatry. (*See* Defendant's Exhibit 101.) Mr. Brewington has also been prescribed increasing doses of opiates, such as Methadone, Dilaudid, Fentanyl, and OxyContin, to address his complaints of pain. He has also been taking anti-inflammatory medication and anti-anxiety medication. (*See id.*)

Mr. Brewington was offered but declined the opportunity to participate in the Comprehensive Pain Management and Rehabilitation Programs at the VA hospital. (Trial Testimony of Quynh Pham and Hyung Kim; Defendant's Exhibit 101 at 834 (note in record stated "discussed comprehensive pain and rehab program, but patient declined at this time").) He also turned down the VA's offer to attend a non-VA pain management program of his choice, which the VA would subsidize. (*Id.*; Defendant's Exhibit 101 at 740–42 ("Pt was once again reminded that he has been approved by the administration to seek outside expertise for the management of his pain."); 746 ("Pt has been approved by the VA Administration to seek outside pain providers, should he wishes [sic] to seek this option. Pt has previously declined this option because he feels that, this being a VA-initiated issue, he would like the VA to address his concerns."); 759 ("Of note, pt has been approved by the VA Administration to seek outside pain providers, and this option was presented to the patient as well, especially given the time associated with his travel from his residence in Pasadena to WLA.").)

B. *Medical Conditions*

1. *Pain*

The parties' experts disagree as to whether Mr. Brewington suffers from Central Pain Syndrome, which is an irreversible condition, or from Centralized or Centralization of Pain syndrome, which may potentially be reversed with proper care and treatment. (Trial Declaration of Laura Audell ("Audell Decl.") ¶ 14; Fisk Decl. ¶ 17e.) The Court cannot determine by a preponderance of the evidence which of these syndromes actually applies to Mr. Brewington. What the experts *can* agree upon, and which the Court does find, is that Mr. Brewington suffers from chronic pain, resulting from the Velcade injection. Without applying any labels to it, the experts appear to agree that due to neuroplasticity, the severity or persistence of pain alters the central nervous system pathways of pain processing, increasing the number and excitability of the nociceptors that allow pain signals to travel through the sensory nerve fibers. (Audell Decl. ¶ 14; Fisk Decl. ¶¶ 13–14.) Generally, once these changes occur, a person may experience hyperalgesia, an increased response to a normally painful stimulus, and allodynia, a pain response to a stimulus that does not normally produce pain. (*Id.* ¶ 15.)

According to the National Institute of Neurological Disorders and Stroke, Central Pain Syndrome is distinct: it is a "neurological condition caused by physical damage to or dysfunction of the central nervous system (CNS)," which is typically the result of "stroke, multiple sclerosis, tumors, epilepsy, brain or spinal cord trauma, or Parkinson's Disease...." (Audell Decl. ¶ 22.)

Although Mr. Brewington posits that he has Central Pain Syndrome, there is little support in the record that Mr. Brewington suffers from that condition as it has been defined by the National Institute of Neurological Disorders and Stroke. First, Mr. Brewington has not experienced any of the typical causes of the syndrome, such as stroke, multiple sclerosis, tumors, epilepsy, brain or spinal cord trauma, or Parkinson's Disease. (*See* Defendant's Exhibit 101.) Moreover, two MRIs of Mr. Brewington's brain have not revealed any evidence of physical damage to the central nervous system. (Trial Declaration of Edwin Amos, M.D. ("Amos Decl.") ¶ 17 [Doc. # 65].)

*3 Defendant, on the other hand, asserts that Mr. Brewington has Opioid–Induced Hyperalgesia ("OIH"), which Defendant argues is also closely associated with altered central pain processing. OIH is a condition caused by exposure to opioids whereby a patient receiving opioids for the treatment of pain paradoxically becomes more sensitive to painful stimuli. (Fisk Decl. ¶ 19; Plaintiff's Exhibit 22 ("A Comprehensive Review of Opioid–Induced Hyperalgesia").)

The evidence does not establish that Mr. Brewington has OIH. One of the hallmarks of OIH is the worsening of pain at the original site or the appearance of distant and more diffuse pain throughout the body. (*Id.*) First, with respect to worsening pain, the record does not reflect definitive instances where Mr. Brewington's pain increased after taking opioids or decreased after ceasing to use opioids, which would be consistent with OIH. Instead, Mr. Brewington has generally experienced some relief after taking opioids. (*See, e.g.,* Fisk Decl. ¶ 6(13), (15), (16), (20), (30), (31) (summary of notes in medical record); ¶ 19.)

Second, with respect to distant or diffuse pain, Mr. Brewington has reported pain in areas as disparate as his left leg and buttock and thigh areas. (*See* Fisk Decl. ¶

6(28) (summary of September 26, 2012 note in medical record).) The parties disagree as to whether pain in these areas constitutes "diffuse" pain. Plaintiff asserts that diffuse pain would be distributed more evenly across the body and would radiate outward from a location on the body. Defendant, on the other hand, argues that discrete pockets of pain, so long as they are located other than in the left eye, indicate diffuse pain. The Court declines to resolve this issue in light of the conflicting medical testimony presented at trial.

Although there are instances in Mr. Brewington's medical record where OIH is mentioned as a possible concern, he was never diagnosed with OIH. (Defendant's Exhibit 101 at 44, 357, 362, 577, 702, 745, 759.) Nor did Mr. Brewington's doctors at the VA prescribe treatment—namely, cessation of opioid use—that would be appropriate for an OIH diagnosis. Instead, the VA continued to prescribe opioids at ever-increasing dosages to Mr. Brewington. (*See* Defendant's Exhibit 101.)

In short, it has not been shown by a preponderance of the evidence in the record that Mr. Brewington has OIH.

Although the Court cannot find by a preponderance of the evidence that Mr. Brewington has Central Pain Syndrome, Centralization of Pain Syndrome, or OIH, the record is clear that Mr. Brewington has chronic pain resulting from the Velcade injection. As a result of the chronic pain, Mr. Brewington has taken increasing dosages of opioids and, in the process, developed opioid tolerance. (*See* Fisk Decl. ¶ 6(32) ("Mr. Brewington is thinking about going off meds for a while as he believes he is developing a tolerance to it—in the past, this seems to have worked for him.").) A person with opioid tolerance requires more opioids to achieve the same pain-dampening effect. Moreover, Mr. Brewington's prolonged opioid use has exacerbated other problems, such as hypogonadism and sleep apnea. (*See* Fisk Decl. ¶ 6(28) (medical record noted secondary hypogonadism from pain medication use); (30) (note in medical record indicated concerns with prolonged regimen of high dose opioids on Mr. Brewington's endocrine function, immune system function, and central sleep apnea).)

2. *Medication Overuse / Rebound Headaches*

***4** Mr. Brewington has Medication Overuse Headaches ("MOH"). The International Classification of Headache Disorders (3rd edition) has defined MOH as a chronic headache disorder in which the headache occurs for more than three months on 15 or more days per month due to regular overuse of medication. Medications most implicated in MOH include opioids such as methadone and dilaudid, triptans, combination analgesics, and anti-inflammatories. (Audell Decl. ¶ 16.)

3. *Depression and Anxiety*

Mr. Brewington has depression and anxiety, which were caused by the Velcade injection. Both can worsen pain. (Fisk Decl. ¶ 25i, j.) Although the Court does not find that Mr. Brewington has OIH, his increasing tolerance to opioids has heightened his use of opioids. The prolonged use of opioids has affected his wellness in other areas, such as his libido and ability to sleep, deepening his depression and anxiety. This in turn has negatively impacted his experience of pain, propelling him to seek higher dosages of opioids to address the pain.

4. *Cognitive Dysfunction*

Absent a structural brain problem or chemical meningitis, neither of which Mr. Brewington demonstrated he has, Mr. Brewington's cognitive dysfunction is likely due to incompletely treated depression and narcotic medication side effects. (Amos Decl. ¶¶ 17, 24.) Any cognitive dysfunction is thus not directly attributable to the Velcade injection and is potentially remediable. (Amos Decl. ¶ 21.)

5. *Summary Prognosis*

Mr. Brewington suffered an injury to his left eye caused by an injection of Velcade, which caused inflammation to the orbit of the eye and the optic nerve, acute pain, and irreversible blindness in that eye. Although the orbital inflammation has subsided, the severity or duration of the acute pain Mr. Brewington experienced changed the central nervous system pathways that process painful stimuli. Mr. Brewington now experiences chronic pain. Because of his complaints of chronic pain, Mr. Brewington was prescribed opioids at increasing dosages, eventually developing opioid tolerance. Nothing is preventing Mr. Brewington, however, from participating in a comprehensive pain management and rehabilitation program. (Fisk Decl. ¶ 16.)

The Velcade injection also led to depression and anxiety, for which he also takes medication. He has been or is prescribed medication for other conditions, such as sleep apnea, low testosterone, and hypertension. As a result of his heavy use of medication, Mr. Brewington experiences Medication Overuse Headaches. Mr. Brewington also exhibits mild cognitive dysfunction, but it is not directly attributable to the injection.

Mr. Brewington has retained normal sight in his right eye. Furthermore, he does not have deep vein thrombosis, significant cardiac disease, endocrine disease (except low testosterone), urologic disease (except low libido), or gastrointestinal disease. (*See* Defendant's Exhibit 101.) Mr. Brewington also drives an unmodified car, albeit on a limited basis. (PTO ¶ 6b.)

Mr. Brewington's life expectancy as an African American 46.4–year–old male is 28.61 years. (Declaration of Jerald Udinsky ("Udinsky Decl.") ¶ 12.)

In light of the factual findings above, the Court concludes that, even were he to learn to manage his pain without heavy dependence on opioid medication, Mr. Brewington will not be able to return to work because of his chronic pain, depression, and anxiety, which were caused by the injection. Given the nature and range of Mr. Brewington's ailments, the prognosis for his recovery to the point where he can regain his ability to work is poor.

C. *Award of Damages*

1. *Future Health Care and Life Plan Needs*

***5** Mr. Brewington has incurred no medical expenses up to the point of trial because all of his care has been provided and paid for by the VA. (PTO 5e, f.) With respect to future medical benefits, should Mr. Brewington choose not to continue receiving medical care at the VA, the Affordable Care Act ("ACA") ensures that Mr. Brewington will have access to insurance covering his future medical care needs as a result of the Velcade injection. (Pub.L. No. 111, 148, 124 Stat. 119 (Mar. 23, 2010).) Mr. Brewington has access to health insurance plans on California's health benefit exchanges. (*See* California Health Benefit Exchange, http://hbex.coveredca.com/ (last visited July 16, 2015).)

Based upon the Court's factual findings, described *supra,* a review of the relevant health care services provided for in the parties' respective life care plans, and Mr. Brewington's access to ACA coverage, the Court finds by a preponderance of the evidence that $725,147.25 is a reasonable amount to award Mr. Brewington for his future health care expenses.

2. *Back and Front Pay*

For 10 months prior to the Velcade injection, Mr. Brewington had not been employed as a production scheduler. (PTO ¶ 6a.) Based upon his earning history and the published wage data for production schedulers in Los Angeles County, Mr. Brewington's earning capacity in the last year that he worked prior to his injury as a contract production scheduler was about $42,000 per year. (Declaration of Roger Thrush, Ph.D. ("Thrush Decl.") ¶ 6 [Doc. # 62].) Given Mr. Brewington's lack of any documented earning history as a personal trainer and the absence of any reliable data on wages of self-employed personal trainers, it is too speculative to conclude what Mr. Brewington would have earned had he become a self-employed part-time personal trainer. (*Id.*)

As of June 30, 2015, the present cash value of Mr. Brewington's past and future lost earnings as a result of the Velcade injection is $632,536.

3. *Pain and Suffering Damages*

Based on the totality of the circumstances, and having considered the evidence and all of the relevant factors, the Court finds that $250,000 is reasonable compensation for Mr. Brewington's past and future pain and suffering.

II.

CONCLUSIONS OF LAW

A. *California Law Applies Under the Federal Tort Claims Act*

In an action brought pursuant to the Federal Tort Claims Act ("FTCA"), 28 U.S.C. § 2671 *et seq.,* the law of the place where the allegedly negligent act or omission occurred governs the substantive law applied. 28 U.S.C. § 1346(b); *Richards v. United States,* 369 U.S. 1, 9, 82 S.Ct. 585, 591, 7 L.Ed.2d 492 (1962). To have a cognizable claim, the claim must arise from the negligent or wrongful act of a government employee acting within the scope of his employment under circumstances where the United States, if it were a private individual, would be liable under the law of the state where the claim arose. 28 U.S.C. § 1346(b)(1); *Firebaugh Canal Water Dist. v. United States,* 712 F.3d 1296, 1303 (9th Cir. 2013), *cert. denied,* 134 S.Ct. 1300, 188 L.Ed.2d 303 (2014). California law is applicable because the accident occurred in California.

B. *Plaintiff Must Prove His Claimed Damages Were*

Caused by the United States' Acts

In California, plaintiffs must prove by a preponderance of the evidence that their claimed damages were caused by the negligent acts or omissions of an employee of the United States. *See*28 U.S.C. § 2674; Cal. Evid.Code § 115. Defendant admits liability for injecting Velcade into Mr. Brewington's left eye, causing irreversible blindness. Therefore, the only element of his negligence claim is the resulting loss or damage. *See Johnson v.Super. Ct.*, 143 Cal.App. 4th 297, 305 (2006).

C. *Plaintiff's Recovery*

1. *Economic Damages: Future Medical Expenses*

***6** To recover damages for future medical expenses, Mr. Brewington must prove by a preponderance of the evidence: (1) the reasonable value of each of the expected future medical expenses; (2) that the future medical care, services, and supplies are reasonably certain to be needed and given in treatment of the injury; and (3) that the condition requiring the future medical care is causally connected to the injuries inflicted by the United States. *Dimmick v. Alvarez*, 196 Cal.App.2d 211, 216, 16 Cal.Rptr. 308 (1961). Future medical expenses may not be awarded if they are deemed speculative. *See Scognamillo v. Herrick*, 106 Cal.App. 4th 1139, 1150–51, 131 Cal.Rptr.2d 393 (2003).

Defendant asserts an affirmative defense of offset for collateral sources under California's Medical Injury Compensation Reform Act of 1975 ("MICRA"). In particular, Defendant seeks to introduce evidence of Affordable Care Act coverage as a collateral source of future medical care expenses. Under Section 3333.1(a) of the California Civil Code, medical malpractice defendants may introduce evidence of "any amount payable as a benefit to the plaintiff as a result of the personal injury" under "any health, sickness or income-disability insurance, accident insurance that provides health benefits or income-disability coverage, and any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or other health care services." Cal. Civ.Code § 3333.1(a). "[S]ection 3333.1 does not preclude recovery of such damages, but rather, it allows the trier of fact to decide how to apply the evidence in calculation of damages." *S.H. ex rel. Holt v. United States*, No. 2:11–CV–01963–MCE, 2014 WL 5501005, at *3 (E.D.Cal. Oct. 30, 2014) (quoting *Hernandez v. Cal. Hosp. Med. Ctr.*, 78 Cal.App. 4th 498, 506, 93 Cal.Rptr.2d 97 (2000)) (internal quotation marks and brackets omitted).

Although the Ninth Circuit determined in *Taylor v. United States*, 821 F.2d 1428, 1431–32 (9th Cir.1987), that Section 3333.2 applies to FTCA actions, it has not explicitly held yet that Section 3333.1(a) applies to an FTCA action. *S.H.*, 2014 WL 5501005, at *4. Nor has it decided whether Section 3333.1(a) allows introduction of future collateral source benefits. Other district courts have taken future insurance benefits into consideration. *See Silong v. United States*, 2007 WL 2580543, at *13–18 (E.D.Cal. Sept. 5, 2007) (finding that Section 3333.1 allows the trier of fact to determine how to apply future insurance benefits to damages calculation.); *Leung v. Verdugo Hills Hosp.*, 2013 WL 221654, at *4 (Jan. 22, 2013) (assuming without deciding that "the statute permits a defendant to introduce evidence of future insurance benefits that the plaintiff is reasonably certain to receive"). Thus, this Court finds it appropriate to take insurance benefits available under the ACA into consideration in calculating reasonable future life care plan needs.

2. *Economic Damages: Lost Earnings*

To recover damages for lost earnings, Mr. Brewington must prove by a preponderance of the evidence the reasonable amount of the earnings lost on account of his injuries from the injection. CACI No. 3903C (Sept.2003). To recover damages for future loss of earnings or earning capacity, Mr. Brewington must prove by a preponderance of the evidence the following: (1) the reasonable amount of the expected future income, earnings, salary, or wages; (2) that Mr. Brewington is reasonably certain to lose such future income, earnings, salary, or wages; and (3) that the future lost income, earnings, salary, or wages is causally connected to the injuries inflicted by the United States. CACI No. 3903C (Sept.2003).

3. *Noneconomic Damages: Pain and Suffering*

***7** There is no fixed standard to calculate the amount a plaintiff is entitled to for pain and suffering. Any damages awarded for pain and suffering, however, must be reasonable and based on the evidence and factfinder's common sense. CACI No. 3905A (Dec.2009). In addition, any award of pain and suffering damages must be causally connected to the tortious act. *Miller v. San Diego Gas & Elec. Co.*, 212 Cal.App.2d 555, 558, 28 Cal.Rptr. 126 (1963).

MICRA caps a plaintiff's recovery of noneconomic damages for pain and suffering at $250,000. Cal. Civ.Code § 3333.2b; *Taylor*, 821 F.2d at 1431–32 (MICRA applies to medical malpractice cases brought

under the FTCA).

4. *The Duty to Mitigate*

The above findings of fact were made in recognition of California law, which has long required plaintiffs to "take reasonable steps to mitigate [their] damages" and bars "recover[y] for any losses which could have been thus avoided." *Shaffer v. Debbas,* 17 Cal.App. 4th 33, 41, 21 Cal.Rptr.2d 110 (1993). Mr. Brewington's future medical expenses and pain and suffering damages have been caused at least in part by his failure to mitigate damages by accepting the VA's repeated offers of a comprehensive pain management and rehabilitation program. Although its conclusion is tempered by the fact that successful completion of such a program depends in large part on an individual's motivation to reduce opioid dependence and manage one's pain using alternative techniques, the Court concludes that Mr. Brewington could have avoided some of his future medical expenses and pain and suffering (both as a direct result of the injection and as a side effect of his medication use) by agreeing to attend a comprehensive pain management and rehabilitation program whether at the VA or elsewhere. Accordingly, the Court took Plaintiff's failure to mitigate into account in calculating damages.

5. *Attorney's Fees*

Attorney's fees are limited to a maximum of 25% of any recovery. 28 U.S.C. § 2678.

III.

CONCLUSION

In light of the foregoing, the Court awards Plaintiff Stephan Brewington $725,147.25 in future medical expenses; $632,536 in past and future lost earnings; and $250,000 in noneconomic damages. Plaintiff's counsel may submit a motion for reasonable attorney's fees within 30 days from the date of this Order.

All Citations

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PROOF OF SERVICE

STATE OF CALIFORNIA, COUNTY OF LOS ANGELES

At the time of service, I was over 18 years of age and not a party to this action. I am employed in the County of Los Angeles, State of California. My business address is 15760 Ventura Boulevard, 18th Floor, Encino, California 91436-3000.

On October 13, 2015, I served true copies of the following document(s) described as **APPELLANT'S OPENING BRIEF [Filed Concurrently with Appellant's Appendix • Volumes 1-6]** on the interested parties in this action as follows:

SEE ATTACHED SERVICE LIST

BY MAIL: I enclosed the document(s) in a sealed envelope or package addressed to the persons at the addresses listed in the Service List and placed the envelope for collection and mailing, following our ordinary business practices. I am readily familiar with Horvitz & Levy LLP's practice for collecting and processing correspondence for mailing. On the same day that the correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the United States Postal Service, in a sealed envelope with postage fully prepaid.

BY E-MAIL OR ELECTRONIC TRANSMISSION: Based on a court order or an agreement of the parties to accept service by e-mail or electronic transmission via Court's Electronic Filing System (EFS) operated by ImageSoft TrueFiling (TrueFiling) as indicated on the attached service list:

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

Executed on October 13, 2015, at Encino, California.

Kathy Turner

SERVICE LIST
Brian C., a Minor, etc., et al. v. Contra Costa County
A143440 and A144041

Individual / Counsel Served	Party Represented
William L. Veen, Esq. Elinor Leary, Esq. Michael E. Gatto, Esq. The Veen Firm, P.C 711 Van Ness Avenue, Suite 220 San Francisco, California 94102 (415) 673-4800 • FAX: (415) 771-5845	Attorneys for Plaintiff and Respondent Brian C., a Minor, etc., et al. With copy of Appellant's Appendix (Vol 1-6) ***Electronic Copy*** via Court's Electronic Filing System (EFS) operated by ImageSoft TrueFiling (TrueFiling)
Alan Charles Dell'Ario 1561 Third Street, Suite B Napa, California 94559 (707) 666 -5351	Attorneys for Plaintiff and Respondent Brian C., a Minor, etc., et al. With copy of Appellant's Appendix (Vol 1-6) ***Electronic Copy*** via Court's Electronic Filing System (EFS) operated by ImageSoft TrueFiling (TrueFiling)
Hon. Steven K. Austin Contra Costa County Superior Court Wakefield Taylor Courthouse, Dept. 9 725 Court Street Martinez, California 94553-1233 (925) 957-5733	Trial Judge Case No. C09-01786 Without Appellant's Appendix **VIA: US MAIL**
Office of the Attorney General 1515 Clay Street Oakland, California 94612-1499	Pursuant to California Rules of Court, Rule 8.29 Without Appellant's Appendix **VIA: US MAIL**
Clerk of the Court California Supreme Court 350 McAllister Street, Room 1295 San Francisco, California 94102	For Civil cases, filing your documents through e-Filing will satisfy the requirements for service on the Supreme Court under rule 8.212(c)(2). Without Appellant's Appendix