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IN THE SUPREME COURT OF CALIFORNIA

DAVE PEBLEY,
Plaintiff and Respondent,

v.

SANTA CLARA ORGANICS, LLC, et al.,
Defendants and Appellants.

AFTER A PUBLISHED DECISION BY THE COURT OF APPEAL, SECOND APPELLATE DISTRICT, DIVISION SIX
CASE NO. B277893

PETITION FOR REVIEW

HORVITZ & LEVY LLP
LISA PERROCHET (BAR NO. 132858)
*STEVEN S. FLEISCHMAN (BAR NO. 169990)
3601 WEST OLIVE AVENUE, 8TH FLOOR
BURBANK, CALIFORNIA 91505-4681
(818) 995-0800 • FAX: (844) 497-6592
lperrochet@horvitzlevy.com
sfleischman@horvitzlevy.com

BENTON, ORR, DUVAL & BUCKINGHAM
KEVIN M. MCCORMICK (BAR NO. 115973)
PANDA L. KROLL (BAR NO. 211877)
39 NORTH CALIFORNIA STREET
VENTURA, CALIFORNIA 93001
(805) 648-5111 • FAX: (805) 648-7218
kmccormick@bentonorr.com
pkroll@bentonorr.com

ATTORNEYS FOR DEFENDANTS AND APPELLANTS
SANTA CLARA ORGANICS, LLC and JOSE PULIDO ESTRADA

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PETITION FOR REVIEW

ISSUES PRESENTED

In *Howell v. Hamilton Meats & Provisions, Inc.* (2011) 52 Cal.4th 541 (*Howell*), this Court held that an injured plaintiff cannot recover the inflated amount nominally "billed" by medical providers, where providers actually accept much less as payment in full. *Howell* recognized the practical reality that virtually no one (whether insured or uninsured) ever actually pays the full amount "billed" in the unique world of medical care accounting. As a consequence, the recovery of damages for medical services is limited to the market-tested rate that is actually accepted by providers for the medical procedures reasonably performed, and not what is nominally "billed."

Given that background, this case presents important issues regarding the applicability of *Howell*:

1. Under what circumstances can an insured plaintiff circumvent *Howell* by choosing to treat with a doctor who takes a lien on any tort recovery, and who "bills" at a far higher rate than is charged in the market by other providers offering the same quality care? Put differently, can reasonable value under *Howell* be based on amounts nominally "billed" rather than marketplace value?

2. Where a plaintiff chooses to treat with a lien doctor but introduces no evidence that comparable care is unavailable through plaintiff's insurance plan, what roles do mitigation of damages, the avoidable consequences doctrine, and the federal mandate to purchase medical insurance under the Affordable Care Act play in the measure of damages?

INTRODUCTION
WHY REVIEW SHOULD BE GRANTED

No one disputes that injured plaintiffs have the absolute right to treat with any doctor they choose. This case involves the recurring question of whether that choice alters the measure of damages. There is now an explicit split of authority among published Court of Appeal opinions regarding that question, and the proper application of this Court's seminal decision in *Howell*.

Following *Howell*, one line of published Court of Appeal opinions holds, consistent with *Howell*'s rationale, that amounts "billed" by the plaintiff's chosen health care provider are

inadmissible because they are irrelevant to establishing the defendant's liability for past or future economic damages. (*Corenbaum v. Lampkin* (2013) 215 Cal.App.4th 1308, 1330-1331 (*Corenbaum*); *Ochoa v. Dorado* (2014) 228 Cal.App.4th 120 (*Ochoa*); *Romine v. Johnson Controls, Inc.* (2014) 224 Cal.App.4th 990, 1014 (*Romine*); *State Farm Mutual Automobile Ins. Co. v. Huff* (2013) 216 Cal.App.4th 1463, 1471 (*State Farm*).) The reasoning of this line of cases is that the recovery of medical damages should be based on marketplace value—that which is actually paid and accepted for the medical services—not an inflated amount unilaterally billed by some medical providers, knowing they will not collect that amount. As one court has summarized: "Our Supreme Court has endorsed a market or exchange value as the proper way to think about the reasonable value of medical services." (*Markow v. Rosner* (2016) 3 Cal.App.5th 1027, 1050 (*Markow*).)

Under this line of cases, the determining factor is not whether the plaintiff is insured or uninsured. These cases have explicitly held that *Howell* applies even in the absence of a pre-injury negotiated rate that insurers pay, including when the plaintiff seeks treatment on a lien basis or is uninsured: *Howell "is not limited to the circumstance where the medical providers had previously agreed to accept a lesser amount as full payment for the services provided"*; instead, *Howell* and *Corenbaum* "compel the conclusion that the same rule applies equally in circumstances where there was no such prior agreement." (*Ochoa, supra,* 228 Cal.App.4th at pp. 135-136, emphasis added; accord *State Farm, supra,* 216 Cal.App.4th at pp. 1471-1472 [same for uninsured patient].) Thus, under this line

of cases, no plaintiff (insured or uninsured) can recover more than the marketplace value of the medical services provided.

Another line of published cases has rejected this approach. Starting with *Bermudez v. Ciolek* (2015) 237 Cal.App.4th 1311 (*Bermudez*), some courts have rejected the marketplace approach to medical damages articulated in the *Howell* and the *Corenbaum/Ochoa* line of cases, and have permitted personal injury plaintiffs to collect from defendants inflated amounts *billed* without regard to marketplace value. According to *Bermudez*, the determinative factor was the plaintiff's *uninsured* status, that is the absence of a prenegotiated rate, which relieved the plaintiff of abiding by *Howell*. Although *Bermudez* involved an uninsured plaintiff, the court also criticized *Corenbaum* and *Ochoa* regarding insured plaintiffs or plaintiffs who treat on lien basis. (*Id.* at p. 1335, fn. 6, 1337.) A pair of cases from the Third Appellate District have also followed this approach and one has criticized *Ochoa*. (See *Moore v. Mercer* (2016) 4 Cal.App.5th 424, 441 (*Moore*) ["We need not delve into why *Ochoa's* reasoning is faulty"]; *Uspenskaya v. Meline* (2015) 241 Cal.App.4th 996, 1005 (*Uspenskaya*).)

This case involves an *insured* plaintiff who, for no demonstrated *medical* reason, sought treatment from a doctor who generated bills at far higher rates than otherwise available in the marketplace, and who also demanded a lien on plaintiff's tort recovery. Approving recovery based on those bills, without any showing of marketplace value, the Court of Appeal created the legal fiction that such *insured* plaintiffs should nonetheless be treated as

uninsured plaintiffs, and that *Bermudez* rather than *Howell* then applied. (Typed opn. 2; see also typed opn. 10-11 [noting that *Bermudez* rejected the approach in *Ochoa,* and following *Bermudez*].) The Court of Appeal's opinion allows a plaintiff in a personal injury action treating on a lien basis to recover more than a truly uninsured patient would ever pay because, as *Howell* noted, uninsured patients do not pay the face amount of "bills" prepared by providers. (*Howell, supra,* 52 Cal.4th at p. 561 ["Nor do the chargemaster rates . . . necessarily represent the amount an uninsured patient will pay"; noting further that uninsured patients typically pay less than insured patients].)

In reaching its conclusion, the Court of Appeal bought into a false narrative that adherence to *Howell* would interfere with the right of a plaintiff to choose his or her own doctor. It does not. As defendants in this case have repeatedly stressed, injured plaintiffs are free to seek treatment from whatever providers they choose. But that should not mean that they can recover as tort damages inflated amounts "billed" at many times the marketplace value by a lien doctor who has an economic interest in the outcome of the litigation, and whose "bills" reflect amounts that, outside of the litigation context, are not ordinarily paid.

The Court of Appeal's opinion approving damages awards inflated by the litigation dynamic is bad public policy. It encourages patients involved in litigation to choose physicians based on factors unrelated to the quality of medical care provided. It is also contrary to California's strong policy of ensuring that its citizens have health insurance. The state has wholeheartedly embraced and

implemented the Affordable Care Act and over 93 percent of Californians now have health insurance. But the Court of Appeal's opinion creates a perverse economic incentive for Californians *not* to use their health insurance when they need it the most, after an accident requiring medical care. If left undisturbed, it is easy to see how the Court of Appeal's opinion will endorse a litigation tactic where personal injury plaintiffs intentionally *increase* the amount of their medical damages to increase the amount of general damages and in some cases punitive damages—all in contravention of the common law duty to mitigate damages. This will have a dramatic impact on the over 50,000 personal injury cases filed each year in superior courts. (See Judicial Counsel of Cal., Admin. Off. of Cts., Rep. on Court Statistics (2017) Civil Filings, Dispositions, and Case Load Clearance Rate: Fiscal Years 2006-07 through 2015-16, p. 95.)

It has been seven years since this Court decided *Howell*. The issues created by the application of *Howell* have had time to percolate in the appellate courts and there is now an explicit split of authority among published opinions regarding how to apply *Howell*. This Court should grant review to resolve the split.

STATEMENT OF FACTS AND PROCEDURAL BACKGROUND

A. Factual background: Apparently on the advice of counsel, Pebley eschews his health insurance to treat with health care providers offering service on a lien basis.

This is a personal injury action where liability has never been disputed on appeal. Plaintiff Dave Pebley was injured in an automobile accident caused by an employee of defendant Santa Clara Organics, LLC (Santa Clara). (Typed opn. 2.) At all times, Pebley had health insurance, either through Kaiser Permanente (Kaiser), or prior to the surgery at issue, when he became Medicare eligible. (Typed opn. 4 & fn. 1; 1 RT 23:26-24:23; 6 RT 1023.)

Pebley originally sought treatment for his injuries through Kaiser. (Typed opn. 4.) However, Pebley ceased treatment at Kaiser and sought all of his subsequent medical treatment on a lien basis, including a cervical fusion surgery. (*Ibid.*) Pebley never said he was unhappy with the medical treatment he received at Kaiser or that he could not obtain quality medical care through Kaiser or Medicare. (E.g., 6 RT 1023, 1026-1027.)

Because of in limine rulings by the trial court, the defense was not permitted to explore why Pebley sought medical treatment at much higher lien prices. However, an article by Pebley's counsel, cited by the Court of Appeal in its published opinion (typed opn. 4), likely explains why. Pebley's counsel explains, "Typically, medical

liens in personal injury cases have been used where the plaintiff is uninsured, or where the insurance provider will not cover or refuses to authorize recommended medical care." (2 AA 317.)[1] However, the article urges *insured* plaintiffs to seek treatment on a lien basis, which "effectively allows the plaintiff and his or her attorney to sidestep the insurance company and the impact of Howell, Corenbaum and Obamacare."[2] (2 AA 318.) Treating on a lien basis, according to Pebley's counsel, thus increases the "settlement value" of personal injury cases. (*Ibid.*)

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[1] Case law confirms that lien treatment historically was used by *uninsured* plaintiffs seeking services they could not otherwise afford. (See *Moore, supra,* 4 Cal.App.5th at pp. 429-430 [describing lien process]; Rothenberg, *Insurers Use Calif. Fraud Law Against Health Providers* (May 25, 2018) Law360 <https://bit.ly/2Jm0dZQ> [as of June 7, 2018] [describing typical lien process and how insurers are bringing claims against lien doctors for submitting false insurance claims under the Insurance Fraud Prevention Act, Insurance Code section 1871.1].) A lien doctor defers payment until the litigation is resolved and is then paid from the settlement proceeds or the judgment. (See 1 AA 225 [43:22-44:2 (during deposition, one of Pebley's physicians described the lien process: "once the case settles, and if there's a payment, then you get paid to – paid for your services")].)

[2] The article by Pebley's counsel is not alone. (See also Ellison, *Medical Liens: Necessary Evil Or Litigation Advantage?* (Apr. 2013) Plaintiff Magazine p. 3 (hereafter *Ellison*) <https://bit.ly/2M8hmYO> [as of June 8, 2018] [describing how in light of *Howell* more plaintiff attorneys are increasingly referring clients to lien medical providers].)

B. The jury returns a verdict based on evidence of amounts "billed," after a trial in which evidence of much lower market-tested rates and the reasons for plaintiff's choice of provider were excluded.

The parties filed multiple motions in limine regarding evidence of the amounts "billed" by Pebley's providers on a lien basis and Santa Clara's defenses to the damages claims, including Pebley's obligation to mitigate his damages, which are described in the Court of Appeal's published opinion. (Typed opn. 5-7.) The upshot of the trial court's rulings were that:

1. Pebley was allowed to introduce the full amounts "billed" by, but not paid to, his medical providers on a lien basis. As noted by the Court of Appeal, the effect of this ruling was to allow Pebley to prove medical damages without introducing "independent evidence of market rate values for the care he received." (Typed opn. 7.)

2. Santa Clara was prohibited from introducing evidence of amounts actually paid and accepted in the marketplace for comparable medical services, i.e., marketplace value. (Typed opn. 5; 1 AA 238-240; 9 RT 1545:28-1546:12.)

3. Santa Clara was prohibited from introducing evidence that Pebley was referred to his lien doctors by his counsel, that his doctors provided services on a lien basis, and that he otherwise failed to mitigate his damages. (Typed opn. 5-6; 1 AA 243-245; 1 RT 84:26-85:2.)

4. Santa Clara's expert witness on billing issues, Dr. Henry Miller, was prohibited from testifying about the reasonable market value of the amounts sought by Pebley's lien doctors, although he was permitted to testify about the bills sent by the hospital. (Typed opn. 5-7; see 1 AA 121 [during discovery, the hospital where Pebley had his surgery performed admitted that it only recovered, on average, between 16 to 17 percent of amounts nominally billed for medical procedures].)

At a pretrial hearing, the trial court stated, "I'm kind of new to this assignment," and "I went to a class recently and in the class we discussed all this about Corenbaum with judicial officers, and there's not a uniform opinion about what all this means, to be quite candid, and what to do about it." (1 RT 12:13-17; see also 3 RT 427:4 ["This is really kind of a messy area"].) At a hearing on the motions in limine, the trial court ruled that the lien figures nominally "billed" were admissible, extending the Fourth District's ruling in *Bermudez* (an uninsured plaintiff case) to cover the facts of this case, rather than following the Second District's ruling in *Ochoa* (a lien case). (3 RT 422-423; typed opn. 7.)

At trial, one of Pebley's treating physicians, Dr. Gerald Alexander, testified in a conclusory manner that the amounts billed, as reflected on exhibit 85 (a one-page summary of the bills), were "reasonable and customary." (4 RT 618-619; see 5 AA 1063.) Included in the amounts Dr. Alexander testified were reasonable were bills that Pebley's insurer had already paid at lower amounts. (Typed opn. 21.) He admitted he does not collect 100 percent of his so-called bills. (4 RT 629-630; see also Ellison, *supra,* at p. 1

[confirming that lien providers almost always accept less than face amount of bills: lien doctors "likely will be asked to negotiate down" from their billed rates]; Martin & Ma, *Insured Plaintiff Who Treats Outside Medical Plan on Lien Basis is Deemed Uninsured Under the Law Allowing Potential Recovery for Full Amount "Billed" for Such Medical Services* (May 11, 2018) HBB Law <https://bit.ly/2JiB7PA> [as of June 7, 2018] ["The holding in *Pebley* was reached despite recognition that medical providers will substantially reduce the costs of their services when rendered on a lien basis"].) Dr. Alexander provided no opinion about the marketplace value of the services, i.e., what is actually accepted for those medical services by medical providers. (4 RT 618-619.)

Pebley said he is liable for amounts billed regardless of the outcome of the case. (6 RT 1035:1-5.) When asked what the terms of payment are for the medical bills listed on exhibit 85, Pebley replied: "It's none of your business." (6 RT 1070:18-23.) After being advised by the court that he could answer that question, Pebley said, "I don't remember, if you want to know the truth. I have signed paperwork that I would pay all of my bills." (6 RT 1070:24-27.)

Defense expert Dr. Richard Kahmann testified that he collects the full amount shown on bills only "about 5 percent" of the time and that for the other 95 percent of his patients he collects, on

average, approximately 50 percent of the amount billed.[3] (7 RT 1241:6-24.)

Dr. Miller explained this same unique aspect of medical billing that differs from billing in other fields: "Within the health care system, it's widely understood that the charges that appear on bills are not necessarily the amounts that are paid or expected to be paid." (8 RT 1405:19-22.) Dr. Miller testified regarding the reduced "cash price" paid for procedures. (8 RT 1406:20-1407:9.) Dr. Miller then compared prices that the medical facilities accept for cash payment to amounts (in brackets) claimed by Pebley on exhibit 85:

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[3] Dr. Kahmann's testimony is consistent with published case law. (See *Children's Hospital Central California v. Blue Cross of California* (2014) 226 Cal.App.4th 1260, 1268 (*Children's Hospital*) [hospital was only paid full "billed" amount "less than 5 percent" of the time over a two-year period]; *Vencor Inc. v. National States Ins. Co.* (9th Cir. 2002) 303 F.3d 1024, 1029, fn. 9 [only a "small minority of patients" pay the full billed rate]; see also Nation, *Hospital Chargemaster Insanity: Heeling the Healers* (2016) 43 Pepperdine L.Rev. 745, 748 ["Hospital administrators often argue that this [inflated hospital bills] does not matter because no one really pays chargemaster prices"]; Nation, *Determining the Fair and Reasonable Value of Medical Services: The Affordable Care Act, Governments Insurers, Private Insurers and Uninsured Patients* (2013) 65 Baylor L.Rev. 425, 456 [full amounts billed by hospitals are only paid five percent of the time]; Nation, *Obscene Contracts: The Doctrine of Unconscionability and Hospital Billing of the Uninsured* (2005) 94 Ky. L.J. 101, 104 [labeling hospital charges as " 'regular,' 'full,' or 'list,' [is] misleading, because in fact they are actually paid by less than five percent of patients nationally"]; Ireland, *The Concept of Reasonable Value in Recovery of Medical Expenses in Personal Injury Torts* (2008) 14 J. Legal Econ. 87, 88 ["only a small fraction of persons receiving medical services actually pay original amounts billed for those services"].)

- Olympia Medical Center: $35,148.30 [$86,599.85];
- Total Care Medical Center: $385.29 [$1,398.00];
- Pacific Hospital of Long Beach: $1,081.05 [$4,004.00];
- Saint Jude Medical Center: $456.07 [$1,217.60];
- Ventura County Medical Center: $5,963.50 [$14,816.50]; and
- Kaiser: $11,581.35 [$12,840.60].

(8 RT 1407-1408; 5 AA 1063.)

The jury accepted Dr. Alexander's testimony and awarded Pebley $269,000 for past medical services, which was the full amount stated on the bills. (Typed opn. 7-8.) Pebley was also awarded $375,000 for future medical damages and $3 million in past and future noneconomic damages. (Typed opn. 8.)

C. The Court of Appeal in a published opinion affirms the judgment, following *Bermudez* and deepening the split with *Ochoa* and *Corenbaum*.

Santa Clara appealed and the Court of Appeal (Division Six of the Second Appellate District) affirmed in a published opinion. The Court of Appeal phrased the issue as turning on whether Pebley, an insured plaintiff, should nonetheless be treated as an uninsured plaintiff for purposes of recovering medical damages: "Here, we are confronted with an *insured plaintiff* who has chosen to treat with doctors and medical facility providers outside his insurance plan. *We hold that such a plaintiff shall be considered uninsured, as*

opposed to insured, for the purpose of determining economic damages." (Typed opn. 2, emphases added.)

The Court of Appeal explained the current split of authority starting with *Corenbaum* and *Ochoa,* on one hand, and *Bermudez* on the other. (Typed opn. 10-11 [noting that *Bermudez* had "rejected *Ochoa's* reasoning in cases involving uninsured plaintiffs" and deciding to follow *Bermudez* rather than *Ochoa*].) The court held that the "better view" is to treat Pebley as "uninsured (or non-insured) for purposes of proving the amount of his damages for past and future medical expenses." (Typed opn. 15.) The court affirmed the judgment except for a reduction of $1,603, which Pebley conceded reflected amounts actually paid by his insurer that were erroneously awarded by the jury. (Typed opn. 21.)

ARGUMENT

I. The split of authority regarding application of *Howell* warrants review by this Court.

A. *Howell* held that amounts nominally "billed" by medical providers do not reflect market-tested values and thus are not an accurate measure of damages.

In *Howell*, this Court addressed the recurring issue of a plaintiff seeking to recover the inflated amount "billed" by medical providers compared to the reality of what providers collect in the marketplace. The Court held that a plaintiff "may recover as

economic damages *no more than the amounts paid* by the plaintiff or his or her insurer for the medical services received . . . ." (*Howell, supra*, 52 Cal.4th at p. 566, emphasis added.) "To be recoverable, a medical expense *must be both incurred and reasonable*." (*Id.* at p. 555, emphasis added.) "[I]f 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." (*Ibid.*) The necessary corollary to this rule is that if the plaintiff negotiates an inflated rate higher than might reasonably be charged, the plaintiff has not suffered a pecuniary loss in the greater amount.

The Court explained that pricing for medical services is controlled by a unique and complex dynamic—one in which amounts stated on bills and amounts actually collected vary to a significant extent depending on the categories of payees and payors. (*Howell, supra*, 52 Cal.4th at pp. 561-562.) Some payors, such as private health insurers, are "well equipped to conduct sophisticated arm's-length price negotiations." (*Id.* at p. 562.) Other payors, including uninsured patients, are guaranteed certain rates by state law. (*Id.* at p. 561.) Indeed, uninsured patients typically pay the same or even *less* than insured patients. (*Ibid.*) As a result, virtually no patients pay the nominally "billed" amounts, which the Court called "insincere." (*Id.* at pp. 561, 562-563 & fn. 9; see also *Children's Hospital, supra,* 226 Cal.App.4th at p. 1268 [hospital was paid full "billed" amount *"less than 5 percent" of the time* over a two-year period (emphasis added)]; *Sarun v. Dignity Health* (2014) 232

Cal.App.4th 1159, 1163 [class action allegation that uninsured patients received unsolicited 25 percent bill reduction from hospital].) As the Court summarized: "Because so many patients, insured, uninsured, and recipients under government health care programs, pay discounted rates, hospital bills have been called 'insincere, in the sense that they would yield truly enormous profits if those prices were actually paid.' " (*Howell,* at p. 561.)

Given these facts, the Court held the amount *billed* for medical expenses does not reflect *the value of the services recoverable in a tort action*: "[I]t is not possible to say generally that providers' full bills represent the real value of their services, nor that the discounted payments they accept from private insurers are mere arbitrary reductions." (*Howell, supra,* 52 Cal.4th at p. 562.) The Court thus held "evidence of the full billed amount is not itself relevant on the issue of past medical expenses." (*Id.* at p. 567.)

By contrast, evidence of the amount actually *paid* for medical expenses *is* relevant and not barred by the collateral source rule. "[W]hen a medical care provider has . . . 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." (*Howell, supra,* 52 Cal.4th at p. 567; see also *id.* at p. 562 [damages are measured by the "exchange value of medical services the injured plaintiff has been required to obtain"].)

In sum, *Howell* rejected amounts "billed" to the plaintiff in a particular case as the proper measure of damage in lieu of

competent evidence of what is actually paid and accepted for medical services in the marketplace. (*Howell, supra,* 52 Cal.4th at p. 562 [damages are measured by the "exchange value of medical services the injured plaintiff has been required to obtain"]; *id.* at p. 564 ["a medical care provider's billed price for particular services is not necessarily representative of either the cost of providing those services or their market value"].)

B. *Corenbaum* faithfully applied *Howell* and held that amounts billed to plaintiff are inadmissible as to past or future damages, and an expert cannot base opinions on amounts billed.

In *Howell,* this Court did not decide whether evidence of "billed" amounts for medical damages might be relevant and admissible "on other issues, such as noneconomic damages or future medical expenses." (*Howell, supra,* 52 Cal.4th at p. 567.) That issue was decided by Division Three of the Second Appellate District in *Corenbaum.*

Corenbaum dealt squarely with "admissibility in evidence of the full amount of an injured plaintiff's medical billings not only with respect to damages for past medical expenses, but also with respect to future medical expenses . . . ." (*Corenbaum, supra,* 215 Cal.App.4th at p. 1319.) The late Justice Walter Croskey explained that, because "the full amount billed is not an accurate measure of the value of medical services," the "full amount billed for past medical services is not relevant to a determination of the reasonable

value of future medical services." (*Id.* at pp. 1330-1331.) For the same reasons, *Corenbaum* precluded expert witnesses from relying on the inflated "billed amounts" to support opinions regarding future medical expenses. Evidence of billed amounts "*cannot support an expert opinion on the reasonable value of future medical services.*" (*Id.* at p. 1331, emphasis added; see also *id.* at p. 1333 [confirming bills in this context are not relevant to damages for past or future medical expenses].)

C. Numerous cases have followed *Corenbaum*, holding amounts billed are inadmissible.

Cases in state and federal court have followed *Corenbaum* in holding that a plaintiff's billed amounts are inadmissible to prove either past or future medical damages:

- *Markow, supra,* 3 Cal.App.5th at p. 1050 [Second Dist., Div. One] ("Our Supreme Court has endorsed a market or exchange value as the proper way to think about the reasonable value of medical services"; holding *Howell* and *Corenbaum* govern a plaintiff's burden of proving the reasonable value of future medical damages);
- *Cuevas v. Contra Costa County* (2017) 11 Cal.App.5th 163, 179 [First Dist., Div. One] (*Cuevas*) (following *Corenbaum* and *Markow*); *id.* at p. 180 (trial court erred in excluding amounts actually accepted for payment under the Affordable Care Act and Medi-Cal);

- *Romine, supra,* 224 Cal.App.4th at p. 1014 [Second Dist., Div. Five] (*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");

- *Hill v. Novartis Pharmaceuticals Corp.* (E.D.Cal. 2013) 944 F.Supp.2d 943, 963-964 (following *Corenbaum* and applying its holding under the Federal Rules of Evidence);

- *Pooshs v. Phillip Morris USA, Inc.* (N.D.Cal., May 22, 2013, No. C 04-1221 PJH) 2013 WL 2253780, at p. *2 (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. 12CV0908 AJB (WMC)) 2014 WL 1286567, at p. *3, fn. 2 ("evidence of medical expenses that were not actually paid is irrelevant in determining future damages"); and

- *United States v. Berkeley Heartlab, Inc.* (D.S.C., July 12, 2017, No. 9:14-cv-00230-RMG) 2017 WL 2972143, at p. *4 ("it is no secret that the sticker prices of services listed in physician bills and hospital chargemasters are totally unmoored from the reality of arm's-length transactions actually taking place in the marketplace"); *id.* at p. *5 [following *Howell, Corenbaum, Ochoa* and other cases for the proposition that "courts have uniformly acknowledged that physicians' billed charges do not necessarily reflect the market value of physician services").

Cases have also followed *Howell* with respect to government-sponsored insurance plans, such as the Affordable Care Act and

Medi-Cal (*Cuevas, supra,* 11 Cal.App.5th at pp. 178-180), as well as Medicare (*Luttrell v. Island Pacific Supermarkets, Inc.* (2013) 215 Cal.App.4th 196, 198, 205-207) and workers compensation (*Sanchez v. Brooke* (2012) 204 Cal.App.4th 126, 131).

D. *State Farm* and *Ochoa* held *Howell* is not limited to cases involving insurer-negotiated rates.

The issue in this case—whether *Howell* applies in the absence of a prenegotiated rate for medical services—was addressed in a pair of decisions which the Court of Appeal below did not follow.

Division One of the Fourth Appellate District addressed the amount a hospital could collect from a patient's recovery against a third party. (*State Farm, supra,* 216 Cal.App.4th at pp. 1471-1472.) In *State Farm*, a hospital sought to enforce a lien under the Hospital Lien Act (Civ. Code, § 3045.1), which permits a hospital to recover up to the " 'reasonable and necessary' " charges provided. (*State Farm,* at pp. 1469-1470.) There was no prenegotiated rate for the services provided. (*Id.* at p. 1467.) *State Farm* followed *Howell* and *Corenbaum* in holding that the amount billed in that context is not an accurate measure of the value of medical services. (*Id.* at p. 1471.) *State Farm* reversed a judgment based on the hospital bills, which did not constitute substantial evidence to support the judgment. (*Id.* at p. 1472.)

In *Ochoa, supra,* 228 Cal.App.4th 120, Division Three of the Second Appellate District addressed the measure of damages in a personal injury action where, as here, the plaintiffs treated on a lien

basis. (RB 34, fn. 1, 35 [plaintiffs in *Ochoa* "had been treated on a lien"].)[4] The trial court in *Ochoa* admitted evidence of the amount of plaintiff's unpaid medical "bills." (*Ochoa,* at p. 128.) The jury awarded plaintiff $345,539 for past medical damages and $26,000 for future medical damages. (*Ibid.*) The trial court granted a new trial because the "medical bills were not evidence of the reasonableness of the amounts charged." (*Id.* at p. 130.)

The Court of Appeal affirmed the substance of the trial court's new trial ruling. Pursuant to *Howell*, unpaid medical bills are *not* relevant to determining the amount of medical damages. (*Ochoa, supra,* 228 Cal.App.4th at pp. 134-136.) The court held that *Howell* "is not limited to the circumstance where the medical providers had previously agreed to accept a lesser amount as full payment for the services provided"; instead, *Howell* and *Corenbaum* "compel the conclusion that the same rule applies equally in circumstances where there was no such prior agreement." (*Id.* at pp. 135-136.)

Ochoa's holding was based on a long "line of authority holding or suggesting that unpaid medical bills are not evidence of the reasonable value of the services provided." (*Ochoa, supra,* 228 Cal.App.4th at pp. 136-137, citing *Latky v. Wolfe* (1927) 85 Cal.App. 332, 347, *Gimbel v. Laramie* (1960) 181 Cal.App.2d 77, 81 ["It has

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[4] The plaintiffs' opening brief on appeal in *Ochoa*, which is subject to judicial notice, confirms that the plaintiffs sought medical treatment on a lien basis. (Appellants' Opening Brief, *Ochoa v. Dorado* (Mar. 27, 2013, B240595) 2013 WL 1284229, at p. *15; Evid. Code, § 452, subd. (d) [judicial notice may be taken of the records of the court of this state].) In his respondent's brief in the Court of Appeal in this case, plaintiff's counsel (who was also counsel in *Ochoa*) confirms the point. (RB 34, fn. 1, 35.)

long been the rule that the cost alone of medical treatment and hospitalization does not govern the recovery of such expenses"], *Calhoun v. Hildebrandt* (1964) 230 Cal.App.2d 70, 73 [exclusion of unpaid medical bills was proper], and *Pacific Gas & E. Co. v. G. W. Thomas Drayage etc. Co.* (1968) 69 Cal.2d 33, 42-43 [unpaid bills are hearsay].)

Ochoa declined to follow other cases—which Pebley relied on below at page 34 of his respondent's brief—purporting to allow the admission of unpaid medical bills. (*Ochoa, supra*, 228 Cal.App.4th at pp. 137-139 ["We find the reasoning in [*Malinson v. Black* (1948) 83 Cal.App.2d 375, 379-380, *Guerra v. Balestrieri* (1954) 127 Cal.App.2d 511, 520, and *Katiuzhinsky v. Perry* (2007) 152 Cal.App.4th 1288, 1291-1292, 1295-1298] unpersuasive and decline to follow those opinions on this point"].)

Accordingly, *Ochoa* and *State Farm* both applied *Howell* to cases, such as this one, when there is no prenegotiated rate.

E. *Bermudez* created an express conflict when it held *Howell* inapplicable to uninsured plaintiffs.

Corenbaum and *Ochoa* reflected the state of the law regarding the application of *Howell* until 2015, when Division Three of the Fourth Appellate District decided *Bermudez*.

Bermudez involved a plaintiff who had no medical insurance at the time of the accident. (*Bermudez, supra,* 237 Cal.App.4th at p. 1324.) The defendant did not move to exclude unpaid bills, which

were admitted without objection, and the defendant stipulated to the admissibility of an exhibit summarizing the bills. (*Ibid.*)

Notwithstanding that the issue regarding the admissibility of the unpaid medical bills was not properly preserved for appellate review, the court in *Bermudez* nevertheless issued a wide-ranging opinion critical of the line of cases following *Howell* holding that unpaid medical bills were inadmissible, and concluded that *Howell* does not apply to uninsured plaintiffs, who may rely on their unpaid bills to prove medical damages. (*Bermudez, supra,* 237 Cal.App.4th at pp. 1328-1337.) According to *Bermudez*, this Court in *Howell* "did not actually hold that medical charges are inadmissible." (*Id.* at p. 1333, fn. 5.)

Bermudez expressly declined to follow *Corenbaum, State Farm*, and *Ochoa*. (*Bermudez, supra,* 237 Cal.App.4th. at pp. 1335-1337.) *Bermudez* questioned whether *Corenbaum* was correctly decided even with respect to insured plaintiffs (*id.* at p. 1335, fn. 6) and questioned whether *Ochoa* "intended to say something about the admissibility of evidence pertaining to the amount of unpaid medical bills" in which case "we reiterate our critique of *Corenbaum*" (*id.* at p. 1337). The court declined to decide whether a plaintiff bears the burden of introducing expert testimony regarding the market or exchange value of medical services because that issue was not preserved for appeal. (*Id.* at pp. 1339-1340.)

The defendant in *Bermudez* petitioned this Court for review, which was denied on September 9, 2015. (See Petition for Review, *Bermudez v. Ciolek* (Aug. 26, 2015, S228186) 2015 WL 6122297.) Given the thorough preservation of the issues for appellate review

here, this case is an appropriate vehicle to review the split of authority.

F. *Moore* and *Uspenskaya* from the Third Appellate District have also weighed in on the anti-*Howell* side of the ledger.

The Third Appellate District widened the split of authority in *Uspenskaya, supra,* 241 Cal.App.4th 996. As in *Bermudez,* the plaintiff in *Uspenskaya* lacked medical insurance, and she contracted with her medical providers to treat her on a lien basis, without a prenegotiated rate. (*Id.* at p. 999.) The medical provider sold the plaintiff's account receivable to a third-party financing company, and the trial court excluded the amount that the provider accepted in that transaction as one factor bearing on the market value of the services. (*Ibid.*) The Court of Appeal affirmed the exclusion under Evidence Code section 352. (*Ibid.*) The court seemingly rejected the *Howell* marketplace approach to determining the reasonable amount of medical bills by failing to follow *Corenbaum*. (*Id.* at p. 1005.) No petition for review was filed.

The Third District then doubled down on *Uspenskaya* in *Moore, supra,* 4 Cal.App.5th 424. Like *Uspenskaya, Moore* involved an uninsured plaintiff who was treated on a lien basis and the court, again, did not address the admissibility of billed amounts because that issue was not preserved for appellate review. (*Id.* at pp. 432, 441 [admissibility of billed amounts need not be addressed "because defendant in the case before us did not object to the

admission of the full amount of the bills at trial and therefore did not preserve the issue for review on appeal"].) Instead, *Moore* was confronted with the situation of medical providers who sell the plaintiff's account receivable to a medical finance company at a discount (usually 50 percent). (*Id.* at pp. 427-428.) *Moore* addressed whether the sale price of the account receivable capped the plaintiff's damages, and whether a trial court could exclude the sale price under Evidence Code section 352. (*Ibid.*) Even though the admissibility of billed amounts was not before the court, *Moore* criticized *Ochoa,* without explanation, for holding that billed amounts were inadmissible. (*Id.* at p. 441 ["We need not delve into why *Ochoa*'s reasoning is faulty"].) This Court denied the defendant's petition for review on January 11, 2017. (See Petition for Review, *Moore v. Mercer* (Dec. 19, 2016, S238709) 2016 WL 7492578.)

G. The Court of Appeal below followed *Bermudez,* furthering the split of authority and inviting litigation gamesmanship that is contrary to public policy.

It is against this background—*Ochoa* holding that *Howell* applies regardless of any prenegotiated rates and *Bermudez* holding otherwise for uninsured plaintiffs—that the opinion below must be viewed. The court here created the legal fiction that *insured* plaintiffs, such as Pebley, should be treated as *uninsured* when they choose to treat with a doctor who charges above-market rates (typed opn. 2), and that such plaintiffs may collect from defendants the

inflated amounts without the jury hearing evidence that the same care was available to plaintiffs at far lower costs. Without elaboration, the court decided that the "better view" is that Pebley should "be considered uninsured (or non-insured) for purposes of proving the amount of his damages for past and future medical expenses." (Typed opn. 15.)

The Court of Appeal's opinion thus further deepens an explicit split of authority on at least two issues:

> (1) *Corenbaum, Ochoa,* and *Romine* all hold that unpaid billed amounts are not evidence of the recoverable market value of services, whereas *Bermudez* and the Court of Appeal below held that billed amounts are admissible; and
>
> (2) *Ochoa* and *State Farm* hold that *Howell* provides the measure of damages and rule of admissibility regardless of whether services were provided at prenegotiated rates, whereas the Court of Appeal below and *Bermudez* both hold that *Howell* does not apply where the treating provider's bills are unbounded by any pre-injury negotiation.

Review by this Court is sorely needed to address this well-developed split of authority.

Review by this Court is also warranted to address important public policy issues raised by the Court of Appeal's opinion. First, the opinion effectively endorses the admonition by Pebley's counsel that plaintiffs should make decisions about treating providers not with an aim to secure the best medical outcome, but with an aim to maximize the amount that can be blackboarded in litigation against a third party defendant. (2 AA 317-318.) Excluding evidence about

why a plaintiff chose a particular doctor, and allowing a jury to render a verdict based on a doctor's "bills" without allowing the jury to hear that the same or better treatment could be had at a far lower cost, the opinion unwisely departs from the basic premise of reasonable recovery based on market rates. After all, " 'reasonable value' " in this context " 'is a term of limitation, not of aggrandizement.' " (*Howell, supra,* 52 Cal.4th at p. 553.)

Second, California has wholeheartedly embraced the Affordable Care Act (sometimes called Obamacare) and a recent study by the National Center for Health Statistics shows that over 93 percent of Californians have health insurance as of June 2017. (See Nat. Center for Health Statistics, Center for Disease Control & Prevention, U.S. Dept. Health & Human Services, Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, 2017 (May 2018) p. A24 <https://bit.ly/2J3BBZb> [as of June 8, 2018] [showing California's uninsured rate at 6.8 percent as of June 2017].) Having health insurance is critical after an accident requiring medical care, and allows for important continuity of quality care before, during, and after litigation arising from any such accident. Yet the Court of Appeal's opinion undermines this important public policy by creating economic incentives for personal injury plaintiffs *not* to use their health insurance and, instead, to incur vastly inflated lien amounts—amounts that this Court in *Howell* held are rarely, if ever, otherwise paid in real life.

Pebley never said he was unsatisfied with the treatment he received at Kaiser or could have obtained through Medicare.[5] (See 6 RT 1023, 1026-1027.) Instead, according to Pebley's counsel (and others), this is done as a litigation tactic in order to circumvent *Howell, Corenbaum,* and the Affordable Care Act, precisely as described in the Court of Appeal's opinion. (See typed opn. 4; 2 AA

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[5] The Court of Appeal here said that "Pebley had the right to seek the best care available" (typed opn. 15), but *the record contains no evidence that the lien doctors provided the best care available.* About Pebley's choice, the Court of Appeal could say only that Pebley "was comfortable with the surgeon's credentials and experience," but no evidence indicates Pebley would not have been just as "comfortable" with someone charging far less within his insurance plan or who accepts Medicare. (*Ibid.*)

Moreover, the court's comment misconceives the relevant measure of damages. Pebley may of course seek out the best care available, but can *recover from a defendant* only the *reasonable value* for the best care available. If a plaintiff wants to show that marginally better care might be had by flying to Europe to treat with someone recommended by a friend in his "men's group" (typed opn. 4; see 6 RT 1026), the plaintiff should be prepared to demonstrate to a jury why that was reasonable.

The Court of Appeal said a patient like Pebley "may wish to choose a physician or surgeon who specializes in treating the specific type of injury involved, but who does not accept the plaintiff's insurance or any other type of insurance. In addition, health care providers that bill through insurance, rather than on a lien basis, may be less willing to participate in the litigation process." (Typed opn. 14.) But nothing in the record showed specialists akin to Dr. Alexander would not accept Pebley's insurance plan, nor that doctors within his plan would not participate in the litigation process.

Simply put, the Court of Appeal relieved Pebley of his burden to show any reasonable basis for incurring the inflated charges he claimed to have incurred.

317-318; Ellison, *supra*, at p. 3.) It increases not only the economic damages, but also noneconomic damages. As this Court has explained, "the cost of medical care often provides both attorneys and juries in tort cases with an important measure for assessing the plaintiff's general damages." (*Helfend v. Southern Cal. Rapid Transit Dist.* (1970) 2 Cal.3d 1, 11.)

A vast body of commentary has already developed around the *Pebley* decision. Just one example is the observation by a neutral mediator who recently expressed this view: *Pebley* "is a huge holding in the personal-injury and tort world. Introducing the full value of medical services in today's environment of very expensive medical charges can yield much larger damages numbers." (Knight, *Court of Appeal holds that injured plaintiffs have no duty to treat under insurance and, if they treat outside of insurance, the full amount charged may be sought as damages* (May 9, 2018) <https://bit.ly/2sO7lHn> [as of June 7, 2018]; accord, Fiola, *Recent Appellate Decision Favors Plaintiffs in Valuation of Past Medical Damages* (May 10, 2018) <https://bit.ly/2JoHK2K> [as of June 7, 2018] ["In the aftermath of *Pebley*, we can expect a dramatic increase in insured plaintiffs seeking treatment outside of their network, in order to drive up the amount of medical damages, and increase the potential settlement value"].)

Review is warranted, not just to address the explicit split of authority, but also to address the important public policy issues raised by the Court of Appeal's opinion.

II. Review is also warranted to address the role the doctrines of mitigation of damages and the avoidable consequences doctrine play in determining the recoverable reasonable value of medical services.

This case also presents important issues regarding mitigation of damages, the avoidable consequences doctrine, and the interplay between those common law defenses and plaintiff's choice to incur, at least in theory, charges that the plaintiff plans to use as the basis for a litigation claim.

Prior to the Court of Appeal's opinion, California law had been clear that every plaintiff "has a duty to mitigate damages and cannot recover losses it could have avoided through reasonable efforts." (*Thrifty-Tel, Inc. v. Bezenek* (1996) 46 Cal.App.4th 1559, 1568; see also *Shaffer v. Debbas* (1993) 17 Cal.App.4th 33, 41 [same]; *Placer County Water Agency v. Hofman* (1985) 165 Cal.App.3d 890, 897 [same]; *Mayes v. Sturdy Northern Sales, Inc.* (1979) 91 Cal.App.3d 69, 85-86 ["A plaintiff cannot recover damages that would have been avoidable by his or her ordinary care and reasonable exertions"], disapproved on another ground in *Applied Equipment Corp. v. Litton Saudi Arabia Ltd.* (1994) 7 Cal.4th 503, 521, fn. 10.)

Similarly, "[u]nder the avoidable consequences doctrine as recognized in California, 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; see also *Davies v. Krasna* (1975) 14 Cal.3d 502, 515 ["victims of legal wrongs should make reasonable efforts to avoid incurring further damage"].) Under the avoidable consequences doctrine, " 'a plaintiff's recoverable damages do not include those damages that the plaintiff could have avoided with reasonable effort and without undue risk, expense, or humiliation.' " (*Rosenfeld v. Abraham Joshua Heschel Day School, Inc.* (2014) 226 Cal.App.4th 886, 900, citing *State Dept. of Health Services*, at p. 1034.) The doctrine is rooted in the common law and applies to " 'civil actions generally.' " (*Ibid.*) Thus, the doctrine applies equally to contract and tort actions and applies in personal injury actions. (6 Witkin, Summary of Cal. Law (11th ed. 2017) Torts, § 1728, pp. 1232-1234.)

Complementing these common law doctrines, the Affordable Care Act mandates that every individual obtain health insurance (26 U.S.C. § 5000A(a)) and that medical insurance must be offered on a guaranteed issue and renewal basis, despite preexisting conditions (42 U.S.C. §§ 300gg-1(a), 300gg-2(a), 300gg-3(a)). Thus, all Californians have access to, and indeed are required to purchase, health insurance regardless of any preexisting condition.

As Santa Clara argued below (AOB 44-46), these doctrines do not dictate that an injured plaintiff must treat with any particular physician. That choice has always resided with the plaintiff. But these doctrines do militate that a plaintiff cannot unreasonably and intentionally *increase* their damages and shift them onto the defendant tortfeasor. Indeed, without a duty to mitigate damages, there is now no check on the ability of a plaintiff to "run up" medical bills and "incur" inflated charges. For example, if the Court of

Appeal's opinion remains the law, Dr. Alexander (or a friend or family member of the patient) could in the next case, simply "bill" a million dollars for the same surgery and claim that it is "reasonable," yet the defense would be prevented from offering evidence that the plaintiff had multiple less expensive options for the same quality medical procedure. Indeed, public records show that Dr. Alexander accepts Medicare, so Pebley could have had his surgery performed by Dr. Alexander for a fraction of the amount nominally billed and awarded by the jury in this case. (*Pierce v. Gray* (Apr. 18, 2017) 2017 WL 6452159, at p. *2, appeal filed Sept. 13, 2017 (G055432) [trial court's new trial order in case where the plaintiff was a Medicare recipient and Dr. Alexander accepted Medicare, but the plaintiff nonetheless treated on a lien basis for $250,000 when Medicare would have paid $5,000-$25,000].)[6]

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[6] This trial court order is not cited as legal authority, but simply to demonstrate the historical fact that Dr. Alexander has said he accepts Medicare. (See *Ray v. First Federal Bank* (1998) 61 Cal.App.4th 315, 318 & fn. 1 [court looked to unpublished opinion: "The decision is relevant not as legal authority but as an historical fact"].) That is something defense counsel was not allowed to inquire into in this case.

CONCLUSION

For the reasons explained above, this Court should grant review to address these important issues. (Cal. Rules of Court, rule 8.500(b)(1).) Because of the importance of this issue to numerous pending cases, the Court should also exercise its discretion and order that the Court of Appeal opinion cannot be cited pending resolution of the case before this Court. (Cal. Rules of Court, rule 8.1115(e)(3).)

June 15, 2018

HORVITZ & LEVY LLP
LISA PERROCHET
STEVEN S. FLEISCHMAN
BENTON, ORR, DUVAL & BUCKINGHAM
KEVIN M. McCORMICK
PANDA L. KROLL

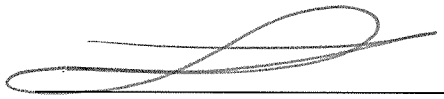
By: _____
Steven S. Fleischman

Attorneys for Defendants and Appellants
SANTA CLARA ORGANICS, LLC and JOSE PULIDO ESTRADA

CERTIFICATE OF WORD COUNT
(Cal. Rules of Court, rule 8.504(d)(1).)

The text of this petition consists of 7,957 words as counted by the Microsoft Word version 2010 word processing program used to generate the petition.

Dated: June 15, 2018



Steven S. Fleischman

Court of Appeal Opinion
B277893 • May 8, 2018

CERTIFIED FOR PUBLICATION

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION SIX

DAVE PEBLEY,

Plaintiff and Respondent,

v.

SANTA CLARA ORGANICS, LLC, et al.,

Defendants and Appellants.

2d Civ. No. B277893
(Super. Ct. No. 56-2013-00436036-CU-PA-VTA)
(Ventura County)

An injured plaintiff with health insurance may not recover economic damages that exceed the amount paid by the insurer for the medical services provided. (*Howell v. Hamilton Meats & Provisions, Inc.* (2011) 52 Cal.4th 541, 566 (*Howell*). The amount of the "full bill" for past medical services is not relevant to prove past or future medical expenses and/or noneconomic damages. (*Id.* at p. 567; *Corenbaum v. Lampkin* (2013) 215 Cal.App.4th 1308, 1330-1331 (*Corenbaum*).) In contrast, the amount or measure of economic damages for an uninsured plaintiff typically

turns on the reasonable value of the services rendered or expected to be rendered. (*Bermudez v. Ciolek* (2015) 237 Cal.App.4th 1311, 1330-1331 (*Bermudez*).) Thus, an uninsured plaintiff may introduce evidence of the amounts billed for medical services to prove the services' reasonable value. (*Id.* at pp. 1330-1331, 1335.)

Here, we are confronted with an insured plaintiff who has chosen to treat with doctors and medical facility providers outside his insurance plan. We hold that such a plaintiff shall be considered uninsured, as opposed to insured, for the purpose of determining economic damages.

Plaintiff Dave Pebley was injured in a motor vehicle accident caused by defendant Jose Pulido Estrada, an employee of defendant Santa Clara Organics, LLC (Santa Clara). Although Pebley has health insurance, he elected to obtain medical services outside his insurance plan. A jury found defendants liable for Pebley's injuries and awarded him $3,644,000 in damages, including $269,000 for past medical expenses and $375,000 for future medical expenses. For the most part, Pebley recovered the amounts that were billed for past services and expected to be incurred for future services.

We conclude the trial court properly allowed Pebley, as a plaintiff who is treating outside his insurance plan, to introduce evidence of his medical bills. Pebley's medical experts confirmed these bills represent the reasonable and customary costs for the services in the Southern California community. Pebley testified he is liable for these costs regardless of this litigation, and his treating surgeons stated they expect to be paid in full. The court permitted defendants to present expert testimony that the reasonable and customary value of the services provided by the

various medical facilities is substantially less than the amounts actually billed, and defendants' medical expert opined that 95% of private pay patients would pay approximately 50% of the treating professionals' bills. The jury rejected this expert evidence and awarded Pebley the billed amounts.

Based on this record, defendants have not demonstrated error except with respect to two charges. It is undisputed the jury improperly awarded Pebley the amounts billed by Ventura County Medical Center (VCMC) and American Medical Response (AMR) instead of the amounts paid to these providers by his insurance carrier. The difference between the amounts billed and the amounts paid is $1,063. We therefore reduce the damage award by that amount and affirm the judgment as modified.

FACTS AND PROCEDURAL BACKGROUND

A. The Accident

On May 9, 2011, Pebley and his wife, Joline, were returning from a camping trip in their motor home. Mrs. Pebley was driving eastbound on the 126 freeway in Ventura County when the vehicle developed a flat tire. She turned on the hazard lights, pulled over to the right shoulder and stopped. A portion of the motor home remained in the No. 2 lane.

In the rearview mirror, Mrs. Pebley saw a Kenworth "big rig" truck bearing down on them from behind. The driver, Estrada, who was travelling at approximately 50 miles per hour, crashed into the left rear end of the motor home with sufficient force to break the passenger seat in which Pebley was seated.

The truck, which was owned by Santa Clara, was carrying a 40,000-pound load at the time of the collision. Pebley was transported to the hospital by ambulance, treated and released. He suffered injuries to his face, teeth, neck and lower back.

B. Pebley's Medical Treatment

Pebley initially sought treatment through his health insurance carrier, Kaiser Permanente (Kaiser). After filing a personal injury action against defendants, Pebley obtained care from an orthopedic spine specialist, Dr. Gerald Alexander, who is outside the Kaiser network. Pebley testified he was referred to Dr. Alexander by members of his men's group. Defendants claim Pebley was referred to the doctor by his attorneys. They point to an internet article co-written by one of Pebley's attorneys. The article notes that "[t]ypically, medical liens in personal injury cases have been used where the plaintiff is uninsured, or where the insurance provider will not cover or refuses to authorize recommended medical care." The authors propose, however, that insured plaintiffs use the lien form of medical treatment, which "effectively allows the plaintiff and his or her attorney to sidestep the insurance company and the impact of *Howell*, *Corenbaum* and Obamacare." They maintain that treating on a lien basis increases the "settlement value" of personal injury cases. Pebley's post-Kaiser medical treatment was provided on that basis.

Dr. Alexander performed a 3-level cervical fusion surgery on March 13, 2014.[1] His co-surgeon was Dr. Carl Lauryssen. At trial, both doctors testified that the injuries Pebley suffered in the accident necessitated the surgery. Dr. Alexander also testified that Pebley would require additional cervical fusion surgery as well as lumbar fusion surgery. Dr. Alexander explained that a person undergoing spinal fusion surgery is "never normal again," and that Pebley could expect decreased

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[1] Defendants claim Pebley became Medicare eligible in 2013, but Medicare was not billed for the surgery.

range of motion, ongoing weakness and numbness, and chronic pain for the rest of his life.

C. Motions in Limine

The parties filed numerous motions in limine addressing the admissibility of evidence concerning Pebley's medical treatment costs. Pebley's motion in limine No. 1 requested exclusion of evidence that Pebley was insured through Kaiser as well as defense arguments concerning Pebley's decision not to seek medical treatment through his insurance. Defendants conceded that Pebley was allowed to treat with doctors outside his insurance plan, but asserted the cost of available in-plan services was relevant to the measure of damages. Pebley claimed a due process right to make medical treatment decisions irrespective of insurance. The trial court granted Pebley's motion in limine.

Pebley's motion in limine No. 2 sought to exclude evidence of the amounts an insurance company may pay, or what a medical provider may accept, for medical services, both past and future. The motion was granted, along with motion in limine No. 5, which excluded evidence that Pebley obtained most of his medical treatment on a lien basis.[2]

Pebley's motion in limine No. 9 sought to preclude the defense's expert, Dr. Henry Miller, from challenging Pebley's evidence regarding the reasonable value of medical services. Pebley asserted that Dr. Miller's methodology for evaluating marketplace costs improperly includes the rates that providers

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[2] The trial court denied defendants' corresponding motions in limine (Nos. 18 and 19) to admit evidence that Pebley sought medical treatment on a lien basis and was insured through Kaiser and Medicare.

accept from insurance companies and Medicare. The trial court conducted a hearing under Evidence Code section 402 to determine the admissibility of Dr. Miller's testimony.

Outside the jury's presence, Dr. Miller explained that part of his methodology in calculating the fair market value of a physician's professional fees is to determine what Medicare pays for that service and then to proportionately increase that rate to reflect pricing in the relevant community. Miller takes into account the Milliman Study, which was jointly funded by the American Hospital Association and insurance companies.

Pebley's surgery was performed at Olympia Medical Center (Olympia). Based on publicly available reports sent to the California Office of State Health Planning and Development, Dr. Miller determined the amount Olympia would accept as payment for its facility services, as distinct from what it would charge. Dr. Miller used the same information to determine the cash prices accepted by other medical facilities. Dr. Miller confirmed his calculation by telephoning Olympia and discovering that the cash price the hospital would accept for the surgical procedure performed on Pebley was $40,000, as opposed to the $86,599.85 billed for the procedure. Dr. Miller employed a different methodology to calculate the costs of professional services (i.e., physician fees rather than facility/hospital fees).

The trial court ruled that Dr. Miller could opine about the facility/hospital fees, but not the professional physician fees. It determined that Dr. Miller was "competent to testify as to everything except for the professional services fees" because his opinion on those fees required references to insurance. As a result, Dr. Miller testified at trial that the amount Olympia, Total Care Medical, Pacific Hospital of Long Beach, St. Jude

Medical Center, VCMC and Kaiser would accept for their services totaled $54,615.56, instead of the $120,876.55 requested by Pebley. Dr. Miller was not permitted to offer any opinions regarding the reasonable value of the treating physicians' care. The amount charged by Drs. Alexander and Lauryssen totaled $103,031.60.

Defendants' motion in limine No. 16 sought to exclude evidence of unpaid "bills" from health care providers pursuant to *Howell* and its progeny. This would have required Pebley to introduce independent evidence of market rate values for the care he received. The trial court denied the motion. It also denied defendants' motion in limine No. 20, which sought to prevent Dr. Alexander from offering opinions on the "reasonableness" of medical expenses based on unpaid billed amounts.

The trial court stated it was extending the ruling in *Bermudez*, which involved an uninsured plaintiff, to cover the facts of this case. As a result, the full lien amounts that were billed were admissible. The court acknowledged, however, that under *Howell*, "clearly, the notion is the full amount billed is not the appropriate amount, it's somewhere . . . below that." It explained: "So it really boils down to a . . . battle of the experts. Plaintiff[] can come in and say, here's [my] bill, it's $300,000 and an expert says, hey, 300 is right on. And the other side is going to come in and say, no, we can get all of these things for $100,000, and, but we can't have any talk at all about insurance, about how the $100,000 is justified."

D. The Verdict and Motion for New Trial

The jury unanimously found that defendants were negligent, and that neither Pebley nor his wife was negligent. It awarded Pebley past medical expenses of $269,000 (the full

amount requested by Pebley), future medical expenses of $375,000, past noneconomic damages of $900,000, and future noneconomic damages of $2,100,000.

Defendants moved for a new trial, arguing the damages were excessive and that the award of medical expenses could not stand under *Howell* and its progeny. The trial court summarily denied the motion. Defendants appeal.

DISCUSSION

A. Standard of Review

Whether a plaintiff ""is entitled to a particular measure of damages is question of law subject to de novo review."" (*Markow v. Rosner* (2016) 3 Cal.App.5th 1027, 1050.) The amount of damages, however, is a question of fact. The award will not be disturbed if it is supported by substantial evidence. (*Ibid.*)

The trial court's evidentiary rulings are reviewed for abuse of discretion. (*Moore v. Mercer* (2016) 4 Cal.App.5th 424, 444 (*Moore*).)

B. Admissibility of Medical Providers' Bills to Prove Economic Damages

"Before 1988 a plaintiff, relying on the collateral source rule, could recover the full amount of a health provider's charges despite the fact that an insurer or governmental agency had prenegotiated a discounted rate for the services and the plaintiff was not liable for the full amount. (*Helfend v. Southern Cal. Rapid Transit Dist.* (1970) 2 Cal.3d 1, 6.) The 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.'" (*Moore*, *supra*, 4 Cal.App.5th at p. 437.)

The 1988 change came when the Court of Appeal decided *Hanif v. Housing Authority* (1988) 200 Cal.App.3d 635 (*Hanif*). That case limited awards for medical damages in cases where the plaintiff has a benefit (in that case Medi-Cal) that has a prenegotiated arrangement with the medical services provider for reduced cost of the services. (*Id.* at pp. 643-644.) A similar rule was adopted for private medical insurance in *Howell*, *supra*, 52 Cal.4th at page 566. Since *Hanif* and *Howell*, "the measure of medical damages is the lesser of (1) the amount paid or incurred, and (2) the reasonable value of the medical services provided." (*Bermudez*, *supra*, 237 Cal.App.4th at p. 1330; see *Howell*, *supra*, 52 Cal.4th at p. 555.)

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." (*Howell*, *supra*, 52 Cal.4th at p. 566.) The court in *Howell* reasoned that because insured plaintiffs incur only the fee amount negotiated by their insurer, not the initial billed amount, insured plaintiffs may not recover more than their actual loss, i.e., the amount incurred and paid to settle their medical bills. (*Id.* at p. 555.) The court explained, "It follows from our holding that when a medical care provider has, by agreement with the plaintiff's private health insurer, 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 p. 567.)

Howell recognized there is "an element of fortuity" involved with respect to the medical expenses a tortfeasor may be liable to pay. (*Howell*, *supra*, 52 Cal.4th at p. 566.) For example, "[a] tortfeasor who injures a member of a managed care organization may pay less in compensation for medical expenses than one who inflicts the same injury on an uninsured person treated at a hospital." (*Ibid.*)

Relying upon *Howell*, the Court of Appeal in *Corenbaum* concluded that in an action involving an insured plaintiff, evidence of the full amount billed for past medical services is irrelevant and thus inadmissible to prove past medical expenses, future medical expenses and/or noneconomic damages. (*Corenbaum*, *supra*, 215 Cal.App.4th at pp. 1328-1333.) In so ruling, the court distinguished *Katiuzhinsky v. Perry* (2007) 152 Cal.App.4th 1288, 1295-1296 (*Katiuzhinsky*), which determined that evidence of the full amount billed is admissible to assess the reasonable value of past medical services if the plaintiff is uninsured and "remained fully liable to [his or her] medical providers for the full amount billed . . . ." (*Corenbaum,* at p. 1328, fn. 10.)

Citing *Howell* and *Corenbaum,* the court in *Ochoa v. Dorado* (2014) 228 Cal.App.4th 120 (*Ochoa*), held that even where there is no prenegotiated discounted rate, "the full amount billed, but unpaid, for past medical services is not relevant to the reasonable value of services provided." (*Id.* at p. 135.) *Ochoa* acknowledged that *Howell* "did not expressly hold that unpaid medical bills are not evidence of the reasonable value of the services provided," but it interpreted *Howell* as "strongly

suggest[ing] such a conclusion." (*Ochoa*, at p. 135.) The court declined to follow *Katiuzhinsky*, finding it unpersuasive with respect to whether billed medical charges reflect the reasonable value of services provided. (*Ochoa*, at p. 138.) Rather, it concluded that "evidence of unpaid medical bills cannot support an award of damages for past medical expenses." (*Id.* at p. 139.)

The Court of Appeal in *Bermudez*, *supra*, 237 Cal.App.4th 1311, rejected *Ochoa's* reasoning in cases involving uninsured plaintiffs. It noted that *Howell* had clarified the law with respect to the recovery of medical damages where the injured person is insured, but that "[t]he ramifications of *Howell* . . . in a case brought by an uninsured plaintiff (who has not paid his bill) are less clear." (*Bermudez*, at p. 1329, italics omitted.) The court explained, "*Howell* certainly did not suggest uninsured plaintiffs are limited in their measure of recovery to the typical amount incurred by an insured plaintiff, or, for that matter, the typical amount incurred by any other category of plaintiff." (*Ibid.*) Nor did *Howell* offer any "bright-line rule on how to determine 'reasonable value' when uninsured plaintiffs have incurred (but not paid) medical bills"; it merely endorsed the use of a "market or exchange value," which *Bermudez* deemed consistent with *Katiuzhinsky*. (*Bermudez*, at p. 1330.) *Bermudez* concluded, "[T]he measure of damages for uninsured plaintiffs who have not paid their medical bills will usually turn on a wide-ranging inquiry into the reasonable value of medical services provided, because uninsured plaintiffs will typically incur standard, nondiscounted charges that will be challenged as unreasonable by defendants." (*Id.* at pp. 1330-1331; accord *Uspenskaya v. Meline* (2015) 241 Cal.App.4th 996, 1007.)

In sum, when a plaintiff is not insured, medical bills are relevant and admissible to prove both the amount incurred and the reasonable value of medical services provided. (*Bermudez*, *supra*, 237 Cal.App.4th at p. 1335, 1337; *Katiuzhinsky*, *supra*, 152 Cal.App.4th at pp. 1295-1296 [bills for charges incurred by the plaintiff were admissible "as they reflected on the nature and extent of plaintiffs' injuries and were therefore relevant to [the jury's] assessment of an overall general damage award"].) But the uninsured plaintiff also must present additional evidence, generally in the form of expert opinion testimony, to establish that the amount billed is a reasonable value for the service rendered. (*Bermudez*, at pp. 1336, 1338.) Thus, if the plaintiff has an expert who can competently testify that the amount incurred and billed is the reasonable value of the service rendered, he or she should be permitted to introduce that testimony. The defendant may then test the expert's opinion through cross-examination and present his or her own expert opinion testimony that the reasonable value of the service is lower. A jury could, based on this "wide-ranging inquiry," best decide the reasonable value of the medical treatment, which is likely to be the cap on the uninsured plaintiff's medical damages. (*Id.* at pp. 1330-1331, 1338.)

C. An Injured Plaintiff Who Elects Not to Use an Available Insurance Plan Will be Treated as "Uninsured"

The threshold issue before us is whether Pebley is to be classified as insured or uninsured under *Howell* and its progeny. Although Pebley admittedly has health insurance, he chose to receive medical services outside his insurance plan. As defendants concede, Pebley had a right to choose physicians and medical facilities outside his plan, but they maintain he also had

a duty to mitigate his damages. They assert he did not meet this duty when he elected to treat with lien providers.

Defendants cite no specific authority for this assertion. They reference general authority that every plaintiff has a duty to take reasonable steps to minimize the loss caused by a defendant's actions. (*Placer County Water Agency v. Hofman* (1985) 165 Cal.App.3d 890, 897.) For example, "[u]nder the avoidable consequences doctrine as recognized in California, 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; *Rosenfeld v. Abraham Joshua Heschel Day School, Inc.* (2014) 226 Cal.App.4th 886, 900 ["'[A] plaintiff's recoverable damages do not include those damages that the plaintiff could have avoided with reasonable effort and without undue risk, expense, or humiliation.'"].)

Defendants maintain Pebley failed to mitigate his medical expenses by opting for the most expensive method to pay for his treatment. They contend that Pebley's unreasonable choice of going outside his insurance plan for treatment resulted in excess medical expenses which constitute avoidable losses Pebley seeks to pass on to defendants.

Defendants do not dispute, however, that Pebley is entitled to recover the lesser of (1) the amount incurred or paid for medical services, and (2) the reasonable value of the services rendered. (*Howell*, *supra*, 52 Cal.4th at pp. 555-556; *Bermudez*, *supra*, 237 Cal.App.4th at pp. 1330-1331, 1337.) The fact that Pebley chose to pay for those services out-of-pocket, rather than use his insurance, is irrelevant so long as these requirements are

met. We therefore reject defendants' argument that Pebley failed to mitigate his damages. A tortfeasor cannot force a plaintiff to use his or her insurance to obtain medical treatment for injuries caused by the tortfeasor. That choice belongs to the plaintiff. If the plaintiff elects to be treated through an insurance carrier, the plaintiff's recovery typically will be limited to the amounts paid by the carrier for the services provided. (*Howell*, at p. 566.) But where, as here, the plaintiff chooses to be treated outside the available insurance plan, the plaintiff is in the same position as an uninsured plaintiff and should be classified as such under the law.

There are many reasons why an injured plaintiff may elect to treat outside his or her insurance plan. As Pebley points out, plaintiffs generally make their health insurance choices before they are injured. These choices may be based on the plaintiffs' willingness to bear the risk posed by a health maintenance organization (HMO) rationing system because the plaintiff is healthy and requires little care. This decision may appear much different after a serious accident, when the plaintiff suddenly needs complex, extensive care that an HMO is not structured to provide. (See, e.g., *Pegram v. Herdrich* (2000) 530 U.S. 211, 220-221 [147 L.Ed.2d 164] ["inducement to ration care goes to the very point of any HMO scheme"].) The plaintiff also may wish to choose a physician or surgeon who specializes in treating the specific type of injury involved, but who does not accept the plaintiff's insurance or any other type of insurance. In addition, health care providers that bill through insurance, rather than on a lien basis, may be less willing to participate in the litigation process.

It is undisputed Pebley required complex surgery to fuse three of his cervical vertebrae. Complications from this type of surgery include paralysis or death. And even absent complications, a poor outcome would leave Pebley with continued pain in his neck and weakness and numbness in his arms and hands. Pebley had the right to seek the best care available and the incentive to do so.

Pebley testified he met with Dr. Alexander and was comfortable with the surgeon's credentials and experience. As a result, Pebley chose to have Dr. Alexander perform the cervical spine fusion surgery. Pebley confirmed he is personally liable for all of the costs of that surgery and his related treatment. Defendants cite no authority suggesting that Pebley's tort recovery should be limited to what Kaiser (and possibly Medicare) would have paid had he chosen to treat with providers who accept that insurance. The better view is that he is to be considered uninsured (or non-insured) for purposes of proving the amount of his damages for past and future medical expenses. (See *Bermudez*, *supra*, 237 Cal.App.4th at pp. 1336-1337.) It would be inequitable to classify Pebley as insured when Pebley, and not an insurance carrier, is responsible for the bills. Indeed, precluding Pebley from recovering the reasonable value of the services for which he is liable would result in both undercompensation for Pebley and a windfall for defendants. (*Katiuzhinsky*, *supra*, 152 Cal.App.4th at p. 1296.)

Finally, we conclude the trial court did not abuse its discretion by excluding evidence of Pebley's insured status under Evidence Code section 352. Pebley had the right to treat outside his plan. Evidence of his insurance would have confused the issues or misled and prejudiced the jury.

D. The Parties Properly Engaged in a "Wide-Ranging Inquiry" Regarding the Reasonable Value of Pebley's Medical Expenses

Because Pebley elected to treat outside his insurance plan, the trial court did not err by allowing him to introduce evidence of the $269,498.65 in billed charges for his past medical services. (*Bermudez*, *supra*, 237 Cal.App.4th at p. 1335, 1337; *Katiuzhinsky*, *supra*, 152 Cal.App.4th at pp. 1295-1296.) But that evidence was insufficient, by itself, to establish the reasonable value of the services rendered. (*Bermudez*, *supra*, at pp. 1336, 1338.) Under *Bermudez*, Pebley was required to proffer expert testimony on the issue. (*Id.* at p. 1335.)

The two surgeons who performed Pebley's cervical fusion surgery, Drs. Alexander and Lauryssen, both offered their opinions concerning the reasonable value of Pebley's medical care. Dr. Alexander testified as a non-retained treating surgeon and also as a retained spine expert. Dr. Alexander, who is board certified, has performed approximately 1,000 cervical spinal fusion surgeries and between 2,000 and 3,000 lumbar surgeries.

Dr. Alexander was shown Exhibit No. 85, which set forth Pebley's billed medical costs for accident-related care through the date of trial. Dr. Alexander explained that "[i]n addition to being familiar with the costs of these types of surgeries for my own patients, I've reviewed hundreds of other cases and I'm very familiar with the standard costs for this type of treatment." This included familiarity with the costs of emergency room treatment, MRIs, CT scans, physical therapy and ambulance transport.

Dr. Alexander testified that all of the costs listed on Exhibit No. 85 are "reasonable and customary costs in the community." With respect to future medical care, Dr. Alexander stated Pebley would require a lumbar fusion surgery, as well as one or two

additional cervical fusion surgeries. He testified that the lumbar surgery would cost "around $175,000," including the hospital charges. As for the cervical fusion surgeries, he said the reasonable and customary cost for one level is $125,000. If two levels are done, the cost is closer to $175,000. He opined that the surgeries are reasonably certain to be necessary at some point in Pebley's lifetime.

On cross-examination, Dr. Alexander testified there is an expectation that a private pay party with a large bill will pay the bill. Pebley has not paid his bill, but Dr. Alexander expects it will be paid. He conceded he does not always get paid 100% of his bills, but stated he does not routinely discount them.

Dr. Lauryssen, the neurosurgeon who served as co-surgeon during Pebley's surgery, testified (via deposition) that he is a former director of spine research at Cedars-Sinai Medical Center and Olympia. He has done close to 4,000 surgeries, about half of which involved the cervical spine. Dr. Lauryssen testified that he lived and practiced in Los Angeles for ten years and is familiar with the costs for cervical and lumbar surgeries at hospitals in that area. He stated the reasonable and customary all-inclusive cost for the cervical fusion surgery that Pebley underwent is about $150,000. He explained this amount would also be a realistic estimate for the reasonable and customary cost of the future cervical fusion surgery that Pebley would require.

As defendants point out, both surgeons emphasized the reasonable cost of the medical services rather than their reasonable value, market value or exchange rate value. The applicable jury instructions, however, refer to "cost" instead of any type of "value." The trial court instructed the jury with CACI No. 3903A, which states: "To recover damages for past medical

expenses, David Pebley must prove the *reasonable cost* of reasonably necessary medical care that he has received." (Italics added.) It further states: "To recover damages for future medical expenses, David Pebley must prove the *reasonable cost* of reasonably necessary medical care that he is reasonably certain to need in the future."[3] (Italics added.) Thus, as far as the jury was concerned, it was Pebley's burden to prove the "reasonable cost" of past and future medical expenses. The surgeons' testimony was consistent with CACI No. 3903A and, in the absence of an objection to the instruction, it was appropriate for them to testify regarding the reasonable cost of reasonably necessary medical care that Pebley has received and is expected to receive in the future.[4]

It is apparent from the record that both surgeons "were qualified to provide expert opinions concerning the reasonable value of the medical costs at issue. [Their] opinion testimony was based in part on the medical costs incurred by [Pebley] and in part on other factors considered by the experts, including their own experiences treating patients. This was not purely speculative evidence without any basis in the real world (like, for

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[3] Defendants did not object to this instruction. Nor do they contend it was given in error.

[4] In contrast to CACI No. 3903A, BAJI No. 14.10 states that the measure of damages for personal injury expenses is "[t]he reasonable value of medical [hospital and nursing] care, services and supplies reasonably required and actually given in the treatment of the plaintiff to the present time [and the present cash value of the reasonable value of similar items reasonably certain to be required and given in the future]. [¶] [These are items of economic damage.]."

instance, speculative lost profits expert testimony in a business dispute). [Pebley] actually suffered severe injuries and underwent expensive medical treatment. The evidence presented was sufficient to support an award of . . . past [and future] medical damages." (*Bermudez*, *supra*, 237 Cal.App.4th at p. 1339; see *Moore*, *supra*, 4 Cal.App.5th at p. 434 [upholding jury's award where the medical experts "testified the amounts they billed reflected their ordinary and customary charges and the reasonable value of their services"].)

Moreover, the trial court allowed defendants to present their own expert evidence regarding the reasonable value of Pebley's past and future medical expenses. (See *Moore*, *supra*, 4 Cal.App.5th at p. 446 [noting "defendant had the opportunity to present evidence to rebut plaintiff's assertion that the reasonable value of the services was the full amount of the charges"].) Dr. Miller testified that the amount the medical facility providers would accept for their services totaled $54,615.56, instead of the $120,876.55 requested by Pebley. Although Dr. Miller was not permitted to testify as to the reasonable value of the professional fees, defendants' other expert, Dr. Richard Kahmann, a spinal surgeon, testified that 95% of patients who pay for his care out of pocket pay about 50% of what he charges.

During closing argument, defense counsel reminded the jury of Dr. Kahmann's testimony and requested that the jury "take the figures that are related to the neck surgery and attendant care and the future medical specials, and that you reduce that by 50 percent, and then go to Dr. Kahmann's column on reasonable cost. And as you take all of these items and apply Dr. Kahmann's testimony, his expert opinion on these issues in addition to Dr. Miller's expert opinion on these issues, the past

medical costs reasonably total . . . $78,214.63. When you perform the same analysis with respect to the future medical specials, the figure is $75,602.52 . . . . The total for the past and future medical specials is $153,817.15 [sic]." This sum is substantially less than the $644,000 awarded by the jury.

As contemplated in *Bermudez*, the trial court permitted a "wide-ranging inquiry into the reasonable value of medical services provided." (*Bermudez*, *supra*, 237 Cal.App.4th at p. 1331.) Each side presented two experts. The jury was instructed that "[if] the expert witnesses disagreed with one another, you should weigh each opinion against the others." The jury presumably followed this instruction and rejected the defense experts' testimony as less credible. (See *People v. Boyette* (2002) 29 Cal.4th 381, 436; *People v. Sanchez* (2001) 26 Cal.4th 834, 852.) The credibility of battling experts is within the jury's province. (*County of Monterey v. W. W. Leasing Unlimited* (1980) 109 Cal.App.3d 636, 646.)

Defendants contend they were unable to effectively engage in a "battle of the experts," because the trial court excluded Dr. Miller's testimony regarding the reasonable value of the medical professionals' fees. This contention would be more persuasive if Dr. Kahmann had not been allowed to opine on the same subject. The fact that Dr. Miller's proposed evidence was cumulative to Dr. Kahmann's testimony undercuts defendants' claim of prejudice. (See *South Bay Chevrolet v. General Motors Acceptance Corp.* (1999) 72 Cal.App.4th 861, 906.) This was not, as defendants assert, a situation in which the only measure of cost or value before the jury was the medical professionals' full bills. (See *Children's Hospital Central California v. Blue Cross of California* (2014) 226 Cal.App.4th 1260, 1279.)

E. The Damage Award Must be Reduced by $1,063

The jury awarded Pebley the full amounts billed by VCMC and AMR ($14,816.50 and $1,608.19, respectively), even though Pebley's insurance carrier paid a lesser amount for the services ($13,828.50 and $1,533.19, respectively). Pebley concedes these two awards violate *Howell* and that the judgment must be reduced by $1,063 -- the difference between the amounts billed and the amounts actually paid. (See *Howell*, *supra*, 52 Cal.4th at p. 566.)

DISPOSITION

The judgment is modified to reduce the award of damages by $1,063 to $3,642,937. In all other respects, the judgment is affirmed. Pebley shall recover his costs on appeal.

CERTIFIED FOR PUBLICATION.

PERREN, J.

We concur:

GILBERT, P. J.

TANGEMAN, J.

Rocky J. Baio, Judge

Superior Court County of Ventura

Horvitz & Levy, Lisa Perrochet and Steven S. Fleischman; Benton, Orr, Duval & Buckingham, Kevin M. McCormick and Panda L. Kroll, for Defendants and Appellants.

The Simon Law Group, Sevy W. Fisher and Greyson M. Goody; The Ehrlich Law Firm and Jeffrey I. Ehrlich, for Plaintiff and Respondent.

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 3601 West Olive Avenue, 8th Floor, Burbank, California 91505-4681.

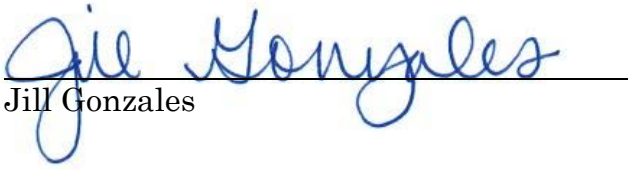
On June 15, 2018, I served true copies of the following document(s) described as **PETITION FOR REVIEW** on the interested parties in this action as follows:

SEE ATTACHED SERVICE LIST

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 June 15, 2018, at Burbank, California.



Jill Gonzales

SERVICE LIST
Pebley v. Estrada
Court of Appeal Case No. B277893

Greyson M. Goody The Simon Law Group, LLP 34 Hermosa Ave. Hermosa Beach, CA 90254 (310) 372-7368 greyson@thesimonlawgroup.com	Attorneys for Plaintiff and Respondent DAVE PEBLEY
Jeffrey I. Ehrlich The Ehrlich Law Firm 237 W 4th Street Claremont, CA 91711-4710 (909) 625-5565 jehrlich@ehrlichfirm.com	Attorneys for Plaintiff and Respondent DAVE PEBLEY
Kevin M. McCormick Panda L. Kroll Benton, Orr, Duval & Buckingham 39 N. California Street Ventura, CA 93001 (805) 648-5111 kmccormick@bentonorr.com pkroll@bentonorr.com	Attorneys for Defendants and Appellants JOSE PULIDO ESTRADA, NELSON SOMERS, BARBARA SOMERS and SANTA CLARA ORGANICS, LLC
California Court of Appeal Second Appellate District, Div. Six 200 E. Santa Clara Street Ventura, CA 93001	Case No. B277893 *Served through TrueFiling*
Hon. Rocky J. Baio Ventura County Superior Court 800 S. Victoria Ave., Dept. 20 Ventura, CA 93009 (805) 289-8807	Ventura County Superior Court Case No.: 56-2013-00436036-CU-PA-VTA *Served via U.S. Mail*