CASE STUDY PREPARED FROM ORIGINAL PUBLISHED OPINION

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Pebley v Santa Clara Organics, LLC 5/8/18

Medically Insured Plaintiff seeks out of plan medical care on lien; *Howell, Bermudez, Katiuzhinsky;* CACI No. 3903A

On May 9, 2011, Plaintiff Dave 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.

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.

Dr. Alexander performed a 3-level cervical fusion surgery on March 13, 2014. 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 range of motion, ongoing weakness and numbness, and chronic pain for the rest of his life.

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.

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 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 v Ciolek (*2015) 237 Cal.App.4th 1311*)*, 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."

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.

The Second District Court of Appeal began its opinion by noting that, "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 v Mercer (*2016) 4 Cal.App.5th 424, at p. 437.)

The 1988 change came when the Court of Appeal decided *Hanif v. Housing Authority* (1988) 200 Cal.App.3d 635. 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. A similar rule was adopted for private medical insurance in *Howell v. Hamilton Meats & Provisions, Inc.* (2011) 52 Cal.4th 541, 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*, at p. 1330)

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*, 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. The court explained, "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."

Howell recognized there is "an element of fortuity" involved with respect to the medical expenses a tortfeasor may be liable to pay. (*Howell*, 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."

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 v. Lampkin* (2013) 215 Cal.App.4th 1308, 1328-1333.) In so ruling, the court distinguished *Katiuzhinsky v. Perry* (2007) 152 Cal.App.4th 1288, 1295-1296, 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, held that even where there is no prenegotiated discounted rate, "evidence of unpaid medical bills cannot support an award of damages for past

medical expenses."

The Court of Appeal in *Bermudez*, rejected *Ochoa's* reasoning in cases involving uninsured plaintiffs. It noted that *Howell* had clarified the law, explaining, "*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." 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* concluded, "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."

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*, at p. 1335, 1337; *Katiuzhinsky*, at pp. 1295-1296) 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.

The threshold issue before the Appellate Justices here 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.

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.) 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*, at pp. 555-556; *Bermudez*, 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.** The Second District Court of Appeal will 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) 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.

It is undisputed Pebley required complex surgery to fuse three of his cervical vertebrae. 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*, at pp. 1336-1337.) **It would be <u>inequitable</u> 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*, at p. 1296.)

Finally, the 2nd DCA concludes 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.

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*, at p. 1335, 1337; *Katiuzhinsky*, at pp. 1295-1296.) But that evidence was insufficient, by itself, to establish the reasonable value of the services rendered. (*Bermudez*, at pp. 1336, 1338.) Under *Bermudez*, Pebley was required to proffer expert testimony on the issue.

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 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 "in 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

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.

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. 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." 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." 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.

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. 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*, at p. 1339)

Moreover, **the trial court allowed defendants to present their own expert evidence regarding the reasonable value of Pebley's past and future medical expenses.** 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." He argued "the past medical costs reasonably total . . . $78,214.63 and the future medical specials, figure is $75,602.52 . . . . The total for the past and future medical specials is $153,817.15." 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*, 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.)

The Justices concluded 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.

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) Thus, an uninsured plaintiff may introduce evidence of the amounts billed for medical services to prove the services' reasonable value**. The DCA holds that such a plaintiff, one that has elected to seek medical care outside an existing insurance plan, shall be considered uninsured, as opposed to insured, for the purpose of determining economic damages.**

The judgment is affirmed. Pebley shall recover his costs on appeal.

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