CASE STUDY PREPARED FROM ORIGINAL PUBLISHED OPINION

ERNEST A. LONG
Alternative Dispute Resolution
❖ Resolution Arts Building ❖
2630 J Street, Sacramento, CA 95816
ph: (916) 442-6739 • fx: (916) 442-4107
elong@ernestalongadr.com • www.ernestalongadr.com

Bermudez v Ciolek 6/22/15

Howell and its Progeny; Measuring Medical Damages of Uninsured Plaintiff

Two vehicles collided at an intersection in Fountain Valley on the afternoon of January 11, 2012. The accident occurred sometime during the traffic light transition from green to yellow to red in the east-west lanes of Talbert Avenue. Westbound defendant Faith Ciolek began a left turn onto Bushard Street. Eastbound defendant Nathan Heacox entered the intersection, intending to proceed straight through. Following the collision, Heacox's car veered to the southeast corner of the intersection, striking plaintiff Omar Bermudez, who was on the sidewalk astride his bicycle. At the time of the collision, Bermudez apparently had no medical insurance.

In a special verdict, the jury found both defendants were "negligent" but concluded only Ciolek was "a substantial factor in causing harm" to Bermudez. Ciolek was therefore found to be responsible for 100 percent of Bermudez's $3,751,969 in damages.

Ciolek claims she is entitled to a new trial on damages because there is insufficient evidence of the reasonable value of Bermudez's medical damages in the record. Citing *Howell v. Hamilton Meats & Provisions, Inc.* (2011) 52 Cal.4th 541, Ciolek faults Bermudez (an uninsured plaintiff, unlike the insured plaintiff in Howell) for relying on the amount of medical expenses incurred and expert testimony attesting to the fairness and reasonableness of the majority of those medical bills. Ciolek asserts Bermudez's experts needed to do more to establish that their testimony was rooted in the "market value" of medical services.

Bermudez was taken by ambulance to University of California Irvine Medical Center (UCI), where he stayed four to five days. Bermudez sustained multiple injuries as a result of the collision, including: (1) a fractured patella (kneecap), for which surgery was necessary; (2) a fractured pelvis and a chip in his front left hip, which required multiple diagnostic procedures; (3) severe shoulder injuries; (4) lacerations; and (5) deep bruising to his left leg and testicles. Debilitating pain after his initial convalescence lead to two separate back surgeries — a microdiscectomy to repair a herniated disc and a separate surgery to remove and replace the injured disc.

Defendants did not file motions in limine to exclude medical damages evidence. The following came into evidence without objection or motion to strike by either defense counsel:

(1) Bermudez testified that the amount of his outstanding medical bills was approximately $450,000. He had not paid any of the bills. Bermudez believed his medical providers will be paid out of any recovery he receives in this case, but he will be responsible for the bills no matter what happens in the litigation.

(2) The parties stipulated to the admissibility (not the reasonableness) of Bermudez's exhibit 239, a summary of past medical bills. The total of the past bills was $445,430.64. The parties also stipulated to the reasonableness (not just the admissibility) of $15,000 in recent medical charges not reflected in exhibit 239.

(3)(a) Experts for the parties testified regarding both the necessity of various procedures and the reasonableness of the charges for those procedures. Dr. William Van Der Reis, an orthopedic surgeon with a practice in Orange County, testified for Bermudez regarding his medical treatment, with the exception of the two back surgeries. Van Der Reis performs surgeries at two hospitals, as well as an outpatient surgery center. Van Der Reis examined Bermudez and reviewed the charges for his care and treatment. UCI charged $111,000 for Bermudez's hospital stay, which Van Der Reis agreed was "fair and reasonable." Van Der Reis similarly agreed that the physician fees for treatment at UCI were "fair and reasonable." Van Der Reis testified that only some of the fees charged for MRI scans were fair and reasonable; he indicated a $6,150 scan should be reduced to $2,030 and a $8,346 scan should be reduced to between

$2,000 to $2,500. In sum, Van Der Reis endorsed some of the medical bill amounts not related to Bermudez's back as fair and reasonable, while discounting other medical bills to what he considered to be a fair and reasonable amount.

Van Der Reis also identified four charges Bermudez would incur in the future for an additional knee surgery to remove the plate inserted during the first knee surgery. These expected charges totaled $14,250. Van Der Reis opined Bermudez would benefit from cortisone injections ($300 to $350 per visit) and physical therapy ($1,500 for 12 sessions). Van Der Reis's testimony about future medical expenses was not linked to existing medical bills.

(3)(b) Dr. Fardad Mobin, a neurosurgeon who performed Bermudez's second back surgery, testified regarding Bermudez's back problems. Mobin maintains an active clinical and surgical practice in Los Angeles County. Mobin was familiar with reasonable and customary charges for spinal surgeries and related services. Mobin reviewed Bermudez's medical records. Mobin opined that charges for initial treatment ($1,820) were reasonable. Mobin opined that the first back surgeon's charge of $65,328 was too high because the cost for this type of surgery in his region was between $20,000 to $25,000. Mobin stated the remainder of the charges for the first surgery were fair and reasonable: $69,500 for the surgical center, $483 for spinal X-rays, $3,250 for anesthesia, $323 for fluoroscopy, and $3,520 for postsurgery medical equipment. With regard to the surgery he performed, Mobin opined that the surgeon's fee ($50,176), anesthesiologist's fee ($3,976), MRI fee ($2,220), and the facility cost ($93,629) were reasonable and within the community standard. He noted these services were provided on a lien. Like Van Der Reis, Mobin endorsed some of the medical bills as fair and reasonable, while discounting other medical bills to what he considered to be a fair and reasonable amount.

As to future medical expenses, Mobin opined Bermudez would require an additional back surgery in the next 10 to 15 years at a total cost of between $160,000 and $180,000. Mobin also identified various other future medical costs pertaining to Bermudez's back: pain management regime, including up to three epidurals per year costing $10,000 each; facet blocks in sets of two for a total of approximately $15,000; and consultations with a spine surgeon twice per year for

four to five years (initial consult at $1,000 to $1,500, follow ups at $400 to $600). Bermudez should obtain annual X-rays ($150 per set), annual MRIs ($2,000 to $2,500), and two computed tomography (CT) scans ($2,000 each) in the next five years. Bermudez will need 16 to 18 physical therapy sessions for the next four to five years, at $100 to $150 per session. Mobin's testimony about future medical expenses was not linked to existing medical bills.

(3)(c) Bermudez's economist expert opined as to the present value of Bermudez's future medical expenses. Based on medical expert testimony and alternate assumptions concerning the growth of health care costs, he testified that ranges of either $582,190 to $816,770, or $691,013 to $984,650 would be incurred.

(4) Dr. Michael Weinstein, an orthopedic surgeon called to testify by defendant Ciolek, also testified regarding the reasonableness of Bermudez's medical costs. He opined that "some of the charges . . . were fine. All the charges from UCI, the surgeries at UCI, I thought they were all fine." Weinstein disagreed with the necessity and reasonableness of the back surgeries and related costs. Even assuming the back surgeries were appropriate, Weinstein put the market value of the first back surgery at $1,200 to $3,000, and the market value of the facility fee at $6,000 to $12,000. The second surgery's market value was $6,000 to $8,000, with a facility fee of $20,000 to $25,000. Weinstein explicitly established his foundation for these opinions by describing his own practice and his knowledge of rates in his areas of practice, including the amounts he actually recovers from insurers or individuals who make cash payments.

The jury was instructed with modified versions of CACI instructions pertaining to damages, including CACI Nos. 3900, 3902, 3903, 3903A, 3903C, 3903D, 3904A, 3905, 3905A, 3924, 3925, 3932, 3933, and 3964. For purposes of the appeal, the Appellate Justices noted that CACI No. 3903A is most pertinent: **"To recover damages for past medical expenses, plaintiff, Omar Bermudez, must prove the reasonable cost of reasonably necessary medical care that he has received. To recover damages for future medical expenses, plaintiff, Omar Bermudez, must prove the reasonable cost of reasonably necessary medical care that he is reasonably certain to need in the future."**

After reviewing the evidence of damages in his closing argument, Bermudez's counsel requested $414,255.59 in past medical expenses; $691,000 to $984,000 for future medical expenses; $11,538 in past lost earnings; $442,400 to $815,000 in future lost earnings; $2,125,000 in past noneconomic losses ("I suggest to you it's worth far more than those economic losses that we've been talking about. Three times, four times, five times more than that because the damage to the person is what hurts us to the core."); and $5.5 million for future noneconomic losses.

Counsel for defendant Ciolek contested the necessity and reasonableness of medical expenses, both past and future, in his closing argument. He put forth the following numbers as appropriate and supported by the evidence: $135,000 — past medical expenses; $12,000 (rounded up) — past lost earnings; and $90,000 for future lost wages. Counsel for Ciolek did not provide a number for future medical expenses or noneconomic damages.

Counsel for defendant Heacox did not question the necessity of Bermudez's various surgeries. He did argue "some of the doctors" charged "a lot of money," "more than Dr. Weinstein thinks is right. But it's up to you to, again, weigh the credibility of those doctors. You've heard the arguments, good arguments on both sides."

The jury's special verdict indicated the following damages for Bermudez: past medical expenses — $460,431; past lost earnings — $11,538; future medical expenses —$425,000; future lost earnings — $130,000; past noneconomic loss — $2 million; and future noneconomic loss — $725,000. Total damages equaled $3,751,969 and the court entered judgment against defendant Ciolek accordingly.

One section of Ciolek's new trial motion classified the damages awarded to Bermudez as excessive because the past medical damage amounts were not based on market value. As previously noted, the court denied the new trial motion. The court stated on the record at the new trial hearing, "Frankly, I don't understand why he survived the accident. Probably one might consider him to have been easily killed in this accident. His injuries were . . . serious. He was badly injured. He is still badly injured. He is going to need more surgeries. And the jury's verdict was probably right on."

Ciolek argued a new trial on damages is necessary because Bermudez "failed to meet his burden of proving that his claims for past and future medical damages were reasonable, as measured by an exchange or market value" and because Bermudez "urged the jury to award noneconomic damages as a multiple of the improperly-grounded economic damages."

The Fourth Appellate District Justices distinguished three separate but related questions that are pertinent to Ciolek's contentions: (1) what is the proper measure of medical damages; (2) what evidence is admissible to prove the proper measure of medical damages; and (3) what evidence is sufficient to affirm an award of medical damages based on the proper measure?

Their opinion began with this fundamental precept: **Tort damages consist of "the amount which will compensate for all the detriment proximately caused" by the breach at issue. (Civ. Code, § 3333.) "Detriment is a loss or harm suffered in person or property." (Civ. Code, § 3282.) "Damages must, in all cases, be reasonable . . . ." (Civ. Code, § 3359.)** The jury was properly instructed in this case to determine "the reasonable cost of reasonably necessary medical care that Bermudez has received" and "the reasonable cost of reasonably necessary medical care that Bermudez is reasonably certain to need in the future." But as a consequence of the discrepancy in recent decades between the amount patients are typically billed by health care providers and the lower amounts usually paid in satisfaction of the charges (whether by a health insurer or otherwise), controversy has arisen as to how to measure the reasonable costs of medical care in a variety of factual scenarios. Citing the **collateral source rule**, some plaintiffs suggested they should be entitled to recover the reasonable costs of medical care, even if that dollar value exceeded the amount actually paid in exchange for the medical services.

Recently, the state Supreme Court rejected this contention: "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*, 52 Cal.4th at p. 566.) In other words, "a plaintiff may recover as economic damages no more than the reasonable value of the medical services

received and is not entitled to recover the reasonable value if his or her actual loss was less." (see also *Corenbaum v. Lampkin* (2013) 215 Cal.App.4th 1308, 1325-1326 "Damages for past medical expenses are limited to the lesser of (1) the amount paid or incurred for past medical expenses and (2) the reasonable value of the services".) *Howell's* holding was in accord with pre-*Howell* case law on the question of the proper measure of damages involving plaintiffs with insurance. (See *Nishihama v. City and County of San Francisco* (2001) 93 Cal.App.4th 298, 306-309; *Hanif v. Housing Authority* (1988) 200 Cal.App.3d 635, 639-644)

The ramifications of *Howell* on the proper measure of damages in a case brought by an uninsured plaintiff (who has not paid his bill) are less clear. En route to its holding, *Howell* observed, "The rule that medical expenses, to be recoverable, must be both incurred and reasonable applies equally to those with and without medical insurance." And *Howell* endorsed "a rule, applicable to recovery of tort damages generally, that the value of property or services is ordinarily its 'exchange value,' that is, its market value or the amount for which it could usually be exchanged." (*Howell* at p. 556, quoting Rest.2d Torts, § 911, com. h, pp. 476-477.)

But the holding in *Howell* ultimately depended upon the "paid or incurred" prong of the test, not the "reasonable value" prong. (*Howell*, 52 Cal.4th at pp. 555-556.) 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. It was not necessary in *Howell* to examine the mechanics of properly measuring damages in the case of an uninsured plaintiff.

***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.** *Howell* noted "pricing of medical services is highly complex and depends, to a significant extent, on the identity of the payer. In effect, there appears to be not one market for medical services but several, with the price of services depending on the category of payer . . . ." (*Howell*, 52 Cal.4th at p. 562.) Howell refused to "suggest hospital bills always exceed the reasonable value of the services provided. . . . With so much variation [in pricing], making any broad

generalization about the relationship between the value or cost of medical services and the amounts providers bill for them — other than that the relationship is not always a close one — would be perilous." **Howell acknowledged that, all other factors being held equal, the amount recovered by an uninsured plaintiff may be higher than that recovered by an insured plaintiff**: "There is, to be sure, an element of fortuity to the compensatory damages the defendant pays under the rule we articulate here. 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 (assuming the hospital does not offer the person a discount from its chargemaster prices). But, as defendant notes, 'fortuity is a fact in life and litigation.'"

Howell offered no bright line rule on how to determine "reasonable value" when uninsured plaintiffs have incurred (but not paid) medical bills. Ciolek is correct that the concept of market or exchange value was endorsed by *Howell* as the proper way to think about the "reasonable value" of medical services. But she is incorrect to the extent she suggests: (1) Bermudez is necessarily in the same market as insured healthcare recipients or wealthy healthcare recipients who can pay cash; or (2) *Howell* prescribes a particular method for determining the "reasonable value" of medical services.

This takeaway from *Howell* is consistent with a pre-*Howell* case involving uninsured plaintiffs who were hurt in an automobile accident and obtained medical care. (See *Katiuzhinsky v. Perry* (2007) 152 Cal.App.4th 1288, 1291-1292) In *Katiuzhinsky*, the healthcare providers secured a lien against any personal injury recovery by plaintiffs, then sold plaintiffs' accounts at a discount to a firm specializing in such transactions (MedFin). The trial court limited plaintiffs' recovery for medical care bills sold to MedFin to the amount MedFin paid for the accounts. The appellate court found error in the trial court's ruling because there was evidence plaintiffs remained liable for the full amount billed; MedFin's purchase of the accounts at a discount did not reduce the amount owed by plaintiffs. Plaintiffs should have been entitled to argue to the jury that "the amounts charged to and incurred by them . . . represented the reasonable value of the medical services provided." *Howell* did not disapprove of *Katiuzhinsky*; it explicitly distinguished the facts before it from *Katiuzhinsky*, noting *Howell* was

"not a case . . . where the plaintiffs 'remained fully liable for the amount of the medical provider's charges for care and treatment.'"

In sum, 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. In practical terms, the measure of damages in insured plaintiff cases will likely be the amount paid to settle the claim in full. It is theoretically possible to prove the reasonable value of services is lower than the rate negotiated by an insurer. But nothing in the available case law suggests this will be a particularly fruitful avenue for tort defendants. Conversely, the 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.

Trial courts typically "enjoy '"broad authority"' over the admission and exclusion of evidence." (*Greer v. Buzgheia* (2006) 141 Cal.App.4th 1150, 1156) Consistent with this principle, several pre-*Howell* cases held courts are not required to exclude evidence of the initial billed amounts of medical expenses, even when a lesser amount was subsequently accepted by the medical care providers as payment in full. (*Olsen v. Reid* (2008) 164 Cal.App.4th 200, 204)

For instance, in *Greer*, 141 Cal.App.4th at page 1156, the tortfeasor contended the court erred in denying his motion in limine to exclude evidence of the full amount initially billed for the plaintiff's medical expenses. When it denied the motion in limine, the trial court ruled that "while a postverdict reduction of the jury's award of medical expenses might be justified, defendant could not prevent the jury from hearing evidence regarding reasonable medical costs for plaintiff's care in the first instance." The appellate court agreed:

"*Nishihama* and *Hanif* stand for the principle that it is error for the plaintiff to recover medical expenses in excess of the amount paid or incurred. Neither case, however, holds that evidence of the reasonable cost of medical care may not be admitted. Indeed, *Nishihama* suggests just the opposite: Such evidence gives the jury a more complete picture of the extent of plaintiff's injuries. Thus, the trial court did not abuse its discretion in allowing evidence of the reasonable cost

of plaintiff's care while reserving the propriety of a *Hanif/Nishihama* reduction until after the verdict."

Katiuzhinsky — as discussed above, a case in which the plaintiffs were uninsured — held the trial court committed error by excluding evidence of medical charges. "The trial court's ruling did not merely preclude plaintiffs from recovering special damages for medical expenses above the discounted rate paid by MedFin, but kept the jurors from considering the medical bills as evidence of the reasonable value of the medical services. This ruling was erroneous. . . . Regardless of whether defendants were entitled to a *Nishihama*-type reduction of the medical damage award, **there was no basis in law to prevent the jurors from receiving evidence of the amounts billed, as they reflected on the nature and extent of plaintiffs' injuries and were therefore relevant to their assessment of an overall general damage award."**

In sum, prior to *Howell*, so long as there was independent evidence that the underlying medical procedures were made necessary by the tort at issue, there was little question as to the admissibility on relevance grounds of the amount plaintiffs were charged for medical services. These cases implied that the amount initially billed is always "relevant" (Evid. Code, §§ 210, 350) to either the question of the amount incurred by the plaintiff or to the "reasonable" value of the services provided, even if the measure of damages is limited by a lower amount actually paid. Relevant evidence is presumptively admissible. (Evid. Code, § 351.)

In *Howell*, the trial court denied a motion in limine to exclude evidence of unpaid medical bills, but granted a posttrial motion to reduce the medical damage award to the amount actually paid by plaintiff and her insurer. As discussed above, *Howell's* holding essentially approved of this reduction (though *Howell* suggested the proper procedure was to grant a new trial unless the plaintiff accepted a reduced judgment). The proper measure of damages was the amount paid pursuant to the reduced rate negotiated by the plaintiff's insurance company.

Despite the motion in limine at the trial court, the admissibility of evidence was not strictly at issue in *Howell*. Nevertheless, the court commented: "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. Evidence that such payments were made in whole or in part by an insurer remains, however, generally inadmissible under the evidentiary aspects of the collateral source rule. 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***. We express no opinion as to its relevance or admissibility on other issues, such as noneconomic damages or future medical expenses. (The issue is not presented here because defendant, in this court, conceded it was proper for the jury to hear evidence of plaintiff's full medical bills.)"

(Footnote 3) In the course of its analysis, *Howell* extensively discussed the complexities and oddities of health care services markets (*Howell*, 52 Cal.4th at pp. 560-566), including the observation that "because so many patients . . . 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* noted, "It is not possible to say generally that providers' full bill represent the real value of their services, nor that the discounted payments they accept from private insurers are mere arbitrary reductions." "Given this state of medical economics, how a market value other than that produced by negotiation between the insurer and the provider could be identified is unclear." To be clear, these observations provide support for the court's statement that the full billed amount was not itself relevant to the issue of past medical expenses when the provider had accepted less pursuant to a prior agreement with an insurer. But *Howell* did not actually hold that medical charges are inadmissible. Nor did it engage with or critique prior case law on this question.

Seizing on the italicized and bolded language, a post-*Howell* case disagreed with pre-*Howell* cases regarding the admissibility of evidence of the amount charged for medical expenses. In *Corenbaum*, 215 Cal.App.4th at pages 1320-1321, plaintiffs sued for injuries suffered in a motor vehicle accident. The trial took place before *Howell*. Defendant did not request the exclusion of evidence pertaining to the amount plaintiffs were billed for their medical care, but instead reserved the right to move posttrial to reduce medical damages to the amount actually paid. The trial court granted plaintiffs' motion to exclude evidence of the amount of medical charges actually paid by a collateral source. "In accordance with the trial court's in limine rulings, the jury heard evidence of the full amounts billed for plaintiffs' past medical care and heard no evidence of the lesser amounts accepted by their medical providers as full payment pursuant to prior agreements with . . . private insurers." Defendant filed a postverdict

motion to reduce the damages awarded "by the difference between the full amounts billed for past medical expenses and the amounts actually accepted by plaintiffs' medical providers as full payment for the services provided." The trial court, though expressing its view that the motion had merit, lost jurisdiction to rule on this motion by the passage of time.

Rather than seeking a mere reduction of the damage award on appeal, the *Corenbaum* defendant appealed on the grounds that the trial court erred by "admitting evidence of the full amounts billed for plaintiffs' medical care when the amounts accepted by their medical providers as full payment were less than the amounts billed." *Corenbaum* held that evidence of the full amount billed for past medical services was not relevant (and was therefore inadmissible) to prove past medical expenses, future medical expenses, and/or noneconomic damages. The analysis was driven by the view that *Howell* "stated that the full amount billed by medical providers is not an accurate measure of the value of medical services." (*Corenbaum*, at p. 1326; but see *Howell*, 52 Cal.4th at p. 561 ["We do not suggest hospital bills always exceed the reasonable value of the services provided"].) Distinguishing *Katiuzhinsky*, 152 Cal.App.4th 1288, *Corenbaum* observed that "the plaintiffs in that case, who apparently had no health insurance, remained fully liable to their medical providers for the full amount billed despite the providers' sale of their accounts to a medical finance company at a discount." The matter was remanded for a new trial as to compensatory damages. Offering guidance to the trial court for its retrial of the damages issue on remand, the court opined that evidence of the full amount billed for past medical services could not support an as yet unoffered expert opinion as to the reasonable value of future medical services.

Another post-*Howell* case involved a dispute between a hospital and insurers "over the reasonable value of the poststabilization emergency medical services provided by" the hospital to the insured patients. (*Children's Hospital Central California v. Blue Cross of California* (2014) 226 Cal.App.4th 1260, 1264.) The trial court erred when it "precluded evidence of the various rates Hospital charges and accepts as payment. Reasonable value is market value, i.e., what Hospital normally receives from the relevant community for the services it provides. Hospital rarely receives payment based on its published charge master rates. Thus, in determining the reasonable value of the poststabilization services,

the full range of fees is relevant. The scope of the rates accepted by or paid to Hospital by other payors indicates the value of those services in the marketplace." Although decided in a different legal context (i.e., pursuant to regulations applicable to hospitals and insurers lacking a preexisting contractual relationship), it is worth considering this case. In holding the court erred by excluding all evidence other than the billed charges, i.e., "the highest amounts that are ever received for the services," the appellate court did not wall off any part of the "full range" as per se irrelevant.

(footnote 4: Of course, this case does not feature an insured plaintiff. But as a general matter, we express some reservations about *Corenbaum*, seemingly holding that the amount initially billed is per se inadmissible in cases of insured plaintiffs whose bills were paid in full for less than the initial billed amount. *Howell* and *Corenbaum* did not contemplate a battle over the reasonableness of the amount paid to settle the bill in full. Unless defendants stipulate to the reasonableness of the amount actually paid to settle in full the medical bill, it seems to us that, consistent with pre-*Howell* case law, evidence of the initial billed amount would be relevant to proving the reasonableness of the discounted amount that was actually paid.)

The Appellate Court's analysis states that two points about the sufficiency of evidence to support a judgment can fairly be taken from *Howell*. First, the amount paid to settle in full an insured plaintiff's medical bills is likely substantial evidence on its own of the reasonable value of the services provided. Second, consistent with pre-*Howell* law (see, e.g., *Latky v. Wolfe* (1927) 85 Cal.App. 332, 346-347, 352 [judgment reduced by $160 because there was no evidence of "reasonable value" for the billed amount]), initial medical bills are generally insufficient on their own as a basis for determining the reasonable value of medical services. Ensuing cases have held that a plaintiff who relies solely on evidence of unpaid medical charges will not meet his burden of proving the reasonable value of medical damages with substantial evidence.

State Farm Mutual Automobile Ins. Co. v. Huff (2013) 216 Cal.App. 4th 1463 was an interpleader action in which a motor vehicle injury victim contested a hospital's asserted lien right to a portion ($34,320.86) of the injury victim's tort recovery (a judgment including $232,708.80 in medical damages). In attempting to prove its claim pursuant to the Hospital Lien Act (Civ. Code, §§ 3045.1-3045.6), the hospital introduced an authenticated hospital bill with itemized charges; testimony that the injury victim had no insurance and had not paid his bill; testimony that the injury victim was on notice of the bill and the lien; and testimony that the injury victim had introduced evidence of the hospital's bill in his tort action. This evidence was insufficient to support a judgment in the

hospital's favor. The hospital was required to prove "the reasonable and necessary charges" (Civ. Code, § 3045.1) as part of its case-in-chief. Huff held medical bills are insufficient evidence of the amount of the lien. The hospital "introduced no evidence the charges in victim's hospital bill were reasonable or were for necessary treatment attributable to the motor vehicle collision." "The bill itself was based on the hospital's standard charges and thus 'is not an accurate measure of the value of medical services.'" **Huff did not suggest the amount the victim incurred was irrelevant and therefore inadmissible on the damages issue.** Indeed, facts pertaining to this amount were accurately described as "evidence," albeit evidence insufficient to prove reasonable medical expenses.

Next came *Ochoa v. Dorado* (2014) 228 Cal.App.4th 120. Once again, plaintiffs were injured in a motor vehicle accident. There is no indication in the opinion that plaintiffs' medical bills had been paid in full, whether for the amount billed or for a lesser amount. Evidence of the amounts of the medical bills was admitted, but no evidence was admitted as to the reasonableness of those medical bills, thanks to a successful motion in limine by defendants to exclude evidence of reasonableness based on the lack of discovery produced on this issue. The jury returned a verdict awarding substantial medical damages.

After discussing *Howell, Corenbaum, Huff*, and a host of older cases, *Ochoa* concluded with three observations: (1) "an unpaid medical bill is not an accurate measure of the reasonable value of the services provided"; (2) "an unpaid medical bill is not evidence of the reasonable value of the services provided"; and (3) "evidence of unpaid medical bills cannot support an award of damages for past medical expenses." It is difficult to precisely identify the holding in *Ochoa*, because its analysis and terminology conflated two related questions (as discussed herein, the admissibility of evidence and the sufficiency of evidence to support a judgment). Uncontroversially, *Ochoa* holds that evidence of unpaid medical bills, without more, is not substantial evidence of the reasonable value of services provided. Less clear is whether *Ochoa* intended to say something about the admissibility of evidence pertaining to the amount of unpaid medical bills — if it did, **we reiterate our critique of *Corenbaum*, as stated in the footnote, above.**

Ciolek argues Bermudez failed to prove the proper measure of damages, i.e., the reasonable value of his past medical costs, with substantial evidence. Ciolek attributes this evidentiary shortfall to Bermudez's alleged failure to present evidence pertaining to the market or exchange value of the services received.

To reiterate, **"damages for past medical expenses are limited to the lesser of (1) the amount paid or incurred for past medical expenses and (2) the reasonable value of the services."** (*Corenbaum*, 215 Cal.App.4th at pp. 1325–1326.) Like insured plaintiffs, uninsured plaintiffs must introduce substantial evidence of both the amount incurred and the reasonable value of the services. The amount incurred sets a cap on medical damages. But unlike the amount paid pursuant to an insurer's negotiated rates, **the amount incurred by an uninsured medical patient is not sufficient evidence on its own to prove the reasonable amount of medical damages.**

Neither Bermudez nor anyone else (e.g., an insurer) had paid for Bermudez's medical expenses at the time of trial. Thus, the operative measure of damages was destined to be "the reasonable value" of the medical services as determined by the jury, rather than the amount incurred by Bermudez. The jury was properly instructed to determine "the reasonable cost of reasonably necessary medical care that he has received" and "the reasonable cost of reasonably necessary medical care that he is reasonably certain to need in the future."

Bermudez offered evidence of both the amount he incurred and the reasonable value of medical care received. Bermudez testified to the amount (approximately $450,000) he had been billed and for which (in his view) he was responsible. The parties stipulated to the admissibility of an exhibit detailing Bermudez's past medical charges ($445,430.64) and to the reasonableness of $15,000 in recently incurred medical expenses not listed in the exhibit. **Bermudez's expert medical witnesses testified (without objection) to the fairness and reasonableness of the medical expenses incurred by Bermudez, up to $414,255.59, and also estimated the costs of future care (without reference to the current medical bills).** Defense experts took issue with the necessity of the back surgeries and the reasonableness of the fees charged for the back

surgeries and related expenses. But even Ciolek's expert and counsel agreed with the UCI hospital fees as proper (as well as other discounted amounts for procedures Ciolek thought were unnecessary or improper).

The jury awarded $460,431 in past medical damages. There is a logical basis for the award ($445,430.64 + $15,000 = $460,431). But the jury's verdict is nonetheless legally incorrect and not supported by substantial evidence because it awarded the full amount incurred by Bermudez, not the reasonable value of his past medical services (i.e., up to $414,255.59). There is no substantial evidence that the total amount incurred was the reasonable value of the services provided. "When the evidence is sufficient to sustain some but not all alleged damages, we will reduce the judgment to the amount supported by the evidence." (*Behr v. Redmond* (2011) 193 Cal.App.4th 517, 533) The Court therefore modified the judgment to reduce the amount of damages by $46,175.41.

Ciolek claims nothing other than the $15,000 stipulated to as reasonable by the parties and (perhaps) $50,000 certified as reasonable by her expert, Weinstein (i.e., damages for which Weinstein discussed his knowledge of market data as supporting his figures, not the UCI fees which Weinstein agreed with but did not provide a foundational basis for his agreement), are supported by substantial evidence. Relying on *Corenbaum*, (which suggested in dicta that the full amount billed cannot provide the basis for an expert opinion of the reasonable cost of future medical expenses in a case where the insurer paid the negotiated rate) and other post-*Howell* case law, Ciolek asserts that Bermudez's experts' classification of Bermudez's medical charges as reasonable was too terse and conclusory to amount to substantial evidence because the experts did not sufficiently make clear they were identifying the market or exchange value of these services. Ciolek reasons these experts simply evaluated the medical bills based on their own vague, idiosyncratic sense of reasonableness.

The 4th DCA rejected Ciolek's view that it was required to grant a new trial on damages or reduce the amount awarded to Bermudez beyond the $46,175.41 reduction acknowledged above. This is not a case in which Bermudez actually incurred a lower amount in medical costs than the initial billed amount. Nor is this a case in which Bermudez simply declared that the incurred amount was reasonable. Bermudez called two medical doctors to testify about the reasonable

costs of procedures about which they were knowledgeable, including one expert who testified concerning the back surgery he performed himself. (Cf. *Ochoa*, 228 Cal.App.4th at p. 141 [treating physician entitled to testify to "reasonable value of medical services that he or she provided"].) These experts did not merely rubber stamp all of the medical bills as reasonable; they identified lower numbers as reasonable in some cases. These doctors were qualified to provide expert opinions concerning the reasonable value of the medical costs at issue. This opinion testimony was based in part on the medical costs incurred by Bermudez 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 instance, speculative lost profits expert testimony in a business dispute). Bermudez actually suffered severe injuries and underwent expensive medical treatment. The evidence presented was sufficient to support an award of $414,255.59 in past medical damages.

Though not framed in this fashion, Ciolek's ***real complaint*** is that expert opinion testimony about the reasonable cost of Bermudez's medical procedures should have been inadmissible because the experts did not sufficiently establish that their method of forming an opinion was linked to a market or exchange value of medical services. (See, e.g., *Sargon Enterprises, Inc. v. University of Southern California* (2012) 55 Cal.4th 747, 753 [trial court properly fulfilled gatekeeper role by excluding speculative expert testimony concerning lost profits].) For instance, in her opening brief, Ciolek states "there was no foundational testimony as to what actual market rates were."

But Ciolek is unable to pursue this argument on appeal because appropriate objections were not made below. (Evid. Code, § 353, subd. (a).) No motion in limine was filed. No objections or motions to strike were made, whether on grounds of relevance or lack of foundation. It would be inappropriate to speculate as to whether any hypothetical objection or motion should have been granted. (See Evid. Code, § 802 ["A witness testifying in the form of an opinion may state . . . the reasons for his opinion and the matter . . . upon which it is based . . . . The court in its discretion may require that a witness before testifying in the form of an opinion be first examined concerning the matter upon which his opinion is based"]; Evid. Code, § 803 ["The court may, and upon objection shall, exclude testimony in the form of an opinion that is

based in whole or in significant part on matter that is not a proper basis for such an opinion"].) The Justices note it is possible that Bermudez's experts could have provided compelling testimony supporting their chosen method of determining the reasonableness of Bermudez's medical expenses for the market in which he was served. The question of how courts should fulfill their gatekeeper role in a case like this is left for an appeal in which the parties have actually litigated the issue at trial.

The Justices likewise rejected Ciolek's assertion that she is entitled to a new trial as to all damages because the jury's award of past medical damages was "fundamentally flawed" and Bermudez's counsel asked the jury to base noneconomic damages on a multiple of economic damages. The jury's award was slightly too high, but the court committed no error and there is no compelling evidence or argument that the excess in past medical damages unfairly prejudiced Ciolek's rights with regard to her noneconomic damages. (See, e.g., *Romine v. Johnson Controls, Inc.* (2014) 224 Cal.App.4th 990, 1013-1014 [no prejudice at trial due to supposed erroneous admission of evidence of full amounts billed in case where lower amount was accepted as payment in full].)

The judgment is modified to reduce the award of damages to Bermudez by $46,175.41 to $3,706,793.60. In all other respects, the judgment is affirmed. Ciolek's request for judicial notice is denied. Bermudez and Heacox shall recover from Ciolek costs incurred on appeal.

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