B306011

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT, DIVISION EIGHT

MALAK MELVIN ABDUL QAADIR,
Plaintiff and Respondent,

v.

UBALDO GURROLA FIGUEROA and PACIFICA TRUCKS, LLC,
Defendants and Appellants.

APPEAL FROM LOS ANGELES COUNTY SUPERIOR COURT
DANIEL S. MURPHY, JUDGE • CASE NO. BC656206

APPLICATION FOR LEAVE TO FILE AMICUS CURIAE BRIEF; PROPOSED ORDER

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THE TRUCKING INDUSTRY DEFENSE ASSOCIATION

APPLICATION FOR LEAVE TO FILE AMICUS CURIAE BRIEF

Under California Rules of Court, rule 8.200(c), the Trucking Industry Defense Association (TIDA) requests permission to file an amicus curiae brief in support of defendants and appellants Ubaldo Gurrola Figueroa and Pacifica Trucks, LLC (collectively, defendants).

No party has paid for any portion of the amicus brief.

TIDA is a non-profit association committed to sharing knowledge and resources among its over 1,600 member motor carriers, trucking insurers, defense attorneys and claims-servicing companies, and to reducing the costs of claims and lawsuits against the trucking industry, including personal injury claims and suits. http://www.tida.org/. TIDA advocates on behalf of the interests of its members and regularly participates as *amicus curiae* in cases involving issues of concern to its members.

Counsel for TIDA has reviewed the appellate briefs on the merits filed in this case and believe this court will benefit from additional briefing regarding the proper measure of medical damages in personal injury actions.

Accordingly, TIDA requests that this court grant TIDA leave to file the amicus brief which is lodged concurrently herewith.

April 19, 2021

MORGENSTERN LAW GROUP
ROBERT A. MORGENSTERN
NINOS SAROUKHANIOFF

By: */s/ Ninos Saroukhanioff*
Ninos Saroukhanioff

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B306011

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Defendants and Appellants.

[PROPOSED] ORDER

The application to file an amicus brief submitted by the Trucking Industry Defense Association is GRANTED. The amicus brief is deemed filed as of _____, 2021.

IT IS SO ORDERED.

Dated: _____, 2021

_____
Presiding Justice

PROOF OF SERVICE

Qaadir v. Adan Ordeonez Trucking
Case No. B306011

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 5850 Canoga Avenue, Suite 600, Woodland Hills, CA 91367.

On April 19, 2021, I served true copies of the following document(s) described as **APPLICATION FOR LEAVE TO FILE AMICUS CURIAE BRIEF; [PROPOSED] ORDER** on the interested parties in this action as follows:

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/s/ Claudia Brodie
Claudia Brodie

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Qaadir v. Adan Ordeonez Trucking
Case No. B306011

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

AMICUS CURIAE BRIEF

Under California Rules of Court, rule 8.200(a)(5), the Trucking Industry Defense Association (TIDA) hereby joins in the *amicus curiae* brief filed by the Association of Southern California Defense Counsel (ASCDC).

April 19, 2021

MORGENSTERN LAW GROUP
ROBERT A. MORGENSTERN
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By: */s/ Ninos Saroukhanioff*
Ninos Saroukhanioff

Attorneys for Amicus Curiae
TRUCKING INDUSTRY DEFENSE ASSOCIATION

CERTIFICATE OF WORD COUNT

[Cal. Rules of Court, rule 8.204(c)(1)]

The text of this brief consists of 30 words as counted by the Microsoft Word 2007 word processing program used to generate the brief.

Dated: April 19, 2021

/s/ Ninos Saroukhanioff
NINOS SAROUKHANIOFF

PROOF OF SERVICE

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STATE OF CALIFORNIA, COUNTY OF LOS ANGELES

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Claudia Brodie

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TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Page(s)

Cases

Statutes

Rules

Miscellaneous

AMICUS CURIAE BRIEF

INTRODUCTION

The Association of Southern California Defense Counsel (ASCDC) submits this amicus curiae brief urging this court to issue a published opinion following *Corenbaum v. Lampkin* (2013) 215 Cal.App.4th 1308 (*Corenbaum*) and *Ochoa v. Dorado* (2014) 228 Cal.App.4th 120 (*Ochoa*) and holding that unpaid medical bills are inadmissible under *Howell v. Hamilton Meats & Provisions, Inc.* (2011) 52 Cal.4th 541 (*Howell*) to prove the reasonable value of medical services, whether or not the plaintiff is insured or treats using his or her medical insurance. In doing so, the court should disagree with *Bermudez v. Ciolek* (2015) 237 Cal.App.4th 1311 (*Bermudez*) and *Pebley v. Santa Clara Organics, LLC* (2018) 22 Cal.App.5th 1266 (*Pebley*), which came to contrary conclusions.

LEGAL ARGUMENT

I. This court should hold that unpaid medical bills are inadmissible to prove the reasonable value of medical services.

A. Chronology of pertinent cases

1. *Howell* adopted marketplace value as the proper measure of the reasonable value of medical services. In doing so, the Court noted that uninsured patients actually pay the same or even less for medical services than insured patients.

The starting place is the Supreme Court's decision in *Howell*, which addressed the recurring issue of a plaintiff seeking

to recover the inflated amount "billed" by medical providers compared to the real world reality of what medical providers collect in the marketplace. *Howell* involved an insured plaintiff who was treated using health insurance. (*Howell*, *supra*, 52 Cal.4th at p. 549.) 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." (*Id.* at p. 566, emphasis added.) "To be recoverable, a medical expense *must be both incurred and reasonable*." (*Id.* at p. 555, emphasis in original and 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 Court explained that pricing for medical services is controlled by a unique and complex dynamic—one in which amounts stated on bills and amounts collected vary largely 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 patient pays the nominally "billed" amounts, which the Court called "insincere." (*Id.* at pp. 561, 562–563 & fn. 9.) 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.' " (*Id.* 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 that where "the [medical] 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.)

By contrast, evidence of the amounts actually *paid to and accepted* by medical providers 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 *id.* at p. 562 [damages are measured by the "exchange value of medical services the injured plaintiff has been required to obtain"].)

Thus, the Court held that a plaintiff "may recover *the lesser* of (a) the amount paid or incurred for medical services, and (b) the reasonable value of the services." (*Howell*, *supra*, 52 Cal.4th at p. 556, emphasis in original.) Inherent in this rule is that if the plaintiff incurs an inflated amount greater than reasonable value, the plaintiff cannot recover that greater amount.

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 marketplace value, i.e., what is actually paid and accepted for medical services in the marketplace. (*Howell*, *supra*, 52 Cal.4th at p. 562; see *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"].)

2. *Corenbaum* followed *Howell* and held that unpaid medical bills are inadmissible to prove past medical, future medical, or noneconomic damages, and cannot be used as a basis for expert opinion.

In *Howell,* the 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 in *Corenbaum.*

Corenbaum dealt squarely with the "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 *id.* at p. 1333 [confirming bills in this context are not relevant to damages for past or future medical expenses].)

Part of *Corenbaum*'s holding was based on longstanding California law that, even outside of the medical damages context, unpaid bills are inadmissible hearsay. (*Corenbaum*, *supra*, 215 Cal.App.4th at p. 1327, fn. 8, citing *Pacific Gas & Elec. Co. v. G.W. Thomas Drayage etc. Co.* (1968) 69 Cal.2d 33, 42–43 (*Pacific Gas & Elec.*).) Only a *paid* bill is admissible as " 'evidence that the charges were reasonable.' " (*Ibid.*) Thus, *Corenbaum* concluded that a medical bill is admissible only "if the bill reflects the amount that the medical provider agreed to accept as full payment." (*Ibid.*)

Both state and federal courts have followed *Corenbaum* in holding that billed amounts are inadmissible to prove either past or future medical damages:

- *Markow v. Rosner* (2016) 3 Cal.App.5th 1027, 1050–1051 [Second Dist., Div. One] (*Markow*) ("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 paid and accepted under the Patient Protection and Affordable Care Act (ACA) and Medi-Cal);

- *Romine v. Johnson Controls, Inc.* (2014) 224 Cal.App.4th 990, 1014 [Second Dist., Div. Five] (*Romine*) (*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. . . . [¶] Although the trial court erred in this case by admitting evidence of the full amount billed for plaintiff's medical care, defendants have failed to show that the error was prejudicial.");

- *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 to exclude evidence of medical expenses billed but not paid);

- *Pooshs v. Phillip Morris USA, Inc.* (N.D.Cal., May 22, 2013, No. C 04–1221 PJH) 2013 WL 2253780, at p. *2 [nonpub.

opn.] (under *Corenbaum*, "evidence of total amounts billed is not relevant to the value of future medical expenses");

- *Asanuma v. U.S.* (S.D.Cal., Mar. 28, 2014, No. 12cv0908 AJB (WMC)) 2014 WL 1286567, at p. *3, fn. 2 [nonpub. opn.] ("evidence of medical expenses that were not actually paid is irrelevant in determining future damages"); 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 (*Berkeley Heartlab*) [nonpub. opn.] ("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* and *Corenbaum*: "courts have uniformly acknowledged that physicians' billed charges do not necessarily reflect the market value of physician services").

3. *Ochoa* held that unpaid medical bills are inadmissible whether or not the plaintiff uses insurance or was treated on a lien basis.

In *Ochoa*, *supra*, 228 Cal.App.4th 120, Division Three addressed the measure of damages in a personal injury action where, as here, the plaintiff was treated on a lien basis. (RB 48.)[1] The trial court in *Ochoa* admitted evidence of the amount of

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[1] 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; see Evid. Code, § 452, subd. (d) [judicial notice may be taken of the records of the court of this state].)

plaintiffs' unpaid medical bills. (*Ochoa*, at p. 128.) The jury awarded plaintiffs $345,539 for past medical damages and $125,000 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.)

Although the Court of Appeal reversed the new trial ruling as premature, it provided guidance approving the substance of that ruling. (*Ochoa*, *supra*, 228 Cal.App.4th at pp. 134–136.) Citing *Howell*, the Court of Appeal held the unpaid medical bills were *not* relevant to determining the amount of medical damages. (*Ibid.*) Rejecting the arguments that plaintiff also makes here, 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 based its holding not just on *Howell* and *Corenbaum* but also 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 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 & Elec.*,

supra, 69 Cal.2d at pp. 42–43 [unpaid bills are hearsay and thus inadmissible independently to prove charges were incurred or reasonable].)

Ochoa declined to follow other cases that could be read to suggest unpaid medical bills might be admissible. (*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"].) Plaintiff here also relies on one of these cases, *Katiuzhinsky*, to argue medical bills are inadmissible when "plaintiff is treated on a lien." (RB 48.) *Ochoa* correctly rejected that argument as inconsistent with *Howell* and *Corenbaum*. (*Ochoa*, at pp. 138–139.) Instead, the court held that "an unpaid medical bill is not evidence of the reasonable value of the services provided" and, thus, cannot support an award of damages for past medical expenses. (*Ibid.*)

Accordingly, *Ochoa* applied *Howell* when, such as here, the plaintiff is treated on a lien basis.

4. *Bermudez* created a split of authority in holding that unpaid medical bills are admissible, at least absent objection, for truly uninsured patients. Marketplace value is ignored.

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 preserved for appellate review, *Bermudez* nevertheless issued a wide-ranging opinion (almost all of which could be characterized as dicta). The court criticized the line of cases following *Howell* and holding that unpaid medical bills were inadmissible; it 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*, *Howell* "did not actually hold that medical charges are inadmissible." (*Id.* at p. 1333, fn. 5; but see *Howell*, *supra*, 52 Cal.4th at p. 567 ["evidence of the full billed amount is not itself relevant on the issue of past medical expenses"].) Instead, *Bermudez* interpreted *Howell* narrowly as applying only to the limited situation where a medical bill is paid in full by the plaintiff's health insurance.

Per *Bermudez*, *Howell* did not "examine the mechanics of properly measuring damages in the case of an *uninsured* plaintiff." (*Bermudez*, *supra*, 237 Cal.App.4th at p. 1329, emphasis added.) According to *Bermudez*, those mechanics are based on reasonable value and *Howell* supposedly addressed only the " 'paid or incurred' prong of the test, not the 'reasonable

value' prong." (*Id.* at p. 1329.) But *Bermudez* ignored *Howell*'s extensive discussion of both prongs and *Howell*'s conclusion that the reasonable value prong should be based on marketplace value, not amounts billed. (*Howell*, *supra*, 52 Cal.4th at pp. 555–556, 562–566.) *Bermudez* also overlooked *Howell*'s statement that uninsured patients actually pay the same or *less* for medical services than insured patients. (*Id.* at p. 561.)

Bermudez expressly declined to follow *Corenbaum* 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 it "reiterate[d its] 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.) And, because there was no objection made in the trial court, *Bermudez* said nothing about the hearsay nature of unpaid medical bills.

5. *Pebley* followed *Bermudez* and created the legal fiction that plaintiffs who (on advice of counsel or otherwise) do not use their medical insurance should be considered uninsured. Marketplace value under *Howell* is again ignored.

It is against this background—*Corenbaum* and *Ochoa* holding that *Howell* precludes the admission of unpaid medical bills whether or not a plaintiff is insured or treated on a lien basis and *Bermudez* holding otherwise for uninsured plaintiffs—that Division Six decided *Pebley*.

Pebley was a personal injury action where the plaintiff originally sought treatment through his medical insurance and then sought treatment from a physician outside of the insurance network. (*Pebley*, *supra*, 22 Cal.App.5th at p. 1270.) The defense contended that the referral to the lien doctor was made at the recommendation of plaintiff's counsel, based on an article written by the attorney advocating for the use of lien treatment to circumvent *Howell*, *Corenbaum*, and the ACA and to increase " 'settlement value.' " (*Ibid.*)[2]

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[2] The article referenced in *Pebley* is titled "Why the Use of Medical Liens Is Expected to Increase by Attorneys and Physicians under Howell, Corenbaum and Obamacare." (Javaheri & Simon, *Why the Use of Medical Liens Is Expected to Increase by Attorneys and Physicians under Howell, Corenbaum and Obamacare* (July 9, 2014) Power Liens <https://bit.ly/39qxKRB> [as of Apr. 1, 2021].) Note that nowhere in the article do the authors, one of whom is a prominent plaintiff's attorney, claim that lien treatment provides better medical treatment for injured parties.

The parties filed a series of motions in limine addressing *Howell* and the admissibility of unpaid bills. (*Pebley*, *supra*, 22 Cal.App.5th at p. 1272.) One of the defendant's motions would have excluded the unpaid bills and required the plaintiff to "introduce independent evidence of market rate values for the care he received." (*Id.* at p. 1272.) The trial court denied the motion. (*Ibid.*) The trial court ruled that it was extending *Bermudez* to cover the facts of the case. (*Ibid.*) As a result, the plaintiff was able to introduce the full amount of the unpaid bills. (*Ibid.*)

Division Six affirmed the trial court's rulings, including the in limine ruling relieving the plaintiff of independently proving the marketplace value of the medical services. (*Pebley*, *supra*, 22 Cal.App.5th at p. 1272.) The court noted that *Bermudez* disagreed with *Ochoa*, but concluded that *Bermudez* represented the "better view." (*Id.* at p. 1277.) In doing so, the court created the legal fiction that an insured plaintiff who treats on a lien basis should be considered as uninsured under *Bermudez*. (*Id.* at pp. 1268, 1276–1278.) The court also affirmed the trial court's ruling permitting the plaintiff's medical damages expert to base his opinion on the " 'reasonable and customary *costs* in the community' " rather than marketplace value. (*Id.* at pp. 1272, 1278–1279, emphasis added.)

Pebley thus created (or cemented) at least three explicit splits of authority among published Court of Appeal opinions:

(1) *Corenbaum*, *Ochoa*, and *Romine* all hold that unpaid billed amounts are not admissible

evidence of the recoverable market value of services, whereas *Bermudez* and *Pebley* hold that billed but unpaid amounts are admissible;

(2) *Ochoa* holds that *Howell* provides the measure of damages and rule of admissibility regardless of whether services were provided at prenegotiated rates, whereas *Pebley* and *Bermudez* both hold that *Howell* does not apply where the treating provider's bills are unbounded by any pre-injury negotiation; and

(3) *Bermudez* and *Pebley* permit a plaintiff's expert to rely on the unpaid medical bills in offering opinions on the reasonable value of medical services, whereas *Corenbaum* explicitly holds to the contrary.

B. This court should follow *Corenbaum* and *Ochoa* because they are more true to *Howell*'s teachings.

1. *Corenbaum* and *Ochoa* were correctly decided and are more consistent with *Howell*.

This court is confronted with an intractable split between *Corebanum/Ochoa* and *Bermudez/Pebley* and must decide which line of cases to follow. ASCDC requests that this court follow *Corenbaum* and *Ochoa* because they are more consistent with *Howell*. We explain.

The whole point of *Howell* is that unpaid medical bills are not a reliable measure of damages because in real life virtually no one ever pays the full amount billed, an amount sometimes

referred to as the "chargemaster" rate. (*Howell*, *supra*, 52 Cal.4th at pp. 560–563.) Thus, the Court observed that billed/chargemaster rates do not "necessarily represent the amount an uninsured patient will pay" and uninsured patients receive various discounts such that they pay amounts " 'closer to those paid by commercial insurers *or even below*.' " (*Id.* at p. 561, emphasis added.)

Case law and studies have repeatedly demonstrated that virtually no one actually pays the full amount billed. (E.g., *Children's Hospital Central California v. Blue Cross of California* (2014) 226 Cal.App.4th 1260, 1268 [trial testimony: hospital was paid full "billed" amount "*less than 5 percent*" of the time, over a two-year period (emphasis added)], superseded by statute on another ground as stated in *Dignity Health v. Local Initiative Health Care Authority of Los Angeles County* (2020) 44 Cal.App.5th 144, 160–161; *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]; *Berkeley Heartlab, supra,* 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"]; *Temple University Hosp., Inc. v. Healthcare Management Alternatives, Inc.* (Pa.Super.Ct. 2003) 832 A.2d 501, 508 [expert testified that the hospital at issue was paid its full published charges in only one to three percent of its cases]; Nation, *Hospitals Use the Pernicious Chargemaster Pricing System to Take Advantage of*

Accident Victims: Stopping Abusive Hospital Billing (2018) 66 Drake L.Rev. 645, 654, 681 <https://bit.ly/3bOacYp> [as of Apr. 1, 2021] [chargemaster rates actually paid by less than five percent of patients]; 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"]; Hoffman & Bindman, *Varying Charges and Questionable Costs* (2015) 30 J. Gen. Internal Med. 1579, 1579 <https://bit.ly/31BAxmM> [as of Apr. 1, 2021] ["Only a small proportion of patients actually pay these [billed] prices"]; 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"]; 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"].)

Howell's conclusion is borne out by case law reflecting that the amount billed is typically five or more times higher than the amount actually accepted in payment for the medical services. (See *Luttrell v. Island Pacific Supermarkets, Inc.* (2013) 215 Cal.App.4th 196, 199 [$690,548 "billed," but $138,082 (20 percent) accepted as full payment]; *Nishihama v. City and County of San Francisco* (2001) 93 Cal.App.4th 298, 306–307, 309

[$17,168 "billed," but $3,600 (20 percent) accepted as payment].) The facts in this case confirm this phenomenon. (RB 28–29 [$838,320.02 billed, but $174,111.53 (20 percent) would have been accepted in payment under an average of Medicare, workers' compensation, and private insurance, based on uncontradicted testimony of defense expert].)

Thus, if a patient is insured, they do not pay the full amount billed. If the patient is uninsured, they typically pay the same or even less (and as discussed below, the uninsured share of the California population is only about seven percent). (*Howell*, *supra*, 52 Cal.4th at p. 561.) Neither *Bermudez* nor *Pebley* cite any authority to the contrary. *Corenbaum* and *Ochoa* thus represent the practical reality, consistent with *Howell*, that the amount billed is rarely, if ever, actually paid in real life, at least outside of the lien regime created exclusively for personal injury litigation.

For all of these reasons, unpaid medical bills are not admissible to show either the amount incurred for plaintiff's medical care or the reasonable value of that care. The chargemaster rates reflected in those bills are unmoored from the reality of the arm's-length transactions actually taking place in the marketplace. Further, even assuming that a plaintiff could incur such unreasonable rates, that plaintiff would still be limited to recovering the reasonable value of the medical services, which even *Bermudez* acknowledges will be the *lesser* of the two amounts. (*Bermudez*, *supra*, 237 Cal.App.4th at pp. 1330–1311.) As such, unpaid medical bills should not be introduced into

evidence. (See Evid. Code, § 350 ["No evidence is admissible except relevant evidence"].) Nor should an expert be permitted to evade this evidentiary bar by conveying the amount of unpaid bills, which is case-specific hearsay, to the jury or otherwise relying on them in forming opinions. (*People v. Sanchez* (2016) 63 Cal.4th 665, 686 [expert may not convey case-specific hearsay to the jury]; *Corenbaum*, *supra*, 215 Cal.App.4th at p. 1331 [expert cannot base opinion on unpaid bills].)

2. *Bermudez* and *Pebley* either outright abandoned marketplace value as the proper measure of recovery or sidestepped the issue as not preserved for appellate review.

Howell rejected reliance on billed amounts and adopted instead a marketplace value or exchange rate as the proper measure to determine the reasonable value of medical services. (*Howell*, *supra*, 52 Cal.4th at p. 562; *Markow*, *supra*, 3 Cal.App.5th at pp. 1050–1051.) " '[R]easonable value' is a term of limitation, not of aggrandizement." (*Howell*, at p. 553.) What do *Bermudez* and *Pebley* have to say about this? Very little.

In *Bermudez*, the issue was not before the court because plaintiff's expert's testimony was admitted without any objection or motion to strike and no motion in limine was filed to prevent the expert from offering opinions untethered to marketplace value. (*Bermudez*, *supra*, 237 Cal.App.4th at pp. 1339–1340.)

Bermudez nonetheless suggests that billed amounts may be admissible as part of a "wide-ranging inquiry" regarding the reasonable value of medical care. (*Bermudez*, *supra*, 237

Cal.App.4th at pp. 1330–1331.) But *Howell* endorsed a marketplace value, not a wide-ranging inquiry. (*Howell*, *supra*, 52 Cal.4th at pp. 556–557, 561–562.) Where *Bermudez* fundamentally erred is thus ignoring marketplace value—what is actually paid and accepted in the marketplace—as the correct standard for the reasonableness prong. It is no answer that the plaintiff may be uninsured, as *Howell* considered this issue and taught that uninsured patients actually pay the same or less than insured patients. (*Id.* at p. 561.)

Pebley is equally infirm in failing to reach the merits of why it allowed the amounts billed into evidence and expert testimony based on the billed amounts, rather than requiring expert testimony based on marketplace value, i.e., what is actually paid and accepted in the relevant community. *Pebley* affirmed the denial of a defense motion in limine that would have required the plaintiff "to introduce independent evidence of market rate values for the care he received." (*Pebley*, *supra*, 22 Cal.App.5th at p. 1272.) It upheld the verdict based on testimony from two of the plaintiff's experts that "emphasized the reasonable *cost* of the medical services rather than their reasonable value, market value or exchange rate value." (*Id.* at p. 1279.) The only reason provided, however, was that the defendant failed to object to CACI No. 3903A, which uses the word "cost" rather than "value." (*Ibid.*) In other words, another procedural default, as in *Bermudez*, without any substantive explanation for why marketplace value was abandoned as the proper standard.

That brings us to the second legal fiction endorsed by *Pebley*: " 'uninsured plaintiffs will typically incur standard, nondiscounted charges.' " (*Pebley*, *supra*, 22 Cal.App.5th at p. 1275.) In reality, plaintiffs rarely, if ever, actually pay the full amount billed because the lien providers routinely negotiate the lien downwards. Consider:

- "The main advantage for doctors and other providers to treat on a lien basis is they are able to bill at the 'usual and customary' rate, which is almost always higher than the negotiated fees paid by health insurers, *though they likely will be asked to negotiate down from the higher rate.*" (Ellison, *Medical Liens: Necessary Evil or Litigation Advantage?* (Apr. 2013) Plaintiff Magazine <https://bit.ly/3vvxFFA> [as of Apr. 1, 2021], emphasis added.)

- "*Fortunately, medical lien holders are almost always willing to negotiate a lower payoff amount.* . . . [¶] . . . [¶] . . . *They would rather get a reduced amount to pay off the lien than end up with nothing if you can't settle your injury claim.* [¶] . . .[¶] You are more likely to successfully negotiate a compromise when you'll be left with an unfairly low portion of compensation for pain and suffering, or you need the settlement to avoid financial hardship." (Gueli, *Negotiating Medical Liens: How to Keep More Settlement Money* (June 28, 2019) Injury Claim Coach <https://bit.ly/30IIaaG> [as of Apr. 1, 2021], emphasis added.)

- "The economic realities of settling personal injury cases today (particularly in terms of soft tissue injury cases) mandate negotiating with medical care providers to reduce their

liens." (Miller & Quinley, Insurance Settlements (2012) §§ 2900A–2970A <https://bit.ly/3bNsDfS> [as of Apr. 14, 2021].)

- "However, an experienced California injury lawyer can often negotiate a reduction of the lien amount on the patient's behalf — even if the lawyer did not negotiate the lien agreement. . . .[¶] . . .[¶] We are often able to negotiate a reduction so that the doctor is happy but the patient still has something left over as compensation for pain and suffering." (*Should I Use "Medical Lien" in a California Personal Injury or Accident Case*? (Nov. 2, 2020) Shouse Injury Law Group <https://bit.ly/3eHcrPf> [as of Apr. 1, 2021].)

The reality is that *Pebley* endorses a litigation strategy based on the legal fiction that billed amounts are paid, yet the literature analyzing that same issue demonstrates that no one ordinarily ever pays those billed amounts, whether or not they were treating on a lien basis. The proper standard is marketplace value, as adopted by *Howell.*

The legal fiction endorsed by *Pebley* creates troubling incentives. Because the full amount of the lien is really just a starting point for negotiation, and not a market value, the physician providing services on the lien is effectively being compensated on a contingency basis dependent on the outcome of a settlement or trial. Consider the facts of this case. Plaintiff allegedly incurred $838,320.02 in bills for past medical services on a lien basis, an amount which even his own expert could not justify as reasonable. (7 RT 1655:20–1656:3.) Instead, the plaintiff's expert testified that only $632,456.34 (75 percent) was

reasonable. (*Ibid.*) The jury awarded $532,000 for past medical expenses. (14 RT 4201–4202.) No one should expect Mr. Qaadir to have to pay the $205,863.68 difference between the amount billed and the amount Dr. Morris testified was reasonable, let alone the $306,320.02 difference between the amount billed and the amount the jury awarded; those amounts should be written off by the lien providers. But whether or not the amounts are written off, Mr. Qaadir's counsel may have referred him to physicians charging more than the reasonable value of the medical services.

Rules of Professional Conduct, rule 3.4(d) is instructive. It provides that a lawyer shall not directly or indirectly acquiesce in the payment of compensation to a witness contingent on the outcome of the case. Because a lien provider's compensation is, as a practical matter, contingent on the outcome of the case, the testimony by such a witness seems contrary to the spirit, if not the letter, of rule 3.4(d). The rule contains exceptions authorizing the payment of reasonable expenses incurred by a witness in testifying, reasonable compensation to a witness for the loss of time in testifying, and reasonable expert witness fees. (*Ibid.*) But medical treatment does not fall within any of those exceptions. Even *Bermudez* recognizes a lien doctor's financial incentive to overstate the reasonable value of the services provided, but merely suggested that issue should be left to cross-examination. (*Bermudez*, *supra*, 237 Cal.App.4th at p. 1340, fn. 11.) The pretense that lien rates reflect marketplace values despite the overwhelming contrary evidence creates dangerous

incentives that undermine the goal of obtaining substantial justice for plaintiffs and defendants both.

Therefore, neither *Bermudez* nor *Pebley* are persuasive on the issue of why billed amounts should be introduced into evidence to prove the reasonable value of medical services in light of *Howell*, which emphasized that billed amounts are almost never paid and that the relevant inquiry instead should be marketplace value.

3. *Pebley* represents bad public policy and frustrates the purpose of the Affordable Care Act, which California has embraced.

The ACA aims to "increase the number of Americans covered by health insurance and decrease the cost of health care." (*National Federation of Independent Business v. Sebelius* (2012) 567 U.S. 519, 538 [132 S.Ct. 2566, 183 L.Ed.2d 450] (*Sebelius*); see ACA, Pub.L. No. 111-148 (Mar. 23, 2010) 124 Stat. 119.) California has embraced the ACA. To fully implement it, California has created an independent public entity, California Health Benefit Exchange (also known as Covered California), "to serve the public interest of the individuals and small businesses seeking health care coverage through the Exchange." (Gov. Code, § 100500, subds. (a) & (d).)

Under the ACA's individual mandate, most Californians are required to maintain health insurance. (26 U.S.C. § 5000A(a); but see *Texas v. United States* (5th Cir. 2019) 945 F.3d 355, 369 [concluding that "individual mandate is unconstitutional because it can no longer be read as a tax" but

remanding to the district court to address issues of severability and scope of remedy], cert. granted *sub nom. California v. Texas* (2020) __ U.S. __ [140 S.Ct. 1262, 206 L.Ed.2d 253].) The mandate allows for only limited exceptions, such as for prisoners and undocumented aliens. (26 U.S.C. § 5000A(d)(3) & (4).) Under the ACA's guaranteed issue and renewal requirements, insurance companies are barred from denying coverage to Californians with preexisting medical conditions. (42 U.S.C. §§ 300gg-1(a), 300gg-2(a), 300gg-3(a); Ins. Code, § 10198.7; see *Sebelius*, *supra*, 567 U.S. at p. 548 [the ACA prohibits "insurance companies from denying coverage to those with such conditions or charging unhealthy individuals higher premiums than healthy individuals"]; *Cuevas*, *supra*, 11 Cal.App.5th at p. 178 [discussing the ACA's guaranteed issue and renewal requirements].)

A recent study by the National Center for Health Statistics showed that over 93 percent of Californians had 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 Apr. 1, 2021] [showing California's uninsured rate at 6.8 percent as of June 2017]; see also Public Policy Inst. of Cal., Uncertainty about federal health policy has California exploring state options (Jan. 2018) <https://bit.ly/2OTQoKk> [as of Apr. 1, 2021] [93 percent insured in 2018]; Anderson, *More Californians got health insurance annually over 4 years. Here's why the rate stalled*, Sacramento

Bee (Sept. 12, 2019) <https://bit.ly/3cxh1Nn> [as of Apr. 1, 2021] [92.8 percent in 2019]; Elflein, Health insurance status of the population of California 2019 (Nov. 18, 2020) Statista <https://bit.ly/2Qbkf1H> [as of Apr. 1, 2021] [93 percent in 2019].)

Everyone can agree on two basic points: (1) an individual is better off having health insurance than being uninsured; and (2) having health insurance is most important when an individual becomes sick or has an accident.

Notwithstanding the ACA and its important policies, including controlling the cost of medical care, *Pebley* creates perverse economic incentives for plaintiffs *not* to use their health insurance and, instead, to seek treatment on a lien basis for amounts virtually no one else in the marketplace ever actually pays. If 93 percent of Californians have health insurance, why does it seem like more than 93 percent of plaintiffs in personal injury actions now opt *not* to use their health insurance and instead seek medical treatment on a lien basis? *Pebley* tells us. It is because many attorneys encourage their clients to seek treatment on a lien basis in order to increase settlement value by circumventing *Howell*, *Corenbaum*, and the ACA. (See *Pebley*, *supra*, 22 Cal.App.5th at p. 1270; see also Schabloski, *Independent Medical Providers: To Lien, or Not to Lien* (Nov. 2019) Advocate Magazine <https://bit.ly/3eJ66CL> [as of Apr. 6, 2021] (hereafter *To Lien*) ["Treating on a lien can increase the dollar amount of medical damages after past [medical] damages were limited" in *Howell*, citing *Pebley*].)

By encouraging clients to treat on a lien basis rather than through insurance, attorneys can attempt to claim greater damages at trial. As a prominent plaintiff's attorney explained in an article written after *Howell*:

> "If I have a client who's on Medicare, and they have a $100,000 medical bill, Medicare pays $10,000. The only thing admissible at trial is that $10,000," [Michael] Cooper explains. "If I have a client who goes out and gets treated on a lien and is obligated to pay $100,000, then that's what they have to pay at the end of the case: $100,000. And I can introduce the entire $100,000 as a bill at the time of trial."

(Ellison, *supra*, Plaintiff Magazine <https://bit.ly/3vvxFFA>.)

Consider this quote from the appellate brief written by *a lien provider* identifying settlement value as the reason for not billing the plaintiff's insurance:

> After engaging counsel for her Personal Injury Action, Ghafoori sought physical and occupational therapy treatments from Advance for her accident related injuries, specifically injuries to her shoulder, arms and hands. [Citations]. Ghafoori informed Advance that she had retained Plummer Law to file a Personal Injury Action for the injuries she sustained as a result of the accident and requested that Advance provide her with physical and occupational therapy for her accident related injuries under a medical lien. (1 C.T. p. 113 at ¶7; 1 C.T. p. 220.) Ghafoori and her counsel *requested Advance not bill her insurance* for her treatment as she was *advised by her attorney* to treat under a medical lien *to increase the settlement value of her case.* (1 C.T. p. 113 at ¶7; 1 C.T. p. 220.)

(Appellant's Opening Brief, *Ghafoori v. Advance Occupational and Hand Therapy Center* (Feb. 1, 2021, G059486) 2021 WL 490385, at pp. *11–*12, emphasis added; see *id.* at pp. *27–*28 [describing how plaintiff in personal injury action "proceeded under the Medical Lien to increase the settlement value" under *Pebley*].)

So why might an attorney push lien treatment so aggressively? The attorney may seek to blackboard the highest possible number for medical damages during closing argument, which, in turn, can influence the jury's award of noneconomic damages. (See *Helfend v. Southern Cal. Rapid Transit Dist.* (1970) 2 Cal.3d 1, 11 ["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"], superseded by statute on another ground as stated in *Waite v. Godfrey* (1980) 106 Cal.App.3d 760, 767, fn. 3; *Corenbaum*, *supra*, 215 Cal.App.4th at p. 1333 ["Lawyers have used the amount of economic damages as a point of reference in their argument to a jury, or in settlement discussions, as a means to help determine the amount of noneconomic damages"].)

Nor is it an answer for plaintiff to claim that the ACA may be repealed at some time in the future. *Cuevas* rejected this contention. (*Cuevas*, *supra*, 11 Cal.App.5th at pp. 180–181.) In any event, this court must apply the law as it currently exists, not based on speculation about future legislative changes. (See *District of Columbia Court of Appeals v. Feldman* (1983) 460 U.S. 462, 477 [103 S.Ct. 1303, 75 L.Ed.2d 206] ["A judicial inquiry

investigates, declares and enforces liabilities as they stand on present or past facts and under laws supposed already to exist" (internal quotation marks omitted)], quoting *Prentis v. Atlantic Coast Line Co.* (1908) 211 U.S. 210, 226 [29 S.Ct. 67, 53 L.Ed. 150]; see also *Weldon v. Weldon* (Tex.App. 1998) 968 S.W.2d 515, 518 ["A trial judge rules on a statute that is *in effect at the time of the case* and is not in the position of predicting future changes by the legislature" (emphasis added)].)

At its core, *Pebley* endorses a litigation strategy contrary to California's strong public policy in implementing the ACA. The court should consider that public policy in deciding whether to follow *Corenbaum/Ochoa* or *Bermudez/Pebley*.

4. Patient choice is a red herring. A plaintiff who elects to treat on a lien basis still cannot recover more than the reasonable value of the medical services, defined by marketplace value.

Notwithstanding the defendant's express concession in *Pebley* that it was not attempting to dictate where or how injured plaintiffs may treat their injuries (*Pebley*, *supra*, 22 Cal.App.5th at p. 1276 ["defendants concede, Pebley had a right to choose physicians and medical facilities outside his plan"]), *Pebley* nonetheless based its ruling on patient choice (*id.* at pp. 1276–1277). This is a red herring. No one is arguing that the defendant in a personal injury case can dictate the medical treatment the plaintiff receives.

If a personal injury plaintiff elects (on the advice of counsel or otherwise) to be treated by physicians who do not accept the

plaintiff's insurance, the plaintiff is still limited to the *lesser* of the amount incurred or the reasonable value of the medical services. (*Howell*, *supra*, 52 Cal.4th at p. 556.) Thus, under *Howell*, a plaintiff can never recover more than the reasonable value of the medical services, which, as discussed above, is determined based on marketplace value, i.e., what is actually paid and accepted by medical providers as payment in full.

Proof of the reasonable marketplace value of medical services can be established using objective data. For example, numerous cases (including from this court) and the Legislature have approved using amounts actually paid under Medicare or the ACA in determining the reasonable value of medical services. Indeed, it's unclear how market value could be determined *without* accounting for these large parts of the market. As the plaintiff's expert acknowledged in this case, Medicare is the largest payor of medical services in the United States. (7 RT 1639:22–24.)

Howell itself recognized that "looking to the negotiated prices *providers accept from insurers* makes at least as much sense, and arguably more, than relying on chargemaster [billed] prices that are not the result of direct negotiation between buyer and seller." (*Howell*, *supra*, 52 Cal.4th at p. 562.) Since *Howell*, courts have uniformly recognized that amounts accepted by medical professionals, whether paid by Medicare or private insurance, are relevant in determining the reasonable value of medical services. One of the leading authorities on this subject is this court's opinion in *Stokes v. Muschinske* (2019) 34

Cal.App.5th 45 [Second Dist., Div. Eight] (*Stokes*), which also involved a personal injury.

In *Stokes*, the defense's medical billing expert offered his opinion about the reasonable value of the medical services the plaintiff received, based on 130 percent of the Medicare allowable amounts without any deductions for actual Medicare or other collateral source payments. (*Stokes*, *supra*, 34 Cal.App.5th at p. 59, fn. 10.) On appeal, the plaintiff argued this testimony was improper. (*Id.* at p. 55.) This court rejected plaintiff's contention because the testimony "merely provided context and background information on Stokes's past treatment . . . and on some aspects of [defendant's] experts' calculation of past and future reasonable medical expenses" and thus was "helpful and even necessary to the jury's understanding of the issues." (*Id.* at p. 58.) CACI Nos. 105 and 5001 now cite *Stokes* as one of their sources and authorities.

The First District also approved of the use of government and insurance payments to determine the reasonable value of medical services in *Cuevas*, *supra*, 11 Cal.App.5th at page 166, a medical malpractice case.[3] In *Cuevas*, the trial court precluded the defendant from offering expert testimony about the reasonable value of future medical services available to the plaintiff under the ACA. (*Cuevas*, at p. 166.) The court reviewed *Howell* and its progeny, including *Markow*, *supra*, 3 Cal.App.5th

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[3] *Cuevas* made clear that its holding applied outside of medical malpractice cases even though a statutory exception to the collateral source rule exists in those cases (Civ. Code, § 3333.1). (*Cuevas*, *supra*, 11 Cal.App.5th at p. 178.)

1027 and *Corenbaum*, *supra*, 215 Cal.App.4th 1308, and concluded that "[t]hese cases support the conclusion that the collateral source rule is not violated when a defendant is allowed to offer evidence of the market value of future medical benefits." (*Cuevas*, at pp. 179–180.) The court thus held that the trial court abused its discretion when it excluded the defense's ACA evidence. (*Id.* at pp. 180–181.)

Although not a personal injury case, Division One's opinion in *Sanjiv Goel, M.D., Inc. v. Regal Medical Group, Inc.* (2017) 11 Cal.App.5th 1054 (*Goel*) also confirms the validity of using Medicare reimbursement rates to determine the reasonable value of medical services. *Goel* involved a quantum meruit dispute between a physician and a medical group over the reasonable value of services that the physician provided to four patients. (*Id.* at p. 1057.) The physician had no contract with the medical group but had an agreement with Medicare, under which he would have been paid $6,413.36 for the four patients. (*Id.* at pp. 1057–1058.) He sought to recover $275,383.16, and the medical group paid $9,660.86. (*Id.* at p. 1058.) The physician sued to collect the difference between the amounts billed and paid. (*Ibid.*)

The medical group's billing expert testified that the average rate of private payers in the industry ranged from 135 to 140 percent of Medicare reimbursement rates, and that the medical group had paid the physician at approximately 150 percent of those rates. (*Goel*, *supra*, 11 Cal.App.5th at p. 1059.) The trial

court concluded that the amounts paid " 'reflected the reasonable value of services.' " (*Ibid.*)

On appeal, the physician contended that the trial court erred by considering amounts paid by Medicare or charged by other medical providers to determine the reasonable value of medical services. (*Goel*, *supra*, 11 Cal.App.5th at p. 1059.) Division One rejected the argument. (*Id.* at p. 1060.) It found no "persuasive reason to adopt an absolute rule precluding the consideration of Medicare rates in determining the reasonable value of emergency medical services." (*Id.* at p. 1064.) The trial court "had a reasonable basis in the evidence to conclude that Medicare rates were relevant to the market rate for the medical services at issue." (*Id.* at p. 1065.) Further, the trial court did not err by considering fees collected by other medical providers for similar services. (*Id.* at pp. 1060, 1063.)

The Legislature has adopted the use of Medicare rates to determine the reasonable value of medical services. The "surprise medical bill" statutes (Health & Saf. Code, §§ 1371.30, 1371.31, 1371.9; Ins. Code, §§ 10112.8, 10112.81, 10112.82) limit the amount a patient must pay to an "out-of-network" medical provider at a contracting health facility to the same amount as an " 'in-network' " provider. (Health & Saf. Code, § 1371.9, subds. (a)(1) & (c).) The statutes also require an out-of-network medical provider who collects an amount over the in-network price to refund any overpayment to the patient. (*Id.*, § 1371.9, subd. (a)(4)(A); see *id.*, § 1371.9, subd. (a)(1)–(3).) As part of the statutory scheme, the Legislature adopted a standard of 125

percent of the Medicare reimbursement rate. In other words, in some situations in which the patient is treated out of network, the insurer may pay the medical provider 125 percent of the rate Medicare would pay. (*Id.*, § 1371.31, subd. (a)(1).) Given this legislative enactment, any policy concerns about patient choice of medical providers is greatly reduced. An injured plaintiff now can treat with out-of-network doctors at contracted facilities (almost all hospitals have contracts with insurance companies) and still receive highly discounted medical services based on Medicare reimbursement rates.

In contrast to cases such as *Stokes* and *Goel*, in which expert testimony was based on objective, real life figures—consider the expert testimony in *Bermudez* and *Pebley*. In *Bermudez*, the grand total of the experts' testimony was that the amounts billed were "fair and reasonable." (*Bermudez*, *supra*, 237 Cal.App.4th at pp. 1324–1325.) Nothing in *Bermudez* remotely suggests that the jury's verdict was based on amounts actually paid and accepted in the marketplace. Same with *Pebley*: the experts based their opinions on the " 'reasonable and customary costs in the community' " without addressing what amounts were actually paid and accepted in the marketplace. (*Pebley*, *supra*, 22 Cal.App.5th at p. 1278.)

As Justice Wiley has recently explained, "[i]t does not take much experience as a trial judge in Los Angeles to realize the use of expert witnesses has run riot." (*Brown v. Los Angeles Unified School District* (Feb. 18, 2021, B294240) 60 Cal.App.5th 1092 [2021 WL 631030, at p. *10] (*Brown*) (conc. opn. of Wiley, J.).) It

is no surprise that there exists a reliable stable of medical experts willing to opine on the basis of billed amounts, if courts do not require them to adhere to the marketplace value standard adopted by *Howell*.

Here, plaintiff offered the expert testimony of Dr. Morris, a chiropractor with an ownership interest in one of the facilities that provided medical care on a lien basis. (7 RT 1625, 1634.) He readily admitted that the basis for his opinions—what he called the "reasonable and customary value"–was not the amount actually paid. (See 7 RT 1624:20–22.) He also testified that doctors will accept this "reasonable and customary value," which in this case was 75 percent of the amount billed. (7 RT 1655:20–1656:3 [per Dr. Morris, the reasonable value was only 75 percent of amount billed]; 8 RT 1821.) But this is not surprising. When one considers that the amount billed is typically at least five times greater than the amount accepted (at pp. 28–29, *post*), of course medical providers will gladly accept 75 percent of the amount billed. The real question is *how often* medical providers are actually paid that percentage in the marketplace. Dr. Morris did not address that issue. In stark contrast, the defense expert relied on amounts actually paid (and accepted as payment in full) by Medicare, workers' compensation, and private medical insurers, which collectively comprise 93 to 95 percent of the overall marketplace. (8 RT 1872–1873.)

We anticipate that in answer to this amicus brief, plaintiff will attempt to argue that lien treatment is warranted if the plaintiff cannot afford to pay up front for medical treatment. But

this is irrelevant because plaintiffs are free to treat on a lien basis; they simply cannot recover more than the reasonable value of the medical services, i.e., marketplace value.

At minimum, this court should limit *Pebley* to the facts of the case where the plaintiff had HMO medical coverage through Kaiser that might have limited his treatment options. (*Pebley*, *supra*, 22 Cal.App.5th at p. 1277.) There is no justification for allowing a plaintiff to recover based on the amounts billed when the medical provider accepts the plaintiff's medical insurance and has agreed in advance to accept a lesser amount under *Howell.* (It is the experience of ASCDC's members that this is a routine fact pattern, which no published case has addressed.) Even an article in the leading magazine for the plaintiff's bar admits that liens should not be used when the medical provider accepts the plaintiff's insurance:

> *Thus, if the health-care provider accepts your client's health insurance, do not attempt to obtain that treatment on a lien.* Treating with a health-care provider on a lien basis, when that same health-care provider accepts your client's health insurance, eviscerates the objective legitimacy of the plaintiff's choice in care. Choosing the best possible care (the treating provider), but at the most expensive option (lien), only bolsters the argument that treating on a lien is naught but a ruse to get more money from the defense.

(*To Lien*, *supra*, Advocate Magazine <https://bit.ly/3eJ66CL>, emphasis added.)

Doctor choice is simply irrelevant. Plaintiffs can treat with any medical providers they choose. But if they voluntarily incur more than the reasonable value of those services (on advice of counsel or otherwise), the excess amount is not recoverable.

5. There is no justification for admitting billed amounts to calculate future medical damages.

There is no justification for using billed amounts to calculate *future* medical damages, which are governed by the same standards that govern past medical damages under *Howell*. (See *Cuevas*, *supra*, 11 Cal.App.5th at p. 179; *Markow*, *supra*, 3 Cal.App.5th at p. 1050.) The jury's award will provide the plaintiff sufficient funds (adjusted for inflation) to pay for any future medical care. The plaintiff can use that award to pay insurance premiums covering the cost of future care. And the ACA will prohibit insurers from denying coverage or increasing premiums based on the plaintiff's preexisting medical condition. (See *ante*, pp. 35–36.) Indeed, the ACA *mandates* that the plaintiff obtain insurance coverage to cover the cost of that future care. (See *ibid.*)

Even if a plaintiff elects to violate the ACA and forego insurance coverage, the plaintiff can still pay the lower cash price for future medical services. (See Beck, *How to Cut Your Health-Care Bill: Pay Cash* (Feb. 15, 2016) Wall Street J. <https://on.wsj.com/38LccPv> [as of Apr. 6, 2021] ["Patients who pay up front in cash often get better deals than their insurance plans have negotiated for them"]; *ibid.* [cash advantage chart

comparing lower cash prices to insurance rate at three different medical facilities]; Drummond, *Medical Bills Going Down If You Pay Cash – Way Down*, Happy M.D. <https://bit.ly/3eIkX0g> [as of Apr. 6, 2021] [cash discounts of up to 89 percent for common medical procedures being offered in Southern California healthcare system]; Terhune, *Many hospitals, doctors offer cash discounts for medical bills*, L.A. Times (Mar. 27, 2012) <https://lat.ms/38GnJiM> [as of Apr. 6, 2021] [cash price for medical services is often lower than negotiated insurance rate (e.g., $250 cash price vs. $2,400 Blue Shield negotiated price for a CT scan)]; Lazarus, *Insured price: $2,758. Cash Price: $521. Could our healthcare system be any dumber?*, L.A. Times (July 30, 2019) <https://lat.ms/30O89NL> [as of Apr. 6, 2021] [highlighting insurance rate that was 3.3 times higher than cash price for ultrasounds]; Henderson, *Cash is King, At Least in Healthcare* (Jan. 23, 2020) Motivhealth <https://bit.ly/3rPKatG> [as of Apr. 6, 2021] [discussing difference between cash price and insurance rate].)

There is no economic justification for using liens or billed amounts to determine the amount of *future* medical care.

6. The error in this case was prejudicial.

The respondent's brief argues that the admission of the full billed amount was not prejudicial because the plaintiff's expert testified that a lesser amount was reasonable and the jury awarded an even lesser amount. (RB 55.) Not so. Plaintiff's counsel used the full billed amount in closing argument to bolster the opinions of plaintiff's expert. Counsel contrasted the full

billed amount with the 25 percent reduction proposed by plaintiff's expert to argue the lower amount was reasonable and already reflected a discount. (14 RT 3681–3682.) As such, the improper admission of the full billed amount was prejudicial. (See *Soule v. General Motors Corp.* (1994) 8 Cal.4th 548, 580–581 [courts look to respondent counsel's closing argument in determining prejudice].)

Plaintiff's argument here was a form of "anchoring." A substantial and mounting body of empirical evidence demonstrates what common courtroom experience teaches—allowing counsel to suggest a specific amount of damages significantly skews jurors' ultimate awards and invades the province of the jury by "anchoring" jury expectations regarding the appropriate range of damages to award at an inappropriate level. (See, e.g., Marti & Wissler, *Be careful what you ask for: The effect of anchors on personal injury damages awards* (2000) 6 J. Experimental Psych. Applied 91; Chapman & Bornstein, *The More You Ask For, the More You Get: Anchoring in Personal Injury Verdicts* (1996) 10 Applied Cognitive Psych. 519; Hinsz & Indahl, *Assimilation to Anchors for Damage Awards in a Mock Civil Trial* (1995) J. Applied Soc. Psych. 991; Malouff & Schutte, *Shaping Juror Attitudes: Effects of Requesting Different Damage Amounts in Personal Injury Trials* (1989) 129 J. Soc. Psych. 491.)

But the anchoring here went beyond mere argument; the damages award was skewed by *evidence* regarding an inflated billed amount that even plaintiff's own expert acknowledged was unreasonable. Argument that relies on improper anchoring may

not always be grounds for a new trial. (See *Fernandez v. Jimenez* (2019) 40 Cal.App.5th 482, 492 & fn. 5 [trial court did not abuse its discretion in denying a motion for new trial on the grounds of attorney misconduct where " 'anchoring' " was used during voir dire].) But it does not follow that anchoring can be used to justify the introduction of evidence to circumvent a substantive rule of law, in this case *Howell*.

Accordingly, the admission of the full, unpaid billed amount was prejudicial and a new trial on damages should be ordered.

II. The trial court erred in not permitting cross-examination into the source of plaintiff's referral to the lien doctors, which was relevant to show bias and financial incentive.

Cross-examination into an expert's financial interests in the outcome of lien-based treatment is proper. (*Bermudez, supra,* 237 Cal.App.4th at p. 1340, fn. 11.) An expert witness has a financial incentive in maintaining a good relationship with attorneys who refer work. Out of that financial incentive can grow bias. (*Brown, supra,* 60 Cal.App.5th 1092 [2021 WL 631030, at p. *10] (conc. opn. of Wiley, J.).) That is why experts are frequently examined at trial about how often they have been retained by the attorney or law firm calling them in that case.

The Rutter Group explains that if an attorney refers a client to a lien medical provider, that referral is fair game at trial:

> **PRACTICE POINTERS**: Foregoing insurance in favor of lien-basis medical services poses risks:

> • Defendant may suspect that plaintiff and/or counsel is attempting to inflate damages by pursuing more expensive—and perhaps unnecessary—medical treatment. This could impede settlement.
>
> • *If the attorney referred the client to the lien doctor, the client will have to testify to that at trial.*

(Haning et al., Cal. Practice Guide: Personal Injury (The Rutter Group 2020) ¶ 3:362.3, emphasis added.)

" 'A trial is a search for the truth' " (*People v. Espinoza* (2018) 23 Cal.App.5th 317, 323 (*Espinoza*)) and cross-examination is the "greatest legal engine ever invented for discovery of truth" (*Manufactured Home Communities, Inc. v. County of San Luis Obispo* (2008) 167 Cal.App.4th 705, 712, internal quotation marks omitted). If there's going to be a "wide ranging" inquiry into the reasonableness of medical services under *Bermudez* and *Pebley*, then all relevant information should be admitted, including attorney referrals to lien doctors. The trial court erred in sustaining the objection to Dr. Morris's testimony regarding the source of his referral. (8 RT 1822:2–1823:3.)

III. *Pebley* did not eliminate the centuries-old defense of mitigation of damages. The trial court erred in not permitting proper cross-examination of plaintiff and his experts, which could have been accomplished without mentioning insurance.

"It has been the policy of the courts to promote the mitigation of damages. [Citations.] The doctrine [of mitigation of damages] applies in tort, wilful as well as negligent. [Citations.] A plaintiff cannot be compensated for damages which he could

have avoided by reasonable effort or expenditures." (*Green v. Smith* (1968) 261 Cal.App.2d 392, 396.) "[T]he wrongdoer is not required to compensate the injured party for damages which are avoidable by reasonable effort on the latter's part." (*Ibid.*) Mitigation of damages comes into play after a legal wrong has occurred and the plaintiff has become aware of the resulting injury, but while some damages may still be averted. (*Pool v. City of Oakland* (1986) 42 Cal.3d 1051, 1066; *Tormey v. Anderson-Cottonwood Irr. Dist.* (1921) 53 Cal.App. 559, 566.)

Mitigation of damages applies equally to medical decisions. (See *Withrow v. Becker* (1935) 6 Cal.App.2d 723, 729–730 [mitigation of damages applied where the plaintiff failed to undergo an operation that would have cured his hernia]; see also *Sanford Bros. Boats, Inc. v. Vidrine* (5th Cir. 1969) 412 F.2d 958, 973–974 [plaintiff's failure to accept free medical services at nearby hospital barred him from recovering cost of private health care]; *Brzoska v. Olson* (Del. 1995) 668 A.2d 1355, 1367 [availability of free HIV test presented jury question of whether plaintiff failed to mitigate damages by incurring expense of private testing].)

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 *Davies v. Krasna* (1975) 14 Cal.3d 502, 515 ["victims of legal wrong 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, quoting *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.)

Here, the trial court ruled, apparently as a matter of law, that *Pebley* eliminated mitigation as a defense. (8 RT 1803:24–1804:4 ["*Pebley* has been very clear that you cannot use private insurance for mitigation damages, and I think the law is very clear. I've read the case."].) That was error. *Pebley*'s discussion of mitigation of damages was limited to its holding that unpaid bills are admissible because a plaintiff who treats on a lien basis should be considered uninsured. (*Pebley*, *supra*, 22 Cal.App.5th at p. 1276.) *Pebley* simply held that the duty to mitigate did not mean that a tortfeasor can "force a plaintiff to use his or her insurance to obtain medical treatment." (*Id.* at p. 1277.) In other words, the mitigation discussion in *Pebley* was limited to the patient-choice issue addressed above (which the defendant was never asserting anyway). (See *id.* at pp. 1276–1277.)

Here, defense counsel should have been permitted to cross-examine plaintiff about less expensive treatment options. This

could easily have been done without referencing plaintiff's medical insurance. For example: "Mr. Qaadir, why did you elect to treat at Bay City Surgery Center and incur an expense of $838,320 when you could have chosen to have the same procedures done at UCLA or Cedars-Sinai for $174,111?" In fact, defense counsel expressly disavowed attempting to cross-examine plaintiff regarding his medical insurance. (8 RT 1805:6–10.)

Again, a trial is supposed to be a search for the truth. (*Espinoza*, *supra*, 23 Cal.App.5th at p. 323.) The defense should have been permitted to cross-examine the plaintiff regarding less expensive treatment options, which could have been done without mentioning plaintiff's health insurance.

CONCLUSION

For the foregoing reasons, this court should issue a published opinion following *Corenbaum* and *Ochoa* and disagreeing with *Bermudez* and *Pebley*.[4]

April 16, 2021

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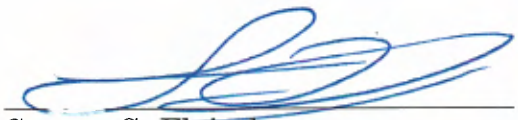
[4] If the court decides to reverse the judgment on other grounds, the court should exercise its discretion to provide guidance to the trial court on how to address the *Howell* issues on remand.

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

The text of this brief consists of 10,644 words as counted by the program used to generate the brief.

Dated: April 16, 2021



Steven S. Fleischman

PROOF OF SERVICE

Qaadir v. Adan Ordeonez Trucking
Case No. B306011

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, CA 91505-4681.

On April 16, 2021, I served true copies of the following document(s) described as **AMICUS CURIAE BRIEF** on the interested parties in this action as follows:

SEE ATTACHED SERVICE LIST

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

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

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

Executed on April 16, 2021, at Burbank, California.

Jill Gonzales

SERVICE LIST
Qaadir v. Adan Ordeonez Trucking
Case No. B306011

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