

The role of medical specials in evaluating injury cases – big or small

By Guy O. Kornblum and David Cardone

“Three times the specials plus the wage loss.” For years that was the mantra for evaluating personal injury cases, particularly soft tissue cases. While perhaps more suitable to soft tissue cases, insurance carriers continue to covertly apply this “formula” when evaluating a broad spectrum of personal injury cases, except for perhaps the most serious. But is this approach still meaningful in light of the *Howell v. Hamilton Meats & Provisions, Inc.*, in which the California Supreme Court held that when a plaintiff has medical insurance, the reduced rate *paid* by the insurer is the proper measure of damages for determining medical specials and that the actual *billed* amount is inadmissible for this purpose?¹ Because of *Howell*, the jury only hears evidence of a substantially reduced medical charge, which may not reflect the reasonable value of all medical services caused by the accident.

But, despite *Howell*, is the reduced *paid* amount really the appropriate indicator of the value of the case? How significant is this number in measuring the injury’s effect on the plaintiff? Does it represent an *accurate* measure of the nature and extent of that injury? Is the old formula of “three times the specials plus the wage loss” even more misleading now that health insurance carriers apply negotiated rates

with medical providers, doctor groups and hospitals, who agree to provide bulk medical services at substantially reduced rates?

Today, because of negotiated rates, medical care that might be *billed* in the hundreds of thousands of dollars at the “going rate” (i.e., what an uninsured person would pay) may very well result in the acceptance by the provider of a dramatically reduced sum that is a modest percentage of that total and fails to reflect the nature and extent of the injuries or the reasonable value of necessary medical care. Since there is no balance billing in California – the plaintiff is not responsible for the difference between the billed amount and the discounted rate – the medical provider must accept the discounted payment from the insurer in full satisfaction of all sums due.² How should this billing reality affect the way injuries are valued in personal injury cases?

As a result of *Howell*, you may need to take a different approach to presenting evidence of the value of a plaintiff’s injuries in cases subject to *Howell* reductions. Other factors may need to play a more prominent role in presenting a demand package to the defense for settlement negotiation purposes, and for presenting the case to a jury. In this article we discuss factors to be considered when faced with a case in

which the discounted sum is the only evidence the jury is allowed to hear regarding the costs of the plaintiff’s medical care.

The issues in new case law

In *Howell*, the California Supreme Court held that once the medical provider accepts payment of an amount that is less than the sum billed, the injured plaintiff can recover only *that* amount as economic damages in the injury action. That is, the plaintiff cannot recover the *undiscounted, full price* stated in the medical provider’s bill because, according to the opinion, that does not constitute an economic loss.³ The *Howell* court refused to apply the collateral source rule in this circumstance.⁴

However, the rule is different if the plaintiff is uninsured for medical services. In that case, the plaintiff (who has been imprudent in going without health coverage, particularly following the advent of “ObamaCare”), can recover the entire amount billed since that is what is owed as there is no *discount* negotiated by a health insurer.⁵ In such a case, someone with the same injury, can be valued higher because the medical specials are now considered at full value (or a least their reasonable value, which is not necessarily the discounted sum). Does this make sense?

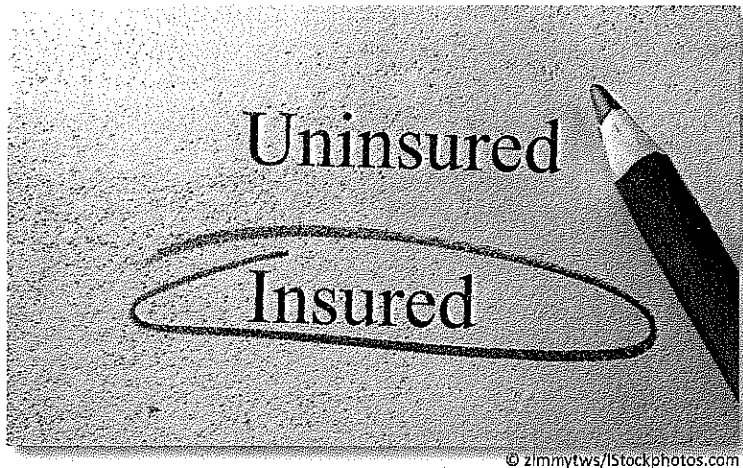
In *Bernandez v. Ciolek*, the court held that, in a case involving a plaintiff *without* medical insurance coverage, the medical bills are relevant to the amount the plaintiff incurred as damages since the plaintiff has responsibility for the full amount.⁶ The court reasoned that “the measure of damages for uninsured plaintiffs who have not paid their medical bills will usually turn on a wide-ranging inquiry into the reasonable



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California now applies a rule assessing damages for medical charges differently in cases where the patient is insured than when there is no insurance.

value of medical services provided, because uninsured plaintiffs will typically incur standard, undiscounted charges that will be challenged as unreasonable by defendants.”⁷

The *Bermudez* court also stated, “The billed amounts are also relevant and admissible with regard to the reasonable value of [plaintiffs’] medical expenses (citing *Katiuzhinsky*, cited at fn. 10, *infra*) The admissibility of the billed amount is consistent with the ‘full range of fees’ being relevant in determining the reasonable value of services in the health care marketplace.”⁸ However, the court then observed that the “initial medical bills are generally insufficient on their own as a basis for determining the reasonable value of medical services. Ensuing cases have held that a plaintiff who relies solely on evidence of unpaid medical charges will not meet his burden of proving the reasonable value of medical damages with substantial evidence.”⁹

Consequently, California now applies a rule assessing damages for medical charges differently in cases where the patient is insured than when there is no insurance.

However, there is a simpler and more equitable solution to this issue. In either case, expert testimony should be allowed as to the *reasonable value* of the medical services provided. In a given case, that could be less than the billed amount and more than the discounted sum. This approach would honor the collateral source rule while giving the defendant an equal opportunity to offer a competing opinion as to the issue of reasonable value. This approach would be entirely consistent with that taken in cases in which the plaintiff does not have health insurance. It would

also eliminate the inequity that results from one rule applying to the insured and another for the uninsured, thus promoting fairness in applying a rule of damages in these cases.

However, one Court of Appeal concluded that this approach was rejected in *Howell*. As the *Correnbaum* decision (cited in fn. 5) noted:

Although *Howell* (citation omitted) did not directly so hold, we are persuaded by the carefully considered reasoning in *Howell*, and therefore *do hold that evidence of the full amount billed for a plaintiff’s medical care is not relevant to the determination of a plaintiff’s damages for past medical expenses*, and therefore inadmissible for that purpose *if the plaintiff’s medical providers, by prior agreement, had contracted to accept a lesser amount as full payment for the services provided* (footnote omitted). In contrast, evidence of the amount accepted by medical provider as full payment does not violate the collateral source rule and is admissible provided that the source of payment is not disclosed to the jury and the evidence satisfies the other rules of evidence. (Citation.) (Emphasis added.)¹⁰

Two consequences flow from the current situation. First, as noted (*fn. 4, supra*), medical providers must accept the discounted sum in full payment of the services rendered as there is no *balance billing*. That is, a plaintiff/insured under a medical policy is not responsible to a medical provider for the difference between the total billed at full rates and the amount the insurer paid.¹¹ Second, from the defense perspective, the amount paid

actually becomes the new *measure* of the seriousness of the injuries even though this amount may not truly reflect that value. In short the tortfeasor benefits from the prudence of the victim having maintained health insurance coverage,¹² and from the contractual relationship between the health insurer and the medical services provider which has nothing to do with the injury caused by the tortfeasor.

Why is this test a problem?

These circumstances allow, and indeed encourage, defense lawyers and insurance adjusters to continue focusing on the amount of past medical expenses as a centerpiece in the process of case evaluation.¹³ While the origin of this approach of using *three times the specials plus the wage loss* is unclear, in light of *Howell* its continued use presents new hurdles for you as a plaintiff’s counsel. The process of evaluation tied to the medical specials when *Howell* applies is likely to result in a miscalculation of the value of the cases with numbers that are artificially low. But this mystical evaluation tool persists, with a heavy focus on the amount of medical specials as primary factor in case assessment. Nonetheless, the jury instruction on pain and suffering/emotional injury, aka *non-economic damages*, makes no mention of this formula and in fact leaves it to the discretion of the jury to set the number.¹⁴ Why, then, should it be used by carriers, and their counsel, in evaluating cases for negotiation purposes?

This formula-based approach for evaluating claims can make it *more difficult* to settle cases. Claims adjusters and others empowered with the evaluation and

payment responsibility for tortfeasors are likely to fixate on this formula. The result is that negotiations stall. The problem becomes even more prominent when an adjuster relies too heavily on the algorithmic computer-based models such as Colossus, which use the *specials* as a key element in establishing a claim's evaluation and settlement range.¹⁵ In response, you must look to factors other than the amount of the medical specials in case evaluation.

Another illustration of how heavy reliance on the medical costs of care in the cases of discounted payments can result in unfairly low and inaccurate evaluations occurs when the injuries are primarily psychiatric, e.g. claims of post-traumatic stress disorder. These cases can result in a long period of psychological counseling for a plaintiff who is essentially unable to move through life, which results in marital discord, loss of a job or earning ability, or other distress. Consider the case of a plaintiff whose leg is seriously injured, resulting in an amputation. That plaintiff previously enjoyed a lifetime of physical activity, or relied on physical skills involving the use of both legs for employment. In each of these cases, there should be other significant economic losses accompanying the medical charges as reduced to negotiated rates. So there is more to argue in the way of evidence of case value, both additional economic losses as well as general damages. These categories of cases involve losses to people that are truly life altering. Juries (and mediators) realize this. The result: The medical expenses are less important in the evaluation process. Instead, a jury has to consider the nature and extent of the injury to the person – all aspects of the loss. So, the case evaluation process should focus on factors other than just what was actually paid for medical care.

How can you address the test?

In a minor injury case, a modest amount of medical bills, discounted or not, is likely to be a more persuasive factor on case value than in larger cases in which there is a substantial discount. However, it is not only the medical costs that result in a lower settlement value. These cases are likely to involve:

- Soft tissue injury such as strains, sprains, bruising, or injuries that resolve in a relatively short period of time.

- Medication that is limited to over the counter drugs for pain relief or reduction of swelling.
- Short term medical treatment, including physical therapy for a few weeks.
- Medical bills largely for diagnosis to rule out more serious injuries rather than treatment.
- No long term or residual injury.
- Little or no emotional injury.
- Non-M.D. providers who are primarily involved in the healing process.

Under *Howell* the full amount billed by medical providers is not regarded as an accurate measure of the value of medical services.¹⁶ Thus, you should be prepared to have the experts provide their opinions about the treatment, the effects on plaintiff, the extent of accompanying pain and its effect, the treatment plan, the prospects for recovery or enduring physical and mental suffering, and the negative impact of these factors on plaintiff's life. In cases of discounted medical services, the experts (particularly the treaters), not the medical bills, have to *tell the tale*.

There are many variables that should be considered in evaluating a case that override primary reliance on the costs of medical care in cases in which the discounted number is all the jury hears. These include:

- The facts as to how the injury occurred. The more startling and serious they are, the more they become a factor in case value.
- Lack of shared fault can result in an assessment that is greater than one where the plaintiff is partially responsible for bringing about an injury.
- A very unsympathetic defendant can add value.
- Strong third party testimony about the accident, fault and injuries add credibility to the case and increase value.
- By the same token, a plaintiff who can tell the story in a convincing way bolsters value.
- If there are hard injuries, e.g. fractures, head injuries, wounds, spinal and nerve damages, the case has a higher value.
- The nature and extent of treatment, medical and rehabilitation services also can raise case value and confirm the genuineness of the injury.¹⁷
- The medication administered, and the symptoms or conditions they treat can form the basis for a higher case value.
- The duration, treatment and recovery are

also factors; long term injuries, particularly permanent damage, are of greater value than those that resolve.

- Emotional injury such as post-traumatic stress disorder, or severe pain that results in sleep disruption, depression or other psychological consequences means greater value.
- Disruptions to life, or significant changes in life, including those involving work, family relationships, and valued life activities that can no longer be enjoyed can add considerable value to the case.

The role of hedonic damages

As expressed in one comprehensive law review article on hedonic damages:

Hedonic damages compensate for the lost enjoyment of life that results from a tortious injury. Those damages are usually considered to go beyond traditional pain and suffering or mental anguish damages. Pain and suffering damages traditionally compensate "for the physical discomfort and the emotional response to the sensation of pain caused by the injury itself," and mental anguish damages traditionally compensate for "shock, fright, emotional upset, and/or humiliation" caused by the tort. Hedonic damages, by contrast, compensate for limitations "on the injured person's ability to participate in and derive pleasure from the normal activities of daily life, or for the individual's inability to pursue his talents, recreational interests, hobbies, or avocations."¹⁸

These *lifestyle injuries* are reflected in California's jury instructions by the simple phrase "loss of enjoyment of life," with no further explanation of what this includes.¹⁹ Hedonic damages are not affected by *Howell*.

You must recognize the potential increase in the importance of hedonic damage claims in a post-*Howell* environment. This presents an additional way to avoid over-reliance on past medical costs by focusing more on how the injuries changed the plaintiff's life, relationships, and daily living. The greater the change, the more value the case has. There can be an economic consequence to the changes if accommodations for engaging in daily life are required: A special bed, modifications

to the home, a vehicle that has special equipment so the plaintiff can drive, or help to assist with getting through the day.

In addition, there is an emotional component to consider. If the injury makes it more difficult for the plaintiff to live life – or enjoy various aspects of it such as family relationships, friends, particular hobbies or interests – then greater compensation is deserved for these losses. Having to give up certain activities that the plaintiff enjoyed is compensable. The more the plaintiff can describe how this has had a negative emotional impact, the more value the claim likely has. *Howell* compels you to analyze these damages claims from a different perspective.

The “golden years” cases

Injuries to healthy *senior citizens*, who are enjoying a retirement for which they worked many years, but who are now subjected to post-injury limited physical activity and pain and suffering, are of increased value. These are referred to as “golden years” cases.²⁰ The retirement years are special years. It is a time in our lives when we realize our own mortality, but also presumably enjoy more time for family, friends, hobbies, and other interests. When someone who has always been physically active loses this ability in the future years, the enjoyment of retirement can be severely diminished, with less opportunity to replace these activities with other interests in life. Further, what may be a small loss of function to a younger person who is active in many other ways may present a larger loss to an older person whose activities are already constrained by age.

Consider, for example, a single woman in her early 70’s who is in good health and physically active, does charity work for her church and local organizations, and has a social life consistent with this activity level. She is struck in a crosswalk and suffers multiple fractures of her left ankle requiring surgery, several months of home confinement, and extensive rehabilitation. She plateaus but remains restricted in her physical activity, suffers mild to moderate ankle pain, and also has a disturbed gait that manifests itself in low back pain, which she never suffered before. The result is that her active lifestyle, and the few good years left according to life expectancy

tables are now disrupted.²¹ Enjoyment of those years has become compromised. Medical bills, after reduction, are reduced to under \$20,000. There is no wage loss. What impact should this have on her case? Do the medical specials, as reduced, tell the story? How relevant are they to this plaintiff’s compromised and less active future years? What is the value of those “lost years” of presumed enjoyment and the compromise to her lifestyle? Is it measured by a formula? Most likely a jury would consider this “lost time” of high value to the victim of the errant driver.

Again, in a post-*Howell* world, you must be prepared to focus on these factors in supporting plaintiff’s damages claims.

Medical cost: past and future

At least for now *Howell* controls as to past medical costs which are paid for by a health insurer. However, *Howell* does not resolve the important question as to what evidence is admissible to prove the costs of *future medical care* and expenses. In the usual case, you will present expert medical testimony as to the need for, and costs of, future medical care, including a life care plan for treatment and medicine. The amounts needed will also be presented through experts,²² either a life care planner or an economist, or both. Should the defense then be able to introduce evidence of the likely sums paid by a health insurer? In response, can plaintiff argue that this evidence is speculative as (a) there is no guarantee that plaintiff will have insurance to cover these expenses, (b) the medical care may not be covered or may be out of plan, and (c) the rates are not assured and may be different than current rates applicable to the anticipated care? Again, the collateral source rule could also be raised.²³ Further, if future value is based on anticipated insurance payments, the plaintiff risks being undercompensated for those damages.²⁴

A concluding thought

As lawyers litigating injury cases for plaintiffs, we must identify and pursue fair, practical models to prove damages. We must be prepared to meet a simplistic approach by insurers and their counsel to the evaluation of our client’s case. In many cases, we need to argue that the amount of

the medical bills paid under *Howell* do not tell the whole story, and do not represent the only key case-evaluation tool. The whole story must be considered, including the impact on the client’s life, relationships, and ability to be a part of what once was. Lifestyle changes and a diminished quality of life should pay a strong role in the process of evaluation and the jury’s decision-making, in contrast to a single number for medical care.

For plaintiff’s counsel, the presentation of damages claims for an injured client requires a departure from the norm. You must be creative when representing an injured party given *Howell* and the new era of severely discounted medical payments. Severely injured plaintiffs need thoughtful consideration of an appropriate approach to damages claims in cases of discounted health insurance payments. The focus should be on the factors that truly reflect case value, whether for settlement or at trial.

¹ 52 Cal.4th 541, 129 Cal.Rptr.3d 325, 257 P.3d 1130 (2011).

² Balance billing happens after a patient has paid the deductible, coinsurance or copayment and the insurance company has also paid everything it is obligated to pay toward the medical charges. If there is still a balance owed on that bill, the provider may try to bill the patient for the unpaid sum. There is no *balance billing* in California. (*Prospect Medical Group, Inc. v. Northridge Emergency Medical Group* (2009) 45 Cal. 4th 497, 198 P.3d 86.)

³ See also, *Corenbaum v. Lampkin*, 215 Cal. App.4th 1308, at 1324-132, 156 Cal.Rptr.3d 347 (2013) holding that “[d]amages for past medical expenses are limited to the lesser of (1) the amount paid or incurred for past medical expenses, and (2) the reasonable value of the services. (Citation omitted.)” Quoting *Howell*, the *Corenbaum* court said that when a sum certain is paid, that is what the plaintiff can recover even if that if it is below prevailing market rates. (215 Cal. App.4th at 1326.)

⁴ “The collateral source rule precludes deduction of payments the plaintiff has received from sources independent of the tortfeasor from damages the plaintiff “would otherwise collect from the tortfeasor.” (*Helvend v. Southern Cal. Rapid Transit Dist.*, 2 Cal.3d 1, 6, 84 Cal.Rptr. 173, 465 P.2d 61 (1970).)

As noted in this article, the approach in *Howell* ignores the policy behind the collateral source rule. So what if there is a windfall for the plaintiff? The issue should be what is the reasonable value of the medical services which is an issue different from a) what was

billed, or b) what the discounted rate was. The tortfeasor should not benefit from what the victim worked for or paid for personally which allowed his medical expenses to be covered by insurance.

⁵ The Patient Protection and Affordable Care Act, Public Law 111-148 (March 23, 2010) ("the Affordable Care Act").

⁶ 237 Cal.App.4th 1311, 188 Cal.Rptr.3d 820 (2015).

⁷ 237 Cal.App.4th 1330-1331.

⁸ 237 Cal.App.4th 1335.

⁹ *Ibid.* More recently, in *Uspenskaya v. Meline*, 241 Cal.App.4th 996, 194 Cal.Rptr.3d 364 (2015), a Court of Appeal held that the full amount of plaintiff's medical bills is admissible to determine the reasonable value of an uninsured plaintiff's medical treatment received pursuant to a lien agreement. The court ruled that the discounted amount was inadmissible under Evidence Code § 352; the amount paid by the purchaser of the lien is based on the reasonable chance of collecting rather than the value of the medical services provided; see also, *Katiuzhinsky v. Perry*, 152 Cal.App.4th 1288, at 1295-1296, 62 Cal.Rptr.3d 309 (2007) (in a case decided before *Howell*, the court held that evidence of the full amount of the medical bills was admissible to determine the reasonable value of medical services in a case involving a plaintiff who had no health insurance despite

the provider's sale of the account to a medical finance company at a discount).

¹⁰ 215 Cal.App.4th at 1328.

¹¹ See fn. 4, *supra*.

¹² Is this justice? The client who *earns* health care coverage either by working or payment of premiums is "punished" for the prudence in obtaining this coverage, while the uninsured person benefits from circumstances in which there is no health care coverage. It appears, based on *Howell*, that the difference is simply based on an analysis of what damages the plaintiff has suffered which benefits the defendant, and the collateral source rule is simply not applicable. (*Howell*, 52 Cal.4th at 548-549.)

¹³ See, e.g. <http://www.alllaw.com/articles/nolo/personal-injury/damages-compensation-formula.html#>.

¹⁴ See CACI 3905A.

¹⁵ Colossus is a software program developed by Computer Science Corporation to evaluate personal claims. CSC touts the program as follows: "Colossus® is the insurance industry's leading expert system for assisting adjusters in the evaluation of bodily injury claims. Colossus provides adjusters access to your company's claims data within a defined business process management framework for evaluating injuries, treatment, resolution, impairment and

general damage settlements. Colossus helps your adjusters reduce variance in payouts on similar bodily injury claims." http://www.csc.com/p_and_c_general_insurance/offerings/26121/57637-colossus. One San Diego personal injury lawyer explains his views on Colossus. See <https://www.youtube.com/watch?v=WMALcAZ8cX8>.

¹⁶ 52 Cal.4th at 562

¹⁷ See, e.g. *Bermudez, supra*, 237 Cal.App.4th at 1335, 1337; *Katiuzhinsky, supra*, 152 Cal.App.4th 1295-1296 (fn. 10).

Correnbaum rejected the argument that the full amount is relevant on the question of noneconomic damages, stating that "the full amount billed for past medical services is not relevant to a determination of the damages for either past or future medical services if the medical providers had agreed to accept a lesser amount as full payment. *We conclude that evidence of the full amount billed is not admissible for the purpose of providing plaintiffs' counsel an argumentative construct to assist a jury in its difficult task of determining the amount of noneconomic damages and is inadmissible for the purpose of proving noneconomic damages.*" (215 Cal.App.4th at 1333, emphasis added.)

In *State Farm Mutual Automobile Ins. Co. v. Huff*, 216 Cal.App.4th 1463 (2013), the court held that in an interpleader action involving the Hospital Lien Act (Civ. Code §§ 3045.1-3045.6), the medical provider

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seeking interpled funds had the burden of showing that the sums charged were "reasonable and necessary." This required more than evidence of the bills themselves, and that additional evidence that the services met the "reasonable and necessary" standard was required.

In *Ochoa v. Dorado*, 228 Cal.App.4th 120 (2014), the court held that where there is no prenegotiated discount rate, the full amount billed and unpaid for past medical services is not admissible; it is not relevant on the issue of the reasonable value of the medical services provided and refused to follow *Katuzhinsky* (cited at fn. 10, *supra*).

¹⁸ S. Bagentos and M. Schlanger, "Hedonic Damages, Hedonic Adaptations, and Disability," 60 *Vanderbilt Law Review*. Vol. 3, 745, at 748 (April 2007). The concept and term emanates from Stan V. Smith, Ph.D. who developed the concept in 1985. <http://www.smitheconomics.com/hedonic-damages.html>. For a summary of decisions dealing with the concept, see <http://www.umsl.edu/~irelandt/Hedonic%20Damages.htm>. For a history, see Ireland, "The Meaning of 'Hedonic Damages' in Tort Litigation," *Journal of Forensic Economics*, Vol. 6, No. 2 (Spring/Summer 1993), pp. 99-104. <http://www.jstor.org/stable/42755465>.

¹⁹ See fn. 13, *supra*.

²⁰ The impact an injury can have on someone who is elderly was recognized in *Giles v. Canada* (Attorney General) [1994] B.C.J. No. 3212 (S.C.), rev'd on other grounds (1996) 21 B.C.L.R. (3d) 190 (C.A.)

²¹ The life expectancy for a female between the ages of 70 and 75 ranges from 16.5 to 13.6 years. Life Expectancy Table - Female, CACI, p. 869.

²² In *Correnbaum*, the court stated: "Our conclusion that the full amount billed by medical providers for past medical services is not relevant to the value of the services provided also has implications for expert opinion testimony that may be offered on remand as to the reasonable value of medical services to be provided in the future. Because the full amount billed for past medical services provided to plaintiffs is not relevant to the value of those services, we believe that the full amount billed for those past medical services can provide no reasonable basis for an expert opinion on the value of future medical services. Evidence of the full amount billed for past medical services provided to plaintiffs therefore cannot support an expert opinion on the reasonable value of future medical services. (Citation.)" (215 Cal.App.4th at 1331.)

²³ In *Varela v. Birdi*, 2015 WL 877793 (unpublished, Cal. Ct. App. 4th Dist.), the court held that neither *Howell* nor *Corenbaum* precludes the admissibility of such estimates for the purpose of evaluating future medical expenses. The restriction in *Howell* is based on known numbers, while the estimate of

future medical care is not. Hence, the medical experts and economists calculations allow an award that is based on probable costs.

²⁴ In *Markow v. Rosner*, 2015 WL 5765470, decided October 4, 2016, the court affirmed a judgment which included \$4.5 million for future economic loss, with \$1.3 million for the future cost of hospitalization. This part of the judgment entered after a jury verdict was based on plaintiffs' life care planning expert who estimated the amount billed for future hospitalization would be \$2 million, and that based on her knowledge and experience, the amount paid would be 50 to 75 percent of the total amount billed. She also testified that with one particular hospitalization the cost was reimbursed at a much lower rate of 12.9 percent. The jury's award of \$1.3 million was approximately 65 percent of the estimated future billing of \$2 million or roughly half way between the 50 and 75 percent reimbursement rate as related by plaintiffs' expert. The court found that substantial evidence supported the jury's award. See also, *Behr v. Redmond* (2011) 193 Cal.App.4th 517, 533, 123 Cal.Rptr.3d 97 (requirement of certainty cannot be strictly applied where future damages are involved since they are based on probabilities).

In an unpublished Court of Appeal opinion from the Third Appellate District, *Frisk v. Cowan*, C077975, filed 7/26/16, the court held that the trial court made prejudicial

evidentiary rulings by 1) permitting the plaintiff to present the amounts charged by medical providers to establish the reasonable value of her past and future medical damages, and 2) precluding defendant from presenting evidence of payments typically received by medical providers for the same services rendered to anticipated to be rendered to the plaintiff. In *Frisk*, the evidence presented established that the medical charges for services to the plaintiff were privately financed through a lienholder. Under the agreement plaintiff remained liable for the full amount of the charges if the lienholder did not recover in the litigation. The court found that the court prejudicially erred by admitting evidence of the amounts billed and excluding evidence of the average amounts accepted by medical providers for purposes of determining the reasonable value of the medical services rendered. The opinion provides a review of the several appellate court cases discussing various aspects of the issues involving claims to the recovery of medical specials in various scenarios.

To what extent the cost of future care for those covered by the Affordable Care Act may be is discussed in Congdon-Hohman J. and Maheson V., "Potential Effects of the Affordable Care Act on the Award of Life Care Expenses," *Journal of Forensic Economics* 24(2) 153-160 (2013).

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