BITING THE BULLET: MEDICAL BILLS IN A POST *HOWELL-CORENBAUM* WORLD

NOTE: This article was authored by Lawrence A. Strid and was published in the Spring 2014 edition of the Orange County Trial Lawyer's publication "THE GAVEL". The article is copyrighted to the OCTLA but is being republished with their permission.

Any prudent personal injury practitioner is aware of the groundbreaking precedent established in *Howell v. Hamilton Meats & Provisions, Inc.* (2011) 52 Cal.4th 541, holding that a plaintiff in a personal injury claim cannot claim more for past economic damages for medical expenses than what the healthcare provider accepted from a collateral source as payment in full, be the collateral source the patient's own medical insurance company or a co-payment directly paid or owed by the patient themself.

The ruling in *Howell* was an extension of a similar ruling in the equally ground-breaking case of *Hanif v. Housing Authority* (1988) 200 Cal.App.3d 635, and which dealt with a plaintiff's medical expenses being adjusted and then paid by Medi-Cal. Despite *Hanif* being limited on its facts to a Medi-Cal beneficiary, many liability carriers in evaluating bodily injury claims post-*Hanif* would only consider the adjusted medical expenses, regardless of the nature of the collateral source provider, to the general consternation of the plaintiffs' bar thereafter.

Similar to *Hanif,* the case of *Nishihama v. City & County of San Francisco* (2001) 93 Cal.App.4th 298, was usually cited in conjunction with *Hanif* by the defense in attempting to limit claims for medical bills to what the provider received and accepted as payment in full, prior to the Supreme Court ruling in *Howell*.

Howell did not directly address the admissibility at trial of the full amount of the medical charges as billed, and inferred that such evidence might still be admissible in order to prove whether the claimed medical expenses were reasonable and necessary. See *Howell, supra*, at 52 Cal.4th 577-578.

Accordingly, in a post-*Howell* era, most plaintiffs' attorneys attempted to submit evidence at trial of the full amount of the medical charges as billed, and then dealt with the pertinent *Howell* reduction by stipulation or a motion post-verdict.

Attorneys who took this approach would rely on pre-*Howell* case authority, with some cases holding

that the full amount of medical charges as billed were still relevant as to an assessment of non-economic damages. For example, see *Greer v. Buzgheia* (2006) 141 Cal.App. 4th 1150, 1157; and *Nishihama, supra,* at 93 Cal.App..4th 309.

That approach was dealt a death-blow by the subsequent ruling in *Corenbaum v. Lampkin* (2013) 215 Cal.App.4th 1308. Further clarifying the ruling in *Howell*, the court in *Corenbaum* held that evidence of the full amount of the medical charges as billed is simply not relevant to the determination of the plaintiff's economic damages at trial, and that evidence of the adjusted amount accepted by the healthcare providers from a collateral source is not made inadmissible by the collateral source rule so long as the source of the payment is not disclosed.

Corenbaum further held that evidence of the full amount of billed charges vs. the adjusted charges after receiving payment from a collateral source would only serve to confuse the jury, and was not relevant to proving non-economic damages or future medical expenses. *Corenbaum, supra*, at 215 Cal.App.4th 1329.

Historically in personal injury practice, the amount of a plaintiff's medical expenses has usually been the "barometer" of the value of any given personal injury case – the greater the amount of the bills, then arguably the greater the severity of the injury; and the greater the severity of the injury, then the more the case was theoretically worth. While it may have been an urban legend to some degree, surely every personal injury attorney (and even some non-lawyers) have heard the old adage about any injury case being worth at least "three times the meds".

When collateral insurance adjusts a provider's bills, the results can often be dramatic in the reduction of the medical charges that would be admissible at trial – reductions of 50% or greater are not uncommon, and if a public benefit collateral source is involved, such as Medicare or Medi-Cal, then the amount of admissible medical charges may end up being ten cents on the dollar. Worst of all are those patients who belong to certain HMOs, where the charges incurred with their primary physician may be "capitated" down to zero or a nominal co-pay.

The law is therefore clear on the limits of what the plaintiff can claim for medical expenses. The bigger question that this article intends to address is whether this application of the law is being followed

by the plaintiffs' bar.

In the personal experience of this practitioner as derived from being an arbitrator at court ordered arbitrations, as a designated neutral in mediation sessions, and as a settlement officer at settlement conferences conducted at Orange County Superior Court, most plaintiffs' attorneys still present evidence of the full amount of medical charges billed, and ignore any adjustments called for by *Howell* and *Corenbaum*.

Many of these plaintiffs' attorneys do not even have the amounts of the adjusted medical bills set forth in their briefs or settlement statements, much less being able to relay what that adjusted number is when confronted with that question. Rest assured that defense counsel and the adjuster have this information calculated down to the near penny.

The only reasons that this practitioner can envision as to why a plaintiff's attorney would not have the adjusted medical expenses itemized at their disposal would be that **(1)** they are hoping that the defense carrier and their counsel have never heard of the holdings in *Hanif*, *Howell*, and *Corenbaum*; **(2)** it is too much work to review the bills and explanation of benefits and calculate the adjusted medical expenses yourself; and/or **(3)** it is easier to rely on the defense to provide the adjusted medical expenses and hope that their figures are correct.

None of these reasons make any sense, and the failure of the plaintiff's attorney to directly deal with the adjusted medical expenses will mean that a critical aspect of the value of the case is being ignored, and it can also leave a less than favorable impression with the defense carrier's perspective on the expertise of the plaintiff's attorney.

If there is a bright side to this development in the law for the plaintiff's bar, it might be that it is now easier to argue that the medical expenses are reasonable and necessary, after they have been adjusted. Moreover, some defense attorneys will stipulate at trial as to the amount of the adjusted figure so that the custodians of record of the various providers don't have to come to trial to testify, and the evidence for the total adjusted expenses can then be reduced to a written summary that the plaintiff's testifying physician can lay a foundation for, so that just the summary alone can come into evidence.

Notwithstanding the writing on the wall as to the admissible amount of past medical expenses, some

plaintiff's practitioners have been creative in attempting to circumvent it, in one of two methods: **(1)** counseling the client not to utilize their medical insurance to defray their past medical bills; and **(2)** utilizing a "factoring" company to assume legal title to the bills. Both of these approaches leave much to be desired and a lot to risk for both the plaintiff and their attorney.

Insofar as not billing the client's medical insurance, this issue would probably not arise to the extent that a client requires emergency medical treatment, and at which time they are more interested in seeing a physician on an emergency care basis versus immediately consulting with an attorney. Most emergency care providers collect the patient's medical insurance information as a condition of admission, and automatically bill the carrier thereafter. Few clients, if any, would be aware of the consequences of *Howell* and *Corenbaum* until after they have consulted with counsel.

As to non-emergency care providers that the client may see thereafter, if the client has applicable medical insurance that would defray all or part of such expenses, it is the opinion of this practitioner that an attorney who advises their client not to utilize their insurance is most likely doing their client a disservice, and may be setting themselves up for a legal malpractice case down the road.

As the saying goes, there are only two things in life that are certain, and the end result of a legal claim or a personal injury lawsuit do not fall into either of those two categories. Most policies of medical insurance require that the bills be submitted to the insurer in a set window of time to qualify for benefits, and the majority of most mainstream healthcare providers will not take a lien. Many healthcare providers that will not take a lien will send the account out to collection if no payment is forthcoming in a fixed period of time, and which may lead to a negative credit history report, collection agency activity with inflated interest charges being tacked onto the bill, or even a collection lawsuit being filed against the client.

Meanwhile, the client's claim or legal case grinds on, with the eventual monetary outcome never a certainty until it occurs. As any attorney knows, there are any number of myriad reasons as to why cases are lost or under-compensated for in the claims and litigation arena. If the end monetary result is less than sufficient to satisfy outstanding medical bills that the attorney has advised their client not to submit to their insurance, and then it is too late to do so thereafter, then the attorney will be a natural target of blame by the client, had timely billed charges to their medical insurance been counseled and then satisfied in whole or in

part by their medical insurance.

In addition, the personal injury victim has an obligation to *mitigate* their damages, and a failure to submit medical expenses to an insurance carrier that may have satisfied such expenses may leave the client's case vulnerable to this argument.

The other mode that may be used to avoid the ramifications of the adjusted medical billing is to have the full amount of the bills assigned to a factoring company, and then the attorney negotiates with the factoring company after the settlement to try and reach some sort of compromise on what it will take to satisfy same.

This latter approach was recently addressed in the recent case of *Dodd v. Cruz* (Second Appellate District, February 5, 2014) __Cal.Rptr.3d __, WL 461158, LEXIS 118.

In *Dodd*, a plaintiff involved in a motor vehicle accident had shoulder surgery performed on a lien at a surgery center. This provider then sold the lien to a factoring company. The defendant attempted to subpoena the records from the factoring company to determine what was paid on the assignment of the lien. The factoring company refused to comply, objecting on the basis of confidentiality, proprietary concerns, and relevance.

The trial court granted its motion to quash, but on appeal the appellate court reversed, citing both *Howell* and *Corenbaum*, in holding that the amount paid for the provider's account receivable was reasonably calculated to lead to the discovery of admissible evidence as to the reasonable value of the medical services provided. Whether or not such evidence would be admissible, it could be relied on by expert witnesses to opine what the reasonable charges should be.

In *Dodd* , the president of the factoring company was the plaintiff's own attorney, and which adds another interesting hair in the ointment insofar as a potential conflict of interest may be concerned. Furthermore, one of the surgical center's limited partners was the brother of the factoring company's vice-president.

From this practitioner's perspective, attorneys counseling clients not to use their medical insurance or for the attorney to be directly (or even indirectly) involved in assignments of medical liens, just to avoid the ramifications of *Howell* and *Corenbaum*, are creating liability scenarios for themselves and pitfalls for

their client's case.

There have been other changes in the law over the passage of time that have not been plaintiff friendly: the passage of MICRA; the Fair Responsibility Act codified in Civil Code secs. 1431.1 and 1431.2; the demise of *Becker v. IRM Corp.*; and other changes in codes and case law have sometimes curtailed the ability of some injured parties to obtain full or certain types of compensation, given the fact situation of any given case.

Notwithstanding this, injured parties can still obtain compensation given the facts and coverage applicable to any injury incident, and the plaintiff personal injury bar shows no immediate sign of dropping personal injury cases and trying to practice family law or immigration law as a fall-back practice after the rulings enunciated in *Hanif, Howell,* and *Corenbaum*.

From the perspective of this practitioner, it is best to "bite the bullet": calculate and present the adjustment on the medical bills to the defense carrier and defense attorney (including any calculation thereof in response to a defendant's form interrogatories), to any neutral presiding over a settlement conference or mediation, and to the ultimate trier of fact. Put the best slant possible on your client's case given the other factors in the case that would be an argument for greater value being placed on the matter – it is all any self-respecting plaintiff's attorney can do.