IN THE SUPREME COURT OF THE STATE OF NEVADA

BARRY JAMES RIVES, M.D.; and LAPAROSCOPIC SURGERY OF NEVADA, LLC, Appellants/Cross-Respondents, vs. TITINA FARRIS and PATRICK FARRIS, Respondents/Cross-Appellants.	Case No. 80271
BARRY JAMES RIVES, M.D.; and LAPAROSCOPIC SURGERY OF NEVADA, LLC, Appellants, vs. TITINA FARRIS and PATRICK FARRIS, Respondents.	Case No. 81052

APPELLANTS' APPENDIX
VOLUME 4

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ATTORNEYS FOR APPELLANTS

CHRONOLOGICAL INDEX TO APPELLANTS' APPENDIX

[1] These additional documents were added after the first 29 volumes of the appendix were complete and already numbered (6,493 pages).

EXHIBIT K

ALEX BARCHUK, M.D.
Physical Medicine & Rehabilitation

PHYSICAL MEDICINE AND REHABILITATION
LIFE CARE PLANNING EVALUATION

RE:	Titina Marie Farris
DATE OF BIRTH:	10/24/1962
DATE OF INJURY:	7/3/2015
DATE OF EXAMINATION:	3/20/2018
LOCATION OF EXAMINATION:	Kentfield Hospital Outpatient Department
PRESENT DURING EVALUATION:	Patient's husband
REFERRED BY:	George Hand, Esq.
CURRENT ADDRESS:	6450 Crystal Dew Drive Las Vegas, NV 89118
TYPE OF RESIDENCE:	House
NUMBER OF STORIES IN HOME:	One

NUMBER OF STAIRS TO THE FRONT DOOR: Four

NUMBER OF STAIRS TO SECOND FLOOR: N/A

HOME MODIFICATIONS:	Bathroom/shower bars. Bars in bathroom stall.
PEOPLE LIVING AT THE RESIDENCE:	Patrick Farris – Husband Elisabeth Farris - Daughter
CELLULAR PHONE:	702-472-3904
MARITAL STATUS:	Married for 14 years. .
CHILDREN:	Three children. Two daughters – 30 and 12 One son – 33 years old.
EDUCATION:	GED. Graduated 1980. Ms. Farris did not attend college.
OCCUPATION:	Retail.

NAME OF LAST EMPLOYER:

Walmart.

ADDRESS OF LAST EMPLOYER:

3615 S Rainbow Boulevard
Las Vegas, NV

JOB SATISFACTION:

Good.

CAUSE OF INJURY:

"Hernia repair surgery July 3/15 perforated Bowl Septic put on a ventilator and Developed foot drop in both feet. Need of a colostomy. Also combined to wheelchair – not able to walk."

SPECIFIC COMPLAINTS:

1. Pain in leg – consistent.
2. Feet ache
3. Mobility is poor
4. Lower back – pain

ACTIVITIES THAT CHANGE THE NATURE OF MS. FARRIS' PAIN:

Sitting aggravates "Lower back"
Standing has no effect.
Rising from sitting Aggravates "ankles – Back (lower)"
Leaning forward: Aggravates. "Can't standing will fall"
Walking: "Can only walk holding walker"
Lying on side aggravates "legs – lower back"
Lying on your back: "For short time"
Lying on stomach: Aggravates. "Sore were surgey happened"
Driving: "Can Not Drive (Drop Foot)"
Coughing or sneezing: No effect.

Running: Aggravates. Cannot run.
Stretching Program: Relieves.
Aerobics Program: Aggravates. "can Not Do"
Sleeping: Aggravates. Wake up from pain."

HELPFUL TREATMENT MODALITIES:

TENS: Helpful. "little help" Last session: 3/1/18.

Physical Therapy: Helpful. Duration of effect "6 months."
Acupuncture: Helpful. "8 sessions". Last session 2/4/16.
Bed Rest: Helpful.

TREATMENT MODALITIES NOT TRIED:

Ms. Farris has not tried hot packs, ice, chiropractic care, massage, biofeedback, or trigger point injections.

FUNCTIONAL STATUS PRIOR TO INJURY:

Feeding: "Same"
Grooming/Hygiene: "No problems"
Upper Extremity Dressing: "No problems"
Lower Extremity Dressing: "Need help putting on clothes shoes"
Bathing/Showering: "No problems"
Grooming/Hygiene: "No problems"
Toileting: "No problems"
Standing up from Seated Position: "No problems"
Bed Mobility: "No problems"
Lying on side to sit: "No problems"
Transfers: "No problems"
Ambulation: No problems"
Wheelchair Mobility: "N/A"
Driving: "Not recent – one car".
Hobbies: "Dancing, ride Bike, moderate hiking"

CURRENT FUNCTIONAL STATUS:

Feeding: "Same"
Grooming/Hygiene: "Need help showering"
Upper Extremity Dressing: "No problems"
Lower Extremity Dressing: "Need help putting on clothes/shoes"
Bath/Showering: "Need help getting in out and drying off"
Grooming/Hygiene: "Taking care of feet"
Toileting: "helping to get in"
Standing Up from Seated Position: "Need help with balance"

Bed Mobility: "poor mobility"
Lying on side to sit: "Pain – leg side"
Transfers: "need help get into a vehicle"
Ambulation: "can not walk without walker"
Wheelchair Mobility: "ok"
Driving: "No"
Hobbies: "None"

TYPICAL DAY:

Ms. Farris can comfortably sit for 2 hours, and comfortably stand for 1 minute.
She can comfortably walk without holding on – 2 steps.
Ms. Farris can sleep uninterrupted for two hours.

The above activities are limited by pain and weakness.

Ms. Farris' typical day is spent sitting for 4 hours and walking 2 hours. If she performs any lifting the object weighs no more than three pounds.

TIME MISSED FROM WORK IN THE PAST YEAR:

"NA"

CURRENT THERAPIES:

Ms. Farris is performing a home exercise program on a regular basis.

She is not being seen by a Physical Therapist, an Occupational Therapist, or a Psychologist.

ATTENDANT CARE:

"No. My husband takes care of me."

ACTIVITIES/DUTIES PERFORMED BY ATTENDANT:

"help me into shower/cooks"
"Cleans takes are of dog our Daughter"
"Laundry Shopping"

CURRENT MEDICATIONS:

1. Buspirone (new) – 15 mg tablet when needed. Related to injury. Helpful.
2. Alprazolam (new) 5 - .05 mg tablets daily. Related to injury. Helpful.
3. Citalopram (new) 10 mg tablets when needed/daily. Related to injury. Helpful.
4. Oxycodone – Percocet (new) 10/325 tab 3-4 times a day. Related to injury. Helpful.
5. Metformin (pre) 1000 mg tab. Frequency – 2 daily. Unrelated to injury.
6. Januvia (pre) 100 mg, 1 daily. Unrelated to injury. Helpful.
7. Lisinopril (pre) 2.5 mg tab. Frequency – 1 daily. Unrelated to injury. Helpful.
8. Carvedilol (pre) 12.5 mg tab. Frequency – 1 daily. Unrelated to injury. Helpful.
9. Jardiance (empagliflozin) (pre) – 1 daily. Unrelated to injury. Helpful.
10. Duloxetine (new) 60 mg capsule. Frequency – 1 daily. Unrelated to injury. Helpful.
11. Probiotic, 1 daily. Related to injury ("colon support"). Helpful.
12. Lantus (pre) solostar 45 units Daily.

MEDICATIONS PRIOR TO INJURY:

Medications for diabetes and high blood pressure.

MEDICATION ALLERGIES:

Aspirin.

MEDICAL ISSUES PRIOR TO THIS INJURY:

Diabetes and high blood pressure.

SURGERIES PRIOR TO THIS INJURY:

Three C-sections – January 13, 1985, January 17/1988, and November 11/11/05.
August 7, 2014 – Hernia repair performed by Dr. Rivas.
July 3, 2015 – Barry J. Rives, MD.
July 16/15 Dr. Hamilton.

CURRENT PHYSICIANS:

Dr. Chaney. Visit once a month. Dr. Chaney is following Ms. Farris' blood pressure, diabetic management and injury-related problems.

FAMILY HISTORY:

Parents still living – 82 years of age.

No known family history of rheumatoid arthritis, diabetes, cancer, heart disease, chronic muscle pain, or depression.

HABITS:

Ms. Farris denies smoking cigarettes or drinking alcohol.

ACTIVITIES MS. FARRIS WISHES TO RETURN TO:

"Dance
Walk Daughters to school
Play with Dogs
Go on vactions
Go to concerts
Go to beach
Visit family more than now
Go to Disneyland
Go camping"

WISH LIST:

1. Standard bike
2. Scooter
3. Physical therapy
4. Acupuncture therapy
5. Water therapy
6. Supportive counseling
7. Podiatrist

EQUIPMENT AND SERVICES RELATED TO INJURY:

"Wheelchair
Cane
Place bars in shower and stall
Walker
Shoes"

REVIEW OF SYSTEMS:

HENT: Ms. Farris complains of near and far blurry vision. She wears glasses for reading. She does not know whether this is related to her injury.

Pulmonary: Noncontributory.

Cardiac: History of hypertension.

Gastrointestinal: As stated above. No incontinence.

Genitourinary: Noncontributory. No incontinence.

Height: 5' 2" tall.

Weight: 160 lbs. Premorbid weight 143 lbs.

Psychological: Ms. Farris complains of depression and anxiety. No premorbid history. She is open to psychological supportive counseling, however states that currently she is unable to afford it. Ms. Farris also complains of impaired short term memory.

Endocrine: Ms. Farris states she takes insulin twice daily. She denies any hypoglycemic events. Typically, her blood sugar is in the 150-200 range. She states that her last hemoglobin A1-C was "elevated." She is not seeing a dietician.

Therapies: Ms. Farris states that acupuncture therapy has been helpful, however she is no longer able to afford it. She also states that she is unable to afford a Podiatrist.

Activities of Daily Living: Ms. Farris states that her husband now has to do all of the cleaning, gardening, laundry, shopping as well as cooking and taking care of their 4 dogs. Premorbidly, Ms. Farris states that she did the majority of the cleaning as well as the laundry and taking care of their dogs. She did 50% of the shopping and approximately 25% of the cooking. She estimates that her husband has to help an additional 4-5 hours per day for the above activities. Ms. Farris states that she can dress herself independently except for requiring 100% help with donning and doffing her shoes. She can go to the bathroom independently. Her husband has to cut her toenails.

Mobility: Ms. Farris states that she uses her wheelchair approximately 25% of the time inside the house and approximately 50% of the time outside the house for mobility. She uses a walker approximately 75% of the time inside her house and 50% of the time outside the house depending on the distance. She would like to have an electric scooter for long distance mobility.

Falls: Ms. Farris states that she has fallen twice in the last 12 months, once while using her walker and the other when transferring. She states that for the most part, she can perform a level transfer independently, however requires some assistance with complex transfers.

Musculoskeletal: Ms. Farris complains of left shoulder pain when using her walker and pushing her wheelchair. She states that she had some problems with left shoulder pain premorbidly. She states that she her most recent shoulder injection was performed early in 2016.

PHYSICAL EXAMINATION:

In general, the patient is a well-developed, well nourished, pleasant, cooperative female.

Head: NC/AT.

HENT: Pupils are equally round. Extraocular movements are intact. Ears, nose without discharge. Pharynx clear.

Cervical flexion 80% of normal. Cervical extension 70% of normal. Cervical rotation to the right and left 70% of normal. Complaints of left sided neck pain on range of motion testing.

Lungs clear to auscultation.

Heart regular rate and rhythm.

Extremities: Functional range of motion of the upper and lower extremities except for right ankle dorsiflexion, negative 10 degrees and left ankle dorsiflexion 0 degrees. Complaints of bilateral shoulder pain, left greater than right, with range of motion testing and impingement maneuver.

No significant atrophy noted.

Skin: Multiple abrasions right shin region. Pictures were taken. Left medial heal ulcer stage 3. Pictures taken. Well healed mid abdominal surgical scar.

Abdomen: Reducible ventral hernia, which is nontender to palpation.

Palpation: Tenderness to palpation left upper trapezius and lower paracervical spinal musculature as well as central lumber spine. Tenderness to palpation left rotator cuff region and bicipital tendon. Positive Tinel's left ulnar groove.

Mild Dupuytren's contractures bilateral hands.

Spine: Unable to touch the feet in the seated position. Able to reach the ankles bilaterally. Complaints of low back pain on range of motion testing.

Neurologic: Alert and oriented. Cranial nerves 2-12 intact. Emotional lability noted. Manual muscle testing 3+/5 motor strength bilateral upper extremities with normal tone and isolated movement. Hip flexors 3+/5 bilaterally. Hip extensors 3+/5 bilaterally. Knee extensors 3/5 bilaterally. Knee flexors 3/5 bilaterally. Foot dorsiflexors and plantar flexors 0/5 bilaterally.

Sensation: Severely impaired below the knees bilaterally to temperature and light touch. Absent position sense in the toes and ankles bilaterally. Positive Phalen's maneuver bilaterally. Decreased sensation in the median nerve distribution bilateral hands.

No evidence for spasticity or hyperreflexia.

Sit to stand is possible only with upper extremity support and use of a walker.

Gait: Steppage gait with impaired balance. Unable to tandem. Unable to ambulate on toes or heels. Severe instability without use of a walker, requiring direct physical contact.

Pictures and short video clips were taken of positive physical findings.

RECORD REVIEW SUMMARY:

Date:	Provider:	Notes:
DISCHARGE SUMMARIES		
ADMIT: 07/18/16 D/C: 07/25/16	Elizabeth Hamilton, MD St. Rose Dominican Hospitals (SRDH)	**DISCHARGE SUMMARY** HPI: 53 y.o. female admitted on 07/18/16 for colostomy takedown. DIAGNOSIS: 1. Colostomy s/p exploratory laparotomy, right hemicolectomy, ileocolic anastomosis, repair of incomplete hernia with biologic mesh, and additional small bowel resection. S/p colostomy takedown. 2. Abdominal pain. 3. Acute diarrhea. 4. Acute kidney injury. 5. Dehydration. 6. Hyponatremia. 7. Diabetes type 2. 8. Morbid obesity. 9. Major depressive disorder. 10. GERD.
ADMIT: 07/05/15 D/C: 08/11/15	Wendy Mojica, DO SRDH	**DISCHARGE SUMMARY** DIAGNOSIS: 1. Sepsis. 2. Abdominal pain. 3. Atrial flutter. 4. Diabetes.
OPERATIVE REPORTS		
07/18/16	Elizabeth Hamilton, MD SRDH	**OPERATIVE REPORT** POST-OP DIAGNOSIS: 1. Colostomy with request for takedown. 2. Obesity. 3. Diabetes. 4. Neuropathy from prolonged immobilization. 5. Previous colon injury. 6. Incisional hernia. PROCEDURE: I. Exploratory laparotomy. 2. Completion right hemicolectomy with ileocolic anastomosis. 3. Additional small bowel obstruction.

		4. Repair of incisional hernia with biologic mesh.
07/16/16	Elizabeth Hamilton, MD SRDH	**OPERATIVE REPORT** POST-OP DIAGNOSIS: 1. Perforated viscus with free intra-abdominal air. 2. Sepsis. 3. Respiratory failure. 4. Anasarca. 5. Fever. 6. Leukocytosis. 7. Recent incisional hernia repair with prosthetic mesh. 8. Previous incisional hernia repair with prosthetic mesh. 9. Overweight. PROCEDURE: 1. Exploratory laparotomy. 2. Removal of prosthetic mesh and washout of abdomen. 3. Partial colectomy and right ascending colon end ileostomy. 4. Extensive lysis of adhesions over 30 minutes. 5. Retention suture placement. 6. Decompression of the stool from the right colon into the ostomy. 7. Fecal disimpaction of the rectum.
07/31/15	SRDH	**ANESTHESIA DOCUMENTATION** Pre-Sedation Assessment.
07/14/15	Ashraf Osman, MD SRDH	**OPERATIVE REPORT** POST-OP DIAGNOSIS: Failure to wean from the ventilator. PROCEDURE: 1. Placement of percutaneous tracheostomy tube, tracheostomy Shiley size 8. 2. Flexible bronchoscopy. 3. Percutaneous endoscopic gastrostomy tube placement.
07/03/15	Barry Rives, MD SRDH	**OPERATIVE REPORT** POST-OP DIAGNOSIS: Incarcerated incisional hernia. PROCEDURE: 1. Laparoscopic reduction and repair of incarcerated incisional hernia with mesh. 2. Colonography x2.
07/31/15	Kok Tan, MD	**OPERATIVE REPORT**

	SRDH	POST-OP DIAGNOSIS: Abscess paracolic. PROCEDURE: CT-guided abscess drain.
07/30/15	Matthew Ripplinger, MD SRDH	**OPERATIVE REPORT** POST-OP DIAGNOSIS: Abdominal abscesses. PROCEDURE: CT-guided abscess drain placement.
07/16/15	Elizabeth Hamilton, MD SRDH	**OPERATIVE REPORT** POST-OP DIAGNOSIS: CC, perforated viscus, sepsis, respiratory failure, anasarca, fever, leukocytosis, recent incisional hernia repair with prosthetic mesh. PROCEDURE: Excision laparoscopic partial colectomy with right end colostomy. Washout of abdomen, drain placement, extensive LOA for over 30 min, retention suture placement, removal of prosthetic mesh. Additional procedure: decompressed stool and contrast from right colon into ostomy and disimpaction rectum and flushed left colon.
07/14/15	Ashraf Osman, MD SRDH	**OPERATIVE REPORT** POST-OP DIAGNOSIS: Failure to wean. PROCEDURE: Percutaneous tracheostomy, flexible bronchoscopy.
07/04/15	Yann-Bor Lin, MD SRDH	**PROCEDURE REPORT** POST-OP DIAGNOSIS: Acute respiratory failure. PROCEDURE: Intubation.
07/03/15	Barry Rives, MD SRDH	**OPERATIVE REPORT** POST-OP DIAGNOSIS: Incarcerated incisional hernia. PROCEDURE: Laparoscopic reduction and repair of incarcerated incisional hernia with mesh and colonography x2.
08/07/14	Barry Rives, MD SRDH	**OPERATIVE REPORT** POST-OP DIAGNOSIS: 1. Abdominal wall lipoma. 2. Incarcerated ventral hernia. PROCEDURE: 1. Excision of abdominal wall lipoma/mass. 2. Repair of incarcerated ventral hernia with mesh.

CONSULTATIONS, HISTORY & PHYSICALS AND ED REPORTS		
07/18/16	Elizabeth Hamilton, MD SRDH	**H&P** CC: Colostomy takedown. HPI: Laparoscopic recurrent incisional hernia. Her operation was complicated by a colonic injury, which subsequently leaked. Several weeks after her original operation she had evidence of sepsis and need for urgent surgery. She had a partial right and transverse colectomy. She had a long Hartmann's pouch left at the ascending colon just distal to the cecum, was brought up as an ostomy and the abdomen was washed out.
07/31/15	Tanveer Akbar, MD SRDH	**H&P** Handwritten notes.
07/13/15	Ashraf Osman, MD SRDH	**CONSULT** REASON: Respiratory failure for evaluation for tracheostomy. ASSESSMENT: This is a 52 y.o. female patient who has been on a ventilator for about eight days; which seems to be that she is not going to be able to be extubated soon. The ICU team asked me for placement of tracheostomy and I do agree with that.
07/09/15	Gregg Ripplinger, MD SRDH	**CONSULT** REASON: Second general surgical opinion. IMPRESSION: Obese female who is s/p repair of an incisional hernia with placement of mesh, who is on a ventilator with an elected white blood cell count. I think there is a reason to be concerned for possible leak from one of the two colon repairs or an early aggressive infection of the mesh.
07/09/15	Gregg Ripplinger, MD SRDH	**CONSULT** IMPRESSION: Re: second general surgical opinion. RECOMMENDATION: CT abdomen and pelvis with IV, oral and rectal contrast.
07/05/15	Arvin Gupta, MD SRDH	**CONSULT** REASON: Acute kidney failure. PLAN:

		1. Acute kidney failure. 2. Anemia. 3. Hyperkalemia. 4. Tachycardia/hypoxia. 5. Lactic acidosis.
07/04/15	Syed Zaidi, MD SRDH	**CARDIOLOGY CONSULT** REASON: Tachycardia, possible atrial flutter. ASSESSMENT: 1. Tachycardia, likely flutter vs. atrial tachycardia vs. sinus tachycardia. 2. Acidosis. 3. S/p hernia surgery for incarcerated hernia. 4. Metabolic abnormalities.
07/04/15	Farooq Shaikh, MD SRDH	**INFECTIOUS DISEASE CONSULT** REASON: Fecal peritonitis, low-grade fever, leukocytosis, persistent intra-abdominal infection or sepsis. ASSESSMENT/PLAN: 1. A 52-year-old female, status post reduction of incarcerated incisional hernia, operative nick to the colon and repair, now with post-op abdominal pain, distention, sepsis, leukocytosis, and fever. This could represent fecal peritonitis. 2. The patient is developing acute renal insufficiency, uncontrolled hyperglycemia. In this patient, from Infectious Diseases, I would recommend: a. modify antibiotics to intravenous meropenem 1 g q.12 h. This would cover gram negatives as well as enterococcus species. b. intravenous Flagyl to continue. c. I would add intravenous Diflucan 200 mg once daily. We will discontinue intravenous cefepime and vancomycin. d. The patient should have an abdominal imaging as a CT scan of the abdomen in the next 2-3 days if she clinically does not improve. Surgical follow-up, wound care rehabilitation, follow up need of NG tube.
07/04/15	Kenneth Mooney, MD SRDH	**CONSULT** REASON: S/p incarcerated incisional hernia repair.
07/04/15	Tanveer Akbar, MD SRDH	**CONSULT** CC: Laparoscopic reduction and repair of incarcerated incisional hernia with mesh.

		ASSESSMENT: 1. Laparoscopic reduction and repair of incarcerated incisional hernia with mesh and colonography x2. 2. Previous excision of lipomatous mass and repair of incarcerated ventral hernia with mesh. 3. Hypertension. 4. Diabetes mellitus type 2. 5. Depression.
07/03/15	Barry Rives, MD SRDH	**CONSULT** Same as above.
06/23/15	Barry Rives, MD SRDH	**H&P** CC: F/u on CT results. ASSESSMENT: Incarcerated incisional hernia.
04/30/15	Barry Rives, MD SRDH	**H&P** CC: PCP told patient she had a hematoma. ASSESSMENT: Ventral hernia.
07/31/14	Barry Rives, MD SRDH	**H&P** CC: Lipoma removal. ASSESSMENT: Lipoma of skin and subcutaneous tissue.
CT SCANS		
03/21/16	Steinberg Diagnostic/ Southern Nevada Surgery Specialists	**CT ABD/PEL WITH CONTRAST** IMPRESSION: 1. Interval partial colectomy with creation of an end colostomy in the right mid abdomen. There is a persistent right ventral abdominal wall hernia containing omental fat and a loop of small bowel. No bowel obstruction or inflammation. 2. Unremarkable pelvic CT.
06/12/15	Steinberg Diagnostic Medical Imaging Centers	**CT ABD/PEL WITH CONTRAST** IMPRESSION: 1. Weakening/hernia of the right paracentral anterior abdomen with the opening measuring 5.7 cm and the herniated portion measuring 7.7 x 0.9 cm. Contains large bowel; no evidence of obstruction. 2. Unremarkable pelvic CT.

08/07/15	SRDH	**CT ABD/PEL W/O CONTRAST** IMPRESSION: 1. No fluid surrounding the drainage catheter in the epigastric region immediately below the left lobe of the liver. 2. Significant decrease in the fluid collection surrounding the drainage catheter near the ostomy in the right lower quadrant. Small 2.7 x 2.2 cm fluid collection is noted. 3. No new fluid collections in the abdomen or pelvis. 4. Small specks of contrast leaking from the colon up to the anterior abdominal wall wound suggesting a fistulous communication.
08/05/15	SRDH	**CT SOFT TISSUE NECK W/O CONTRAST** IMPRESSION: Unremarkable CT of the neck.
07/31/15	SRDH	**CT-GUIDED CATH PERC DRAINAGE WITH CATH PLACEMENT** CONCLUSION: Successful abscess drainage catheter placed under CT-guidance.
07/30/15	SRDH	**CT-GUIDED CATH PERC DRAINAGE WITH CATH PLACEMENT** IMPRESSION: 1. 8-French pigtail drain placement in the epigastric abscess. 2. Patient could not tolerate further time on the table to enable drain placement in the other locations I had planned (dominant right lateral abdominal abscess inferolateral to the colostomy bag, as well as the right abdominal wall abscess). 3. Please note there is also perihepatic fluid, likely abscess, as well as deep in the pelvis; these should be monitored and could be drained also in the future if they do not resolve other drain placements.
07/29/15	SRDH	**CT ABD/PEL WITH CONTRAST** IMPRESSION: 1. Perihepatic fluid collection extending along the paracolic gutter into the abdomen. The fluid is very thin in the perihepatic region. However, in the paracolic gutter it measures about 6.2 x 6.3 cm and is at the level of ostomy. The fluid pocket anterior to the liver is likely in communication with the cranial aspect of the abdominal wall incision.

		2. A second irregular pocket of fluid in the pelvis along the dome of the bladder.
07/15/15	SRDH	**CT ABD/PEL W/O CONTRAST** IMPRESSION: 1. Pneumoperitoneum with free fluid in the abdomen predominantly in the right perihepatic and sub-phrenic space. 2. Large air-fluid level in the supraumbilical mid abdomen; not entirely clear if this is a dilated loop of bowel vs. a peritoneal collection of air fluid level. 3. Ventral hernia containing large pocket of air due to gas-filled bowel loop vs. extraluminal gas. 4. Subcutaneous air/fluid along the right lateral abdominal wall.
07/09/15	SRDH	**CT ABD/PEL WITH CONTRAST** IMPRESSION: 1. Small amount of abdominal ascites. 2. There is a right supraumbilical parasagittal ventral hernia. Hernia sac contains fluid and free air. Component of free air has decreased. 3. There is no extravasation of oral contrast from the bowel. 4. Small right and trace left pleural effusions with bibasilar atelectasis. 5. Anasarca.
07/05/15	SRDH	**CTA CHEST & CT ABD/PEL WITH CONTRAST** IMPRESSION: 1. No central pulmonary embolism. Respiratory motion limits evaluation of the segmental and subsegmental vessels. 2. Small right pleural effusion. Bilateral areas of consolidation in the lungs bilaterally likely representing atelectasis. Pneumonia is not excluded. 3. Recent repair of incisional hernia. A small hernia remains over the anterior abdomen and contains free air and free fluid. 4. Small amount of free fluid in the abdomen with no drainable fluid collection identified.

RADIOLOGY		
07/04/15 To 09/14/15	SRDH	**GENERAL RADIOLOGY** 07/04/15 – Treadmill/Echocardiogram 07/04/15 – PICC Line Placement 07/22/15 – U/S Chest 07/04/15 –Lower Extremities Venous Duplex U/S 08/11/15 – Chest 08/02/15 – Chest 07/27/15 – Chest 07/22/15 – Chest 07/20/15 – Chest 07/19/15 – Chest 07/15/15 – Chest 07/14/15 – Chest 07/13/15 – Abdomen 07/12/15 – Abdomen 07/12/15 – Chest 07/11/15 – Chest 07/10/15 – Chest 07/09/15 – Abdomen 07/08/15 (2) – Chest 07/07/15 – Chest 07/06/15 – Chest 07/04/15 – Chest 07/04/15 – Abdomen 07/04/15 – Chest 09/14/15 – EMG & NCV
PATHOLOGY		
07/17/15 & 07/16/16	Various	**SURGICAL PATHOLOGY REPORTS** 07/17/15 – Old prosthetic abdominal mesh. Transverse colon.; SRDH 07/16/15 - Old prosthetic abdominal mesh. Transverse colon; Associated Pathologists Chartered
PROGRESS NOTES		
08/01/16 To 09/11/15	Southern Nevada Surgery Specialists	**OUTPATIENT REPORTS** 08/01/16 - Post-op colon perforation 07/01/16 – One-month f/u 08/01/16 – Post-op colon perforation 07/01/16 – One-month f/u 05/13/16 – F/u 04/22/16 – Two-month f/u 02/12/16 – F/u

		11/06/15 – F/u 09/11/15 – F/u
REHABILITATION THERAPY NOTES		
08/14/15 To 07/28/15	SRDH	**REHAB THERAPY NOTES** 08/14/15 – PT D/C Summary 08/12/15 – OT D/C Summary 08/11/15 – PT 08/10/15 – PT 08/09/15 - PT 08/08/15 - PT 08/06/15 - PT 08/05/15 - PT 08/04/15 - PT 08/03/15 - PT 08/02/15 - PT 08/01/15 - PT 07/30/15 - PT 07/29/15 - PT 07/28/15 (2) - PT
07/27/15 To 08/04/15	SRDH	**PHYSICAL THERAPY DAILY NOTES** 07/27/15 07/26/15 07/24/15 07/21/15 07/19/15 07/18/15 07/16/15 08/11/15 08/10/15 08/09/15 08/08/15 08/06/15 08/05/15 08/04/15
08/03/15 To 07/16/15	SRDH	**PHYSICAL THERAPY DAILY NOTES** 08/03/15 08/02/15 07/30/15 07/29/15 07/28/15 (2) 07/27/15 07/26/15 07/24/15

		07/23/15 07/19/15 07/18/15 07/17/15 08/08/15 08/01/15 – Weekly Summary 07/21/15 – Weekly Summary 07/16/15 – Initial Evaluation
07/16/15 To 08/10/15	SRDH	**SPEECH THERAPY DAILY NOTES** 08/07/15 08/06/15 08/05/15 08/04/15 08/03/15 07/31/15 07/30/15 07/29/15 07/28/15 07/27/15 07/18/15 07/17/15 07/16/15 08/01/15 – Swallow Evaluation 07/25/15 – Trach/Speaking Valve Evaluation 08/10/15 – D/C Summary
07/16/15 To 08/10/15	SRDH	**OCCUPATIONAL THERAPY DAILY NOTES** 08/09/15 08/07/15 (2) 08/05/15 07/31/15 08/11/15 08/10/15 08/09/15 08/07/15 08/05/15 08/04/15 08/03/15 (2) 08/01/15 07/19/15 07/18/15 07/17/15 07/16/15 07/31/15 – Initial Evaluation 08/07/15 – Weekly Summary

05/27/16 To 11/12/15	Desert Valley Therapy	**PHYSICAL THERAPY PROGRESS NOTES** 05/27/16 04/20/16 04/15/16 03/21/16 03/17/16 03/14/16 03/07/16 02/25/16 02/22/16 02/18/16 02/16/16 02/10/16 02/08/16 02/09/16 01/28/16 01/26/16 01/21/16 01/14/16 01/11/16 12/03/15 12/01/15 11/18/15 11/12/15 04/20/16 04/15/16 03/07/16 02/09/16
07/05/15	SRDH	**PHOTOS** Scanned photos.
PROGRESS NOTES		
08/10/15 & 08/11/15	SRDH	**PROGRESS NOTES** 08/11/15 – Surgical 08/11/15 – Labs 08/11/15 – Renal 08/10/15 – Surgical 08/10/15 – Renal 08/10/15 - Surgical
08/10/15 & 08/09/15	SRDH	**PROGRESS NOTES** 08/10/15 – Labs 08/09/15 – Renal 08/09/15 – Nausea

		08/09/15 – Labs 08/09/15 – Fluid collection
08/08/15	SRDH	**PROGRESS NOTES** Labs Critical Care Surgery Surgical Renal
08/07/15	SRDH	**PROGRESS NOTES** Renal surgery post-op Labs Critical Care Surgical
08/06/15	SRDH	**PROGRESS NOTES** Critical Care Labs Renal surgery post-op Renal
08/06/15 & 08/05/15	SRDH	**PROGRESS NOTES** 08/06/15 – Surgical 08/05/15 – Renal surgery post-op 08/05/15 – Critical Care 08/05/15 – Renal 08/05/15 - Labs
08/05/15 & 08/04/15	SRDH	**PROGRESS NOTES** 08/05/15 – Surgical 08/04/15 – Critical Care 08/04/15 – Labs 08/04/15 – Surgical 08/04/15 – Renal 08/04/15 - Surgery
08/04/15 To 08/02/15	SRDH	**PROGRESS NOTES** 08/04/15 – Critical Care 08/03/15 – Renal surgery post-op 08/03/15 – Labs 08/03/15 – Surgical 08/03/15 – Renal 08/02/15 - Labs
08/02/15 &	SRDH	**PROGRESS NOTES**

08/01/15		08/02/15 – Critical Care 08/02/15 – Renal 08/02/15 – Renal surgery post-op 08/02/15 – SOAP 08/01/15 – S/p drainage 08/01/15 - Labs
08/01/15 & 07/31/15	SRDH	**PROGRESS NOTES** 08/01/15 – Renal 08/01/15 – Renal surgery post-op 08/01/15 – Critical Care 07/31/15 – Labs 07/31/15 – Renal surgery post-op
07/31/15 & 07/30/15	SRDH	**PROGRESS NOTES** 07/31/15 – SOAP 07/31/15 – Critical Care 07/31/15 – Renal 07/30/15 – Renal surgery post-op 07/30/15 – Surgical 07/30/15 – Critical Care 07/30/15 – NG tube
07/30/15 & 07/29/15	SRDH	**PROGRESS NOTES** 07/30/15 – Renal 07/29/15 – Perihepatic fluid collection 07/29/15 – Renal surgery post-op 07/29/15 – Dyspneic 07/29/15 - Surgical
07/29/15 To 07/27/15	SRDH	**PROGRESS NOTES** 07/29/15 – Renal 07/28/15 – Low grade fever 07/28/15 – Critical Care 07/28/15 – Surgical 07/28/15 – Renal 07/27/15 – Renal surgery post-op 07/27/15 – Surgical
07/27/15 & 07/26/15	SRDH	**PROGRESS NOTES** 07/27/15 – Critical Care 07/27/15 – Renal 07/26/15 – SOAP 07/26/15 – Edema
07/26/15 &	SRDH	**PROGRESS NOTES**

07/25/15		07/26/15 – Slight uptick in wbc 07/26/15 – Critical Care 07/26/15 – Renal surgery post-op 07/25/15 – Renal
07/25/15	SRDH	**PROGRESS NOTES** SOAP Renal surgery post-op Critical Care
07/25/15 & 07/24/15	SRDH	**PROGRESS NOTES** 07/25/15 – Surgical 07/24/15 – Renal Surgery post-op 07/24/15 – Critical Care 07/24/15 – HCP Cardiology
07/24/15 & 07/23/15	SRDH	**PROGRESS NOTES** 07/24/15 – SOAP 07/24/15 – Renal 07/23/15 – SOAP 07/23/15 – Renal surgery post-op
07/23/15 & 07/22/15	SRDH	**PROGRESS NOTES** 07/23/15 – Respiratory failure post-op 07/23/15 – Critical Care 07/23/15 – Renal 07/22/15 – Surgical 07/22/15 – IM Cross Cover PN
07/22/15 & 07/21/15	SRDH	**PROGRESS NOTES** 07/22/15 – Critical Care 07/22/15 – Renal surgery post-op 07/22/15 – Renal 07/21/15 – Renal surgery post-op 07/21/15 - SOAP
07/21/15 & 07/20/15	SRDH	**PROGRESS NOTES** 07/21/15 – IM Cross Cover PN 07/21/15 – Renal 07/21/15 – Critical Care 07/20/15 – Renal surgery post-op 07/20/15 – SOAP 07/20/15 – Atrial flutter
07/20/15 & 07/19/15	SRDH	**PROGRESS NOTES** 07/20/15 – Critical Care

		07/20/15 – Renal 07/19/15 – Atrial flutter 07/19/15 – Renal surgery post-op 07/19/15 – Renal 07/19/15 – SOAP 07/19/15 – Critical Care
07/18/15	SRDH	**PROGRESS NOTES** PN SOAP Critical Care Surgery post-op Renal Critical Care PN
07/17/15 & 07/16/15	SRDH	**PROGRESS NOTES** 07/17/15 – Critical Care 07/17/15 – Surgery post-op 07/17/15 – Renal 07/16/15 – SOAP 07/16/15 – Critical Care 07/16/15 - PN
07/16/15 & 07/15/15	SRDH	**PROGRESS NOTES** 07/16/15 – SOAP 07/16/15 – Critical Care 07/16/15 – PN 07/16/15 – Critical Care 07/16/15 – Renal 07/15/15 – PN 07/15/15 – Critical Care
07/15/15	SRDH	**PROGRESS NOTES** PN SOAP Med/Surgical Short PN Critical Care PN
07/14/15	SRDH	**PROGRESS NOTES** SOAP Cardiology Critical Care Med/Surgical Short PN PN

07/13/15	SRDH	**PROGRESS NOTES** PN Critical Care Med/Surgical Short PN Critical Care (2)
07/13/15	SRDH	**PROGRESS NOTES** SOAP Critical Care PN
07/12/15	SRDH	**PROGRESS NOTES** SOAP Med/Surgical Short PN Critical Care PN
07/12/15	SRDH	**PROGRESS NOTES** 07/12/15 – Acute renal insufficiency 07/11/15 – Same as above 07/11/15 - Med/Surgical Short PN 07/11/15 - SOAP
07/11/15 & 07/10/15	SRDH	**PROGRESS NOTES** 07/11/15 – Critical Care 07/11/15 – Renal 07/10/15 – Cardiology 07/10/15 - Med/Surgical Short PN 07/10/15 – SOAP 07/10/15 - PN
07/10/15 & 07/09/15	SRDH	**PROGRESS NOTES** 07/10/15 – Critical Care 07/10/15 – Renal 07/09/15 – Cardiology 07/09/15 – PN 07/09/15 - Med/Surgical Short PN
07/09/15	SRDH	**PROGRESS NOTES** SOAP Critical Care PN
07/08/15	SRDH	**PROGRESS NOTES** Med/Surgical Short PN

		PN PN – S/p reduction of incarcerated incisional hernia Critical Care
07/08/15 & 07/07/15	SRDH	**PROGRESS NOTES** 07/08/15 – SOAP 07/08/15 – Renal 07/07/15 – Acute renal insufficiency 07/07/15 – PN 07/07/15 – Tachycardia 07/07/15 – SOAP
07/07/15 & 07/06/15	SRDH	**PROGRESS NOTES** 07/07/15 – Critical Care 07/07/15 – Renal 07/06/15 - Tachycardia
07/06/15	SRDH	**PROGRESS NOTES** PN SOAP Critical Care
07/06/15 & 07/05/15	SRDH	**PROGRESS NOTES** 07/06/15 - Med/Surgical Short PN 07/06/15 – Renal 07/05/15 – Tachycardia 07/05/15 – PN 07/05/15 - SOAP
07/16/15 To 07/05/15	SRDH	**PROGRESS NOTES** 07/05/15 - Med/Surgical Short PN 07/05/15 – Critical Care 07/04/15 – PN 07/04/15 - Med/Surgical Short PN 07/04/15 – PN 07/04/15 – Pulmonary Function Test 08/04/15 – Ostomy Note 07/29/15 – Ostomy Note 07/17/15 – Ostomy Note

Additional Records Received:

1/11/17	Steinberg Diagnostic Medical Imaging Centers	**MRI LEFT FOOT:** Impression: 1. Plantar medial heel skin ulceration. No foot abscess or osteomyelitis. 2. 1 cm in length plantar fibroma at the midfoot level, overlying the second metatarsal proximal shaft. No plantar fasciitis. 3. Mild posterior tibialis tendinosis and tenosynovitis.
6/22/16	Steinberg Diagnostic Medical Imaging Centers	**MRI LUMBAR SPINE: (corrected report)** Impression: No significant lumbar disc disease. No acquired neural impingement at any level.
6/13/14	Steinberg Diagnostic Medical Imaging Centers	**MRI LUMBAR SPINE:** Impression: Normal lumbar lordosis with mild posterior facet arthropathy at L4-L5 and L5-S1. No significant canal stenosis or neural foraminal narrowing is seen.
1/11/17-6/13/14	Steinberg Diagnostic Medical Imaging Centers	**RADIOLOGY:** 1/11/17: Lower Extremity Arterial Doppler 9/16/15: Chest Radiograph 6/13/14: Bilateral Digital Screening Mammogram

PROBLEM LIST:

1. Perforated viscus with intraabdominal sepsis status post exploratory laparotomy and removal of prosthetic mesh
2. Acute respiratory failure status post tracheostomy placement
3. History of incarcerated incisional hernia status post laparoscopic repair with mesh and colonorrhaphy x 2
4. Encephalopathy secondary to sepsis and medications
5. Acute blood loss anemia
6. Acute kidney injury
7. Neuropathy from prolonged immobilization
8. Residual:
    a. Severe sensory loss and motor weakness below the knees bilaterally involving the tibial and peroneal nerves
    b. Probable carpal tunnel syndrome bilaterally
    c. Probable rotator cuff tear/tendinitis left shoulder
    d. Right ankle contracture with bilateral foot drop
    e. Left heal stage III decubitus
    f. Ventral hernia
    g. Dupuytren's contracture bilateral hands
    h. Weight gain
    i. Situational depression and anxiety
    j. Sleep disturbance
    k. Chronic neuropathic musculoskeletal myofascial pain
    l. High fall risk
    m. Impaired mobility and ADL status
    n. Impaired avocational status

Past Medical History of:

o. Diabetes mellitus

p. Left shoulder pain

q. GERD

r. Hypertension

s. Dyslipidemia

DISCUSSION:

Ms. Titina Marie Farris is a 55-year-old married female with history of perforated viscus with intra-abdominal sepsis with numerous sequelae who was seen at Kentfield Rehabilitation & Specialty Hospital on 3/20/2018 at which time a history was obtained and a physical examination was performed.

Ms. Farris' residual complaints and symptoms included severe motor and sensory loss below the knees bilaterally with very significant gait impairment. She was also noted to have a reducible ventral hernia along with bilateral hand Dupuytren's contractures involving both of her hands. She also had probable carpal tunnel syndrome bilaterally, as well as probable rotator cuff tendinitis on the left. She had a chronic left heel stage 3 decubitus which was being treated with local dressing changes. Ms. Farris also complained of chronic neuropathic and musculoskeletal pain involving her low back and bilateral lower extremities. As a result of her chronic pain as well as functional loss, she complained of situational depression, anxiety as well as sleep disturbance. Ms. Farris was no longer able to perform her usual and customary activities of daily living as well as avocational activities as discussed above.

As a result of Ms. Farris' injuries, she should be followed by a Physical Medicine & Rehabilitation specialist in addition to her Primary Care Physician as well as a Podiatrist for nail and wound care. It is also anticipated that she will require the services of Orthopedics, Hand Surgery as well as Psychology/Psychiatry in the future. In view of her relative immobility, weight gain as well as premorbid history of diabetes, she should be followed by a dietician. It is anticipated that Ms. Farris will require intermittent Physical and Occupational Therapy throughout her lifetime. She should be provided with massage therapy and acupuncture therapy for her chronic pain. She should attend a wound clinic for her heel ulcer. She is an excellent candidate for an adaptive aquatic swim therapy program performed under direct supervision by a Physical Therapist or PT Aid when her wounds have healed.

It is anticipated that Ms. Farris will require carpal tunnel surgery in the future along with joint and trigger point injections for pain management. An MRI needs to be performed of her left shoulder to evaluate the degree of rotator cuff pathology. Electrodiagnostic studies should be performed of her upper and lower extremities to further delineate the degree of neuropathy in view of her ongoing neurological complaints.

Ms. Farris is an excellent candidate for an electric wheelchair for community distance mobility. She should be provided with bilateral custom AFO's for her bilateral foot drop as well as ankle contractures. She should also be provided with heel protector boots for night use in view of her heel pressure ulcer and neurological compromise to both of her feet.

Additional assistive devices should be provided such as a single point cane as well as a 4-wheeled walker with a seat and a reacher along with bathroom supplies. An abdominal binder should be provided for her ventral hernia.

Currently Ms. Farris requires approximately 4-6 hours of attendant/chore services per day. These needs will probably increase as she ages with her injuries.

Appropriate physical restrictions are as follows:

- No climbing
- No higher balance activities
- No repetitive bending or twisting
- No repetitive pushing, pulling or reaching
- No repetitive use of the bilateral upper extremities
- No crawling or kneeling
- No lifting over 3 lbs
- Frequent change in position
- Ability to stretch every 30 minutes
- No standing without supervision
- No walking without supervision

It is anticipated that Ms. Farris will require a fully wheelchair accessible home in 5-10 years.

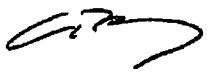
With appropriate medical as well as therapeutic care, it is not anticipated that the injuries Ms. Farris sustained in the above matter will shorten her overall life expectancy.

For a comprehensive list of future care needs, please see the Life Care Planning Worksheet.

All medical legal opinions are expressed with a reasonable degree of medical probability and are based on my education, training, experience as well as my examination of Titina Marie Farris and my extensive review of supplied records.

Thank you for this interesting referral and the opportunity to have evaluated Titina Marie Farris from a Physical Medicine and Rehabilitation/Life Care Planning perspective.

Respectfully submitted,



Alex Barchuk, M.D.
Board Certified in Physical Medicine & Rehabilitation
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AB:llm

EXHIBIT L

Premiere Surgical Specialists
General, Vascular, Trauma & Laparoscopic Surgery

Alvaro H. Devia, M.D., F.A.C.S.
Certified
American Board
of Surgery

Brian E. Juell, M.D., F.A.C.S.
Certified
American Board
of Surgery and
Surgical Critical Care

Thomas E. Rembetski, M.D.
Certified
American Board
of General and
Vascular Surgery

12/16/2018

I have been asked to review the deposition transcript of Dr. Barry Rives and to respond to reports of expert witnesses in the case of Farris v. Rives.

Response to Expert Report of Michael B. Hurwitz, MD

Dr Hurwitz indicates that he regards himself to be an expert in hernia repair and management of infections. He does not explicitly indicate his experience in the diagnosis of anastomotic leaks. Patient presentations from bowel and stomach spontaneous perforations and from leaks from surgical repairs and anastomoses present in highly variable patterns. I frequently see patients with perforated colon who have been sick for days and sometimes weeks before presenting to the ER. The response to sepsis by the patient is also highly variable. Some patients are genetically prone to sepsis and may have rapidly fatal courses despite heroic medical and surgical intervention. Other patients seem to be able to withstand major intestinal perforations and infections and survive despite diagnostic delays. Surgical bowel repairs and anastomoses fail with some regularity. All surgeons who perform these surgeries have such failures. Some failures can be managed without reoperation. These failures may be immediate early or quite delayed. All surgeons preforming these surgeries have a high index of suspicion for these complications when the patient has complications after surgery. Diagnosis can be vexing. Reoperation has inherent risks in and of itself. Dr Hurwitz from the position of a Monday Morning Quarterback supports the allegations of the plaintiff but fails to make the case that intervention was explicitly warranted based on the collective data at hand at any one time in Ms. Farris's course. Patient was attended to and evaluated by multiple physicians and surgeons and until a leak was diagnosed on post op day #12 a decision for reoperation based the inherent risks vs benefits was unclear.

Ms. Farris underwent laparoscopic hernia repair complicated by colon injury and repair. The use of an energy device to free the colon from the adherent mesh has been associated with an increased risk of bowel perforation and delayed leak development. The use of sharp dissection has similar complications. Dr Rives was aware of this, recognized and repaired the resulting injuries and inspected the adequacy of the repairs.

Ms. Rives had surgery. Postoperatively she had pain and developed abdominal and bowel distension. She developed a tachycardia and increasing respiratory failure and hypoxia. She had an elevated WBC count and a moderate lactic acidosis. She had hypovolemia and required vigorous fluid resuscitation and developed acute kidney injury. She was admitted to ICU and ultimately required intubation and ventilator support. She did not have bacteremia. She did have septic syndrome criteria but also could have had respiratory failure due to progressive hypoventilation and atelectasis or more likely pulmonary aspiration syndrome. The Infectious Disease specialist operational diagnosis of fecal peritonitis is supported primarily from the events in surgery and supported the use of broad-spectrum

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antibiotics. Abdominal pain following surgery is expected. An elevated WBC is nonspecific and could be due to stress. CT scan on post op day 2 had findings expected following the surgery preformed but no incontrovertible evidence of bowel leak. Physical findings did support such diagnosis. As Dr Rives stated in his deposition the was no bowel contents leaking out of her wounds. Her condition was stabilized. Dr Hurwitz states that the patient continued to deteriorate. This in fact is not true. She was sick but her condition actually improved. Her tachycardia and lactic acidosis resolved. She had no significant fever. Her abdominal exam did not progress adversely. She a persistently elevated WBC count but that is a nonspecific finding. Her overall failure to improve led to a second surgical opinion by Dr Ripplinger on POD #6. He like Dr Rives felt there should be a low threshold for considering reoperation. In fact, he did not state there was an absolute indication to proceed to surgery based on his examination of the patient, her clinical course and all available data. Dr Ripplinger recommended that another CT scan be obtained. One was this time with radio-opaque contrast in the intestine. The CT scan showed no leak of contrast from the bowel and no adverse changes from the previous pathognomonic for bowel leak. Is this the point where Dr Hurwitz felt that reoperation was mandatory?

Ms. Farris remained relatively stable until POD #12 when her condition did deteriorate. CT done then demonstrated findings consistent with a leak. She did not have surgery until the next day by Dr. Hamilton. Findings at surgery where both acute and chronic inflammation and leaking surgical repairs. She had a protracted course but ultimately survived and recovered. MS Farris had significant comorbidities. It is open to speculation that a any earlier operation would have altered her necessary surgery or subsequent recovery.

Dr Hurwitz concludes that Dr Rives fell below the standard of care on 4 counts:

1. Intraoperative technique; Dr Hurwitz does not specify which techniques. Use of thermal energy In approximation to the bowel is relatively contraindicated but may have been unavoidable was successful, and the resulting injuries were reasonably repaired. These repairs were later inspected before the conclusion of surgery. The subsequent suture line disruption cannot be directly linked to a technical failure.
2. Failure to adequately repair the colon injuries on initial operation. Dr Rives was satisfied. Dr Hurwitz does not indicate why stapling the holes closed was inadequate.
3. Failure to timely diagnose and treat feculent peritonitis. It is abundantly unclear when there was an absolute indication to reoperate based on the patient's course and subsequent favorable outcome. Surgical decision making was difficult for multiple surgeons. It is unclear that Ms. Farris's course would have significantly different.
4. Poor post -operative management; redundant at best.

Dr Hurwitz supports the allegations of the plaintiff. He fails to make the case for a smoking gun for earlier reoperation or a technical error by Dr Rives constituting an act of malpractice.

Response to Expert Report of Dr Alan J. Sein, MD

Dr Stein is an Infectious Disease specialist practicing in New York. Clearly, he is not an expert in surgery. He retrospectively states that Dr Rives fell below the standard of care regarding a decision for reoperation. He correctly reiterates Ms. Farris's failure to progress on a day to day basis. Ms. Farris certainly was in critical condition. His statement that other causes of her early postoperative deterioration were eliminated is clearly open to debate. Bowel perforation and abdominal sepsis were

always on the list but the precise point where surgery was necessary is not specified. He does not make a case that Ms. Farris outcome, which was favorable would have been significantly improved by earlier intervention. Dr. Stein statement that CT scans are not sensitive to determine sources of intra-abdominal sources of infection in the early postoperative period is a misleading statement at best.

Ms. Farris had an unusually confounding postoperative course but likely had the same operation she would have received had the indications for reoperation been mandated at an earlier point in her care. These experts fail to make a case that her clinical course and recovery would have been significantly altered to point constituting malpractice on the part of Dr Rives.

In conclusion, I continue to believe the care Mrs. Farris received from Dr. Rives met the standard of care. The opinions expressed in this report and my original report are held to a reasonable degree of medical probability.

Brian E Juell MD FACS

CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I certify that on the 2nd day of October, 2019, service of a true and correct copy of the foregoing:

DECLARATION OF CHAD COUCHOT IN SUPPORT OF OPPOSITION TO PLAINTIFFS' MOTION TO STRIKE DEFENDANTS' FOURTH AND FIFTH SUPPLEMENT TO NRCP 16.1 DISCLOSURE OF WITNESSES AND DOCUMENTS ON ORDER SHORTENING TIME

was served as indicated below:

☒ served on all parties electronically pursuant to mandatory NEFCR 4(b);

☐ served on all parties electronically pursuant to mandatory NEFCR 4(b) , exhibits to follow by U.S. Mail;

☐ by depositing in the United States Mail, first-class postage prepaid, enclosed ;

☐ by facsimile transmission; or

☐ by personal service as indicated.

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an employee of Schuering Zimmerman & Doyle, LLP
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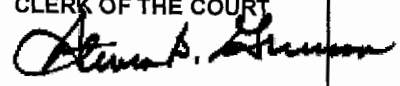

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Attorneys for Defendants BARRY RIVES, M.D. and LAPAROSCOPIC SURGERY OF NEVADA, LLC

DISTRICT COURT

CLARK COUNTY, NEVADA

TITINA FARRIS and PATRICK FARRIS, Plaintiffs, vs. BARRY RIVES, M.D.; LAPAROSCOPIC SURGERY OF NEVADA, LLC, et al., Defendants.	CASE NO. A-16-739464-C DEPT. NO. 31 **DECLARATION OF THOMAS J. DOYLE IN SUPPORT OF OPPOSITION TO PLAINTIFFS' MOTION TO STRIKE DEFENDANTS' FOURTH AND FIFTH SUPPLEMENT TO NRCP 16.1 DISCLOSURE OF WITNESSES AND DOCUMENTS ON ORDER SHORTENING TIME**

I, THOMAS J. DOYLE, declare:

1. I am an attorney at law licensed to practice in the State of Nevada. I am a partner of the law firm of Schuering Zimmerman & Doyle, LLP, attorneys of record for Defendants BARRY J. RIVES, M.D.; LAPAROSCOPIC SURGERY OF NEVADA, LLC.

2. I spoke to William Brenske on October 1, 2019. Mr. Brenske represented Plaintiffs Vickie Center and Thomas Center in the matter of *Center v. Rives*. The trial in *Center v. Rives* began on April 1, 2019. According to Mr. Brenske, George Hand contacted him about Dr. Barry Rives "weeks to months" before the trial in Center began.

I declare under penalty of perjury under the laws of the State of Nevada that the foregoing is true and correct, and if called to testify, I could competently do so.

Executed this 2ND day of October, 2019, at Sacramento, California.

/s/ Thomas J. Doyle
THOMAS J. DOYLE

CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I certify that on the 2nd day of October, 2019, service of a true and correct copy of the foregoing:

DECLARATION OF THOMAS J. DOYLE IN SUPPORT OF OPPOSITION TO PLAINTIFFS' MOTION TO STRIKE DEFENDANTS' FOURTH AND FIFTH SUPPLEMENT TO NRCP 16.1 DISCLOSURE OF WITNESSES AND DOCUMENTS ON ORDER SHORTENING TIME

was served as indicated below:

☒ served on all parties electronically pursuant to mandatory NEFCR 4(b);

☐ served on all parties electronically pursuant to mandatory NEFCR 4(b), exhibits to follow by U.S. Mail;

☐ by depositing in the United States Mail, first-class postage prepaid, enclosed ;

☐ by facsimile transmission; or

☐ by personal service as indicated.

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DISTRICT COURT

CLARK COUNTY, NEVADA

TITINA FARRIS and PATRICK FARRIS, Plaintiffs, vs. BARRY RIVES, M.D.; LAPAROSCOPIC SURGERY OF NEVADA, LLC et al., Defendants.	CASE NO.: A-16-739464-C DEPT. NO.: XXXI

REPLY IN SUPPORT OF PLAINTIFFS' MOTION TO STRIKE DEFENDANTS' FOURTH AND FIFTH SUPPLEMENT TO NRCP 16.1 DISCLOSURE OF WITNESSES AND DOCUMENTS ON ORDER SHORTENING TIME

COMES NOW Plaintiffs PATRICK FARRIS and TITINA FARRIS, by and through their attorneys of record, KIMBALL JONES, ESQ. and JACOB G. LEAVITT, ESQ., with the Law Offices of **BIGHORN LAW** and GEORGE F. HAND, ESQ., with the Law Offices of **HAND & SULLIVAN**, LLC, and hereby submit this Reply in Support of their Motion to Strike Defendants'

Fourth and Fifth Supplement to NRCP 16.1 Disclosure of Witnesses and Documents on Order Shortening Time ("Motion").

This Reply is made and based upon all of the pleadings and papers on file herein and the attached Memorandum of Points and Authorities.

DATED this 3rd day of October, 2019.

BIGHORN LAW

By: */s/ Kimball Jones*

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MEMORANDUM OF POINTS AND AUTHORITIES

I. STATEMENT OF RELEVANT FACTS

Plaintiff Titina Farris was a patient of Defendant Rives. Rives, while performing surgery on Plaintiff, negligently cut her colon in three places, though he only identified two holes during surgery. Thereafter, Rives failed to adequately repair the colon and/or sanitize the abdominal cavity. With feces actively in her abdomen, Plaintiff predictably went into septic shock and was transferred to the ICU. Nevertheless, Rives still failed to recommend any surgery to repair the punctured colon until he was ultimately removed from the case thirteen (13) days later. Unfortunately, the consequences of Rives' negligence caused Plaintiff's organs to begin shutting down and her extremities to suffer permanent impairment. Ultimately, Plaintiff developed critical care neuropathy, destroying all nerve function in her lower legs and feet, commonly referred to as bilateral drop foot.

Defendants seemingly attempt to argue that the presence of their expert Dr. Juell's supplemental report, in their September 12, 2019 disclosure, absolves the late nature of all the other untimely submitted material in future disclosures. Clearly, it does not. Whereas Dr. Juell's supplemental report is arguably timely, as it was barely disclosed thirty (30) days before trial, based upon Rule 16.1—the other disclosed material is woefully late.

Defendants attempt to still slip in this information—including the identities of the eighteen (18) new witnesses by claiming that the late disclosure is "harmless." This is a specious argument. Disclosing these witnesses forty-five (45) days after the close of discovery is incredibly prejudicial. Even if Plaintiffs may have known who these witnesses are, Plaintiffs did not depose these witnesses believing they were <u>not</u> going to be called as they were not identified by Defendants. Now that discovery is closed, this cannot be remedied. Furthermore, there is simply not time enough to vet the witnesses internally prior to trial. This dump of eighteen (18) previously undisclosed witnesses is the antithesis of "harmless" as Plaintiffs' Counsel, already stretched to capacity—is now forced to utilize

precious resources and bandwidth to analyze witnesses who Plaintiffs were unaware would be testifying.

Defendants' argument, that the disclosure was harmless as eleven (11) names were in medical records, demonstrates that Defendants have no good cause for delaying to name these witnesses until forty-five (45) days after the close of discovery. Defendants knew of these individuals, and they knew that they would be interested in their testimony—yet they chose to game the system by naming them a month-and-a-half after the close of discovery so Plaintiffs could not depose them. As such, Defendants' Fourth Supplement is properly Stricken—and the eighteen (18) witnesses named therein should be precluded from testifying.

Likewise, Dr. Adornato's supplement—his opinions on the articles, additional medical articles, and supplemental report—are all properly Stricken. This submission came after the deadline in Rule 26 and Rule 16.1 to supplement expert reports. It also came fifty-six (56) days after the close of discovery and only twenty-one (21) days before trial.

Defendants attempt to justify its inclusion by claiming that it was done in response to the July 24, 2019 deposition of Dr. Adornato. This argument is entirely erroneous and unsupported by the content of the deposition. Nevertheless, even if true it would not justify the delay. Certainly, Defendants were left with ample time to supplement the expert's report prior to the deadline established by the Court. Defendants have offered no good reason for their delay. Likewise, this submission, three (3) weeks before trial fails to leave time sufficient time to answer the opinions given by Dr. Adornato. As such, this Fifth Supplement is also properly Stricken.

Defendants have failed to justify their late submission of their Fourth and Fifth Supplements. They are prejudicial, and there has been no showing of good cause to admit the and they are properly Stricken and Excluded from Trial.

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II. LEGAL ARGUMENT AND ANALYSIS

Plaintiff and Defendants have both briefed the Court on the applicable and controlling law in this matter. However, Defendants have failed to show that their tardiness was justified, or that the disclosures are harmless.

NRCP 37(c)(1) states, "(1) A party that without substantial justification fails to disclose information required by Rule 16.1, 16.2, or 26(e)(1), or to amend a prior response to discovery as required by Rule 26(e)(2), **is not, unless such failure is harmless, permitted to use as evidence at a trial, at a hearing, or on a motion any witness or information not so disclosed.** In addition to or in lieu of this sanction, the court, on motion and after affording an opportunity to be heard, may impose other appropriate sanctions. **In addition to requiring payment of reasonable expenses, including attorney's fees, caused by the failure, these sanctions may include any of the actions authorized under Rule 37(b)(2)(A), (B), and (C) and may include informing the jury of the failure to make the disclosure."** (Emphasis added.)

As noted above, discovery closed in this matter on July 24, 2019. Yet, on September 12, 2019 and over forty-five (45) past the close of discovery, Defendants untimely disclosed eighteen (18) new witnesses in their Fourth Supplement to NRCP 16.1 Disclosure of Witnesses and Documents.

Defendants admit in their Opposition that they knew of these witnesses well in advance of the close of discovery in this matter, as the witnesses were in Plaintiff Titina's medical records. However, only Defendants knew that they were going to call these eighteen (18) witnesses. Defendants' gamesmanship is incredibly prejudicial to Plaintiffs' case as their was no opportunity to depose these witnesses, and no indication that Defendants were going to call them as witnesses at trial. This ignorance is only and solely attributable to the fact that Defendants occulted the fact they were going to do so, in violation of their discovery obligation, until forty-five (45) days after discovery ended.

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As noted above, NRCP 37 forbids the use of this late-disclosed evidence unless the failure to disclose is "harmless." Plaintiffs have repeatedly noted the surprise inherent in Defendants' disclosures, the lack of ability to cure the surprise, and the lack of explanation from Defendants as to why the disclosures were so late.

Defendants' opposition fails to illuminate these matters. No compelling rationale for the delay is given and the harm is self-evident. As such, this Fourth Supplement is properly stricken.

Likewise, the Fifth Supplement is a Supplemental Report from Dr. Adornato which arrives only three (3) weeks prior to trial. This late supplement violates Rule 16.1 and Rule 26. Furthermore, there is no justification for its lateness as, by Defendants' own admission, was made in response to a July 24, 2019 deposition. Defendants' decision to hold the submission for nearly two (2) months, and disclose it after the expert supplement deadline feels purposeful.

Plaintiffs are now unable to timely evaluate Dr. Adornato's statements. Plaintiffs are unable to speak with their own experts as to the propriety of the articles contained therein.

Thus, this Fifth Supplement is also properly Stricken. It is damaging to Plaintiffs' case, it constituted surprise as it was submitted mere weeks prior to trial, its lateness is not excused or even explained by Defendants, and there can be no cure. As such, Defendants' Fourth and Fifth Supplements are properly Excluded from Trial.

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III. CONCLUSION

For the foregoing reasons, Plaintiffs respectfully requests that this Court GRANT Plaintiffs' Motion to Strike Defendants' Fourth and Fifth Supplement to NRCP 16.1 Disclosure of Witnesses and Documents on Order Shortening Time.

DATED this 3rd day of October, 2019.

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CERTIFICATE OF SERVICE

Pursuant to NRCP 5, NEFCR 9 and EDCR 8.05, I hereby certify that I am an employee of **BIGHORN LAW**, and on the 3rd day of October, 2019, I served the foregoing ***REPLY IN SUPPORT OF PLAINTIFFS' MOTION TO STRIKE DEFENDANTS' FOURTH AND FIFTH SUPPLEMENT TO NRCP 16.1 DISCLOSURE OF WITNESSES AND DOCUMENTS ON ORDER SHORTENING TIME*** as follows:

☒ Electronic Service – By serving a copy thereof through the Court's electronic service system; and/or

☐ U.S. Mail—By depositing a true copy thereof in the U.S. mail, first class postage prepaid and addressed as listed below:

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DISTRICT COURT

CLARK COUNTY, NEVADA

TITINA FARRIS and PATRICK FARRIS Plaintiffs, vs. BARRY RIVES, M.D.; LAPAROSCOPIC SURGERY OF NEVADA, LLC Defendants.	CASE NO. A-16-739464-C DEPT. NO. 31 **DEFENDANTS' PROPOSED LIST OF EXHIBITS**

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EXHIBIT INDEX

DEFENDANTS' TRIAL EXHIBITS **CASE NO. A-16-739464-C**

TITINA FARRIS &PATRICK FARRIS **v.** **BARRY RIVES, M.D. and LAPAROSCOPIC SURGERY OF NEVADA, LLC**

PLAINTIFFS' COUNSEL: _____ **DEFENSE COUNSEL: _____**

NO.	DESCRIPTION	DATE OFFERED	OBJECTION	DATE ADMITTED
A	Portions of medical records from Laparoscopic Surgery of Nevada **Bates: A000001 – A-000042**			
B	Medical records from St. Rose Dominican Hospital - San Martin Campus, for the admission on August 7, 2014. **Bates: B-000001 – B-000143**			
C	Medical records from Spring Valley Internal Medicine (Dr. Naomi Chaney). **Bates: C-000001 – C-000111**			
D	Medical records from Advanced Orthopedics and Sports Medicine (Dr. Randall Yee / Dr. Tomman Kuruvilla) **Bates: D-000001 – D-000011**			
E	Imaging Study from St. Rose Dominican Hospital - San Martin Campus- July 5, 2015 CT scan of chest, abdomen, and pelvis			
F	Imaging Study from St. Rose Dominican Hospital - San Martin Campus- July 9, 2015 CT scan of chest, abdomen, and pelvis			
G	Imaging Study from St. Rose Dominican Hospital - San Martin Campus- July 15, 2015 CT scan of chest, abdomen, and pelvis			
H	Imaging Study from St. Rose Dominican Hospital – San Martin Camps – July 4, 2015 (15:51:10) – XR Chest 1 View AP or PA			

No.	Description	Date Offered	Objection	Date Admitted
I	Imaging Study from St. Rose Dominican Hospital – San Martin Camps – July 4, 2015 (15:50:31) – XR Abdomen AP			
J	Imaging Study from St. Rose Dominican Hospital – San Martin Campus – July 4, 2015 (20:04:51) – XR Chest 1 View AP or PA			
K	Imaging Study from St. Rose Dominican Hospital – San Martin Campus – July 4, 2015 (20:59:58) – XR Chest 1 View AP or PA			
L	Imaging Study from St. Rose Dominican Hospital – San Martin Campus – July 4, 2015 (20:59:58) – XR Chest 1 View AP or PA			
M	Imaging Study from St. Rose Dominican Hospital – San Martin Campus – July 6, 2015 (04:02:00) – XR Chest 1 View AP or PA			
N	Imaging Study from St. Rose Dominican Hospital – San Martin Campus – July 7, 2015 (03:11:25) – XR Chest 1 View AP or PA			
O	Imaging Study from St. Rose Dominican Hospital – San Martin Campus – July 8, 2015 (03:23:09) – XR Chest 1 View AP or PA			
P	Imaging Study from St. Rose Dominican Hospital – San Martin Campus – July 7, 2015 (03:11:25) – XR Chest 1 View AP or PA			
Q	Imaging Study from St. Rose Dominican Hospital – San Martin Camps – July 9, 2015 (15:50:31) – XR Abdomen AP+DECUB+OR ERECT			
R	Imaging Study from St. Rose Dominican Hospital – San Martin Campus – July 8, 2015 (20:30:56) – XR Chest 1 View AP or PA			
S	Imaging Study from St. Rose Dominican Hospital – San Martin Campus – July 10, 2015 (04:25:01) – XR Chest 1 View AP or PA			
T	Imaging Study from St. Rose Dominican Hospital – San Martin Campus – July 11, 2015 (03:57:39) – XR Chest 1 View AP or PA			

No.	Description	Date Offered	Objection	Date Admitted
U	Imaging Study from St. Rose Dominican Hospital – San Martin Campus – July 12, 2015 (03:55:06) – XR Chest 1 View AP or PA			
V	Imaging Study from St. Rose Dominican Hospital – San Martin Camps – July 12, 2015 (09:16:42) – XR Abdomen AP+DECUB+OR ERECT			
W	Imaging Study from St. Rose Dominican Hospital – San Martin Campus – July 14, 2015 (03:39:35) – XR Chest 1 View AP or PA			
X	Imaging Study from St. Rose Dominican Hospital – San Martin Camps – July 13, 2015 (11:44:12) – XR Abdomen AP			
Y	Imaging Study from St. Rose Dominican Hospital – San Martin Campus – July 15, 2015 (03:30:33) – XR Chest 1 View AP or PA			
Z	Imaging Study from Steinberg Diagnostic Medical Imaging Centers – June 12, 2015- CT abdomen			
AA	Titina Farris' Responses to Defendants' First Set of Interrogatories **Bates: AA-000001 – AA-000012**			
BB	Patrick Farris' Responses to Defendants' First Set of Interrogatories **Bates: BB-000001 – BB-000009**			
CC	Expert reports by Bart Carter, M.D., P.C. **Bates: CC-0000001 – CC-000012**			
DD	Expert reports by Brian E. Juell, M.D. **Bates: DD-000001 – DD-000008**			
EE	Expert reports by Lance Stone, D.O. **Bates: EE-000001 – EE-000006**			
FF	Expert reports by Sarah Larsen, RN **Bates: FF-000001 – FF-000020**			

No.	Description	Date Offered	Objection	Date Admitted
GG	Expert reports by Bruce Adornato, M.D. **Bates: GG-000001 – GG-000005**			
HH	Expert reports by Kim Erlich, M.D. **Bates: HH-000001 – HH-000006**			
II	Expert reports by Scott Kush, M.D. **Bates: II-000001 – II-000019**			
JJ	Expert reports by Erik Volk **Bates: JJ-000001 – JJ-000025**			
KK	Expert Reports by Michael Hurwitz, M.D. **Bates: KK-000001 – KK-000008**			
LL	Expert file of Michael Hurwitz, M.D. **Bates: LL-000001 – LL-000028**			
MM	Expert fee schedule of Michael Hurwitz, M.D.			
NN	Expert case list of Michael Hurwitz, M.D.			
OO	Expert Reports by Justin Willer, M.D. **Bates: OO-000001 – OO-000010**			
PP	Expert file of Justin Willer, M.D. **Bates: PP-000001 – PP-000003**			
QQ	Expert fee schedule of Justin Willer, M.D.			
RR	Expert case list of Justin Willer, M.D.			
SS	Expert Reports by Alan J. Stein, M.D. **Bates: SS-000001 – SS-000008**			
TT	Expert fee schedule of Alan J. Stein, M.D.			
UU	Expert case list of Alan J. Stein, M.D.			

No.	Description	Date Offered	Objection	Date Admitted
VV	Expert Reports by Dawn Cook, R.N. **Bates: VV-000001 – VV-000085**			
WW	Expert file of Dawn Cook, R.N. **Bates: WW-000001 – WW-000011**			
XX	Expert fee schedule of Dawn Cook, R.N.			
YY	Expert case list of Dawn Cook, R.N. **Bates: YY-000001 – YY-000003**			
ZZ	Expert Reports by Terrence M. Clauretie **Bates: ZZ-000001 – ZZ-000018**			
AAA	Expert file of Terrence M. Clauretie **Bates: AAA-000001 – AAA-000066**			
BBB	Expert fee schedule of Terrence M. Clauretie			
CCC	Expert case list of Terrence M. Clauretie **Bates: CCC-000001 – CCC-000024**			
DDD	Expert Reports by Alex Barchuk, M.D. **Bates: DDD-000001 – DDD-000032**			
EEE	Expert file of Alex Barchuk, M.D. **Bates: EEE-000001 – EEE-000060**			
FFF	Expert fee schedule of Alex Barchuk, M.D.			
GGG	Expert case list of Alex Barchuk, M.D. **Bates: GGG-000001 – GGG-000010**			

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DISTRICT COURT

CLARK COUNTY, NEVADA

TITINA FARRIS and PATRICK FARRIS, Plaintiffs, vs. BARRY RIVES, M.D.; LAPAROSCOPIC SURGERY OF NEVADA, LLC, et al., Defendants.	CASE NO. A-16-739464-C DEPT. NO. 31 **DEFENDANTS BARRY RIVES, M.D.'S AND LAPAROSCOPIC SURGERY OF NEVADA, LLC'S REPLY TO PLAINTIFFS' OPPOSITION TO MOTION TO COMPEL THE DEPOSITION OF GREGG RIPPLINGER, M.D. AND EXTEND THE CLOSE OF DISCOVERY (9TH REQUEST) ON AN ORDER SHORTENING TIME** **Date: October 15, 2019** **Time: 9:00 a.m.**

Defendants BARRY J. RIVES, M.D. and LAPAROSCOPIC SURGERY OF NEVADA, LLC ("Defendants") hereby reply to plaintiffs TITINA FARRIS and PATRICK FARRIS' Opposition to Defendants' Motion to Compel the Deposition of Gregg Ripplinger, M.D. and to Extend the Close of Discovery as follows.

Case Number: A-16-739464-C

I.

ARGUMENT

Defendants' Motion to Compel the Deposition of Gregg Ripplinger, M.D. and to Extend the Close of Discovery sought to compel the deposition of Dr. Ripplinger and to extend the close of discovery deadlines to allow for the deposition of Dr. Michael Hurwitz, which occurred on September 18, 2019, and the potential deposition of Dr. Ripplinger to occur during the permissible discovery period, so that their deposition transcripts could properly be used at the time of trial. Subsequent to the filing of their Motion, Defendants vacated the deposition of Dr. Ripplinger. Accordingly, the only remaining issue in Defendants' Motion is whether the close of discovery deadline should be extended to encompass the September 18, 2019 deposition of Dr. Hurwitz, such that the parties will be able to use the deposition transcript at the time of trial.

Plaintiffs' Opposition does not address the propriety of the request to extend the discovery deadline to cover the September 18, 2019 deposition of Dr. Hurwitz. Plaintiffs have therefore waived any opposition to the extension of the discovery deadline to encompass the September 18, 2019 deposition of Dr. Hurwitz. Accordingly, Defendants are entitled to an Order extending the discovery deadline to cover the September 18, 2019 deposition of Dr. Hurwitz.

II.

CONCLUSION

Defendants are entitled to an Order extending the close of discovery deadline under NRCP 26(b)(4)(A) to cover the mutually agreed upon deposition of Dr. Hurwitz which took place on September 18, 2019 because Defendants' failure to take the deposition of Dr. Hurwitz during the currently set discovery deadline was based on their excusable neglect created by the parties' mutual plan to continue the trial date, which

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was denied on September 5, 2019. Accordingly, Defendants respectfully request an Order extending discovery to September 18, 2019.

Dated: October 10, 2019

SCHUERING ZIMMERMAN & DOYLE, LLP

By */s/ Aimee Clark Newberry*

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CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I certify that on the 10th day of October, 2019, service of a true and correct copy of the foregoing:

DEFENDANTS BARRY RIVES, M.D.'S AND LAPAROSCOPIC SURGERY OF NEVADA, LLC'S REPLY TO PLAINTIFFS' OPPOSITION TO MOTION TO COMPEL THE DEPOSITION OF GREGG RIPPLINGER, M.D. AND EXTEND THE CLOSE OF DISCOVERY (9TH REQUEST) ON AN ORDER SHORTENING TIME

was served as indicated below:

☒ served on all parties electronically pursuant to mandatory NEFCR 4(b);

☐ served on all parties electronically pursuant to mandatory NEFCR 4(b) , exhibits to follow by U.S. Mail;

☐ by depositing in the United States Mail, first-class postage prepaid, enclosed ;

☐ by facsimile transmission; or

☐ by personal service as indicated.

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DISTRICT COURT

CLARK COUNTY, NEVADA

TITINA FARRIS and PATRICK FARRIS, Plaintiffs, vs. BARRY RIVES, M.D.; LAPAROSCOPIC SURGERY OF NEVADA, LLC, et al., Defendants.	CASE NO. A-16-739464-C DEPT. NO. 31 **DEFENDANTS BARRY RIVES, M.D.'S AND LAPAROSCOPIC SURGERY OF NEVADA, LLC'S TRIAL BRIEF REGARDING THEIR REQUEST TO PRECLUDE DEFENDANTS' EXPERT WITNESSES' INVOLVEMENT AS A DEFENDANT IN MEDICAL MALPRACTICE ACTIONS**

Defendants BARRY J. RIVES, M.D. and LAPAROSCOPIC SURGERY OF NEVADA, LLC ("Defendants") hereby provide the following trial brief in support of their position evidence

of Defendants' expert witnesses' involvement as a defendant in medical malpractice actions should be excluded. Defendants are entitled to a ruling precluding evidence of

Case Number: A-16-739464-C

their expert witnesses' involvement in other medical malpractice actions because such evidence is not relevant to this action, it will confuse the issues, waste time and mislead the jury and it is impermissible character evidence. Defendants further request the order precluding evidence of their expert witnesses' involvement in other actions for medical malpractice be reciprocal.

I.

BACKGROUND

This medical malpractice action arose from the care the Defendants provided to plaintiff TITINA FARRIS in connection with a laparoscopic hernia repair. Defendants disclosed the following expert witnesses: Dr. Bruce Adornato, Dr. Kim Erlich, Dr. Bart Carter, Dr. Brian Juell and Dr. Lance Stone.

The deposition of Dr. Carter was taken on June 13, 2019. At the deposition of Dr. Carter, Plaintiff's counsel asked Dr. Carter about his involvement as a defendant in medical malpractice actions. Exhibit 1, p. 32:30-33:12. Dr. Carter testified that he had been a defendant in a medical malpractice action 3 times. Exhibit 1, p. 32:22-23.

The deposition of Dr. Juell was taken on June 12, 2019. At the deposition of Dr. Juell, Plaintiff's counsel asked Dr. Juell about his involvement as a defendant in medical malpractice actions. Exhibit 2, p. 92:19-94:15. Dr. ~~Carter~~ Juell testified that he had been a defendant in a medical malpractice action 4 times. Exhibit 2, p. 92:22-24.

Plaintiffs' counsel failed to ask Defendants' other expert witnesses Dr. Adornato, Dr. Erlich and Dr. Stone about their involvement as a defendant in actions for medical malpractice. Defendants anticipate Plaintiffs will seek to elicit testimony from all of Defendants' expert witnesses at the time of trial regarding their prior history as a defendant in actions for medical malpractice.

II.

STATUTORY AUTHORITY

NRS 48.015 provides in pertinent part:

Relevant evidence defined. Relevant evidence means evidence having any tendency to make the existence of any fact that is of consequence to the determination of the action more or less probable than it would be without the evidence.

NRS 48.025(2) provides in pertinent part:

Evidence which is not relevant is not admissible.

NRS 48.045 provides in pertinent part:

1. Evidence of a person's character or a trait of his or her character is not admissible for the purpose of proving that the person acted in conformity therewith on a particular occasion.

. . .

NRS 48.035 provides in pertinent part:

Exclusion of relevant evidence on grounds of prejudice, confusion or waste of time.

1. Although relevant, evidence is not admissible if its probative value is substantially outweighed by the danger of unfair prejudice, of confusion of the issues or of misleading the jury.

2. Although relevant, evidence may be excluded if its probative value is substantially outweighed by considerations of undue delay, waste of time or needless presentation of cumulative evidence.

III.

ARGUMENT

A. EVIDENCE DEFENDANTS EXPERT WITNESSES WERE REMOTELY INVOLVED AS A DEFENDANT IN MEDICAL MALPRACTICE ACTIONS IS NOT RELEVANT TO ANY CAUSE OF ACTION IN THIS CASE.

Relevant evidence is evidence "having any tendency to make the existence of any fact that is of consequence to the determination of an action more or less probable than it would without the evidence." NRS 48.015. Evidence that is not relevant is in admissible. NRS 48.025(2).

In this action, Plaintiffs' only theory of liability against Defendants arises from Defendants' alleged medical malpractice. In order to prevail on a claim for medical malpractice, a plaintiff must show the defendant's conduct departed from the accepted standard of care or practice and the departure was the actual and proximate cause of the injuries suffered. *See, Prabhu v. Levine*, 112 Nev. 1538, 930 P.2d 103 (1996).

The issues of the standard of care and causation in a medical malpractice action, must be proven by expert witness testimony. NRS 41A.100(1). Expert medical testimony may only be given by a provider of health care who practices or has practiced in an area that is substantially similar to the type of practice engaged in at the time of the alleged negligence. NRS 41A.100(2).

Evidence of Defendants' expert witnesses' involvement as a defendant in other actions for medical malpractice is not relevant to Plaintiffs' cause of action for medical malpractice and such evidence is therefore inadmissible. The fact some of Defendants' expert witnesses were named and then dismissed in remote and unrelated actions for medical malpractice has no bearing on the relevant issues in this case: whether Defendants breached the standard of care, whether Defendants' care caused injury to Ms. Farris, and the measure of Plaintiffs' damages, if any.

While Defendants' expert witnesses' experience, training and education is relevant to establish their qualification as an expert witness regarding the care Defendants provided to Ms. Farris, their personal legal history is not relevant to the issue of their qualifications. Not only does their personal legal history have no bearing on whether they had the requisite experience, training and education to provide expert opinions, but the nature of the allegations in those remote and unrelated medical malpractice actions shares no similarity with the care in this case.

The fact Defendants' expert witnesses were named as a defendant in medical malpractice actions is not an element of Plaintiffs' cause of action for medical

malpractice. Such evidence has no tendency to make the existence of a fact of consequence to Plaintiffs' cause of action for medical malpractice more or less probable. Therefore, Defendants are entitled to a ruling excluding evidence of Defendants' expert witnesses' involvement in other medical malpractice actions as a defendant.

B. EVIDENCE DEFENDANTS' EXPERT WITNESSES WERE A DEFENDANT IN OTHER MEDICAL MALPRACTICE ACTIONS SHOULD BE EXCLUDED BECAUSE IT WILL CONFUSE THE ISSUES, WASTE TIME AND MISLEAD THE JURY.

Although relevant, evidence is not admissible if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues or misleading the jury. NRS 48.035(1). Defendants contend any evidence their expert witnesses were involved as a defendant in other actions for medical malpractice has no probative value, however, even if such evidence was relevant, it is inadmissible because any probative value the evidence might have would be substantially outweighed by the danger the evidence would confuse the issues, waste time and mislead the jury.

The care at issue in this case is the care Defendants provided to Ms. Farris, not the care Defendants' expert witnesses provided to any of their own patients, including those alleging medical malpractice against Defendants' expert witnesses. If the jury hears evidence of their involvement as a defendant in other actions the jurors will experience confusion regarding the limited scope of their fact finding task. Additionally, the jury may be misled by evidence the expert witnesses retained by Defendants were a defendant in medical malpractice actions. The jury may be misled to discount the expert witnesses' testimony given their involvement as a defendant in medical malpractice actions.

If the jury hears evidence Defendants' expert witnesses were named as a defendant in actions for medical malpractice, Defendants will need to put on evidence regarding the facts, and results of those actions. Accordingly, introduction of evidence

of their involvement as a defendant in other action will result in an additional expenditure and a waste of time with the expert witnesses on the witness stand to obtain all of the information necessary about their involvement in the medical malpractice actions to provide full context for the jury. Accordingly, evidence of their involvement as a defendant in other actions for medical malpractice should be excluded.

C. EVIDENCE OF DEFENDANTS' EXPERT WITNESSES' INVOLVEMENT AS A DEFENDANT IN OTHER MEDICAL MALPRACTICE ACTIONS SHOULD BE EXCLUDED BECAUSE IT IS IMPERMISSIBLE CHARACTER EVIDENCE.

Evidence of character or a character trait is inadmissible for the purpose of showing a person acted in conformity with such evidence on a particular occasion. NRS 48.045(1). Evidence of character or a character trait is admissible only in limited circumstances, including criminal actions and for attacking a person's credibility. *Id.* Defendants' expert witnesses' involvement in other actions for medical malpractice as a defendant cannot be used to show their opinions lack credibility. None of the exceptions for admitting character evidence are applicable in this action. This action is a civil action and evidence used to attack or support the credibility of a witness is limited to opinion evidence relating to truthfulness or untruthfulness pursuant to Nevada Revised Statutes 50.085(1). The expert witnesses' involvement in other medical malpractice actions is not an opinion and it does not relate to truthfulness or untruthfulness.

IV.

CONCLUSION

For the reasons set forth above, evidence Defendants' expert witnesses were a defendant in other actions for medical malpractice is not relevant, poses a risk of confusion of the issues, misleading the jury and an unnecessary consumption of time,

and it is impermissible character evidence. Accordingly, Defendants are entitled to a ruling

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excluding evidence their expert witnesses and Plaintiffs' expert witnesses were a defendant in other medical malpractice actions.

Dated: October 14, 2019

SCHUERING ZIMMERMAN & DOYLE, LLP

By */s/ Thomas J. Doyle*

THOMAS J. DOYLE
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(916) 567-0400
Attorneys for Defendants BARRY RIVES, M.D. and LAPAROSCOPIC SURGERY OF NEVADA, LLC

CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I certify that on the 14th day of October, 2019, service of a true and correct copy of the foregoing:

DEFENDANTS BARRY RIVES, M.D.'S AND LAPAROSCOPIC SURGERY OF NEVADA, LLC'S TRIAL BRIEF REGARDING THEIR REQUEST TO PRECLUDE DEFENDANTS' EXPERT WITNESSES' INVOLVEMENT AS A DEFENDANT IN MEDICAL MALPRACTICE ACTIONS

was served as indicated below:

☒ served on all parties electronically pursuant to mandatory NEFCR 4(b);

☐ served on all parties electronically pursuant to mandatory NEFCR 4(b) , exhibits to follow by U.S. Mail;

☐ by depositing in the United States Mail, first-class postage prepaid, enclosed ;

☐ by facsimile transmission; or

☐ by personal service as indicated.

Attorney	Representing	Phone/Fax/E-Mail
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An employee of Mandelbaum, Clark Newberry & Associates
1737-10881

EXHIBIT 1

DISTRICT COURT

CLARK COUNTY, NEVADA

TITINA FARRIS and PATRICK FARRIS, Plaintiffs, vs. BARRY RIVES, M.D., LAPAROSCOPIC SURGERY OF NEVADA LLC; DOES I-V, inclusive; and ROE CORPORATIONS I-V, inclusive, Defendants.	Case No. A-16-739464-C

VIDEOTAPED DEPOSITION OF BART CARTER, M.D.

Safford, Arizona
June 13, 2019
10:10 a.m.

Prepared by:
SUSAN D. BINGHAM, CR, RPR
Certificate No. 50364

Prepared for:
DISTRICT COURT

(Original)

Mr. Couchot after I'd done so.

Q. Have you done any reviews for Mr. Couchot's firm prior to this case?

A. I don't know. You could ask him, I think.

Q. Do you know how much you've been paid so far for your work on this case?

A. I haven't been paid yet.

Q. You haven't charged for your time?

A. No, sir.

Q. How much is your time so far for this to date?

A. I don't know.

Q. So in breaking down your work as an expert witness, plaintiff versus defendant cases, how would you allocate the percentage, if you could?

A. Probably 92 or 3 percent defense, 8 or 10 percent plaintiff's.

Q. Have you ever been sued for malpractice?

A. I have.

Q. Could you -- how many times?

A. Three times.

Q. Could you tell me what those cases were about.

A. Sure. I have to keep a list, which is

here. There was a -- all three of these cases were in Phoenix when I was a teaching attending at Good Samaritan on the trauma service. One case was a retained foreign body left by a cardiothoracic surgeon; the second case was a gunshot wound to the neck that was extubated prematurely by a pulmonary physician; and the third case was an arm fracture case on a trauma case, and they sued Good Samaritan and the orthopedic surgeon and I was named as part of that.

Q. If we could go to your first report.

A. Okay.

Q. Is there a date on that report?

A. There is not a date on this initial report.

Q. I'm looking at -- I'm going to go to the first paragraph. You're stating you are giving opinions to a reasonable degree of medical probability, and you state that it is your opinion Dr. Rives complied with the standard of care in the care and treatment provided to Mrs. Farris.

When you use that word "standard" -- or that phrase "standard of care," what do you mean by that?

STATE OF ARIZONA)
) ss
COUNTY OF MARICOPA)

BE IT KNOWN that the foregoing deposition was taken by me, SUSAN D. BINGHAM, CR No. 50364, a Certified Reporter for the State of Arizona; that prior to being examined, the witness named was duly sworn to testify to the whole truth; that the questions propounded and the answers of the witness thereto were taken down by me and thereafter reduced to computerized transcription under my direction and supervision; that the foregoing is a true and correct transcript of all proceedings had upon the taking of said deposition, all done to the best of my skill and ability.

I further certify that I am in no way related to any party to said action nor in any way interested in the outcome thereof.

DATED at Phoenix, Arizona, this 27th day of June, 2019.

SUSAN D. BINGHAM
CR No. 50364

EXHIBIT 2

DISTRICT COURT

CLARK COUNTY, NEVADA

TITINA FARRIS and PATRICK FARRIS,

Plaintiffs,

vs.

BARRY RIVES, M.D., LAPAROSCOPIC SURGERY OF NEVADA LLC; et al.,

Defendants.

Case No. A-16-739464-C

Dept. 31

VIDEOTAPED DEPOSITION OF BRIAN E. JUELL, M.D.

Wednesday, June 12, 2019

8:41 a.m.

Reno, Nevada

Reported by: Terry Ellis Thompson
Nevada CCR #6
Computer-Assisted Transcription

report for me.

We've marked it as an exhibit.

A Yes, I have it.

Q Okay. You make a statement on the first page, you talk about Dr. Hurwitz does not explicitly state his experience in diagnosis of anastomotic leaks.

Can you tell me what you mean by that?

A Well, he's a surgeon, I believe. And that he doesn't really indicate what his experience is with, you know, diagnosis of anastomotic leaks or suture failures, so...

Q Do you have any issue with his qualifications as a --

A No, I don't know anything about him, to tell you the truth.

I know he's a board certified surgeon. I have respect for that.

Q Have you ever been a defendant in a malpractice case?

A Yes.

Q Okay. Can you tell me about it? How many were there?

A Jeez, I've been sued four times, I think. When I was a resident, I was involved in

the care of a trauma patient that developed complication from an arterial line that ended up with limb loss.

But I was a resident and, you know, that did go to trial.

I wasn't in trial; but I was -- I think there was a settlement made on my behalf by the University. I wasn't party to that settlement resolution, but I was deposed.

You know, there was a situation where I really was trying to do the right thing for the patient, but the attending physician ultimately made the decision to try to reverse that situation, but it was too late.

So the -- then I was sued on a case here where a patient had aspiration pneumonia following a hernia repair, and the cause of the aspiration was due to a medication error by the nursing staff, you know, that led to obtundation and failure to, you know, protect his reflexes.

I was deposed, but dropped from that lawsuit.

Then I was sued on a very complicated case where the patient also had aspiration pneumonia, but developed shock and had complications following a

vascular procedure and died.

And I really didn't do anything wrong, but there was a settlement made on my behalf. I agreed to settle, and then the insurance company and arbitration led to a settlement of $150,000. That was basically risk management, you know, on behalf of the insurance company. I think, you know, they, they told me that I would probably win the case, you know, if it went to trial, but they elected not to pursue it.

And then I had a case of a nerve injury that resolved, and I was dismissed with prejudice on that case by the judge.

So I think those are the only four times that I've personally been sued.

MR. HAND: He has got to change his tape.

THE VIDEOGRAPHER: We are going off the record at 10:54. This ends Media No. 1.

(Recess taken.)

THE VIDEOGRAPHER: This is Media No. 2 in the deposition of Brian E. Juell, M.D., on June 12th, 2019.

We are back on the record at 10:56.

Please go ahead.

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STATE OF NEVADA,)
) ss.
COUNTY OF WASHOE.)

I, TERRY ELLIS THOMPSON, a Certified Court Reporter in and for the County of Washoe, State of Nevada, do hereby certify;

That on the 12th day of June, 2019, at the offices of Bonanza Reporting & Videoconferencing Center, 1111 Forest Street, Reno, Nevada, I reported the videotaped deposition of BRIAN E. JUELL, M.D., who was sworn by me and deposed in the matter entitled herein; that the reading and signing of the deposition were requested by Counsel for Defendants;

That the foregoing transcript, consisting of pages 1 through 99, is a full, true and correct transcript of my stenotype notes of said deposition to the best of my knowledge, skill and ability.

That I further certify that I am not an attorney or counsel for any of the parties, nor a relative or employee of any attorney or counsel involved in said action, nor a person financially interested in the action.

DATED: At Reno, Nevada, this 24th day of June, 2019.

Terry Ellis Thompson, Nevada CCR #6

Electronically Filed
10/14/2019 3:10 PM
Steven D. Grierson
CLERK OF THE COURT

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Attorneys for Defendants BARRY RIVES, M.D. and LAPAROSCOPIC SURGERY OF NEVADA, LLC

DISTRICT COURT

CLARK COUNTY, NEVADA

TITINA FARRIS and PATRICK FARRIS, Plaintiffs, vs. BARRY RIVES, M.D.; LAPAROSCOPIC SURGERY OF NEVADA, LLC, et al., Defendants.	CASE NO. A-16-739464-C DEPT. NO. 31 **DEFENDANTS BARRY RIVES, M.D.'s AND LAPAROSCOPIC SURGERY OF NEVADA, LLC'S TRIAL BRIEF REGARDING THE NEED TO LIMIT EVIDENCE OF PAST MEDICAL EXPENSES TO ACTUAL OUT-OF-POCKET EXPENSES OR THE AMOUNTS REIMBURSED**

Defendants BARRY J. RIVES, M.D. and LAPAROSCOPIC SURGERY OF NEVADA, LLC ("Defendants") hereby provide this Court with the following trial brief in support of their position evidence of past medical expenses must be limited to the evidence of actual out

Case Number: A-16-739464-C

of pocket expenses or the amounts reimbursed and Defendants' entitlement to introduce collateral source payments as evidence at the time of trial, pursuant to NRS 42.021.

I.

BACKGROUND

This medical malpractice action arises from the care and treatment Defendants provided to Ms. Farris in connection with a laparoscopic hernia repair. Ms. Farris claims past medical expenses.

Plaintiff had health insurance at the time of the care at issue claimed in her past medical expenses. Plaintiffs contend it was a health plan subject to ERISA. There is no evidence however that the plan was a self-funded plan.

The total amounts billed by the various healthcare providers were not the same as the total amounts actually paid for the care at issue. Plaintiff's medical bills were reduced by contractual adjustments between the insurance company and the healthcare provider. Accordingly, the amounts actually paid for the past medical expenses by Ms. Farris' health insurance company or Ms. Farris herself are substantially less than the total amounts initially billed by the healthcare providers. The total amount billed is approximately $1,750,000, of which a significantly smaller portion was actually paid.

Defendants request this Court issue a ruling precluding Plaintiffs from presenting evidence of "gross bills" where the healthcare providers have accepted less than the full amount as full payment. The Court should require that the measure of Plaintiffs' damages be limited to the amounts accepted as full payment by Ms. Farris' healthcare providers. Further, Defendants should be able to introduce evidence and question the Plaintiffs regarding any reduced amounts accepted as full payment pursuant to NRS 42.021.

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II.

LEGAL ARGUMENT

A. PLAINTIFFS' PRESENTATION OF PAST MEDICAL BILLS SHOULD BE LIMITED TO THOSE AMOUNTS ACTUALLY PAID BY THEIR INSURANCE.

Tort damages in Nevada are intended to make an aggrieved party "whole." *K-Mart v. Ponsock*, 103 Nev. 39, 49 (1987), abrogated on other grounds. They are not intended to provide a plaintiff with a windfall by awarding expenses that a plaintiff, or someone on their behalf, never paid. Nevada Pattern Jury Instruction 10.02 instructs the jury that a plaintiff may recover only "the reasonable medical expenses that Plaintiff has necessarily incurred as a result of the accident."

Unpaid medical bills are not evidence of the reasonable value of the services provided. Other courts that have directly addressed this issue have agreed a plaintiff's recovery is limited to the amounts actually paid. *See, Ward-Conde v. Smith*, 19 F.Supp.2d 539 (B.D. Va. 1998) (excluding from evidence any medical expenses which were above payment amounts specifically negotiated by health care provider, or which were written off by provider).[1] *See, Hanif v. Housing Auth.*, 200 Cal. App. 3d 635, 639 (Cal. 1988) (reversing an award which include total medical expenses billed where the bill was in excess of what Medi-Cal actually paid the hospital on Plaintiffs

[1]Non-Nevada case law is attached hereto as Exhibit 1.

behalf.); *see also Howell v. Hamilton Meats & Provisions, Inc.*, 52 Cal.4th 541, (Cal. 2011). The same sound principle should be applied in this case to bar Plaintiffs from introducing evidence beyond expenses actually paid or paid by plaintiffs themselves or their health insurance company.

In fact, Nevada has provided specific protections for health care provider defendants in terms of the abrogation of the collateral source rule in an action for medical malpractice. The abrogation of NRS 42.021 for medical malpractice actions, and the limitation of evidence of past medical expenses to the amounts actually paid and or the introduction of collateral source evidence, serves the purposes for the institution of the variety of protections afforded to healthcare providers who are defendants in medical malpractice actions under the Keep Our Doctors in Nevada (KODIN) legislation from 2004. Similarly, the opportunity for a healthcare provider defendant in a medical malpractice action to admit evidence of the plaintiff's health insurance on the issue of future medical expenses also furthers the intent and goals of KODIN.

The right to recovery on behalf of a health insurance company depends on the type of ERISA plan at issue. There are essentially two types of ERISA plans: "self funded" and "fully funded." A self funded plan is where the employer pays the benefits directly through its general assets or through a trust fund established for that purpose. With a fully funded plan, on the other hand, the employer does not pay the benefits, but rather the employer purchases a health insurance policy via the plan and the insurance company pays the expenses. A self funded plan may not be treated as insurance by state law, though there is no such prohibition applying to a fully funded plan. *See, FMC Corp., v. Holliday*, 498 US 52, 62 (1990.) Accordingly, there is no right to recovery under a fully funded ERISA plan, and as Plaintiffs have not shown evidence of Ms. Farris' plan being a self funded insurance company.

Plaintiffs should not be permitted to present evidence of gross bills, when those amounts were never paid. There would be no reason for a jury to see evidence of gross bills because these bills are both unreliable and irrelevant as to the measure of Plaintiffs' damages. Plaintiffs' damages should be limited to what was accepted by their providers as full payment. Allowing Plaintiffs to present amounts for past medical bills that were never actually paid would perpetrate a fraud on the jury and could result in the jury disregarding the amounts actually paid and awarding past medical expenses above and beyond what was actually paid. The only relevant and reliable evidence concerning Plaintiffs' medical bills is the amount accepted as full payment.

B. THIS COURT SHOULD PERMIT DEFENDANTS TO INTRODUCE EVIDENCE OF COLLATERAL SOURCE PAYMENTS PURSUANT TO NRS 42.021.

NRS 42.021 provides in relevant part:

> In an action for injury or death against a provider of health care based upon professional negligence, if the defendant so elects, the defendant may introduce evidence of any amount payable as a benefit to the plaintiff as a result of the injury or death pursuant to the United States Social Security Act, any state or federal income disability or worker's compensation act, any health, sickness or income-disability insurance, accident insurance that provides health benefits or income-disability coverage, and any contract or agreement of any group, organization, partnership or corporation to provide, pay for or reimburse the cost of medical, hospital, dental or other health care services. If the defendant elects to introduce such evidence, the plaintiff may introduce evidence of any amount that plaintiff has paid or contributed to secure his right to any insurance benefits concerning which the defendant has introduced evidence. [Emphasis added.]

As is evident from the clear language of NRS 42.021, defendants in a professional negligence case may elect to introduce evidence of collateral sources, if they so choose. This matter is clearly a professional negligence case and Defendants hereby ask this Court to apply existing Nevada law and permit them to introduce collateral sources pursuant to NRS 41.021.

The public policy behind permitting collateral evidence to be introduced is clear upon a consideration of the history of NRS 42.021. It was part of an Act proposed by Initiative Petition and approved by the Nevada voters in the 2004 general election. The Initiative, on the Ballot as Question 3 and entitled "Keep Our Doctors in Nevada" ("KODIN"), contained several sections which made various changes to the statutory framework of a medical malpractice action in Nevada. Section 9 amended Chapter 42 of the Nevada Revised Statutes so that, in an action for medical malpractice, the defendant may introduce evidence at trial of any amount payable as a benefit to the plaintiff as a result of injury or death. The Initiative was placed on the ballot to address "skyrocketing medical malpractice insurance costs [which] have resulted in a potential breakdown in the delivery of health care for the medically indigent, a denial of access to health care for the economically marginal, and the depletion of physicians such as to substantially worsen the quality of health care available to the residents of this state." When the Initiative passed, Section 9 was codified at NRS 42.021.

Pursuant to NRS 42.021, Defendants are permitted to introduce any and all benefits paid as a result of the Plaintiffs' alleged injuries. To hold otherwise, would be against the clear intent of NRS 42.021.

III.

CONCLUSION

Based upon the foregoing, Defendants respectfully request this Court prohibit Plaintiffs from offering evidence of past medical expenses which they, or any health insurance company did not pay. Further, Defendants respectfully request that this

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Court permit them to offer evidence of collateral source payments.

Dated: October 14, 2019

SCHUERING ZIMMERMAN & DOYLE, LLP

By */s/ Thomas J. Doyle*

THOMAS J. DOYLE
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Attorneys for Defendants BARRY RIVES, M.D. and LAPAROSCOPIC SURGERY OF NEVADA, LLC

CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I certify that on the 14th day of October, 2019, service of a true and correct copy of the foregoing:

DEFENDANTS BARRY RIVES, M.D.'s AND LAPAROSCOPIC SURGERY OF NEVADA, LLC'S TRIAL BRIEF REGARDING THE NEED TO LIMIT EVIDENCE OF PAST MEDICAL EXPENSES TO ACTUAL OUT-OF-POCKET EXPENSES OR THE AMOUNTS REIMBURSED

was served as indicated below:

☒ served on all parties electronically pursuant to mandatory NEFCR 4(b);

☐ served on all parties electronically pursuant to mandatory NEFCR 4(b) , exhibits to follow by U.S. Mail;

☐ by depositing in the United States Mail, first-class postage prepaid, enclosed ;

☐ by facsimile transmission; or

☐ by personal service as indicated.

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An employee of Mandelbaum, Clark Newberry & Associates
1737-10881

EXHIBIT 1

LexisNexis®

1. *Fmc Corp. v. Holliday, 498 U.S. 52*

Client/Matter: 1737-10881

Search Terms: 498 US 52, 62

Search Type: Natural Language

Narrowed by:

Content Type	Narrowed by
Cases	-None-

Fmc Corp. v. Holliday

Supreme Court of the United States

October 2, 1990, Argued ; November 27, 1990, Decided

No. 89-1048

Reporter
498 U.S. 52 *; 111 S. Ct. 403 **; 112 L. Ed. 2d 356 ***; 1990 U.S. LEXIS 6114 ****; 59 U.S.L.W. 4009; 12 Employee Benefits Cas. (BNA) 2689; 90 Cal. Daily Op. Service 8609

FMC CORPORATION, PETITIONER v. CYNTHIA ANN HOLLIDAY

Prior History: [**1]** CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT.

Disposition: *885 F. 2d 79*, vacated and remanded.

Core Terms

state law, deemer, plans, insurance company, regulate insurance, pre-emption, employee benefit plan, insurer, regulation, insurance contract, benefits, pre-empted, purporting, saving clause, subrogation, exempt, insurance business, benefit plan, self-insured, banking, investment company, trust company, provisions, insurance regulation, state regulation, reimbursement, purposes, legislative history, insurance law, antisubrogation

Case Summary

Procedural Posture

Petitioner employer sought certiorari to review a decision of the United States Court of Appeals for the Third Circuit, after it granted respondent's motion for summary judgment. The court of appeals held that *75 Pa. Cons. Stat. § 1720*, unless preempted by the Employee Retirement Income Security Act of 1974 (ERISA), *29 U.S.C.S. § 1001 et seq.*, prohibited petitioner's exercise of subrogation rights on respondent's tort recovery.

Overview

Petitioner employer provided an employee welfare benefit plan within the meaning of the Employee Retirement Income Security Act of 1974 (ERISA) for employees and their dependents. Respondent, dependent child of employee, was injured in an automobile accident. Respondent's father brought a negligence action, and petitioner attempted to seek reimbursement for the amounts it paid for respondent's medical expenses. The court vacated and remanded the court of appeals' decision, and held that ERISA preempted the application of Pennsylvania's Motor Vehicle Financial Responsibility Law, *75 Pa. Cons. Stat. § 1720*, to petitioner employer's welfare benefit plan for employees. The court held that ERISA's "deemer

clause" was not directed solely at laws governing the business of insurance; it was directed at any law of any state that regulates insurance, while the saving clause protected state insurance regulation of insurance contracts purchased by employee benefit plans. A "deemer clause" that exempted employee benefit plans from only those state regulations would encroach upon ERISA's provisions and undermine Congress's desire to avoid endless litigation over the validity of a state action.

Outcome
The court vacated and remanded the decision of the court of appeals and held that he Employee Retirement Security Act of 1974 preempted the application of Pennsylvania's Motor Vehicle Financial Responsibility Law to petitioner employer's welfare benefit plan for employees.

LexisNexis® Headnotes

Business & Corporate Compliance > ... > Workers' Compensation & SSDI > Third Party Actions > Subrogation

Insurance Law > Claim, Contract & Practice Issues > Subrogation > General Overview

HN1[↓] **Workers' Compensation, Subrogation**

See *75 Pa. Cons. Stat. § 1720* (1987).

Insurance Law > ... > Excess Insurance > Obligations > Indemnification Obligations

Insurance Law > Contract Formation > Policy Delivery

HN2[↓] **Obligations, Indemnification Obligations**

See *75 Pa. Cons. Stat. § 1719* (1987).

Civil Procedure > ... > Subject Matter Jurisdiction > Federal Questions > General Overview

Constitutional Law > Supremacy Clause > General Overview

HN3[↓] **Subject Matter Jurisdiction, Federal Questions**

In determining whether federal law pre-empts a state statute, the Supreme Court looks to congressional intent.

Pensions & Benefits Law > ERISA > Federal Preemption > General Overview

HN4[] **ERISA, Federal Preemption**

Preemption may be either express or implied, and is compelled whether Congress' command is explicitly stated in the statute's language or implicitly contained in its structure and purpose. A court begins with the language employed by Congress and the assumption that the ordinary meaning of that language accurately expresses the legislative purpose.

Pensions & Benefits Law > ERISA > Federal Preemption > Savings Clause

Pensions & Benefits Law > ERISA > Federal Preemption > General Overview

Pensions & Benefits Law > ERISA > Federal Preemption > State Laws

HN5[] **Federal Preemption, Savings Clause**

Except as provided in subsection (b) of this section, the saving clause, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan. § 514(a) of the Employee Retirement Income Security Act of 1974, *29 U.S.C.S. § 1144 (a)* (preemption clause).

Insurance Law > ... > Federal Regulations > ERISA > Deemer Clause

Pensions & Benefits Law > ERISA > Federal Preemption > Savings Clause

Pensions & Benefits Law > ERISA > Federal Preemption > General Overview

HN6[] **ERISA, Deemer Clause**

Except as provided in subparagraph (B), the deemer clause, nothing in this subchapter shall be construed to exempt or relieve any person from any law of any state which regulates insurance, banking, or securities. § 514(b)(2)(A), as set forth in *29 U.S.C.S. § 1144(b)(2)(A)* (saving clause).

Insurance Law > ... > Federal Regulations > ERISA > Deemer Clause

Pensions & Benefits Law > ERISA > Federal Preemption > Deemer Clause

Pensions & Benefits Law > ERISA > Federal Preemption > General Overview

HN7[] **ERISA, Deemer Clause**

Neither an employee benefit plan nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any state

purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies. § 514(b)(2)(B), *29 U.S.C.S. § 1144(b)(2)(B)* (deemer clause).

Insurance Law > Claim, Contract & Practice Issues > Subrogation > General Overview

***HN8*[↓] Claim, Contract & Practice Issues, Subrogation**

A law relates to an employee welfare plan if it has a connection with or reference to such a plan.

Pensions & Benefits Law > ERISA > Federal Preemption > State Laws

Pensions & Benefits Law > ERISA > Federal Preemption > General Overview

***HN9*[↓] Federal Preemption, State Laws**

Employee Retirement Security Act of 1974's preemptive scope is as broad as its language under *29 U.S.C.S. § 1144(b)(4)*.

Pensions & Benefits Law > ERISA > Federal Preemption > General Overview

***HN10*[↓] ERISA, Federal Preemption**

Where a patchwork scheme of regulation would introduce considerable inefficiencies in benefit program operation, the court applies the preemption clause to ensure that benefit plans will be governed by only a single set of regulations.

Business & Corporate Compliance > ... > Workers' Compensation & SSDI > Third Party Actions > Subrogation

Pensions & Benefits Law > Governmental Employees > State Pensions

Workers' Compensation & SSDI > Administrative Proceedings > Awards > Credits

Insurance Law > Claim, Contract & Practice Issues > Subrogation > General Overview

***HN11*[↓] Workers' Compensation, Subrogation**

Application of differing state subrogation laws to plans would frustrate plan administrators' continuing obligation to calculate uniform benefit levels nationwide. The most efficient way to meet these administrative responsibilities is to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits.

Contracts Law > Contract Conditions & Provisions > General Overview

Insurance Law > ... > Federal Regulations > ERISA > Deemer Clause

Contracts Law > Third Parties > Subrogation

Insurance Law > Claim, Contract & Practice Issues > Subrogation > General Overview

Pensions & Benefits Law > ERISA > Federal Preemption > General Overview

HN12[⬇] **Contracts Law, Contract Conditions & Provisions**

75 Pa. Cons. Stat. § 1720 directly controls the terms of insurance contracts by invalidating any subrogation provisions that they contain. It does not merely have an impact on the insurance industry; it is aimed at it.

Antitrust & Trade Law > Exemptions & Immunities > McCarran-Ferguson Act Exemption

Insurance Law > ... > Federal Regulations > ERISA > Deemer Clause

Insurance Law > ... > Alternative Risk Transfers > Self Insurance > General Overview

Insurance Law > Industry Practices > General Overview

HN13[⬇] **Exemptions & Immunities, McCarran-Ferguson Act Exemption**

The business of insurance, and every person engaged therein, shall be subject to the laws of the several states which relate to the regulation or taxation of such business. *15 U.S.C.S. § 1012(a)*. This includes not only direct regulation of the insurer but also regulation of the substantive terms of insurance contracts.

Insurance Law > ... > Federal Regulations > ERISA > Deemer Clause

Pensions & Benefits Law > ERISA > Federal Preemption > Deemer Clause

Insurance Law > Industry Practices > Federal Regulations > General Overview

Pensions & Benefits Law > ERISA > Federal Preemption

Pensions & Benefits Law > ERISA > Federal Preemption > General Overview

Pensions & Benefits Law > ERISA > Federal Preemption > Savings Clause

HN14[⬇] **ERISA, Deemer Clause**

Congress intended by the Employee Retirement Security Act of 1974 to establish pension plan regulation as exclusively a federal concern.

Lawyers' Edition Display

Decision

Application of state statute, prohibiting exercise of subrogation rights on tort recovery, to employee welfare benefit plan held pre-empted by ERISA (*29 USCS 1001 et seq.*).

Summary

Section 514(a) of the Employee Retirement Income Security Act of 1974 (ERISA) (*29 USCS 1144(a)*), states that except as provided by 514(b), ERISA supersedes all state laws insofar as they may relate to any employee benefit plan. Section 514(b) contains a "saving clause" (*29 USCS 1144(b)(2)(A)*), which reserves to the states the power to enforce state laws regulating insurance, and a "deemer clause" (*29 USCS 1144(b)(2)(B)*), which provides that an employee benefit plan governed by ERISA shall not be deemed an insurance company, an insurer, or engaged in the business of insurance for the purposes of any state law purporting to regulate insurance companies or insurance contracts. A Pennsylvania statute provides that in actions arising out of the maintenance or use of a motor vehicle, there shall be no right of subrogation or reimbursement from a claimant's tort recovery with respect to benefits payable under any program, group contract, or other arrangement for the payment of benefits. The daughter of an employee covered by an employee welfare benefit plan was injured in an automobile accident, and the plan paid a portion of her medical expenses. The plan was self-funded and did not purchase any insurance policy to satisfy its obligations. The provisions of the plan included a subrogation clause under which a plan member agreed to reimburse the plan for benefits paid if the member recovered on a liability claim against a third party. The employee brought a negligence action in Pennsylvania state court against the driver of the automobile in which his daughter was injured. The claim was settled. While the action was pending, the employer notified the employee that it would seek reimbursement for the amounts the plan had paid for his daughter's medical expenses. The employee and his daughter contended that the Pennsylvania statute precluded such reimbursement. The employee's daughter filed a diversity action in the United States District Court for the Western District of Pennsylvania and obtained a declaratory judgment that the Pennsylvania statute prohibited the employer's exercise of subrogation rights. On appeal, the United States Court of Appeals for the Third Circuit affirmed, holding that (1) the Pennsylvania statute, unless pre-empted, barred the employer from enforcing the plan's subrogation provision; and (2) ERISA did not pre-empt the Pennsylvania statute, inasmuch as ERISA's deemer clause (a) was meant mainly to reach back-door attempts by states to regulate core ERISA concerns in the guise of insurance regulation, and (b) did not exempt the employer's plan from state subrogation laws (*885 F2d 79*).

On certiorari, the United States Supreme Court reversed and remanded. In an opinion by O'Connor, J., joined by Rehnquist, Ch. J., and White, Marshall, Blackmun, Scalia, and Kennedy, JJ., it was held that ERISA pre-empted the application of the Pennsylvania statute to the employer's plan, because (1) the Pennsylvania statute "relate[s] to" an employee benefit plan within the meaning of 514(a) of ERISA, inasmuch as (a) the Pennsylvania statute has a reference to benefit plans governed by ERISA, and (b) it also has a connection to ERISA benefit plans; (2) although the Pennsylvania statute falls within ERISA's saving clause permitting states

to regulate insurance except as provided by the deemer clause, the deemer clause, by forbidding states to deem an employee benefit plan to be an insurance company, an insurer, or engaged in the business of insurance, exempts self-funded ERISA plans from state laws regulating insurance, although plans that are insured are subject to indirect state insurance regulation insofar as such regulation applies to the plans' insurers; and (3) interpretations of the deemer clause as excepting from the saving clause only state insurance regulations that are pretexts for impinging upon core ERISA concerns, or only state statutes that apply to insurance as a business, are not supported by ERISA's language.

Stevens, J., dissented, expressing the view that (1) while ERISA's saving clause exempts from pre-emption all state laws that have the broad effect of regulating insurance, the deemer clause allows pre-emption of only those state laws that expressly regulate insurance; and (2) the Pennsylvania statute fits into the broader category of laws that fall within the saving clause only.

Souter, J., did not participate.

Headnotes

COURTS §775 > PENSIONS AND RETIREMENT FUNDS §1 > STATES, TERRITORIES, AND POSSESSIONS §46 > STATUTES §91 > state law prohibiting subrogation -- pre-emption by ERISA -- consistency with prior decision -- congressional intent -- > Headnote:
LEdHN[1A][⬇] [1A]***LEdHN[1B]***[⬇] [1B]***LEdHN[1C]***[⬇] [1C]***LEdHN[1D]***[⬇] [1D]***LEdHN[1E]***[⬇] [1E]***LEdHN[1F]***[⬇] [1F]***LEdHN[1G]***[⬇] [1G]

The application of a state statute--which statute provides that in actions arising out of the maintenance or use of a motor vehicle, there shall be no right of subrogation or reimbursement from a claimant's tort recovery with respect to benefits payable under any program, group contract, or other arrangement for the payment of benefits--to a self-funded employee welfare benefit plan, which provides for reimbursement for benefits paid to a plan member if the member recovers on a claim in a liability action against a third party, is pre-empted by the Employee Retirement Income Security Act of 1974 (ERISA) (*29 USCS 1001 et seq.*), because (1) 514(a) of ERISA (*29 USCS 1144(a)*) states that except as provided by 514(b), ERISA supersedes all state laws insofar as they may relate to any employee benefit plan; (2) the state statute relates to an employee benefit plan, inasmuch as a law relates to an employee benefit plan if it has a connection with or reference to such a plan, and the state statute (a) has a reference to benefit plans covered by ERISA, and (b) also has a connection to ERISA benefit plans, because it (i) prohibits plans from being structured so as to require reimbursement in the event of recovery from a third party, and (ii) requires plan providers in that state to calculate benefit levels based on expected liability conditions that differ from those in states that have not enacted similar legislation; (3) application of different state subrogation laws to plans would frustrate plan administrators' continuing obligation to calculate uniform benefit levels nationwide; (4) although the state statute falls within the saving clause of 514(b)(2)(A) of ERISA (*29 USCS 1144(b)(2)(A)*), permitting states to regulate insurance except as provided by ERISA's deemer clause (*29 USCS 1144(b)(2)(B)*), the deemer clause, by forbidding states to deem an employee

benefit plan to be an insurance company, an insurer, or engaged in the business of insurance, exempts self-funded ERISA plans from state laws regulating insurance, although plans that are insured are subject to indirect state insurance regulation insofar as such regulation applies to the plan's insurer; (5) this reading of the deemer clause (a) is consistent with a prior Supreme Court decision under ERISA which distinguished between insured plans and self-funded plans, and left the former, but not the latter, open to indirect state regulation, (b) is respectful of the presumption that Congress does not intend to pre-empt areas of traditional state regulation, and (c) protects employers from conflicting or inconsistent state and local regulation of employee benefit plans; and (6) interpretations of the deemer clause as excepting from the saving clause only state insurance regulations that are pretexts for impinging upon core ERISA concerns, or only state statutes that apply to insurance as a business, are not supported by ERISA's language, would be fraught with administrative difficulties, and would, contrary to congressional intent, lead to the expenditure of plan funds in litigation to define core ERISA concerns and what constitutes business activity. (Stevens, J., dissented from this holding.)

STATES, TERRITORIES, AND POSSESSIONS §22 > STATUTES §164 > pre-emption of state law -- congressional intent -- language used -- > Headnote:
LEdHN[2][⬇] [2]

In determining whether federal law pre-empts a state statute, the United States Supreme Court looks to congressional intent; the court begins with the language employed by Congress and the assumption that the ordinary meaning of that language accurately expresses the legislative purpose.

STATES, TERRITORIES, AND POSSESSIONS §21 > federal law -- express or implied pre-emption -- > Headnote:
LEdHN[3][⬇] [3]

Federal pre-emption of a state statute may be either express or implied, and is compelled whether Congress' command is explicitly stated in the statute's language or implicitly contained in its structure and purpose.

PENSIONS AND RETIREMENT FUNDS §1 > STATES, TERRITORIES, AND POSSESSIONS §38 > STATUTES §110 > employee benefit plans -- state laws -- pre-emption by ERISA -- other provisions of statute -- > Headnote:
LEdHN[4][⬇] [4]

The words "relate to" in 514(a) of the Employee Retirement Income Security Act (ERISA) (29 USCS 1144(a))--which states that, except as provided by 514(b) (29 USCS 1144(b)), the provisions of ERISA "shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan"--are used in their broad sense, and do not mean to pre-empt only state laws specifically designed to affect employee benefit plans, as that interpretation would have made it unnecessary for Congress to enact 514(b)(4) of ERISA (29 USCS 1144(b)(4)), which exempts from pre-emption generally applicable criminal laws of a state.

PENSIONS AND RETIREMENT FUNDS §1 > STATES, TERRITORIES, AND POSSESSIONS §38 > pension plan regulation -- federal pre-emption -- > Headnote:
LEdHN[5][⬇] [5]

The Employee Retirement Income Security Act (ERISA) (29 USCS 1001 et seq.) is intended to establish pension plan regulation as exclusively a federal concern.

Syllabus

After petitioner FMC Corporation's self-funded health care plan (Plan) paid a portion of respondent's medical expenses resulting from an automobile accident, FMC informed respondent that it would seek reimbursement under the Plan's subrogation provision from any recovery she realized in her Pennsylvania negligence action against the driver of the vehicle in which she was injured. Respondent obtained a declaratory judgment in Federal District Court that § 1720 of Pennsylvania's Motor Vehicle Financial Responsibility Law -- which precludes reimbursement from a claimant's tort recovery for benefit payments by a program, group contract, or other arrangement -- prohibits FMC's exercise of subrogation rights. The Court of Appeals **[****2]** affirmed, holding that the Employee Retirement Income Security Act of 1974 (ERISA), which applies to employee welfare benefit plans such as FMC's, does not pre-empt § 1720.

Held: ERISA pre-empts the application of § 1720 to FMC's Plan. Pp. 56-65.

(a) ERISA's pre-emption clause broadly establishes as an area of exclusive federal concern the subject of every state law that "relate[s] to" a covered employee benefit plan. Although the statute's saving clause returns to the States the power to enforce those state laws that "regulate insurance," the deemer clause provides that a covered plan shall not be "deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance" for purposes of state laws "purporting to regulate" insurance companies or insurance contracts. Pp. 56-58.

(b) Section 1720 "relate[s] to" an employee benefit plan within the meaning of ERISA's pre-emption provision, since it has both a "connection with" and a "reference to" such a plan. See Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 96-97, 77 L. Ed. 2d 490, 103 S. Ct. 2890. Moreover,

although there is no dispute that *§ 1720* "regulates **[****3]** insurance," ERISA's deemer clause demonstrates Congress' clear intent to exclude from the reach of the saving clause self-funded ERISA plans by relieving them from state laws "purporting to regulate insurance." Thus, such plans are exempt from state regulation insofar as it "relates to" them. State laws directed toward such plans are pre-empted because they relate to an employee benefit plan but are not "saved" because they do not regulate insurance. State laws that directly regulate insurance are "saved" but do not reach self-funded plans because the plans may not be deemed to be insurance companies, other insurers, or engaged in the business of insurance for purposes of such laws. On the other hand, plans that are insured are subject to indirect state insurance regulation insofar as state laws "purporting to regulate insurance" apply to the plans' insurers and the insurers' insurance contracts. This reading of the deemer clause is consistent with *Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 735, n.14, 747, 85 L. Ed. 2d 728, 105 S. Ct. 2380*, and is respectful of the presumption that Congress does not intend to pre-empt areas of traditional state **[****4]** regulation, see *Jones v. Rath Packing Co., 430 U.S. 519, 525, 51 L. Ed. 2d 604, 97 S. Ct. 1305*, including regulation of the "business of insurance," see *Metropolitan Life Ins. Co. v. Massachusetts, supra, at 742-744*. Narrower readings of the deemer clause -- which would interpret the clause to except from the saving clause only state insurance regulations that are pretexts for impinging on core ERISA concerns or to preclude States from deeming plans to be insurers only for purposes of state laws that apply to insurance as a business, such as laws relating to licensing and capitalization requirements -- are unsupported by ERISA's language and would be fraught with administrative difficulties, necessitating definition of core ERISA concerns and of what constitutes business activity, and thereby undermining Congress' expressed desire to avoid endless litigation over the validity of state action and requiring plans to expend funds in such litigation. Pp. 58-65.

Counsel: H. Woodruff Turner argued the cause for petitioner. With him on the briefs was Charles Kelly.

Deputy Solicitor General Shapiro argued the cause for the United States as amicus **[****5]** curiae urging reversal. With him on the brief were Solicitor General Starr, Christopher J. Wright, Allen H. Feldman, Steven J. Mandel, and Mark S. Flynn.

Charles Rothfeld argued the cause for respondent. On the brief were Thomas G. Johnson and David A. Cicola. *

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* Briefs of amici curiae urging reversal were filed for the Central States, Southeast and Southwest Area Health and Welfare Fund by Anita M. D'Arcy, James L. Coghlan, and William J. Nellis; for the Chamber of Commerce of the United States of America by Harry A. Rissetto, E. Carl Uehlein, Jr., and Stephen A. Bokat; for the National Coordinating Committee for Multiemployer Plans by Gerald M. Feder, David R. Levin, and Diana L. S. Peters; for the Teamsters Health and Welfare Fund of Philadelphia & Vicinity et al. by James D. Crawford, James J. Leyden, Henry M. Wick, Jr., and Jack G. Mancuso; and for Travelers Insurance Co. by A. Raymond Randolph, M. Duncan Grant, and Waltraut S. Addy.

Briefs of amici curiae urging affirmance were filed for the American Chiropractic Association by George P. McAndrews and Robert C. Ryan; for the American Optometric Association by Ellis Lyons, Bennett Boskey, and Edward A. Groobert; for the National Conference of State Legislatures et al. by Benna Ruth Solomon and Charles Rothfeld; and for the Pennsylvania Trial Lawyers Association by John Patrick Lydon.

Briefs of amici curiae were filed for the American Podiatric Medical Association by Wemer Strupp; and for the Self-Insurance Institute of America, Inc., by George J. Pantos.

[**6]**

Judges: O'CONNOR, J., delivered the opinion of the Court, in which REHNQUIST, C. J., and WHITE, MARSHALL, BLACKMUN, SCALIA, and KENNEDY, JJ., joined. STEVENS, J., filed a dissenting opinion, post, p. 65. SOUTER, J., took no part in the consideration or decision of the case.

Opinion by: O'CONNOR

Opinion

[*54] [*362] [**405]** JUSTICE O'CONNOR delivered the opinion of the Court.

LEdHN[1A][↑] [1A]This case calls upon the Court to decide whether the Employee Retirement Income Security Act of 1974 (ERISA), 88 Stat. 829, as amended, *29 U. S. C. § 1001 et seq.*, pre-empts a Pennsylvania law precluding employee welfare benefit plans from exercising subrogation rights on a claimant's tort recovery.

I

Petitioner, FMC Corporation (FMC), operates the FMC Salaried Health Care Plan (Plan), an employee welfare benefit plan within the meaning of ERISA, § 3(1), *29 U. S. C. § 1002(1)*, that provides health benefits to FMC employees and their dependents. The Plan is self-funded; it does not purchase an insurance policy from any insurance company in order to satisfy its obligations **[****7]** to its participants. Among its provisions is a subrogation clause under which a Plan member agrees to reimburse the Plan for benefits **[**406]** paid if the member recovers on a claim in a liability action against a third party.

Respondent, Cynthia Ann Holliday, is the daughter of FMC employee and Plan member Gerald Holliday. In 1987, **[*55]** she was seriously injured in an automobile accident. The Plan paid a portion of her medical expenses. Gerald Holliday brought a negligence action on behalf of his daughter in Pennsylvania state court against the driver of the automobile in which she was injured. The parties settled the claim. While the action was pending, FMC notified the Hollidays that it would seek reimbursement for the amounts it had paid for respondent's medical expenses. The Hollidays replied that they would not reimburse the Plan, asserting that *§ 1720* of Pennsylvania's Motor Vehicle Financial Responsibility Law, *75 Pa. Cons. Stat. § 1720* (1987), precludes subrogation by FMC. *Section 1720* states that "in actions arising out of the maintenance or use of a motor vehicle, there shall be no right of subrogation or reimbursement from a claimant's tort recovery with respect **[****8]** to . . . benefits . . . payable under *section 1719*." [1] *Section 1719* refers to benefit payments by "any program, group contract or other arrangement." [2]

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[1] *Section 1720* of Pennsylvania's Motor Vehicle Financial Responsibility Law is entitled "subrogation" and provides:

[**9]** **[*56]** Petitioner, **[***363]** proceeding in diversity, then sought a declaratory judgment in Federal District Court. The court granted respondent's motion for summary judgment, holding that *§ 1720* prohibits FMC's exercise of subrogation rights on Holliday's claim against the driver. The United States Court of Appeals for the Third Circuit affirmed. *885 F.2d 79 (1989)*. The court held that *§ 1720*, unless pre-empted, bars FMC from enforcing its contractual subrogation provision. According to the court, ERISA pre-empts *§ 1720* if ERISA's "deemer clause," § 514(b)(2)(B), *29 U. S. C. § 1144(b)(2)(B)*, exempts the Plan from state subrogation laws. The Court of Appeals, citing *Northern Group Services, Inc. v. Auto Owners Ins. Co., 833 F.2d 85, 91-94 (CA6 1987)*, cert. denied, *486 U.S. 1017, 100 L. Ed. 2d 216, 108 S. Ct. 1754 (1988)*, determined that "the deemer clause [was] meant mainly to reach back-door attempts by states to regulate core ERISA concerns in the guise of insurance regulation." *885 F.2d at 86*. Pointing out that the parties had not suggested that the Pennsylvania antisubrogation **[****10]** law addressed "a core type of ERISA matter which Congress sought to protect by the preemption provision," *id., at 90*, the court concluded that the Pennsylvania law is not pre-empted. The Third Circuit's holding conflicts with decisions of other Courts of Appeals that have construed ERISA's deemer clause to protect self-funded plans from all state insurance regulation. See, *e.g., Baxter v. Lynn, 886 F.2d 182, 186 (CA8 1989)*; *Reilly v. Blue Cross and Blue Shield United of Wisconsin, **[**407]** 846 F.2d 416, 425-426* (CA7), cert. denied, *488 U.S. 856, 102 L. Ed. 2d 117, 109 S. Ct. 145 (1988)*. We granted certiorari to resolve this conflict, *493 U.S. 1068 (1990)*, and now vacate and remand.

II

LEdHN[1B] [1B]***LEdHN[2]*** [2]***LEdHN[3]*** [3]***HN3*** In determining whether federal law pre-empts a state statute, we look to congressional intent. "' **[****11]** ***HN4*** Pre-emption may be either express or implied, and "is compelled whether Congress' **[*57]** command is explicitly stated in the statute's language or implicitly contained in its structure and purpose."'" *Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 95, 77 L. Ed. 2d 490, 103 S. Ct. 2890 (1983)* (quoting *Fidelity Federal Savings & Loan Assn. v. De la Cuesta, 458 U.S. 141, 152-153, 73 L. Ed. 2d 664, 102 S. Ct. 3014 (1982)*, in turn quoting *Jones v. Rath Packing Co., 430 U.S. 519, 525, 51 L. Ed. 2d 604, 97 S. Ct. 1305 (1977)*); see also *Chevron U. S. A. Inc. v. Natural Resources*

HN1 "In actions arising out of the maintenance or use of a motor vehicle, there shall be no right of subrogation or reimbursement from a claimant's tort recovery with respect to workers' compensation benefits, benefits available under section 1711 (relating to required benefits), 1712 (relating to availability of benefits) or 1715 (relating to availability of adequate limits) or benefits in lieu thereof paid or payable under *section 1719* (relating to coordination of benefits)."

[2] *Section 1719*, entitled "coordination of benefits," reads:

HN2 "(a) General rule. – Except for workers' compensation, a policy of insurance issued or delivered pursuant to this subchapter shall be primary. Any program, group contract or other arrangement for payment of benefits such as described in section 1711 (relating to required benefits), 1712(1) and (2) (relating to availability of benefits) or 1715 (relating to availability of adequate limits) shall be construed to contain a provision that all benefits provided therein shall be in excess of and not in duplication of any valid and collectible first party benefits provided in section 1711, 1712 or 1715 or workers' compensation.

"(b) Definition. -- As used in this section the term 'program, group contract or other arrangement' includes, but is not limited to, benefits payable by a hospital plan corporation or a professional health service corporation subject to 40 Pa. C. S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations)."

Defense Council, Inc., 467 U.S. 837, 842-843, 81 L. Ed. 2d 694, 104 S. Ct. 2778 (1984) ("If the intent of Congress is clear, that is the end of the matter; for the court . . . must give effect to the unambiguously expressed intent of Congress" (footnote omitted)). We "begin with the language employed by Congress and the assumption that the ordinary meaning of that language accurately expresses the legislative purpose." *Park ' N Fly, Inc. v. Dollar Park and Fly, Inc., 469 U.S. 189, 194, 83 L. Ed. 2d 582, 105 S. Ct. 658 (1985)*. **[****12]** Three provisions of ERISA speak expressly to the question of pre-emption:

> ***HN5***[↑] " **[***364]** Except as provided in subsection (b) of this section [the saving clause], the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." § 514(a), as set forth in *29 U. S. C. § 1144 (a)* (pre-emption clause).
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> ***HN6***[↑] "Except as provided in subparagraph (B) [the deemer clause], nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." § 514(b)(2)(A), as set forth in *29 U. S. C. § 1144(b)(2)(A)* (saving clause).
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> ***HN7***[↑] "Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, **[****13]** trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or **[*58]** investment companies." § 514(b)(2)(B), *29 U. S. C. § 1144(b)(2)(B)* (deemer clause).

LEdHN[1C][↑] [1C]We indicated in *Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 85 L. Ed. 2d 728, 105 S. Ct. 2380 (1985)*, that these provisions "are not a model of legislative drafting." *Id., at 739*. Their operation is nevertheless discernible. The pre-emption clause is conspicuous for its breadth. It establishes as an area of exclusive federal concern the subject of every state law that "relate[s] to" an employee benefit plan governed by ERISA. The saving clause returns to the States the power to enforce those state laws that "regulate insurance," except as provided in the deemer clause. Under the deemer clause, an employee benefit plan governed by ERISA shall not be "deemed" an insurance company, an insurer, or engaged **[****14]** in the business of insurance for purposes of state laws "purporting to regulate" insurance companies or insurance contracts.

III

LEdHN[1D][↑] [1D]***LEdHN[4]***[↑] [4]Pennsylvania's antisubrogation law "relate[s] to" an employee benefit plan. We made clear in *Shaw v. Delta Air Lines, supra*, that ***HN8***[↑] a law relates to an employee welfare plan if it has "a connection with or reference to such a plan." *463 U.S. 85, 96-97, 103 S. Ct. 2890, 77 L. Ed. 2d 490* (footnote omitted). **[**408]** We based our reading in part on the plain language of the statute. Congress used the words "'relate to' in § 514(a) [the pre-emption clause] in their broad sense." *Id., at 98*.It did not mean to pre-empt only state laws specifically designed to affect employee benefit plans. That interpretation would have made it unnecessary for Congress to enact ERISA § 514(b)(4), *29 U. S. C. § 1144(b)(4)*, which

exempts from pre-emption **[****15]** "generally" applicable criminal laws of a State. We also emphasized that to interpret the pre-emption clause to apply only to state laws dealing with the subject matters covered by ERISA, such as reporting, disclosure, and fiduciary duties, would be incompatible with the provision's legislative history because the House and **[***365]** Senate versions of the bill that became ERISA **[*59]** contained limited pre-emption clauses, applicable only to state laws relating to specific subjects covered by ERISA. [3] These were rejected in favor of the present language in the Act, "indicating that the section's ***HN9*** pre-emptive scope was as broad as its language." *Shaw v. Delta Air Lines, 463 U.S. at 98*.

[**16]**

LEdHN[1E] [1E]Pennsylvania's antisubrogation law has a "reference" to benefit plans governed by ERISA. The statute states that "in actions arising out of the maintenance or use of a motor vehicle, there shall be no right of subrogation or reimbursement from a claimant's tort recovery with respect to . . . benefits . . . paid or payable under *section 1719*." *75 Pa. Cons. Stat. § 1720* (1987). *Section 1719* refers to "any program, group contract or other arrangement for payment of benefits." These terms "include, *but [are] not limited to*, benefits payable by a hospital plan corporation or a professional health service corporation." *§ 1719* (emphasis added).

The Pennsylvania statute also has a "connection" to ERISA benefit plans. In the past, we have not hesitated to apply ERISA's pre-emption clause to state laws that risk subjecting plan administrators to conflicting state regulations. See, *e. g., Shaw v. Delta Air Lines, supra, at 95-100* (state laws making unlawful plan provisions that discriminate on the basis of pregnancy and requiring plans to provide specific benefits "relate to" benefit **[****17]** plans); *Alessi v. Raybestos-Manhattan, [*60] Inc., 451 U.S. 504, 523-526 (1981)* (state law prohibiting plans from reducing benefits by amount of workers' compensation awards "relate[s] to" employee benefit plan). To require plan providers to design their programs in an environment of differing state regulations would complicate the administration of nationwide plans, producing inefficiencies that employers might offset with decreased benefits. See *Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 10, 96 L. Ed. 2d 1, 107 S. Ct. 2211 (1987)*. Thus, ***HN10*** where a "patchwork scheme of regulation would introduce considerable inefficiencies in benefit program operation," we have applied the pre-emption clause to ensure that benefit plans will be governed by only a single set of regulations. *Id., at 11*.

Pennsylvania's antisubrogation law prohibits plans from being structured in a manner requiring reimbursement in the event of recovery from a third party. It requires plan providers to calculate benefit levels in Pennsylvania based on **[****18]** expected liability conditions that differ from those in States that have not enacted similar antisubrogation legislation. **[**409]** ***HN11*** Application of differing state **[***366]** subrogation laws to plans would therefore frustrate plan

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[3] The bill introduced in the Senate and reported out of the Committee on Labor and Public Welfare would have pre-empted "any and all laws of the States and of political subdivisions thereof insofar as they may now or hereafter relate to the subject matters regulated by this Act." S. 4, 93d Cong., 1st Sess., § 609(a) (1973). As introduced in the House, the bill that became ERISA would have superseded "any and all laws of the States and of the political subdivisions thereof insofar as they may now or hereafter relate to the fiduciary, reporting, and disclosure responsibilities of persons acting on behalf of employee benefit plans." H. R. 2, 93d Cong., 1st Sess., § 114 (1973). The bill was approved by the Committee on Education and Labor in a slightly modified form. See H. R. 2, 93d Cong., 1st Sess., § 514(a) (1973).

administrators' continuing obligation to calculate uniform benefit levels nationwide. Accord, *Alessi v. Raybestos-Manhattan, Inc., supra* (state statute prohibiting offsetting worker compensation payments against pension benefits pre-empted since statute would force employer either to structure all benefit payments in accordance with state statute or adopt different payment formulae for employers inside and outside State). As we stated in *Fort Halifax Packing Co. v. Coyne, supra, at 9*, "the most efficient way to meet these [administrative] responsibilities is to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits."

There is no dispute that the Pennsylvania law falls within ERISA's insurance saving clause, which provides, **[****19]** "*except as provided in [the deemer clause]*, nothing in this subchapter **[*61]** shall be construed to exempt or relieve any person from any law of any State which regulates insurance," § 514(b)(2)(A), *29 U. S. C. § 1144(b)(2)(A)* (emphasis added). *Section 1720* ***HN12***[↑] directly controls the terms of insurance contracts by invalidating any subrogation provisions that they contain. See *Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. at 740-741*. It does not merely have an impact on the insurance industry; it is aimed at it. See *Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 50, 95 L. Ed. 2d 39, 107 S. Ct. 1549 (1987)*. This returns the matter of subrogation to state law. Unless the statute is excluded from the reach of the saving clause by virtue of the deemer clause, therefore, it is not pre-empted.

We read the deemer clause to exempt self-funded ERISA plans from state laws that "regulate insurance" within the meaning of the saving clause. By forbidding States to deem employee benefit plans "to be an insurance company **[****20]** or other insurer . . . or to be engaged in the business of insurance," the deemer clause relieves plans from state laws "purporting to regulate insurance." As a result, self-funded ERISA plans are exempt from state regulation insofar as that regulation "relate[s] to" the plans. State laws directed toward the plans are pre-empted because they relate to an employee benefit plan but are not "saved" because they do not regulate insurance. State laws that directly regulate insurance are "saved" but do not reach self-funded employee benefit plans because the plans may not be deemed to be insurance companies, other insurers, or engaged in the business of insurance for purposes of such state laws. On the other hand, employee benefit plans that are insured are subject to indirect state insurance regulation. An insurance company that insures a plan remains an insurer for purposes of state laws "purporting to regulate insurance" after application of the deemer clause. The insurance company is therefore not relieved from state insurance regulation. The ERISA plan is consequently bound by state insurance regulations insofar as they apply to the plan's insurer.

[*62] Our reading of the **[****21]** deemer clause is consistent with *Metropolitan Life Ins. Co. v. Massachusetts, supra.* That case involved a Massachusetts **[***367]** statute requiring certain self-funded benefit plans and insurers issuing group health policies to plans to provide minimum mental health benefits. *471 U.S. 724, 734, 105 S. Ct. 2380, 85 L. Ed. 2d 728*. In pointing out that Massachusetts had never tried to enforce the portion of the statute pertaining directly to benefit plans, we stated, "in light of ERISA's 'deemer clause,' which states that a benefit plan shall not 'be deemed an insurance company' for purposes of the insurance saving clause, Massachusetts has never tried to enforce [the statute] as applied to benefit plans directly, effectively conceding that such an application of [the statute] would be pre-empted by ERISA's pre-emption clause." *Id., at 735, n.14* (citations omitted). We concluded that the statute, as

applied to insurers of **[**410]** plans, was not pre-empted because it regulated insurance and was therefore saved. Our decision, we acknowledged, "results in a distinction between insured and uninsured plans, leaving the former **[****22]** open to indirect regulation while the latter are not." *Id., at 747*. "By so doing, we merely give life to a distinction created by Congress in the 'deemer clause,' a distinction Congress is aware of and one it has chosen not to alter." *Ibid.* (footnote omitted).

Our construction of the deemer clause is also respectful of the presumption that Congress does not intend to pre-empt areas of traditional state regulation. See *Jones v. Rath Packing Co., 430 U.S. at 525*. In the McCarran-Ferguson Act, 59 Stat. 33, as amended, *15 U. S. C. § 1011 et seq.*, Congress provided that ***HN13***[↑] the "business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business." *15 U. S. C. § 1012(a)*. We have identified laws governing the "business of insurance" in the Act to include not only direct regulation of the insurer but also regulation of the substantive terms of **[**411]** insurance contracts. *Metropolitan Life Ins. Co. v. Massachusetts, supra, at 742-744*. **[****23]** **[*63]** By recognizing a distinction between insurers of plans and the contracts of those insurers, which are subject to direct state regulation, and self-insured employee benefit plans governed by ERISA, which are not, we observe Congress' presumed desire to reserve to the States the regulation of the "business of insurance."

Respondent resists our reading of the deemer clause and would attach to it narrower significance. According to the deemer clause, "neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State *purporting* to regulate insurance companies [or] insurance contracts." § 514(b)(2)(B), *29 U. S. C. § 1144(b)(2)(B)* (emphasis added). Like the Court of Appeals, respondent would interpret the deemer clause to except from the saving clause only state insurance regulations that are pretexts for impinging upon core ERISA concerns. The National Conference of State Legislatures et al. as *amici curiae* in support of respondent **[****24]** offer an alternative interpretation of the deemer **[***368]** clause. In their view, the deemer clause precludes States from deeming plans to be insurers only for purposes of state laws that apply to insurance as a business, such as laws relating to licensing and capitalization requirements.

These views are unsupported by ERISA's language. Laws that *purportedly* regulate insurance companies or insurance contracts are laws having the " appearance of" regulating or "intending" to regulate insurance companies or contracts. Black's Law Dictionary 1236 (6th ed. 1990). Congress' use of the word does not indicate that it directed the deemer clause solely at deceit that it feared state legislatures would practice. Indeed, the Conference Report, in describing the deemer clause, omits the word "purporting," stating, "an employee benefit plan is not to be considered as an insurance company, bank, trust company, or investment **[*64]** company (and is not to be considered as engaged in the business of insurance or banking) for purposes of any State law that regulates insurance companies, insurance contracts, banks, trust companies, or investment companies." H. R. Conf. Rep. No. 93-1280, p. **[****25]** 383 (1974).

Nor, in our view, is the deemer clause directed solely at laws governing the business of insurance. It is plainly directed at "any law of any State purporting to regulate insurance

companies, insurance contracts, banks, trust companies, or investment companies." § 514(b)(2)(B), *29 U. S. C. § 1144(b)(2)(B)*. Moreover, it is difficult to understand why Congress would have included *insurance contracts* in the pre-emption clause if it meant only to pre-empt state laws relating to the operation of insurance as a business. To be sure, the saving and deemer clauses employ differing language to achieve their ends -- the former saving, except as provided in the deemer clause, "any law of any State which regulates insurance" and the latter referring to "any law of any State purporting to regulate insurance companies [or] insurance contracts." We view the language of the deemer clause, however, to be either coextensive with or broader, not narrower, than that of the saving clause. Our rejection of a restricted reading of the deemer clause does not lead to the deemer clause's engulfing the saving clause. As we have pointed out, *supra, at 62-63*, the **[****26]** saving clause retains the independent effect of protecting state insurance regulation of insurance contracts purchased by employee benefit plans.

LEdHN[1F][1F]***LEdHN[5]***[5]***HN14***Congress intended by ERISA to "establish pension plan regulation as exclusively a federal concern." *Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504 at 523, 68 L. Ed. 2d 402, 101 S. Ct. 1895* (footnote omitted). Our interpretation of the deemer clause makes clear that if a plan is insured, a State may regulate it indirectly through regulation of its insurer and its insurer's insurance contracts; if the plan is uninsured, the State may not regulate it. As a result, employers will not face "'conflicting or inconsistent State and local regulation of employee benefit plans.'" **[*65]** *Shaw v. Delta Air Lines, Inc., 463 U.S. at 99* (quoting remarks of Sen. Williams). A construction of the deemer clause that exempts employee benefit plans from only those **[****27]** state regulations that encroach upon **[***369]** core ERISA concerns or that apply to insurance as a business would be fraught with administrative difficulties, necessitating definition of core ERISA concerns and of what constitutes business activity. It would therefore undermine Congress' desire to avoid "endless litigation over the validity of State action," see 120 Cong. Rec. 29942 (1974) (remarks of Sen. Javits), and instead lead to employee benefit plans' expenditure of funds in such litigation.

LEdHN[1G][1G]In view of Congress' clear intent to exempt from direct state insurance regulation ERISA employee benefit plans, we hold that ERISA pre-empts the application of *§ 1720* of Pennsylvania's Motor Vehicle Financial Responsibility Law to the FMC Salaried Health Care Plan. We therefore vacate the judgment of the United States Court of Appeals for the Third Circuit and remand the case for further proceedings consistent with this opinion.

It is so ordered.

JUSTICE SOUTER took no part in the consideration or decision of this case.

Dissent by: STEVENS

Dissent

JUSTICE STEVENS, dissenting.

The Court's construction **[****28]** of the statute draws a broad and illogical distinction between benefit plans that are funded by the employer (self-insured plans) and those that are insured by regulated insurance companies (insured plans). Had Congress intended this result, it could have stated simply that "all State laws are pre-empted insofar as they relate to any self-insured employee plan." There would then have been no need for the "saving clause" to exempt state insurance laws from the pre-emption clause, or the "deemer clause," which the Court today reads as merely reinjecting **[*66]** into the scope of ERISA's pre-emption clause those same exempted state laws insofar as they relate to self-insured plans.

From the standpoint of the beneficiaries of ERISA plans -- who after all are the primary beneficiaries of the entire statutory program -- there is no apparent reason for treating self-insured plans differently from insured plans. Why should a self-insured plan have a right to enforce a subrogation clause against an injured employee while an insured plan may not? The notion that this disparate treatment of similarly situated beneficiaries is somehow supported by an interest in uniformity is singularly unpersuasive. **[****29]** If Congress **[**412]** had intended such an irrational result, surely it would have expressed it in straightforward English. At least one would expect that the reasons for drawing such an apparently irrational distinction would be discernible in the legislative history or in the literature discussing the legislation.

The Court's anomalous result would be avoided by a correct and narrower reading of either the basic pre-emption clause or the deemer clause.

I

The Court has endorsed an unnecessarily broad reading of the words "relate to any employee benefit plan" as they are used in the basic pre-emption clause of § 514(a). I acknowledge that this reading is supported by language in some of our **[***370]** prior opinions. It is not, however, dictated by any prior holding, and I am persuaded that Congress did not intend this clause to cut nearly so broad a swath in the field of state laws as the Court's expansive construction will create.

The clause surely does not pre-empt a host of general rules of tort, contract, and procedural law that relate to benefit plans as well as to other persons and entities. It does not, for example, pre-empt general state garnishment rules insofar **[****30]** as they relate to ERISA plans. *Mackey v. Lanier Collection Agency & Service, Inc., 486 U.S. 825, 100 L. Ed. 2d 836, 108 S. Ct. 2182 (1988)*. Moreover, the legislative history of the provision indicates that **[*67]** throughout most of its consideration of pre-emption, Congress was primarily concerned about areas of possible overlap between federal and state requirements. Thus, the bill that was introduced in the Senate would have pre-empted state laws insofar as they "relate to the subject matters regulated by this Act," [1] **[****31]** and the House bill more specifically identified state laws relating "to the fiduciary, reporting, and disclosure responsibilities of persons acting on behalf of employee benefit plans." [2] Although the compromise that produced the statutory language "relate to any employee benefit

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[1] S. 4, 93d Cong., 1st Sess., § 609(a) (1973), reprinted at 1 Legislative History of the Employee Retirement Income Security Act of 1974 (Committee Print compiled by the Subcommittee on Labor of the Senate Committee on Labor and Public Welfare) 93, 186 (1976) (Leg. Hist.).

[2] H. R. 2, 93d Cong., 1st Sess., § 114 (1973); 1 Leg. Hist. 51.

plan" is not discussed in the legislative history, the final version is perhaps best explained as an editorial amalgam of the two bills rather than as a major expansion of the section's coverage.

When there is ambiguity in a statutory provision preempting state law, we should apply a strong presumption against the invalidation of well-settled, generally applicable state rules. In my opinion this presumption played an important role in our decisions in *Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 96 L. Ed. 2d 1, 107 S. Ct. 2211 (1987)*, and *Mackey v. Lanier Collection Agency & Service, Inc., supra.* Application of that presumption leads me to the conclusion that the pre-emption clause should apply only to those state laws that purport to regulate subjects regulated by ERISA or that are inconsistent with ERISA's central purposes. I do not think Congress intended to foreclose Pennsylvania from enforcing the antisubrogation provisions of its state Motor Vehicle Financial Responsibility Law against ERISA plans -- most certainly, it did not intend to pre-empt enforcement of that statute against self-insured plans while preserving enforcement against insured plans.

[*68] II

[**32]** Even if the "relate to" language in the basic pre-emption clause is read broadly, a proper interpretation of the carefully drafted text of the deemer clause would caution against finding pre-emption in this case. Before identifying the key words in that text, it **[**413]** is useful to comment on the history surrounding enactment of the deemer clause.

The number of self-insured employee **[***371]** benefit plans grew dramatically in the 1960's and early 1970's. [3] The question whether such plans were, or should be, subject to state regulation remained unresolved when ERISA was enacted. It was, however, well recognized as early as 1967 that requiring self-insured plans to comply with the regulatory requirements in state insurance codes would stifle their growth:

> "Application of state insurance laws to uninsured plans would make direct payment of benefits pointless and in most cases not feasible. This is because a welfare plan would have to be operated as an insurance company in order to comply with the detailed regulatory requirements of state insurance codes designed with the typical operations of insurance companies in mind. It presumably would be necessary to form a captive **[****33]** insurance company with prescribed capital and surplus, capable of obtaining a certificate of authority from the insurance department of all states in which the plan was 'doing business,' establish premium rates subject to approval by the insurance department, issue policies in the form approved by the insurance department, pay commissions and premium taxes required by the insurance law, hold and deposit reserves established by the insurance department, make investments permitted under the law, and comply with all filing and examination requirements of the insurance department. The result would be to reintroduce **[*69]** an insurance company, which the direct payment plan was designed to dispense with. Thus it can be seen that the real issue is not whether uninsured plans are to be *regulated* under state insurance laws, but whether they are to be *permitted*." Goetz, Regulation of Uninsured Employee Welfare Plans Under State Insurance Laws, 1967 Wis. L. Rev. 319, 320-321 (emphasis in original).

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[3] See Comment, State Regulation of Noninsured Employee Welfare Benefit Plans, 62 Geo. L. J. 339, 340 (1973).

[**34]** In 1974 while ERISA was being considered in Congress, the first state court to consider the applicability of state insurance laws to self-insured plans held that a self-insured plan could not pay out benefits until it had satisfied the licensing requirements governing insurance companies in Missouri and thereby had subjected itself to the regulations contained in the Missouri insurance code. *Missouri* v. *Monsanto Co.*, Cause No. 259774 (St. Louis Cty. Cir. Ct., Jan. 4, 1973), rev'd, *517 S.W.2d 129 (Mo. 1974)*. Although it is true that the legislative history of ERISA or the deemer clause makes no reference to the Missouri case, or to this problem -- indeed, it contains no explanation whatsoever of the reason for enacting the deemer clause -- the text of the clause itself plainly reveals that it was designed to protect pension plans from being subjected to the detailed regulatory provisions that typically apply to all state-regulated insurance companies -- laws that purport to regulate insurance companies and insurance contracts.

The key words in the text of the deemer clause are "deemed," "insurance **[***372]** company," and "purporting." [4] It provides **[*70]** **[****35]** that an employee welfare plan shall not be *deemed* to be an *insurance company* or to be engaged in the business of insurance for the purpose of determining whether it is an entity that is regulated by any state law *purporting* to regulate *insurance companies* and insurance contracts.

[414]** Pennsylvania's insurance code purports, in so many words, to regulate insurance companies and insurance contracts. It governs the certification of insurance companies, *Pa. Stat. [****36] Ann., Tit. 40, § 400* (Purdon 1971), their minimum capital stock and financial requirements to do business, § 386 (Purdon 1971 and Supp. 1990-1991), their rates, *e.g.*, § 532.9 (Purdon 1971) (authorizing Insurance Commissioner to regulate minimum premiums charged by life insurance companies), and the terms that insurance policies must, or may, include, *e. g.*, § 510 (Purdon 1971 and Supp. 1990-1991) (life insurance policies), § 753 (Purdon 1971) (health and accident insurance policies). The deemer clause prevents a State from enforcing such laws purporting to regulate insurance companies and insurance contracts against ERISA plans merely by deeming ERISA plans to be insurance companies. But the fact that an ERISA plan is not deemed to be an insurance company for the purpose of deciding whether it must comply with a statute that purports to regulate "insurance contracts" or entities that are defined as "insurance companies" simply does not speak to the question whether it must nevertheless comply with a statute that expressly regulates subject matters other than insurance.

There are many state laws that apply to insurance companies as well as to other entities. Such laws **[****37]** may regulate some aspects of the insurance business, but do not require one to be an insurance company in order to be subject to their terms. Pennsylvania's Motor Vehicle Financial Responsibility Law is such a law. The fact that petitioner's plan is not deemed to be an insurance company or an insurance contract does not have any bearing on the question

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[4] Section 514(b)(2)(B), as set forth in *29 U. S. C. § 1144(b)(2)(B)*, provides:

"Neither an employee benefit plan . . . nor any trust established under such a plan, shall be *deemed* to be an *insurance company* or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State *purporting* to *regulate insurance companies*, insurance contracts, banks, trust companies, or investment companies." (Emphasis added.)

whether petitioner, **[*71]** like all other persons, must nevertheless comply with the Motor Vehicle Financial Responsibility Law.

If one accepts the Court's broad reading of the "relate to" language in the basic pre-emption clause, the answer to the question whether petitioner must comply with state laws regulating entities including, but not limited to, insurance companies depends on the scope of the saving clause. [5] In this case, I am prepared to accept the Court's broad reading of that clause, but it is of critical **[***373]** importance to me that the category of state laws described in the saving clause is broader than the category described in the deemer clause. A state law "which regulates insurance," and is therefore exempted from ERISA's pre-emption provision by operation of the saving clause, does not necessarily have **[****38]** as its purported subject of regulation an "insurance company" or an activity that is engaged in by persons who are insurance companies. Rather, such a law may aim to regulate another matter altogether, but also have the effect of regulating insurance. The deemer clause, by contrast, reinjects into the scope of ERISA pre-emption only those state laws that "purport to" regulate insurance companies or contracts -- laws such as those which set forth the licensing and capitalization requirements for insurance companies or the minimum required provisions in insurance contracts. While the saving clause thus exempts from the pre-emption clause all state laws that have the broad effect of regulating insurance, the deemer clause simply allows pre-emption of those state laws that expressly regulate insurance and that would therefore be applicable to ERISA plans only if States were allowed to deem such plans to be insurance companies.

[**39]** **[*72]** Pennsylvania's Motor Vehicle Financial Responsibility Law fits into the broader category of state laws that fall within the saving clause only. The Act regulates persons in addition to insurance companies and affects subrogation and indemnity agreements that are not necessarily insurance contracts. Yet **[**415]** because it most assuredly is not a law "purporting" to regulate any of the entities described in the deemer clause -- "insurance companies, insurance contracts, banks, trust companies, or investment companies," the deemer clause does not by its plain language apply to this state law. Thus, although the Pennsylvania law is exempted from ERISA's pre-emption provision by the broad saving clause because it "regulates insurance," it is not brought back within the scope of ERISA pre-emption by operation of the narrower deemer clause. I therefore would conclude that petitioner is subject to Pennsylvania's Motor Vehicle Financial Responsibility Law.

I respectfully dissent.

References

60A Am Jur 2d, Pensions and Retirement Funds 115, 118, 124, 130

Federal Procedure, L Ed, Declaratory Judgments 23:41

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[5] Section 514(b)(2)(A), as set forth in *29 U. S. C. § 1144(b)(2)(A)*, provides:

"Except as provided in subparagraph (B) nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities."

29 USCS 1144 **[****40]** *(a), 1144(b)(2)(A), 1144(b)(2)(B)*

RIA Employment Coordinator B-10,715--B-10,718

RIA Pension Coordinator 80,120-80,123

US L Ed Digest, Pensions and Retirement Funds 1; States, Territories, and Possessions 38, 46

Index to Annotations, Employee Retirement Income Security Act; Insurance and Insurance Companies; Pre-emption; States

Annotation References:

Construction and application of pre-emption exemption, under Employee Retirement Income Security Act (*29 USCS 1001 et seq.*), for state laws regulating insurance, banking ,or securities (*29 USCS 1144(b)(2)*). *87 ALR Fed 797*.

Pre-emption of state fair employment laws under provisions of 514 of Employee Retirement Income Security Act (*29 USCS 1144*). *72 ALR Fed 489*.

Federal question jurisdiction in declaratory judgment suit challenging state statute or regulation on grounds of federal pre-emption. *69 ALR Fed 753*.

End of Document

LexisNexis

1. *Hanif v. Housing Authority, 200 Cal. App. 3d 635*

Client/Matter: 1737-10881

Search Terms: Hanif v. Housing Authority, 200 Cal. App. 3d 635

Search Type: Natural Language

Narrowed by:

Content Type	Narrowed by
Cases	-None-

2. Hanif v. Housing Authority, 200 Cal. App. 3d 635_Attachment1

Client/Matter: 1737-10881

Search Terms: Hanif v. Housing Authority, 200 Cal. App. 3d 635

Search Type: Natural Language

Narrowed by:

Content Type	Narrowed by
Cases	-None-

Hanif v. Housing Authority

Court of Appeal of California, Third Appellate District

April 21, 1988

No. C000119

Reporter
200 Cal. App. 3d 635 *; 246 Cal. Rptr. 192 **; 1988 Cal. App. LEXIS 388 ***

SAJJAD HANIF, a Minor, etc., Plaintiff and Respondent, v. HOUSING AUTHORITY OF YOLO COUNTY, Defendant and Appellant

Notice: [*1]** Certified for partial publication - Pursuant to rule 976.1 of the California Rules of Court, the Reporter of Decisions is directed to publish all portions of this opinion except parts I and II.

Prior History: Superior Court of Yolo County, No. 41898, Harry A. Ackley, Judge.

Disposition: The judgment is modified by reducing the special damages award by $ 12,301. As modified, the judgment is affirmed.

Core Terms

reasonable value, damages, attendant, bushes, special damage, medical care, amount paid, oleander, roadway, measure of damages, trial court, contending, dollars, medical expenses, medical services, no evidence, modified

Case Summary

Procedural Posture
Defendant housing authority challenged a judgment from the Superior Court of Yolo County (California), which awarded damages to plaintiff minor resident in his action for personal injuries, because the amount of special damages awarded to plaintiff was more than the actual amount of special damages he paid or for which he incurred liability.

Overview
Defendant housing authority sought review of the trial court's decision which awarded special damages to plaintiff, a minor resident, that exceeded the amount that plaintiff had actually incurred for his medical bills and challenged the amount awarded to plaintiff's parents for the home care of plaintiff. The trial court based the award of special damages on the reasonable value of those services and not on the amount paid or incurred by plaintiff. On appeal, the court modified plaintiff's special damage award and decreased it by the amount not paid or incurred by plaintiff and the court affirmed the judgment as modified. The court found that where a certain sum was paid or incurred for past medical care and services, that amount was the most plaintiff

could recover despite the fact it may have been less than the prevailing market rate unless evidence was produced that showed plaintiff would have incurred liability for the unpaid amount. The court found that the 24-hour home attendant care was reasonably necessary and actually provided by plaintiff's parents and that the amount of the award, which was based on the prevailing market rate for those services, was proper.

Outcome

The court modified the trial court's award of special damages and affirmed the judgment as modified. The court reduced plaintiff minor resident's award of special damages because the award included amounts over and above what plaintiff had paid for the medical services and no evidence was submitted to show that plaintiff had incurred liability for those amounts.

LexisNexis® Headnotes

Torts > ... > Damages > Collateral Source Rule > General Overview

HN1[⬇] **Damages, Collateral Source Rule**

The collateral source rule does not preclude a plaintiff's recovery, in the form of special damages, from defendant for any payments by third parties for all injury-related medical care and services.

Torts > ... > Compensatory Damages > Types of Losses > Medical Expenses

HN2[⬇] **Types of Losses, Medical Expenses**

A person injured by another's tortious conduct is entitled to recover the reasonable value of medical care and services reasonably required and attributable to the tort.

Torts > ... > Types of Damages > Compensatory Damages > General Overview

HN3[⬇] **Types of Damages, Compensatory Damages**

In tort actions damages are normally awarded for the purpose of compensating the plaintiff for injury suffered, i.e., restoring him as nearly as possible to his former position, or giving him some pecuniary equivalent.

Torts > ... > Types of Damages > Compensatory Damages > General Overview

Torts > Remedies > Damages > General Overview

HN4[⬇] **Types of Damages, Compensatory Damages**

The primary object of an award of damages in a civil action, and the fundamental principle on which it is based, are just compensation or indemnity for the loss or injury sustained by the complainant, and no more.

Torts > ... > Types of Damages > Compensatory Damages > General Overview

Torts > Remedies > Damages > General Overview

HN5[⬇] **Types of Damages, Compensatory Damages**

A plaintiff in a tort action is not, in being awarded damages, to be placed in a better position than he would have been had the wrong not been done.

Civil Procedure > Remedies > Damages > Monetary Damages

Torts > ... > Compensatory Damages > Types of Losses > Medical Expenses

Torts > Remedies > Damages > General Overview

Torts > ... > Types of Damages > Compensatory Damages > General Overview

HN6[⬇] **Damages, Monetary Damages**

In tort actions under *Cal. Civ. Code § 1431.2(b)(1)* medical expenses fall generally into the category of economic damages, representing actual pecuniary loss caused by the defendant's wrong.

Torts > ... > Types of Damages > Compensatory Damages > General Overview

Torts > Remedies > Damages > General Overview

HN7[⬇] **Types of Damages, Compensatory Damages**

Under *Cal. Civ. Code § 3359* "reasonable value" is a term of limitation, not of aggrandizement.

Torts > ... > Types of Damages > Compensatory Damages > General Overview

Torts > Remedies > Damages > General Overview

HN8[⬇] **Types of Damages, Compensatory Damages**

When a plaintiff seeks to recover for expenditures made or liability incurred to third persons for services rendered, normally the amount recovered is the reasonable value of the services rather than the amount paid or charged. If, however, the injured person paid less than the exchange rate, he can recover no more than the amount paid, except when the low rate was intended as a gift to him.

Torts > ... > Compensatory Damages > Types of Losses > Medical Expenses

Torts > ... > Types of Damages > Compensatory Damages > General Overview

HN9[] **Types of Losses, Medical Expenses**

The reasonable value of nursing services required by the defendant's tortious conduct may be recovered from the defendant even though the services were rendered by members of the injured person's family and without an agreement or expectation of payment. Where services in the way of attendance and nursing are rendered by a member of the plaintiff's family, the amount for which the defendant is liable is the amount for which reasonably competent nursing and attendance by others could have been obtained. The fact that the injured party had a legal right to the nursing services, as in the case of a spouse does not, as a general rule, prevent recovery of their value.

Civil Procedure > Trials > Judgment as Matter of Law > General Overview

Torts > Remedies > Damages > General Overview

Civil Procedure > Judgments > Relief From Judgments > General Overview

Civil Procedure > Judgments > Relief From Judgments > Motions for New Trials

HN10[] **Trials, Judgment as Matter of Law**

The point that damages are excessive cannot be raised for the first time on appeal, but must be presented to the lower court on the motion for new trial.

Torts > Remedies > Damages > General Overview

HN11[] **Remedies, Damages**

The court is entitled to consider the nature and the value of the services rendered as shown by the evidence and to draw upon its own judgment and experience in determining a reasonable amount to be awarded.

Headnotes/Summary

Summary
CALIFORNIA OFFICIAL REPORTS SUMMARY

In a personal injury action by a child struck by an automobile, the trial court awarded as special damages the reasonable value of medical care and services, even though the award exceeded the amount paid by Medi-Cal on plaintiff's behalf for that care. The trial court also awarded as special damages the reasonable value of 24-hour home attendant care provided by the child's parents, based on the prevailing market rate for trained home nurses. (Superior Court of Yolo County, No. 41898, Harry A. Ackley, Judge.)

The Court of Appeal modified the judgment by reducing the special damages award, and, as modified, affirmed. The court held that plaintiff was entitled to recover as special damages for medical care only the amount actually paid by Medi-Cal on plaintiff's behalf, but not more, and modified the award to the amount actually paid. The court also held that the trial court's award of special damages for home attendant care by plaintiff's parents was properly based on the prevailing market rate for trained home nurses, notwithstanding plaintiff's parents were unskilled in home nursing and notwithstanding any legal duty the parents may have had to provide that care or that they rendered the services without an agreement or expectation of payment. (Opinion by Evans, J., with Puglia, P. J., and Marler, J., concurring.)

Headnotes
CALIFORNIA OFFICIAL REPORTS HEADNOTES

Classified to California Digest of Official Reports, 3d Series

CA(1)[⬇] **(1)**

Damages § 6—Compensatory Damages—Collateral Source Rule—Medical Payments Made by Medi-Cal.

--A plaintiff's recovery as special damages of the amount paid for injury-related medical care and services is not affected by the fact that the payments were made by Medi-Cal on plaintiff's behalf; under the collateral source rule, plaintiff is deemed to have personally paid or incurred liability for these services and is entitled to recompense accordingly.

CA(2)[⬇] **(2)**

Damages § 13—Measure of Damages—Personal Injuries—Medical Care—Limitation of Recovery to Amount Actually Paid.

--The award as special damages of the reasonable value of past medical care and services was error, where the award exceeded the actual amount paid by Medi-Cal on plaintiff's behalf. Although a person injured by another's tortious conduct is entitled to recover the reasonable value of medical care and services reasonably required and attributable to the tort, he is not entitled to recover more than the actual amount he paid or for which he incurred liability; he is

entitled to recover up to, and no more than, the actual amount expended or incurred, so long as that amount is reasonable.

CA(3)[⬇] **(3)**

Damages § 13—Measure of Damages—Personal Injuries—Home Attendant Care of Child by Parents.

--In an action to recover for personal injuries to a child, the trial court properly awarded as special damages the reasonable value of home attendant care provided by the child's parents. The reasonable value of nursing services required by defendant's tortious conduct may be recovered, even though the services were rendered by members of the injured person's family, and without an agreement or expectation of payment, and the fact that the injured party had a legal right to the nursing services does not prevent recovery.

CA(4)[⬇] **(4)**

Damages § 35—Issue of Excessiveness—Appeal—Motion for New Trial.

--The point that damages are excessive cannot be raised for the first time on appeal, but must be presented to the lower court on a motion for new trial.

CA(5)[⬇] **(5)**

Damages § 17.2—Awards Not Excessive—Personal Injuries—Home Attendant Care—Prevailing Market Rate for Services.

--In an action to recover for personal injuries to a child, the trial court's award as special damages of the reasonable value of home attendant care provided by the child's parents was not excessive. The trial court properly based the award on the prevailing market rate for those who perform such services, despite the fact that plaintiff's parents were unskilled in home nursing. Moreover, defendant failed to produce any evidence to controvert plaintiff's evidence as to a reasonable rate of compensation, the rate did not appear unreasonable on its face, and the court was entitled to consider the nature and value of the services rendered as shown by the evidence and to draw upon its own judgment and experience in determining a reasonable amount to be awarded.

Counsel: Robert M. Cole and Cole & Cole for Defendant and Appellant.

James V. Nolan and Chalmers, Sans, Gardner & Nolan for Plaintiff and Respondent.

Judges: Opinion by Evans, J., with Puglia, P. J., and Marler, J., concurring.

Opinion by: EVANS

Opinion

[*637] [193]** This personal injury action arises out of an accident that occurred on defendant Housing Authority's property in which an automobile struck and injured plaintiff, Sajjad Hanif. Following a bench trial, judgment was entered for plaintiff. Defendant appeals, challenging various of the court's findings and conclusions respecting liability and special damages. We shall modify the judgment to reduce the amount of special damages awarded. As modified, the judgment will be affirmed.

Facts

On September 3, 1979, at about **[***2]** 7 p.m., plaintiff, then seven years old, and Betty Brady, an adult companion, were cutting flowers from oleander bushes along a two-foot strip of land abutting Donelly Circle in Woodland. Donelly Circle is a 26-foot-wide paved, unmarked roadway running through defendant's housing project. The strip of land on which the oleander bushes were planted is directly across Donelly Circle from the housing project and is owned and maintained by defendant. Growth from the tall **[*638]** bushes was spilling across the curb and protruding into Donelly Circle for a distance of one to two feet. Plaintiff dropped his scissors and, in retrieving them, stepped onto the roadway and into the path of an oncoming car being driven by Lydia Ulloa. Plaintiff did not see the car. Brady attempted to pull him out of harm's way, but she was unsuccessful. Both she and plaintiff were struck. The impact forced plaintiff under the car, and he was dragged a considerable distance. He suffered severe and permanent injuries.

According to eyewitnesses Bob Barton and Vernon Washabaugh, who were attending a nearby ice cream vending truck, Ulloa was traveling about 35 miles per hour, and her car was brushing the **[***3]** oleander bushes as it proceeded along the road. Plaintiff was struck by the front of the car midway between the right headlight and the center of the grill. Ulloa did not slow down or alter her course, either before or after striking Brady and plaintiff; she stopped only after Barton had flagged her down.

Ulloa and her passenger, Maria Enriquez, testified they were driving into the sun at the time but that their vision was not significantly impaired. The car's sun visor was down and the windshield appeared to be clean. Ulloa and Enriquez saw the ice cream truck in the distance, which was stopped on the opposite side of the road. Neither one of them saw Brady or plaintiff, however, and they were initially unaware the car had struck anybody; they attributed the thumping noises under the car to a possible flat tire.

Housing Authority groundskeeping and maintenance personnel, as well as the Housing Authority's director, testified that the oleander bushes were trimmed back from the roadway and beyond the curb "as needed," ordinarily in the spring and the fall, but on no regular schedule. The reason for trimming them back was to permit an unimpeded path for the city's streetsweepers.

[*4]** William Neuman, an expert on accident reconstruction and highway design and safety, testified that the oleander bushes, at the time of the accident, were in a condition contrary to accepted safety standards and practices in roadway maintenance. The bushes, protruding as

they did into the roadway, would tend to obscure the vision of both drivers and pedestrians, creating a classic "dart out" hazard.

Woodland Police Officer Craig Vierra, who investigated the accident, as well as Barton and Washabaugh, testified that children commonly played in and around the oleander bushes along Donelly Circle. Donald Parker, the Housing Authority's director, knew that many children lived in the housing project, and the Housing Authority did not prohibit them from playing in the area of the oleander bushes.

[*639] The trial court apportioned 80 percent of the fault for this accident to Ulloa and **[**194]** 20 percent to defendant. [1] Considering plaintiff's age, the court found no comparative fault on his part. As to defendant, a public entity, the court found the overhanging and untrimmed oleander bushes, which protruded into the roadway and obscured Ulloa's and plaintiff's view of one **[***5]** another, constituted a dangerous condition on defendant's property and were a proximate cause of plaintiff's injuries. The court found defendant's negligent failure to have kept the bushes trimmed back from the roadway created a reasonably foreseeable risk of the kind of injury that did in fact occur. The court awarded, as special damages for past medical expenses and home attendant care, $ 53,314 and, as general damages for pain and suffering and impaired future earning capacity, $ 250,000. Defendant's motion for new trial was denied, and this appeal followed.

I, II [Text omitted.] NOT CERTIFIED FOR PUBLICATION.

III

Over defendant's objection, plaintiff introduced evidence that the "reasonable value" of the medical services rendered in this case was in excess of amounts Medi-Cal had actually paid the providers. The trial court found the reasonable value of the physician services to have been $ 4,618, whereas Medi-Cal had **[***6]** paid only $ 2,823, and the reasonable value of the hospital services to have been $ 27,000, whereas Medi-Cal had paid only $ 16,494. There was no evidence, however, that plaintiff was or would become liable for the difference. And the balance between the amount billed to Medi-Cal and the amount paid was "written off" by the hospital. Nevertheless, the court awarded, as special damages, the reasonable value of the medical services rendered. On appeal, defendant contends the court erred in its application of the controlling measure of damages in this regard, arguing that plaintiff's recovery is limited to the amount actually paid. [2] We agree the trial court's award overcompensated plaintiff for this item of damages.

[*7]** ***CA(1)***[↑] **(1)** Preliminarily, we note there is no question here ***HN1***[↑] that Medi-Cal's payment for all injury-related medical care and services does not preclude plaintiff's recovery from defendant, as special damages, of the amount paid. **[*640]** This follows from the collateral source rule. (See *Helfend v. Southern Cal. Rapid Transit Dist. (1970) 2 Cal.3d 1, 6-16 [84 Cal.Rptr. 173, 465 P.2d 61, 77 A.L.R.3d 398]*; *De Cruz v. Reid (1968) 69 Cal.2d 217, 223-224*

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[1] Ulloa is a nonappealing defendant, against whom a default was entered below.

[2] Defendant had stipulated at trial that the medical services at issue here were reasonably necessary and attributable to the accident and the amount Medi-Cal had actually paid for these services was reasonable.

[70 Cal.Rptr. 550, 444 P.2d 342]; *Reichle v. Hazie (1937) 22 Cal.App.2d 543, 547-548 [71 P.2d 849]*; *Rest.2d Torts, § 920A* & *com. b*; see generally Annot., Collateral Source Rule: Receipt of Public Relief or Gratuity as Affecting Recovery in Personal Injury Action *(1977) 77 A.L.R.3d 366*; cf. *Waite v. Godfrey (1980) 106 Cal.App.3d 760, 766-775 [163 Cal.Rptr. 881]*.) For purposes of analysis, plaintiff is deemed to have personally paid or incurred liability for these services and is entitled to recompense accordingly. This is not unreasonable or unfair in light of Medi-Cal's subrogation and judgment lien **[***8]** rights (*Welf. & Inst. Code, § 14124.70 et seq.*; cf. *Gov. Code, § 985, subd. (f)(1)*, added by Stats. 1987, ch. 1201, § 25). (See *Helfend v. Southern Cal. Rapid Transit Dist., supra, 2 Cal.3d at pp. 10-11*.)

CA(2)[↑] **(2)** Nor is there any question about the appropriate measure of recovery: ***HN2***[↑] a person injured by another's tortious conduct is entitled to recover the reasonable value of medical care and services reasonably required and attributable to the tort. (*Melone v. Sierra Railway Co. (1907) 151 Cal. 113, 115 [91 P. 522]*; *Gimbel v. Laramie (1960) 181 Cal.App.2d 77, 81 [5 Cal.Rptr. 88]*; see *BAJI No. 14.10* (7th ed. 1987 pocket pt.) p. 13.)

The question here involves the application of that measure, i.e., whether the "reasonable **[**195]** value" measure of recovery means that an injured plaintiff may recover from the tortfeasor more than the actual amount he paid or for which he incurred liability for past medical care and services. Fundamental principles underlying recovery of compensatory damages in tort actions compel the following answer: no.

[*9]** ***HN3***[↑] "In tort actions damages are normally awarded for the purpose of *compensating* the plaintiff for injury suffered, i.e., restoring him as nearly as possible to his former position, or giving him some pecuniary equivalent. [Citations.]" (Italics in original, 4 Witkin, Summary of Cal. Law (8th ed. 1974) Torts, § 842, p. 3137; see *Civ. Code, §§ 3281* ["Every person who suffers detriment from the unlawful act or omission of another, may recover from the person in fault a compensation therefor in money, which is called damages."], 3282 ["Detriment is a loss or harm suffered in person or property."], 3333 ["For the breach of an obligation not arising from contract, the measure of damages, except where otherwise expressly provided by this code, is the amount which will compensate for all the detriment proximately caused thereby, whether it could have been anticipated or not."].) "***HN4***[↑] *The primary object of an award of damages* in a civil action, and the fundamental principle on which it is based, are *just compensation* or indemnity for the loss or injury sustained by the complainant, *and no more* [citations]." (Italics **[***10]** **[*641]** in original, *Mozzetti v. City of Brisbane (1977) 67 Cal.App.3d 565, 576 [136 Cal.Rptr. 751]*.) "***HN5***[↑] A plaintiff in a tort action is not, in being awarded damages, to be placed in a better position than he would have been had the wrong not been done." (*Valdez v. Taylor Automobile Co. (1954) 129 Cal.App.2d 810, 821-822 [278 P.2d 91]*.)

HN6[↑] In tort actions, medical expenses fall generally into the category of economic damages, representing actual pecuniary loss caused by the defendant's wrong. (See *Civ. Code, § 1431.2, subd. (b)(1)*.) Applying the above principles, it follows that an award of damages for past medical expenses in excess of what the medical care and services actually cost constitutes overcompensation.

A misunderstanding may have arisen in this case from the language of *BAJI No. 14.10*, which states the measure of damages for personal injury as follows: "The *reasonable value* of medical

[hospital and nursing] care, services and supplies reasonably required and actually given in the treatment of the plaintiff to the present time [and the present cash value of the reasonable value of similar **[***11]** items reasonably certain to be required and given in the future]." (Italics added.) A comment to *BAJI No. 14.10* states: "The reasonable value of medical and nursing care may be recovered although rendered gratuitously or paid for by a source independent of the wrongdoer." (*BAJI No. 14.10* (7th ed. 1986) p. 160.) This comment, however, merely restates the collateral source rule, which is not an issue in this case. The issue here is the import of the term "reasonable value" when applied to past medical services, to which neither *BAJI No. 14.10* nor its comment provide any clue. ***HN7***[↑] "Reasonable value" is a term of limitation, not of aggrandizement. (See *Civ. Code, § 3359*.) Thus, when the evidence shows a sum certain to have been paid or incurred for past medical care and services, whether by the plaintiff or by an independent source, that sum certain is the most the plaintiff may recover for that care despite the fact it may have been less than the prevailing market rate.

In *Melone v. Sierra Railway Co., supra, 151 Cal. 113*, the defendant appealed, contending error in instructing the jury on the measure of damages. "In instructing the jury **[***12]** upon the measure of damages the court declared as one of the elements of damage, 'Such sum as will compensate him for the *expense, if any*, he has *paid or incurred* in the employment of a physician and the purchase of drugs during the time he was disabled by the injuries, not exceeding the amounts alleged in the complaint.' It is objected to this instruction that the correct measure of damage in this regard is not the amount which he may have paid or become liable for, but the necessary and reasonable value of such services as may have been rendered him. **[**196]** Such *reasonable sum*, in other words, as has been *necessarily expended or incurred* **[*642]** in treating the injury. Such, unquestionably, is the true rule, yet we do not believe that the jury could have been led into error prejudicial to the defendant by the instruction which was given. The reasonableness of the expenses which plaintiff had incurred was not disputed." (Italics added, *id., at p. 115*.)

In *Townsend v. Keith (1917) 34 Cal.App. 564 [168 P. 402]*, the defendant appealed, contending the court erred in failing to instruct the jury to limit damages for past **[***13]** medical expenses to their reasonable value: "The expenses incurred amount to approximately two hundred dollars, i.e., one hundred and fifty dollars for physician, ten dollars for a specialist, thirty-two dollars hospital bill and thirty dollars or forty dollars for medicines. This, on its face, does not seem to be unreasonable. The reasonableness of the expenses which plaintiff had incurred was not disputed by defendant on the trial, and therefore the failure of the trial court's charge to the jury to *limit its finding to the reasonable value of the expenses incurred* was not an error which prejudiced the defendant. [Citation.]" (Italics added, *id., at p. 566*.)

In *Castro v. Giacomazzi Bros. (1949) 92 Cal.App.2d 39 [206 P.2d 688]*, the defendant appealed, also contending instructional error. The jury had been instructed with the following measure of damages: "'. . . the sum that will fairly and reasonably compensate plaintiffs, or either of them, for the expenses, if any, that each has reasonably and necessarily incurred or paid for medical attention, such as physicians, hospitalization and drugs, and caring for him -- and drugs and **[***14]** curing him of any injuries suffered as a direct and proximate result of the accident complained of; provided that you find from the evidence that plaintiffs sustained any injuries.'" (*Id., at p. 46*.) Noting that there appeared to be in the record no evidence of medical expenses,

the court held, "The amount was to be computed, 'if any.' *If there was no evidence of medical exenses, there was no necessity to give the instruction*, but it has not been shown that defendants were prejudiced thereby." (Italics added, id., at pp. 46-47.)

And in Guerra v. Balestrieri (1954) 127 Cal.App.2d 511 [274 P.2d 443], the defendant appealed, contending error in the giving of an instruction concerning the cost of medical care: "He claims error because no evidence of the cost of such services was introduced, although there was some evidence of the nature and extent of the services rendered. [para.] The proper measure is the reasonable value of such services, not the amount paid or incurred therefor, although the amount paid or incurred would be some evidence of value. [Citation.] There should be some evidence concerning the value of **[***15]** professional services of a physician or surgeon. There was no such evidence in this case. [para.] However, we fail to see how the defendant could have been prejudiced. The instruction expressly limited the recovery for **[*643]** such items to the reasonable value thereof '*not exceeding the cost to the plaintiff*,' and there was no evidence of any such cost to him." (Italics added, id., at p. 520.)

Implicit in the above cases is the notion that a plaintiff is entitled to recover *up to, and no more than*, the actual amount expended or incurred for past medical services so long as that amount is reasonable. (And see generally Annot., Necessity and Sufficiency, in Personal Injury or Death Action, of Evidence as to Reasonableness of Amount Charged or Paid for Accrued Medical, Nursing, or Hospital Expenses *(1967) 12 A.L.R.3d 1347*.) This notion is supported by the following comment on "value" from the Restatement Second of Torts, which comment directly addresses the point at issue here: ***HN8***[↑] "When the plaintiff seeks to recover for expenditures made or liability incurred to third persons for services rendered, normally the amount recovered is the **[***16]** reasonable value of the services rather than the amount paid or charged. *If, however, the injured person paid less than the exchange rate, he can recover no more than the amount paid*, except when the low rate was intended as a gift to him." (Italics added, Rest.2d Torts, § 911, ***[**197]** com. h.) [3] The record fails to disclose any evidence or any inference from evidence that the low rate charged was intended as a gift to the plaintiff.

The rule we express is consistent with fundamental principles underlying recovery in tort of compensatory damages, and it is in harmony with other rules and practices flowing from those principles, such as the practice of discounting future damages to present value (see Rest.2d Torts, § 913A & com. a [discounting to present value **[***17]** prevents "over-compensation"]), the bar against double recovery (see Mozzetti v. City of Brisbane, supra, 67 Cal.App.3d at p. 576; 4 Witkin, Summary of Cal. Law, Torts, *supra*, § 844, p. 3139), the rule that damages not be imaginary (see Earp v. Nobmann (1981) 122 Cal.App.3d 270, 294-295 [175 Cal.Rptr. 767]), the rule that when damages may be calculated by either of two alternative measures the plaintiff may recover only the lesser (see Ferraro v. Southern Cal. Gas Co. (1980) 102 Cal.App.3d 33, 49-50 [162 Cal.Rptr. 238]; 4 Witkin, Summary of Cal. Law, Torts, *supra*, §§ 909-910, 918-919, pp. 3196-3198, 3203-3204), and the rule that damages be mitigated where reasonably possible (see 4 Witkin, Summary of Cal. Law, Torts, *supra*, §§ 870-875, pp. 3158-3162; 2 Speiser, Krause & Gans, The American Law of Torts (1985) § 8:15, p. 524 ["mitigation of damages"

[3] Any suggestion that Medi-Cal benefits are gratuities or otherwise intended as gifts to the recipient in this context is belied by Medi-Cal's subrogation and lien rights.

includes anything that tends to show the claimed damages are not as large as the plaintiff asserts]).

We conclude, therefore, that the trial court in this case erred in awarding plaintiff, as special damages for past medical care and services, the reasonable **[***18]** **[*644]** value of that amount exceeding the actual amount paid. Because defendant does not dispute that the amount paid by Medi-Cal was reasonable and was for services reasonably required and proximately caused by the accident, it is appropriate for this court, on the record before us, to simply modify the judgment accordingly rather than to remand for a retrial on the issue. The trial court found the amount paid by Medi-Cal for accrued medical care and services to have been $ 19,317. Defendant does not dispute that amount. The trial court awarded, as the "reasonable value" of those services, the sum of $ 31,618. Plaintiff was therefore overcompensated in the amount of $ 12,301, by which amount the judgment will be reduced.

IV

The trial court found that, for the four-month period (Oct. 1979 through Jan. 1980) immediately following plaintiff's initial hospitalization, and excluding an intervening ten-day second hospitalization, plaintiff's parents provided the following home attendant care: helping plaintiff get into and out of bed, helping him to and from the bathroom, changing his bandages, exercising his limbs, feeding him, administering prescribed medications, applying **[***19]** creams and lotions to his body, attending him while he was in pain (nighttime as well as daytime), assisting him in the use of a wheelchair, assisting him in learning to walk again, assisting him in the use of crutches, and generally acting as practical nurse. The court found that 24-hour home attendant care was reasonably necessary and actually provided by plaintiff's parents, that plaintiff's parents had insufficient resources to hire a home nurse, that Medi-Cal disapproved home nursing care for plaintiff, and that the reasonable value of such home nursing care, could it have been obtained, was $ 8 per hour. These findings are supported by uncontroverted evidence. Damages were awarded for the reasonable value of this home attendant care in the amount of $ 21,696, calculated by multiplying 2,712 hours (113 days x 24 hours per day) times $ 8. On appeal, defendant contends that the reasonable value of home attendant care provided by the plaintiff's parents is an improper item of damages and that, even assuming it is recoverable, the amount awarded is excessive under the circumstances. Neither contention has merit.

[198]** **[***20]** ***CA(3)***[⬆] **(3)**It is established that "***HN9***[⬆] The reasonable value of nursing services required by the defendant's tortious conduct may be recovered from the defendant even though the services were rendered by members of the injured person's family and without an agreement or expectation of payment. Where services in the way of attendance and nursing are rendered by a member of the plaintiff's family, the amount for which the defendant is liable is the amount for which reasonably competent nursing and attendance by others could have been obtained. The fact that the injured party **[*645]** had a legal right to the nursing services (as in the case of a spouse) does not, as a general rule, prevent recovery of their value, . . ." (Fns. omitted, *22 Am.Jur.2d, Damages, § 207*, pp. 288-289; see *Bradford v. Edmands (1963) 215 Cal.App.2d 159, 167-168 [30 Cal.Rptr. 185]*; *Large v. Williams (1957) 154 Cal.App.2d 315, 320 [315 P.2d 919]*; *Seedborg v. Lakewood Gardens etc. Assn. (1951) 105 Cal.App.2d 449, 454 [233 P.2d 943]*.)

Thus, in Rodriguez v. McDonnell Douglas Corp. (1978) 87 Cal.App.3d 626 [151 Cal.Rptr. 399], [***21] the plaintiff was entitled to recover the reasonable value of 24-hour home attendant care provided by his spouse and necessitated by the defendant's tortious conduct: "We reject the premise that the cost of attendant care, past or future, should not have been an item for consideration by the jury because of the presence of [the plaintiff's wife]. It is not part of her duties as a wife to render 24-hour-a-day attendant care." (Id., at p. 661.) Moreover, the jury was entitled to calculate the reasonable value of that care on the basis of uncontroverted evidence respecting the wage ordinarily paid to those who provide such services. (Id., at pp. 661-662.)

Accordingly, defendant's argument that "Since parents are expected to care for their minor child, as a parental duty, they are generally not entitled to capture any monies by way of special damages for providing for the care which the law requires them at all events to provide" is totally without support. [4]

[***22] CA(4)[↑] (4) Defendant's second contention that, even assuming the reasonable value of home attendant care is compensable, the amount awarded in this case is excessive must also be rejected. Defendant failed to raise this issue on its motion for new trial. [5] "HN10[↑] 'The point that damages are excessive cannot be raised for the first time on appeal, but must be presented to the lower court on the motion for new trial.'" (*Schroeder* v. *Auto Driveaway Co.* (1974) 11 Cal.3d 908, 918 [114 Cal.Rptr. 622, 523 P.2d 662].) CA(5)[↑] (5) In any event, defendant's argument that plaintiff's parents, being unskilled, are not worth the $ 8 per hour it would have cost to hire a trained home nurse is without merit. As observed above, the recognized measure for such attendant care is the prevailing market rate for those who perform such services. Accordingly, plaintiff's parents' relative lack of skill in professional home nursing is [*646] irrelevant. Additionally, defendant failed to produce any evidence to controvert plaintiff's evidence that $ 8 per hour was a reasonable rate of compensation. That rate not appearing unreasonable on its face, the court did not err in accepting [***23] it. In like fashion, the court did not err in calculating the award based on 24-hour-a-day care. HN11[↑] The court was entitled to consider the nature and the value of the services rendered as shown by the evidence and to draw upon its own judgment and experience in determining a reasonable amount to be awarded. (See Rodriguez v. McDonnell Douglas Corp., supra, 87 Cal.App.3d at p. 662; Seedborg v. Lakewood [**199] Gardens etc. Assn., supra, 105 Cal.App.2d at p. 454.) The amount awarded was not excessive.

The judgment is modified by reducing the special damages award by $ 12,301. As modified, the judgment is affirmed.

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[4] It must be emphasized in this regard that this action is on plaintiff's behalf, not that of his parents. Accordingly whatever pecuniary losses plaintiff's parents may have suffered by the experience (e.g., wage loss) is irrelevant.

[5] The only point raised in this regard on the new trial motion was that recovery of the reasonable value of home attendant care was an improper item of damages in the first instance. No contention was made that, even assuming it was a proper item for consideration, the amount awarded was excessive under the circumstances.

LexisNexis

1. *Howell v. Hamilton Meats & Provisions, Inc., 52 Cal. 4th 541*

Client/Matter: 1737-10881

Search Terms: Howell v. Hamilton Meats & Provisions, Inc., 52 Cal. 4th 541

Search Type: Natural Language

Narrowed by:

Content Type	Narrowed by
Cases	-None-

2. Howell v. Hamilton Meats & Provisions, Inc., 52 Cal. 4th 541_Attachment1

Client/Matter: 1737-10881

Search Terms: Howell v. Hamilton Meats & Provisions, Inc., 52 Cal. 4th 541

Search Type: Natural Language

Narrowed by:

Content Type	Narrowed by
Cases	-None-

Questioned
As of: September 19, 2019 6:52 PM Z

Howell v. Hamilton Meats & Provisions, Inc.

Supreme Court of California

August 18, 2011, Opinion Filed

S179115

Reporter
52 Cal. 4th 541 *; 257 P.3d 1130 **; 129 Cal. Rptr. 3d 325 ***; 76 Cal. Comp. Cases 1147 ****; 2011 Cal. LEXIS 8119

REBECCA HOWELL, Plaintiff and Appellant, v. HAMILTON MEATS & PROVISIONS, INC., Defendant and Respondent.

Subsequent History: Reported at *Howell (Rebecca) v. Hamilton Meats & Provisions, Inc., 2011 Cal. LEXIS 8768 (Cal., Aug. 18, 2011)*

Time for Granting or Denying Rehearing Extended *Howell (Rebecca) v. Hamilton Meats & Provisions, Inc., 2011 Cal. LEXIS 9437 (Cal., Sept. 8, 2011)*

Rehearing denied by *Howell v. Hamilton Meats & Provisions, 2011 Cal. LEXIS 11417 (Cal., Nov. 2, 2011)*

Petition for Rehearing and Request(s) for Modification Denied by Supreme Court November 2, 2011

Prior History: **[1]** Civil No. D053620—Court of Appeal, Fourth Appellate District, Division One; San Diego County Superior Court No. GIN053925—Hon. Adrienne A. Orfield, Judge

Howell v. Hamilton Meats & Provisions, Inc., 179 Cal. App. 4th 686, 101 Cal. Rptr. 3d 805, 2009 Cal. App. LEXIS 1874 (Cal. App. 4th Dist., 2009)

Disposition: Petition for review from a judgment of the Court of Appeal, Fourth Appellate District, Division One. Petition for review *granted*, judgment *reversed*, and matter *remanded*.

Core Terms

collateral source rule, damages, insurer, reasonable value, tortfeasor, providers, medical provider, discounted, billed, medical expenses, negotiated rate, differential, medical services, patients, negotiated, amounts, charges, medical care, full payment, recoverable, uninsured, benefits, prices, expenses, italics, preferred provider, injured plaintiff, amount paid, costs, entitled to recover

Case Summary

Procedural Posture

In a case arising out of an automobile accident caused by a driver for defendant corporation, the trial court granted a defense motion to reduce plaintiff's past medical damages award to reflect the amount medical providers accepted as payment in full. The California Court of Appeal, Fourth Appellate District, Division One, reversed the reduction order. Defendant's petition for review was granted.

Overview

The court concluded that plaintiff could recover as damages for her past medical expenses no more than her medical providers had accepted as payment in full from plaintiff and her health insurer. Plaintiff did not incur liability for her providers' full bills, because at the time the charges were incurred, the providers had already agreed on a different price schedule for the insurer's members. Having never incurred the full bill, plaintiff could not recover it in damages for economic loss. For this reason alone, the collateral source rule was inapplicable. Plaintiff received the benefits of the health insurance for which she paid premiums: her medical expenses had been paid per the policy, and those payments were not deducted from her tort recovery. Plaintiff's insurance premiums contractually guaranteed payment of her medical expenses at rates negotiated by the insurer with the providers; they did not guarantee payment of much higher rates the insurer never agreed to pay. The appellate court incorrectly believed that the reduction order violated the collateral source rule.

Outcome

The judgment of the appellate court was reversed, and the case was remanded to that court for further proceedings.

LexisNexis® Headnotes

Torts > ... > Damages > Collateral Source Rule > Insurance Payments

Torts > ... > Compensatory Damages > Types of Losses > Medical Expenses

HN1[⬇] **Collateral Source Rule, Insurance Payments**

When a tortiously injured person receives medical care for his or her injuries, the provider of that care often accepts as full payment, pursuant to a preexisting contract with the injured person's health insurer, an amount less than that stated in the provider's bill. In that circumstance, the injured person may not recover from the tortfeasor, as economic damages for past medical expenses, the undiscounted sum stated in the provider's bill but never paid by or on behalf of the injured person. No such recovery is allowed for the simple reason that the injured plaintiff did not suffer any economic loss in that amount. *Civ. Code, §§ 3281*, *3282*.

Torts > ... > Damages > Collateral Source Rule > Insurance Payments

52 Cal. 4th 541, *541; 257 P.3d 1130, **1130; 129 Cal. Rptr. 3d 325, ***325; 76 Cal. Comp. Cases 1147, ****1147; 2011 Cal. LEXIS 8119, *****8119

Torts > ... > Compensatory Damages > Types of Losses > Medical Expenses

HN2[] **Collateral Source Rule, Insurance Payments**

The collateral source rule, which precludes deduction of compensation the plaintiff has received from sources independent of the tortfeasor from damages the plaintiff would otherwise collect from the tortfeasor, ensures that the plaintiff may recover in damages the amounts his or her insurer paid for the plaintiff's medical care. The rule, however, has no bearing on amounts that were included in a provider's bill but for which the plaintiff never incurred liability because the provider, by prior agreement, accepted a lesser amount as full payment. Such sums are not damages the plaintiff would otherwise have collected from the defendant. They are neither paid to the providers on the plaintiff's behalf nor paid to the plaintiff in indemnity of his or her expenses. Because they do not represent an economic loss for the plaintiff, they are not recoverable in the first instance. The collateral source rule precludes certain deductions against otherwise recoverable damages, but does not expand the scope of economic damages to include expenses the plaintiff never incurred.

Civil Procedure > Remedies > Damages > Compensatory Damages

Torts > ... > Compensatory Damages > Types of Losses > Medical Expenses

HN3[] **Damages, Compensatory Damages**

Compensatory damages are moneys paid to compensate a person who suffers detriment from the unlawful act or omission of another, *Civ. Code, § 3281*, and the measure of damages generally recoverable in tort is the amount which will compensate for all the detriment proximately caused by the tort. *Civ. Code, § 3333*. *Civ. Code, § 3282*, in turn, defines "detriment" as a loss or harm suffered in person or property. A person who undergoes necessary medical treatment for tortiously caused injuries suffers an economic loss by taking on liability for the costs of treatment. Hence, any reasonable charges for treatment the injured person has paid or, having incurred, still owes the medical provider are recoverable as economic damages.

Torts > ... > Damages > Collateral Source Rule > General Overview

Torts > ... > Compensatory Damages > Types of Losses > Medical Expenses

HN4[] **Damages, Collateral Source Rule**

When the costs of medical treatment are paid in whole or in part by a third party unconnected to the defendant, the collateral source rule is implicated. The collateral source rule states that if an injured party receives some compensation for his or her injuries from a source wholly independent of the tortfeasor, such payment should not be deducted from the damages which the plaintiff would otherwise collect from the tortfeasor. Put another way, payments made to or benefits conferred on the injured party from other sources, i.e., those unconnected to the

defendant, are not credited against the tortfeasor's liability, although they cover all or a part of the harm for which the tortfeasor is liable. The rule thus dictates that an injured plaintiff may recover from the tortfeasor money an insurer has paid to medical providers on his or her behalf.

Insurance Law > Claim, Contract & Practice Issues > Subrogation > General Overview

Torts > ... > Damages > Collateral Source Rule > Insurance Payments

HN5[] **Claim, Contract & Practice Issues, Subrogation**

The collateral source rule ensures plaintiffs will receive the benefits of their decision to carry insurance and thereby encourages them to do so. Since insurance policies frequently allow the insurer to reclaim the benefits paid out of a tort recovery by refund or subrogation, the rule, without providing the plaintiff a double recovery, ensures the tortfeasor cannot avoid payment of full compensation for the injury inflicted.

Civil Procedure > ... > Jury Trials > Jury Instructions > General Overview

Evidence > Relevance > Exclusion of Relevant Evidence > Confusion, Prejudice & Waste of Time

Torts > ... > Damages > Collateral Source Rule > General Overview

Civil Procedure > Appeals > Standards of Review > Reversible Errors

Evidence > Admissibility > Procedural Matters > Rulings on Evidence

HN6[] **Jury Trials, Jury Instructions**

The collateral source rule has an evidentiary as well as a substantive aspect. Because a collateral payment may not be used to reduce recoverable damages, evidence of such a payment is inadmissible for that purpose. Even if relevant on another issue (for example, to support a defense claim of malingering), under *Evid. Code, § 352*, the probative value of a collateral payment must be carefully weighed against the inevitable prejudicial impact such evidence is likely to have on the jury's deliberations. Admission of evidence of collateral payments may be reversible error even if accompanied by a limiting instruction directing the jurors not to deduct the payments from their award of economic damages.

Torts > ... > Damages > Collateral Source Rule > General Overview

Torts > ... > Compensatory Damages > Types of Losses > Medical Expenses

HN7[] **Damages, Collateral Source Rule**

The California Legislature has abrogated or altered the collateral source rule for two classes of actions. First, in a professional negligence action against a health care provider, the defendant may introduce evidence of collateral payments and benefits provided to the plaintiff for his or her injury; the plaintiff, in turn, may introduce evidence of premiums paid or contributions made to secure the benefits. *Civ. Code, § 3333.1, subd. (a)*. Second, a public entity defendant may move, after trial, to reduce a personal injury award against it by the amount of certain collateral source payments. *Gov. Code, § 985, subd. (b)*. The trial court has discretion to reduce the judgment, though its discretion is guided and limited in several respects, including that the total deduction may not exceed one-half of the plaintiff's net recovery. *§ 985, subd. (g)*.

Torts > ... > Damages > Collateral Source Rule > General Overview

Torts > ... > Compensatory Damages > Types of Losses > Medical Expenses

HN8[] **Damages, Collateral Source Rule**

While California courts have referred to the "reasonable value" of medical care in delineating the measure of recoverable damages for medical expenses, in this context "reasonable value" is a term of limitation, not of aggrandizement. A tort plaintiff's recovery for medical expenses is limited to the amount paid or incurred for past medical care and services, whether by the plaintiff or by an independent source.

Torts > ... > Damages > Collateral Source Rule > General Overview

Torts > ... > Compensatory Damages > Types of Losses > Medical Expenses

HN9[] **Damages, Collateral Source Rule**

A plaintiff may recover as economic damages no more than the reasonable value of the medical services received and is not entitled to recover the reasonable value if his or her actual loss was less. California decisions have focused on "reasonable value" in the context of limiting recovery to reasonable expenditures, not expanding recovery beyond the plaintiff's actual loss or liability. To be recoverable, a medical expense must be both incurred and reasonable.

Torts > ... > Damages > Collateral Source Rule > Insurance Payments

Torts > ... > Compensatory Damages > Types of Losses > Medical Expenses

HN10[] **Collateral Source Rule, Insurance Payments**

The rule that a plaintiff's expenses, to be recoverable, must be both incurred and reasonable accords, as well, with California's damages statutes. Damages must, in all cases, be reasonable. *Civ. Code, § 3359*. But if 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. *Civ. Code, §§ 3281*, *3282*. The same rule applies when a collateral source, such as the plaintiff's health insurer, has obtained a discount for its payments on the plaintiff's behalf.

Torts > ... > Damages > Collateral Source Rule > Gratuitous Benefits

HN11 **Collateral Source Rule, Gratuitous Benefits**

While the measure of recovery for the costs of services a third party renders is ordinarily the reasonable value of those services, if the injured person paid less than the exchange rate, the injured person can recover no more than the amount paid, except when the low rate was intended as a gift to him or her.

Torts > ... > Damages > Collateral Source Rule > General Overview

HN12 **Damages, Collateral Source Rule**

With respect to the recovery of tort damages generally, the value of property or services is ordinarily its exchange value, that is, its market value or the amount for which it could usually be exchanged.

Torts > ... > Damages > Collateral Source Rule > General Overview

Torts > ... > Compensatory Damages > Types of Losses > Medical Expenses

HN13 **Damages, Collateral Source Rule**

If a personal injury plaintiff obtains property or services for less than the exchange value, only the amount paid may be recovered. The expenses of medical care are logically included in the rule articulated. Thus, a personal injury plaintiff may recover the lesser of (a) the amount paid or incurred for medical services, and (b) the reasonable value of the services.

Torts > Remedies > Damages > Collateral Source Rule

HN14 **Damages, Collateral Source Rule**

To be recoverable as "expenses," monies must generally have been expended, or at least incurred; that they must also be reasonable does not alter this general rule.

Torts > ... > Damages > Collateral Source Rule > Insurance Payments

Torts > ... > Compensatory Damages > Types of Losses > Medical Expenses

HN15 **Collateral Source Rule, Insurance Payments**

Medical providers that agree to accept discounted payments by managed care organizations or other health insurers as full payment for a patient's care do so not as a gift to the patient or insurer, but for commercial reasons and as a result of negotiations. Hospitals and medical groups obtain commercial benefits from their agreements with health insurance organizations; the agreements guarantee the providers prompt payment of the agreed rates and often have financial incentives for plan members to choose the providers' services. That plaintiffs are not permitted to recover undiscounted amounts from those who have injured them creates no danger these negotiations and agreements will disappear; the medical provider has no financial reason to care whether the tortfeasor is charged with or the plaintiff recovers the negotiated rate differential. Having agreed to accept the negotiated amount as full payment, a provider may not recover any difference between that and the billed amount through a lien on the tort recovery.

Torts > ... > Damages > Collateral Source Rule > General Overview

Torts > ... > Compensatory Damages > Types of Losses > Medical Expenses

HN16 **Damages, Collateral Source Rule**

Where the exact amount of expenses has been established by contract and those expenses have been satisfied, there is no longer any issue as to the amount of expenses for which the plaintiff will be liable. In the latter case, the injured party should be limited to recovering the amount paid for the medical services.

Torts > ... > Damages > Collateral Source Rule > Gratuitous Benefits

Torts > ... > Compensatory Damages > Types of Losses > Medical Expenses

HN17 **Collateral Source Rule, Gratuitous Benefits**

A tortfeasor does not obtain a "windfall" merely because the injured person's health insurer has negotiated a favorable rate of payment with the person's medical provider. When an injured plaintiff has received collateral compensation or benefits as a gift, allowing a deduction from damages in that amount would result in a windfall for the tortfeasor and underpayment for the injury. Because the tortfeasor would not pay the full cost of his or her negligence or wrongdoing, the deduction would distort the deterrent function of tort law.

Torts > ... > Damages > Collateral Source Rule > Insurance Payments

Torts > ... > Compensatory Damages > Types of Losses > Medical Expenses

HN18 **Collateral Source Rule, Insurance Payments**

A negotiated rate differential is not a collateral payment or benefit subject to the collateral source rule. No credit against the tortfeasor's liability and no deduction from the damages which the plaintiff would otherwise collect from the tortfeasor is allowed for the amount paid through insurance.

Torts > ... > Damages > Collateral Source Rule > Insurance Payments

Torts > ... > Compensatory Damages > Types of Losses > Medical Expenses

HN19[] **Collateral Source Rule, Insurance Payments**

An injured plaintiff whose medical expenses are paid through private insurance may recover as economic damages no more than the amounts paid by the plaintiff or his or her insurer for the medical services received or still owing at the time of trial. This holding does not abrogate or modify the collateral source rule as it has been recognized in California. The negotiated rate differential - the discount medical providers offer the insurer - is not a benefit provided to the plaintiff in compensation for his or her injuries and therefore does not come within the collateral source rule.

Evidence > Admissibility > Conduct Evidence > Payment of Medical Expenses

Torts > ... > Damages > Collateral Source Rule > Insurance Payments

Torts > ... > Compensatory Damages > Types of Losses > Medical Expenses

HN20[] **Conduct Evidence, Payment of Medical Expenses**

When a medical care provider has, by agreement with the plaintiff's private health insurer, accepted as full payment for the plaintiff's care an amount less than the provider's full bill, evidence of that amount is relevant to prove the plaintiff's damages for past medical expenses and, assuming it satisfies other rules of evidence, is admissible at trial. Evidence that such payments were made in whole or in part by an insurer remains, however, generally inadmissible under the evidentiary aspect of the collateral source rule. Where the provider has, by prior agreement, accepted less than a billed amount as full payment, evidence of the full billed amount is not itself relevant on the issue of past medical expenses.

Civil Procedure > Judgments > Relief From Judgments > Motions for New Trials

Torts > ... > Damages > Collateral Source Rule > General Overview

Torts > ... > Compensatory Damages > Types of Losses > Medical Expenses

HN21[] **Relief From Judgments, Motions for New Trials**

Where a trial jury has heard evidence of the amount accepted as full payment by the medical provider but has awarded a greater sum as damages for past medical expenses, the defendant may move for a new trial on grounds of excessive damages. *Code Civ. Proc., § 657, subd. 5*. A nonstatutory Hanif motion is unnecessary. The trial court, if it grants the new trial motion, may permit the plaintiff to choose between accepting reduced damages or undertaking a new trial. *Code Civ. Proc., § 662.5, subd. (b)*.

Headnotes/Summary

Summary

CALIFORNIA OFFICIAL REPORTS SUMMARY

In a case arising out of an automobile accident caused by a driver for defendant corporation, the trial court granted a defense motion to reduce plaintiff's past medical damages award to reflect the amount medical providers accepted as payment in full. Accordingly, the trial court reduced the judgment by $130,286.90. (Superior Court of San Diego County, No. GIN053925, Adrienne A. Orfield, Judge.) The Court of Appeal, Fourth Dist., Div. One, No. D053620, reversed the reduction order, concluding it violated the collateral source rule.

The Supreme Court reversed the judgment of the Court of Appeal and remanded the matter to that court for further proceedings. The court concluded that plaintiff could recover as damages for her past medical expenses no more than her medical providers had accepted as payment in full from plaintiff and her health insurer. Plaintiff did not incur liability for her providers' full bills, because at the time the charges were incurred, the providers had already agreed on a different price schedule for the insurer's members. Having never incurred the full bill, plaintiff could not recover it in damages for economic loss. For this reason alone, the collateral source rule was inapplicable. Plaintiff received the benefits of the health insurance for which she paid premiums: her medical expenses had been paid per the policy, and those payments were not deducted from her tort recovery. Plaintiff's insurance premiums contractually guaranteed payment of her medical expenses at rates negotiated by the insurer with the providers; they did not guarantee payment of much higher rates the insurer never agreed to pay. The Court of Appeal incorrectly believed that the reduction order violated the collateral source rule. (Opinion by Werdegar, J., with Cantil-Sakauye, C. J., Kennard, Baxter, Chin, and Corrigan, JJ., concurring. Dissenting opinion by Klein, J.* (see p. 568).) **[*542]**

Headnotes

CALIFORNIA OFFICIAL REPORTS HEADNOTES

CA(1)[↓] **(1)**

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* Presiding Justice of the Court of Appeal, Second Appellate District, Division Three, assigned by the Chief Justice pursuant to *article VI, section 6 of the California Constitution*.

Damages § 6—Compensatory—Collateral Source Rule—Medical Care—Expenses Never Incurred.

The collateral source rule, which precludes deduction of compensation the plaintiff has received from sources independent of the tortfeasor from damages the plaintiff would otherwise collect from the tortfeasor, ensures that the plaintiff may recover in damages the amounts his or her insurer paid for the plaintiff's medical care. The rule, however, has no bearing on amounts that were included in a provider's bill but for which the plaintiff never incurred liability because the provider, by prior agreement, accepted a lesser amount as full payment. Such sums are not damages the plaintiff would otherwise have collected from the defendant. They are neither paid to the providers on the plaintiff's behalf nor paid to the plaintiff in indemnity of his or her expenses. Because they do not represent an economic loss for the plaintiff, they are not recoverable in the first instance. The collateral source rule precludes certain deductions against otherwise recoverable damages, but does not expand the scope of economic damages to include expenses the plaintiff never incurred.

CA(2) **(2)**

Damages § 3—Compensatory—Detriment—Necessary Medical Treatment—Tortiously Caused Injuries—Costs of Treatment.

Compensatory damages are moneys paid to compensate a person who suffers detriment from the unlawful act or omission of another (*Civ. Code, § 3281*), and the measure of damages generally recoverable in tort is the amount which will compensate for all the detriment proximately caused by the tort (*Civ. Code, § 3333*). *Civ. Code, § 3282*, in turn, defines "detriment" as a loss or harm suffered in person or property. A person who undergoes necessary medical treatment for tortiously caused injuries suffers an economic loss by taking on liability for the costs of treatment. Hence, any reasonable charges for treatment the injured person has paid or, having incurred, still owes the medical provider are recoverable as economic damages.

CA(3) **(3)**

Damages § 6—Compensatory—Collateral Source Rule—Medical Care.

When the costs of medical treatment are paid in whole or in part by a third party unconnected to the defendant, the collateral source rule is implicated. The collateral source rule states that if an injured party receives some compensation for his or her injuries from a source wholly independent of the tortfeasor, such payment should not be deducted from the damages which the plaintiff would otherwise collect from the tortfeasor. Put another way, payments made to or benefits conferred on the injured party from other sources (i.e., those unconnected to the defendant) are not credited against the tortfeasor's liability, although **[*543]** they cover all or a part of the harm for which the tortfeasor is liable. The rule thus dictates that an injured plaintiff may recover from the tortfeasor money an insurer has paid to medical providers on his or her behalf.

CA(4)[↓] **(4)**

Damages § 6—Compensatory—Collateral Source Rule—Insurance.

The collateral source rule ensures plaintiffs will receive the benefits of their decision to carry insurance and thereby encourages them to do so. Since insurance policies frequently allow the insurer to reclaim the benefits paid out of a tort recovery by refund or subrogation, the rule, without providing the plaintiff a double recovery, ensures the tortfeasor cannot avoid payment of full compensation for the injury inflicted.

CA(5)[↓] **(5)**

Damages § 6—Compensatory—Collateral Source Rule—Probative Value of Payment—Prejudicial Impact.

The collateral source rule has an evidentiary as well as a substantive aspect. Because a collateral payment may not be used to reduce recoverable damages, evidence of such a payment is inadmissible for that purpose. Even if relevant on another issue (for example, to support a defense claim of malingering), under *Evid. Code, § 352*, the probative value of a collateral payment must be carefully weighed against the inevitable prejudicial impact such evidence is likely to have on the jury's deliberations. Admission of evidence of collateral payments may be reversible error even if accompanied by a limiting instruction directing the jurors not to deduct the payments from their award of economic damages.

CA(6)[↓] **(6)**

Damages § 6—Compensatory—Collateral Source Rule—Abrogation or Modification.

The Legislature has abrogated or altered the collateral source rule for two classes of actions. First, in a professional negligence action against a health care provider, the defendant may introduce evidence of collateral payments and benefits provided to the plaintiff for his or her injury; the plaintiff, in turn, may introduce evidence of premiums paid or contributions made to secure the benefits (*Civ. Code, § 3333.1, subd. (a)*). Second, a public entity defendant may move, after trial, to reduce a personal injury award against it by the amount of certain collateral source payments (*Gov. Code, § 985, subd. (b)*). The trial court has discretion to reduce the judgment, though its discretion is guided and limited in several respects, including that the total deduction may not exceed one-half of the plaintiff's net recovery (*§ 985, subd. (g)*).

CA(7)[↓] **(7)**

Damages § 6—Compensatory—Collateral Source Rule—Medical Care—Reasonable Value—Amount Paid.

While California courts have referred to the "reasonable value" of medical care in delineating the **[*544]** measure of recoverable damages for medical expenses, in this context "reasonable value" is a term of limitation, not of aggrandizement. A tort plaintiff's recovery for medical expenses is limited to the amount paid or incurred for past medical care and services, whether by the plaintiff or by an independent source.

CA(8)[⬇] **(8)**

Damages § 6—Compensatory—Collateral Source Rule—Medical Care—Reasonable Value—Actual Loss.

A plaintiff may recover as economic damages no more than the reasonable value of the medical services received and is not entitled to recover the reasonable value if his or her actual loss was less. California decisions have focused on "reasonable value" in the context of limiting recovery to reasonable expenditures, not expanding recovery beyond the plaintiff's actual loss or liability. To be recoverable, a medical expense must be both incurred and reasonable.

CA(9)[⬇] **(9)**

Damages § 6—Compensatory—Collateral Source Rule—Discount.

The rule that a plaintiff's expenses, to be recoverable, must be both incurred and reasonable accords, as well, with California's damages statutes. Damages must, in all cases, be reasonable (*Civ. Code, § 3359*). But if 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 (*Civ. Code, §§ 3281, 3282*). The same rule applies when a collateral source, such as the plaintiff's health insurer, has obtained a discount for its payments on the plaintiff's behalf.

CA(10)[⬇] **(10)**

Damages § 6—Compensatory—Collateral Source Rule—Reasonable Value—Amount Paid—Gift.

While the measure of recovery for the costs of services a third party renders is ordinarily the reasonable value of those services, if the injured person paid less than the exchange rate, the injured person can recover no more than the amount paid, except when the low rate was intended as a gift to him or her.

CA(11)[⬇] **(11)**

Damages § 6—Compensatory—Collateral Source Rule—Exchange Value.

With respect to the recovery of tort damages generally, the value of property or services is ordinarily its exchange value, that is, its market value or the amount for which it could usually be exchanged.

CA(12) **(12)**

Damages § 6—Compensatory—Collateral Source Rule—Exchange Value—Amount Paid—Medical Care.

If a personal injury plaintiff obtains property or services for less than the exchange value, only the amount paid may be recovered. The expenses of medical care are logically included in the rule articulated. Thus, a personal injury plaintiff may recover the lesser of (a) the amount paid or incurred for medical services, and (b) the reasonable value of the services.

[*545] ***CA(13)*** **(13)**

Damages § 6—Compensatory—Collateral Source Rule—Expenses.

To be recoverable as "expenses," monies must generally have been expended, or at least incurred; that they must also be reasonable does not alter this general rule.

CA(14) **(14)**

Damages § 6—Compensatory—Collateral Source Rule—Medical Care—Discounted Payments—Negotiated Rate Differential.

Medical providers that agree to accept discounted payments by managed care organizations or other health insurers as full payment for a patient's care do so not as a gift to the patient or insurer, but for commercial reasons and as a result of negotiations. Hospitals and medical groups obtain commercial benefits from their agreements with health insurance organizations; the agreements guarantee the providers prompt payment of the agreed rates and often have financial incentives for plan members to choose the providers' services. That plaintiffs are not permitted to recover undiscounted amounts from those who have injured them creates no danger these negotiations and agreements will disappear; the medical provider has no financial reason to care whether the tortfeasor is charged with or the plaintiff recovers the negotiated rate differential. Having agreed to accept the negotiated amount as full payment, a provider may not recover any difference between that and the billed amount through a lien on the tort recovery.

CA(15) **(15)**

Damages § 6—Compensatory—Collateral Source Rule—Medical Care—Amount Paid.

Where the exact amount of expenses has been established by contract and those expenses have been satisfied, there is no longer any issue as to the amount of expenses for which the

plaintiff will be liable. In the latter case, the injured party should be limited to recovering the amount paid for the medical services.

CA(16)[⬇] **(16)**

Damages § 6—Compensatory—Collateral Source Rule—Medical Care—Windfall to Tortfeasor.

A tortfeasor does not obtain a "windfall" merely because the injured person's health insurer has negotiated a favorable rate of payment with the person's medical provider. When an injured plaintiff has received collateral compensation or benefits as a gift, allowing a deduction from damages in that amount would result in a windfall for the tortfeasor and underpayment for the injury. Because the tortfeasor would not pay the full cost of his or her negligence or wrongdoing, the deduction would distort the deterrent function of tort law.

CA(17)[⬇] **(17)**

Damages § 6—Compensatory—Collateral Source Rule—Negotiated Rate Differential.

A negotiated rate differential is not a collateral payment or benefit subject to the collateral source rule. No credit against **[*546]** the tortfeasor's liability and no deduction from the damages which the plaintiff would otherwise collect from the tortfeasor is allowed for the amount paid through insurance.

CA(18)[⬇] **(18)**

Damages § 6—Compensatory—Collateral Source Rule—Negotiated Rate Differential.

An injured plaintiff whose medical expenses are paid through private insurance may recover as economic damages no more than the amounts paid by the plaintiff or his or her insurer for the medical services received or still owing at the time of trial. This holding does not abrogate or modify the collateral source rule as it has been recognized in California. The negotiated rate differential—the discount medical providers offer the insurer—is not a benefit provided to the plaintiff in compensation for his or her injuries and therefore does not come within the collateral source rule.

CA(19)[⬇] **(19)**

Damages § 6—Compensatory—Collateral Source Rule—Agreement—Full Payment—Relevance—Past Medical Expenses.

When a medical care provider has, by agreement with the plaintiff's private health insurer, accepted as full payment for the plaintiff's care an amount less than the provider's full bill, evidence of that amount is relevant to prove the plaintiff's damages for past medical expenses and, assuming it satisfies other rules of evidence, is admissible at trial. Evidence that such

payments were made in whole or in part by an insurer remains, however, generally inadmissible under the evidentiary aspect of the collateral source rule. Where the provider has, by prior agreement, accepted less than a billed amount as full payment, evidence of the full billed amount is not itself relevant on the issue of past medical expenses.

CA(20)[⬇] **(20)**

Damages § 6—Compensatory—Collateral Source Rule—Past Medical Expenses—Motion for New Trial.

Where a trial jury has heard evidence of the amount accepted as full payment by the medical provider but has awarded a greater sum as damages for past medical expenses, the defendant may move for a new trial on grounds of excessive damages (*Code Civ. Proc., § 657, subd. 5*). A nonstatutory *Hanif* motion is unnecessary. The trial court, if it grants the new trial motion, may permit the plaintiff to choose between accepting reduced damages or undertaking a new trial (*Code Civ. Proc., § 662.5, subd. (b)*).

CA(21)[⬇] **(21)**

Damages § 6—Compensatory—Collateral Source Rule—Past Medical Expenses—Full Bill Never Incurred.

In a case arising out of an automobile accident, plaintiff could recover as damages for her past medical expenses no more than her medical providers had accepted as **[*547]** payment in full from plaintiff and her health insurer. Having never incurred the full bill, plaintiff could not recover it in damages for economic loss.

[*Levy et al., Cal. Torts (2011) ch. 53, § 53.01*; 6 Witkin, Summary of Cal. Law (10th ed. 2005) Torts, §§ 1633, 1640, 1670.]

California Compensation Headnotes/Summary

Headnotes

Medical Treatment > Collateral Source Rule

California Supreme Court, reversing judgment of court of appeal, held that injured plaintiff whose medical expenses are paid through private insurance may recover as economic damages no more than amounts paid by plaintiff or his or her insurer for medical services received or still owing at time of trial, thereby in no way abrogating or modifying California collateral source rule, because negotiated rate differential, i.e., discount that medical providers offer insurer, is not benefit provided to plaintiff in compensation for his or her injuries and, therefore, does not come within rule, when Supreme Court found that collateral source rule precludes deduction of compensation that plaintiff has received from sources independent of tortfeasor from damages that

plaintiff [**1149] would otherwise collect from tortfeasor, and that rule has no bearing on amounts that were included in provider's bill but for which plaintiff never incurred liability because provider, by prior agreement, accepted lesser amount as full payment.**

[See generally Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d § 11.24[1][a], [b].]

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52 Cal. 4th 541, *548; 257 P.3d 1130, **1130; 129 Cal. Rptr. 3d 325, ***325; 76 Cal. Comp. Cases 1147, ****1148; 2011 Cal. LEXIS 8119, *****8119

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Judges: Opinion by Werdegar, J. with Cantil-Sakauye, C. J., Kennard, Baxter, Chin, and Corrigan, JJ., concurring. Dissenting opinion by Klein, J.

Opinion by: Werdegar, J. Dissent by Klein, J.

Opinion

[*328] [**1133] WERDEGAR, J.**—*HN1*[↑] When a tortiously injured person receives medical care for his or her injuries, **[***329]** the provider of that care often accepts as full payment, pursuant to a preexisting contract with the injured person's health insurer, an amount less than that stated in the provider's bill. In that circumstance, may the injured person recover from the tortfeasor, as economic damages for past medical expenses, the undiscounted sum stated in the provider's bill but never paid by or on behalf of the injured person? We hold no such recovery is allowed, for the simple reason that the injured plaintiff did not suffer any economic loss in that amount. (See *Civ. Code, §§ 3281* [damages are awarded to compensate for detriment suffered], *3282* [detriment is a loss or harm to person or property].)

HN2[↑] *CA(1)*[↑] **(1)** The **[4]** collateral source rule, which precludes deduction of compensation the plaintiff has received from sources independent of the tortfeasor from damages the plaintiff "would otherwise collect from the tortfeasor" (*Helfend v. Southern Cal. Rapid Transit Dist. (1970) 2 Cal.3d 1, 6 [84 Cal. Rptr. 173, 465 P.2d 61]* (*Helfend*)), ensures that plaintiff here may recover in damages the amounts her insurer paid for her medical care. The rule, however, has no bearing on amounts that were included in a provider's bill but for which the plaintiff never incurred liability because the provider, by prior agreement, accepted a lesser amount as full payment. Such sums are not damages the **[*549]** plaintiff would otherwise have collected from the defendant. They are neither paid to the providers on the plaintiff's behalf nor paid to the plaintiff in indemnity of his or her expenses. Because they do not represent an economic loss for the plaintiff, they are not recoverable in the first instance. The collateral source rule precludes certain deductions against otherwise recoverable damages, but does not expand the scope of economic damages to include expenses the plaintiff never incurred.

FACTUAL AND PROCEDURAL BACKGROUND

Plaintiff Rebecca Howell was **[5]** seriously injured in an automobile accident negligently caused by a driver for defendant Hamilton Meats & Provisions, Inc. (Hamilton). At trial, Hamilton conceded liability and the necessity of the medical treatment plaintiff had received, contesting only the amounts of plaintiff's economic and noneconomic damages.

Hamilton moved in limine to exclude evidence of medical bills that neither plaintiff nor her health insurer, PacifiCare, had paid. Hamilton asserted that PacifiCare payment records indicated significant amounts of the bills from plaintiff's health care providers (the physicians who treated her and Scripps Memorial Hospital Encinitas, where she was **[**1134]** treated) had been

adjusted downward before payment pursuant to agreements between those providers and PacifiCare and that, **[****1150]** under plaintiff's preferred provider organization (PPO) policy with PacifiCare, plaintiff could not be billed for the balance of the original bills (beyond the amounts of agreed patient copayments). Relying primarily on *Hanif v. Housing Authority (1988) 200 Cal. App. 3d 635 [246 Cal. Rptr. 192]* (*Hanif*), [1] Hamilton argued that because only the amounts paid by plaintiff and her insurer could be recovered, **[***330]** the larger amounts billed **[6]** by the providers were irrelevant and should be excluded. The trial court denied the motion, ruling that plaintiff could present her full medical bills to the jury and any reduction to reflect payment of reduced amounts would be handled through "a posttrial *Hanif* motion."

Plaintiff's surgeon and her husband each testified that the total amount billed for her medical care up to the time of trial was $189,978.63, and the **[*550]** jury returned a verdict awarding that same amount as damages for plaintiff's past medical expenses.

Hamilton then made a "post-trial motion to reduce past **[7]** medical specials pursuant to [*Hanif*]," seeking a reduction of $130,286.90, the amount assertedly "written off" by plaintiff's medical care providers, Scripps Memorial Hospital Encinitas (Scripps) and CORE Orthopaedic Medical Center (CORE). In support of the motion, Hamilton submitted billing and payment records from the providers and two declarations, the first by Scripps's collections supervisor, the second by an employee of CORE's billing contractor. The Scripps declaration stated that of the $122,841 billed for plaintiff's surgeries, PacifiCare paid $24,380, plaintiff paid $3,566, and the remaining $94,894 was " 'written off' or waived by [Scripps] pursuant to the agreement between [Scripps] and the patient's private healthcare insurer, in this case Pacificare PPO." The CORE declaration stated that of the surgeon's bill for $52,915, PacifiCare paid $9,665, and $35,392 was waived or written off pursuant to CORE's agreement with PacifiCare. [2] Both declarants stated the providers had not filed liens for, and would not pursue collection of, the written-off amounts.

In opposition, plaintiff argued reduction of the medical damages would violate the collateral source rule. She supported her opposition with copies of the patient agreements she had signed with Scripps, in which she agreed to pay Scripps's "usual and customary charges" for the medical care she was to receive, and with CORE, in which she agreed to pay any part of the physician's fee her insurance did not pay.
[**1151]**

The trial court granted Hamilton's motion, reducing the past medical damages award "to reflect the amount the medical providers accepted as payment in full." Accordingly, the court reduced the judgment by $130,286.90.

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[1] In *Hanif*, the plaintiff introduced evidence that the reasonable value of the medical services he received was greater than the amount Medi-Cal had paid on his behalf, and the trial court awarded him the greater sum. (*Hanif, supra, 200 Cal. App. 3d at p. 639*.) The appellate court held this was error, for "when the evidence shows a sum certain to have been paid or incurred for past medical care and services, whether by the plaintiff or by an independent source, that sum certain is the most the plaintiff may recover for that care despite the fact it may have been less than the prevailing market rate." (*Id. at p. 641*.)

[2] For simplicity, we have rounded these amounts to the nearest dollar, leading to a $1 discrepancy in the Scripps **[8]** total. The $7,858 difference between the total CORE bill and the sum of the PacifiCare payments and writeoffs is not explained in the CORE declaration.

52 Cal. 4th 541, *550; 257 P.3d 1130, **1134; 129 Cal. Rptr. 3d 325, ***330; 76 Cal. Comp. Cases 1147, ****1151; 2011 Cal. LEXIS 8119, *****8119

The Court of Appeal reversed the reduction order, holding it violated the collateral source rule. Because it viewed the reduction of the award as substantively improper, the Court of Appeal did not resolve plaintiff's additional contentions that the procedures used in the trial court were statutorily unauthorized and the evidence Hamilton presented was insufficient.
[*551]

We granted Hamilton's petition for review.

DISCUSSION

HN3[↑] ***CA(2)***[↑] **(2)** Compensatory **[9]** damages are moneys paid to compensate a person who "suffers detriment from the unlawful act or omission of another" (*Civ. Code, § 3281*), and the measure of damages generally recoverable in **[**1135]** tort is "the amount which will compensate for all the detriment proximately caused" by the tort (*id.*, *§ 3333*). *Civil Code section 3282*, in turn, defines "detriment" as "a loss or harm suffered in person or property." A person who undergoes necessary medical treatment for **[***331]** tortiously caused injuries suffers an economic loss by taking on liability for the costs of treatment. Hence, any reasonable charges for treatment the injured person has paid or, having incurred, still owes the medical provider are recoverable as economic damages. (See *Melone v. Sierra Railway Co. (1907) 151 Cal. 113, 115 [91 P. 522]* [plaintiff is entitled to "[s]uch reasonable sum ... as has been necessarily expended or incurred in treating the injury"].)

HN4[↑] ***CA(3)***[↑] **(3)** When, as here, the costs of medical treatment are paid in whole or in part by a third party unconnected to the defendant, the collateral source rule is implicated. The collateral source rule states that "if an injured party receives some compensation for his injuries from a source wholly **[10]** independent of the tortfeasor, such payment should not be deducted from the damages which the plaintiff would otherwise collect from the tortfeasor." (*Helfend, supra, 2 Cal.3d at p. 6*.) Put another way, "Payments made to or benefits conferred on the injured party from other sources [(i.e., those unconnected to the defendant)] are not credited against the tortfeasor's liability, although they cover all or a part of the harm for which the tortfeasor is liable." (*Rest.2d Torts, § 920A*, subd. (2).) The rule thus dictates that an injured plaintiff may recover from the tortfeasor money an insurer has paid to medical providers on his or her behalf.

CA(4)[↑] **(4)** *Helfend*, like the present case, involved a health insurer's payments to medical providers on the plaintiff's behalf. In these circumstances, we explained, ***HN5***[↑] the collateral source rule ensures plaintiffs will receive the benefits of their decision to carry insurance and thereby encourages them to do so. (*Helfend, supra, 2 Cal.3d at pp. 9–10*.) Since insurance policies frequently allow the insurer to reclaim the benefits paid out of a tort recovery by refund or subrogation, the rule, without providing the plaintiff a double recovery, ensures the tortfeasor **[11]** cannot "avoid payment of full compensation for the injury inflicted ... ." (*Id. at p. 10*.)
[*552]

In *Helfend*, we addressed a challenge to the continued acceptance of the collateral source rule. After considering the rule's operation and consequences, we **[****1152]** rejected that challenge, concluding that "in the context of the entire American approach to the law of torts and damages,

... the rule presently performs a number of legitimate and even indispensable functions." (*Helfend, supra, 2 Cal.3d at p. 13*.) *Helfend* did not, however, call on this court to consider *how* the collateral source rule would apply to damages for past medical expenses when the amount billed for medical services substantially exceeds the amount accepted in full payment. While *Helfend* unequivocally reaffirmed California's acceptance of the rule, it did not explain how the rule would operate in the circumstances of the present case.

HN6[↑] ***CA(5)***[↑] **(5)** The collateral source rule has an evidentiary as well as a substantive aspect. Because a collateral payment may not be used to reduce recoverable damages, evidence of such a payment is inadmissible for that purpose. Even if relevant on another issue (for example, to support a defense claim of malingering), **[12]** under *Evidence Code section 352* the probative value of a collateral payment must be "carefully weigh[ed] ... against the inevitable prejudicial impact such evidence is likely to have on the jury's deliberations." (*Hrnjak v. Graymar, Inc. (1971) 4 Cal.3d 725, 732 [94 Cal. Rptr. 623, 484 P.2d 599]*.) Admission of evidence of collateral payments may be reversible error even if accompanied **[***332]** by a limiting instruction directing the jurors not to deduct the payments from their award of economic damages. (*Id. at pp. 729, 734*.)

HN7[↑] ***CA(6)***[↑] **(6)** The Legislature has abrogated or altered the collateral source rule for two classes of actions. First, in a professional negligence action against a health care provider, the defendant may introduce evidence of collateral payments and benefits provided to the plaintiff for his or her injury; the plaintiff, in **[**1136]** turn, may introduce evidence of premiums paid or contributions made to secure the benefits. (*Civ. Code, § 3333.1, subd. (a)*.) Second, a public entity defendant may move, after trial, to reduce a personal injury award against it by the amount of certain collateral source payments. (*Gov. Code, § 985, subd. (b)*.) The trial court has discretion to reduce the judgment, though its discretion is guided **[13]** and limited in several respects, including that the total deduction may not exceed one-half of the plaintiff's net recovery. (*Id.*, *subd. (g)*.) Neither statute applies here.

The California history of the substantive question at issue—whether recovery of medical damages is limited to the amounts providers actually are paid or extends to the amounts of their undiscounted bills—begins with *Hanif, supra, 200 Cal. App. 3d 635*.
[*553]

The injured plaintiff in *Hanif* was a Medi-Cal recipient, [3] and the amounts Medi-Cal paid for his medical care were, according to his evidence, substantially lower than the "reasonable value" of the treatment (apparently the same as the hospital bill, as the opinion notes the hospital had " 'written off' " the difference). (*Hanif, supra, 200 Cal. App. 3d at p. 639*.) Although there was no evidence the **[****1153]** plaintiff was liable for the difference, the court in a bench trial awarded the plaintiff the larger, "reasonable value" amount. (*Ibid.*) The appellate court held the trial court had overcompensated the plaintiff for his past medical expenses; recovery should have been

[3] Medi-Cal is California's implementation of the federal Medicaid program. (See *Olszewski v. Scripps Health (2003) 30 Cal.4th 798, 804 [135 Cal. Rptr. 2d 1, 69 P.3d 927]*.) The amounts paid by Medicaid programs are "usually, if not always" less than a provider's ordinary charges. (*Id. at p. 820*.)

limited to the amount Medi-Cal had actually paid on his behalf. (*Id. at pp. 639, 643–644*.) The court ordered **[14]** the judgment modified to reflect the proper reduction. (*Id. at p. 646*.)

CA(7)[↑] **(7)** *Hanif*'s rationale was straightforward. ***HN8***[↑] While California courts have referred to the "reasonable value" of medical care in delineating the measure of recoverable damages for medical expenses, in this context " '[r]easonable value' is a term of limitation, not of aggrandizement." (*Hanif, supra, 200 Cal. App. 3d at p. 641*.) The "detriment" the plaintiff suffered (*Civ. Code, § 3281*), his pecuniary "loss" (*id.*, *§ 3282*), was only what Medi-Cal had paid on his behalf; to award more was to place him in a better financial position than before the tort was committed. (*Hanif, at pp. 640–641*.) A tort plaintiff's recovery for medical expenses, the *Hanif* court opined, is limited to the amount "paid or incurred for past medical care and services, whether by the plaintiff or by an independent source ... ." (*Id. at p. 641*.)

We cited *Hanif*'s holding with approval in *Olszewski v. Scripps Health, supra, 30 Cal.4th 798*, **[15]** in which we held California's provider lien statute (*Welf. & Inst. Code, § 14124.791*) was preempted by federal law and invalid **[***333]** as applied to a Medi-Cal beneficiary's tort recovery. In so doing, we observed that because a provider's lien for its full fees was not permissible, pursuant to *Hanif* the Medi-Cal beneficiary may recover as damages from the tortfeasor only the amount payable to the provider under Medi-Cal. (*Olszewski, at pp. 826–827*.)

In *Nishihama v. City and County of San Francisco (2001) 93 Cal.App.4th 298 [112 Cal. Rptr. 2d 861]* (*Nishihama*), the Court of Appeal applied *Hanif*'s rationale to payments made by a private health insurer. The jury awarded the injured plaintiff $17,168 for her hospital expenses, an amount based on **[*554]** the hospital's "normal rates." (*Id. at p. 306*.) The record, however, showed the plaintiff participated in a health plan administered by Blue Cross, which had an agreement with the hospital pursuant to which the hospital had accepted $3,600 in full payment for its services to the plaintiff. (*Id. at pp. 306–307*.) Relying on *Hanif*'s holding that only the amount actually paid or incurred is recoverable as compensation for medical expenses, and rejecting the plaintiff's argument that the **[16]** hospital might take a larger sum (its normal **[**1137]** rate) out of her recovery under a lien it had filed, [4] the *Nishihama* court ordered the judgment reduced to reflect only the amount the hospital had received from Blue Cross. (*Nishihama, at pp. 306–309*.)

This court subsequently reached the same conclusion in *Parnell v. Adventist Health System/West (2005) 35 Cal.4th 595, 598 [26 Cal. Rptr. 3d 569, 109 P.3d 69]*, holding the hospital could not assert a lien against a patient's tort recovery for **[****1154]** its full bill when it had agreed to accept an insurer's lesser reimbursement as full payment. At the same time, however, we reserved judgment on whether *Hanif, supra, 200 Cal. App. 3d 635*, and *Olszewski v. Scripps Health, supra, 30 Cal.4th 798*, "apply outside the Medicaid context and limit a patient's tort recovery for medical expenses to the amount actually paid ... ." (*Parnell, at pp. 611–612, fn. 16*.)

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[4] The appellate court held that under the Hospital Lien Act (*Civ. Code, §§ 3045.1–3045.6*) the hospital's lien rights "do not extend beyond the amount it agreed to receive from Blue Cross as payment in full for services provided to plaintiff." (*Nishihama, supra, 93 Cal.App.4th at p. 307*.)

Hanif and *Nishihama* were distinguished in Katiuzhinsky v. Perry (2007) 152 Cal.App.4th 1288 [62 Cal. Rptr. 3d 309]. **[17]** There, although the injured plaintiffs' medical providers had sold some of their bills at a discount to a medical finance company, the plaintiffs remained liable to the finance company for the original amounts of the bills. (Id. at pp. 1290–1291.) The appellate court concluded the trial court, in limiting recovery to the discounted amounts, "did not correctly apply *Hanif* and *Nishihama*. The intervention of a third party in purchasing a medical lien does not prevent a plaintiff from recovering the amounts billed by the medical provider for care and treatment, *as long as the plaintiff legitimately incurs those expenses and remains liable for their payment*." (Id. at p. 1291, italics added.)

None of the above decisions discussed the question, central to the arguments in this case, of whether restricting recovery to amounts actually paid by a plaintiff or on his or her behalf contravenes the collateral source rule. These arguments, although extensive, can be reduced to a few central **[*555]** disputed issues: (1) Was *Hanif* **[***334]** correct that a tort plaintiff can recover only what has been paid or incurred for medical care, even if that is less than the reasonable value of the services rendered? (2) Even **[18]** if *Hanif*, which involved Medi-Cal payments, reached the right result on its facts, does its logic extend to plaintiffs covered by private insurance? (3) Does limiting the plaintiff's recovery to the amounts paid and owed on his or her behalf confer a windfall on the tortfeasor, defeating the policy goals of the collateral source rule? (4) Is the difference between the providers' full billings and the amounts they have agreed to accept from a patient's insurer as full payment—what the appellate court below called the "negotiated rate differential"—a benefit the patient receives from his or her health insurance policy subject to the collateral source rule? We address these questions below.

A. Hanif *and the Measure of Damages for Past Medical Expenses*

CA(8)[↑] **(8)** We agree with the *Hanif* court that ***HN9***[↑] a plaintiff may recover as economic damages *no more* than the reasonable value of the medical services received and is not entitled to recover the reasonable value if his or her actual loss was less. (Hanif, supra, 200 Cal. App. 3d at p. 641.) California decisions have focused on "reasonable value" in the context of *limiting* recovery to reasonable expenditures, not expanding recovery beyond the plaintiff's **[19]** actual loss or liability. To be recoverable, a medical expense must be both incurred *and* reasonable. (See Melone v. Sierra Railway Co., supra, 151 Cal. at p. 115 [proper measure of damages for medical expenses is "[s]uch reasonable sum ... *as has been necessarily expended or incurred* in treating the injury" (italics added)]; Townsend v. Keith (1917) 34 Cal.App. 564, 566 [168 P. 402] [trial court's failure to instruct the jury "to limit its finding to the reasonable value of *the expenses incurred*" did **[****1155]** not prejudice defendant, as **[**1138]** the expenses incurred were, on their face, not unreasonable (italics added)].)

HN10[↑] ***CA(9)***[↑] **(9)** The rule that a plaintiff's expenses, to be recoverable, must be both incurred *and* reasonable accords, as well, with our damages statutes. "Damages must, in all cases, be reasonable ... ." (Civ. Code, § 3359.) But if 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. (*Id.*, §§ 3281, 3282.) The same rule applies when a collateral source, such as the plaintiff's health insurer, has obtained a discount **[20]** for its payments on the plaintiff's behalf.

CA(10)[↑] **(10)** The Restatement rule is to the same effect. ***HN11***[↑] While the measure of recovery for the costs of services a third party renders is ordinarily the **[*556]** reasonable value of those services, "[*i*]*f ... the injured person paid less than the exchange rate, he can recover no more than the amount paid*, except when the low rate was intended as a gift to him." (*Rest.2d Torts, § 911, com. h*, pp. 476–477, italics added.)

CA(11)[↑] **(11)** Plaintiff argues *section 911 of the Restatement* is irrelevant, as it deals only with the wrongful taking of services and damage to property. Not so. *Section 911* articulates a rule, applicable to ***HN12***[↑] recovery of tort damages generally, that the value of property or services is ordinarily its "exchange value," that is, its market value or the amount for which it could usually be exchanged. ***CA(12)***[↑] **(12)** *Comment h to section 911*, on the "[*v*]*alue of services rendered*" (*id.* at p. 476), applies, inter alia, to services the plaintiff must purchase from third parties as a result of the tort, noting that ***HN13***[↑] if the plaintiff obtains these for less than the exchange value, **[***335]** only the amount paid may be recovered. The expenses of medical care, although not specifically mentioned, are logically included **[21]** in the rule articulated. Thus the general rule under the Restatement, as well as California law, is that a personal injury plaintiff may recover *the lesser* of (a) the amount paid or incurred for medical services, and (b) the reasonable value of the services.

CA(13)[↑] **(13)** Contrary to the view of the dissent (dis. opn., *post*, at pp. 575–576), *section 924 of the Restatement*, which provides that a tort plaintiff may recover "reasonable medical and other expenses," expresses no different principle. (*Rest.2d Torts, § 924.*) ***HN14***[↑] To be recoverable as "expenses," monies must generally have been expended, or at least incurred; that they must also be reasonable does not alter this general rule. [5]
[**1156]**

B. Hanif *and Private Health Insurance*

Plaintiff contends *Hanif*'s limitation on recovery, even if correct as to Medi-Cal recipients, does not logically apply to plaintiffs, like her, with private medical insurance. The appellate court below agreed, reasoning that "Howell, who was privately insured, incurred personal liability for her medical providers' usual and customary charges," whereas the plaintiff in *Hanif* "incurred no personal liability for the medical charges billed to **[*557]** Medi-Cal." Observing that *Hanif* stated the measure of recovery for medical expenses was the amounts actually "paid or incurred" (*Hanif, supra, 200 Cal. App. 3d at p. 641*), plaintiff argues she *incurred* liability for the full amount of Scripps's and CORE's bills when she signed patient agreements with those providers and accepted their services.

We find the distinction unpersuasive. Evidence **[23]** presented at the posttrial hearing showed Scripps and CORE accepted the discounted amounts as full payment pursuant to preexisting

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[5] The reporter's note for *section 924* (Rest.2d Torts (appen.) *§ 924*, reporter's notes, p. 445) cites in support of its rule, among other cases, *Birmingham Amusement Co. v. Norris (1927) 216 Ala. 138 [112 So. 633]*, which stated, quoting an earlier Alabama case, that " '[w]hile it is true that the defendant is not liable for any more than the reasonable value of the services of a physician, yet neither is it liable for any more than has actually been paid or is due. *So it is necessary to prove both ... .*' " (*Id., 112 So. at p. 636*, italics added.) **[22]** *Comment f to section 924*, on which the dissent relies (dis. opn., *post*, at pp. 575–576), notes the exception for donated medical services (discussed further below) but does not suggest that recovery for medical expenses may otherwise generally exceed the amount reasonably paid or incurred. (*Rest.2d Torts, § 924, com. f*, pp. 526–527.)

[1139]** agreements with PacifiCare, plaintiff's managed care plan. Since those agreements were in place when plaintiff sought medical care from the providers and signed the patient agreements, her prospective liability was limited to the amounts PacifiCare had agreed to pay the providers for the services they were to render. Plaintiff cannot meaningfully be said ever to have incurred the full charges. (See *Parnell v. Adventist Health System/West, supra, 35 Cal.4th at p. 609* [where hospital had agreed with plaintiff's health plan to accept discounted amounts as payment in full, plaintiff owed hospital nothing beyond those discounted payments]; cf. *People v. Bergin (2008) 167 Cal.App.4th 1166, 1170 [84 Cal. Rptr. 3d 700]* [for purposes of *Pen. Code, § 1202.4, subd. (f)(3)*, requiring restitution in the amount of the "economic loss incurred," crime victim incurred loss only in the amount medical provider accepted as payment from private insurer].) In this respect, plaintiff here was in the same position as the *Hanif* **[***336]** plaintiff, who also bore no personal liability for the providers' charges. **[24]** This is not a case like *Katiuzhinsky v. Perry, supra, 152 Cal.App.4th at page 1296*, where the plaintiffs "remain[ed] fully liable for the amount of the medical provider's charges for care and treatment."

Hanif noted one exception to its rule, viz., for medical services that are gratuitously provided or discounted, an exception included in the Restatement section on which the court relied (*Rest.2d Torts, § 911, com. h*, pp. 476–477). (See *Hanif, supra, 200 Cal. App. 3d at p. 643* [no evidence the low rate charged Medi-Cal "was intended as a gift to the plaintiff"].) The question arises whether this exception, if accepted, limits *Hanif*'s logic in a manner important to the present issue. That is, if a plaintiff, as the Restatement provides, may recover the reasonable value of donated medical services—services for which neither the plaintiff nor the plaintiff's insurer paid—should a plaintiff also be permitted to recover other amounts that were not paid but were reasonably billed by the provider, including the negotiated rate differential? If the amount of a gratuitous discount would be considered a collateral source payment, should the amount of a negotiated discount be treated in the **[25]** same way?

The Restatement reflects the widely held view that the collateral source rule applies to gratuitous payments and services. (*Rest.2d Torts, § 920A, **[*558]** com. c*, subd. **[****1157]** (3), p. 515 ["Thus the fact that the doctor did not charge for his services or the plaintiff was treated in a veterans hospital does not prevent his recovery for the reasonable value of the services."]; see also *Rest.2d Torts, § 924, com. f*, pp. 526–527.) California law is less clear on the point. In *Helfend*, we suggested in dictum that the collateral source rule applies to unpaid services only when those are rendered "with the expectation of repayment out of any tort recovery." (*Helfend, supra, 2 Cal.3d at p. 7, fn. 5*.) But in *Arambula v. Wells (1999) 72 Cal.App.4th 1006 [85 Cal. Rptr. 2d 584]*, the Court of Appeal declined to follow this dictum, finding it inconsistent with other California cases, the law of sister states, and the policy of encouraging charitable action: "We **[26]** doubt such gifts would continue if, notwithstanding a donor's desire to aid the injured, the person who caused the injury ultimately stood to gain a windfall. Donors should not have to consult with a lawyer to make sure their largesse is not hijacked by the tortfeasor." (*Id. at p. 1013*.) Thus, although in *Arambula* the injured plaintiff's employer had continued to pay his salary, the appellate court held the jury should have been permitted to award damages for lost earnings. (*Id. at pp. 1008–1009, 1016*.) This court has neither approved nor disapproved *Arambula*'s holding, nor does this case require that we do so.

CA(14)[↑] **(14)** Assuming California follows the Restatement's view that a plaintiff may recover the value of donated services under the collateral source rule, this exception to *Hanif*'s limitation on recovery does not, we believe, militate against applying *Hanif*'s rule—that only amounts paid or incurred are recoverable—to medical expenses paid by the plaintiff's insurer. ***HN15***[↑] Medical providers that agree to accept discounted payments by managed care organizations or other health insurers as **[**1140]** full payment for a patient's care do so not as a gift to the patient or insurer, but for commercial reasons **[27]** and as a result of negotiations. As plaintiff herself explains, hospitals and medical groups obtain commercial benefits from their agreements with health insurance organizations; the agreements **[***337]** guarantee the providers prompt payment of the agreed rates and often have financial incentives for plan members to choose the providers' services. (See *Stanley v. Walker (Ind. 2009) 906 N.E.2d 852, 863–864* (dis. opn. of Dickson, J.) [detailing administrative and marketing advantages medical providers derive from managed care agreements, particularly those with preferred provider plans].) That plaintiffs are not permitted to recover undiscounted amounts from those who have injured them creates no danger these negotiations and agreements will disappear; the medical provider has no financial reason to care whether the tortfeasor is charged with or the plaintiff recovers the negotiated rate differential. Having agreed to accept the negotiated amount as full payment, a provider may not recover any difference between that and the billed amount through a lien on the tort recovery. (*Parnell v. Adventist Health System/West, supra, 35 Cal.4th at p. 598*.)

[*559]

In jurisdictions where donated services are considered **[28]** to fall within the collateral source rule, the plaintiff is presumably entitled to recover the reasonable value of the services even though he or she did not incur liability in that amount. The dissent argues that to limit the recovery of a plaintiff with medical insurance, such as Howell, to the amounts paid or incurred is anomalous, given that he or she **[****1158]** could have recovered a hypothetically larger reasonable value had the services been gratuitously provided. (Dis. opn., *post*, at p. 572.) We see no anomaly, even assuming we would recognize the gratuitous-services exception to the rule limiting recovery to the plaintiff's economic loss. The rationale for that exception—an incentive to charitable aid (*Arambula v. Wells, supra, 72 Cal.App.4th at p. 1013*)—has, as just explained, no application to commercially negotiated price agreements like those between medical providers and health insurers. Nor, as discussed below, does the tort law policy of avoiding a windfall to the tortfeasor suggest the necessity of treating the negotiated rate differential as if it were a gratuitous payment by the medical provider. [6] (See pt. C., *post*.)

CA(15)[↑] **(15)** The dissent's repeated description of the negotiated rate differential as a *writeoff* from the provider's bill illustrates the confusion between negotiated prices and gratuitous provision of medical services. (See dis. opn., *post*, at pp. 568–569, 571, 572–573, 577.) Where a plaintiff has incurred liability for the billed cost of services and the provider later "writes off" part

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[6] The dissent also argues that since an *uninsured* plaintiff **[29]** would be entitled to recover the reasonable value of medical services received, an insured plaintiff like Howell should be entitled to the same. The dissent's premise is erroneous; a plaintiff who lacks health insurance would *not* be entitled to recover the reasonable value of the medical services if that amount exceeded the liability he or she incurred for the services. The rule that medical expenses, to be recoverable, must be both incurred *and* reasonable (*Civ. Code, §§ 3281, 3282, 3359*; *Melone v. Sierra Railway Co., supra, 151 Cal. at p. 115*) applies equally to those with and without medical insurance.

of the bill because, for example, the plaintiff is unable to pay the full charge, one might argue that the amount of the writeoff constitutes a gratuitous benefit the plaintiff is entitled to recover under the collateral **[30]** source rule. But in cases like that at bench, the medical provider has agreed, before treating the plaintiff, to accept a certain amount in exchange for its services. That amount constitutes the provider's price, which the plaintiff and health insurer are obligated to pay without any writeoff. There is no **[***338]** need to determine a reasonable value of the services, as there is in the case of services gratuitously provided.***HN16***[↑] "[W]here, as here, the exact amount of expenses has been established by contract and those expenses have been satisfied, there is no longer any issue as to the amount of expenses for which the plaintiff will be liable. In the latter case, the injured party should be limited to recovering the amount paid for the **[**1141]** medical services." (*Moorhead v. Crozer Chester Medical Center (2001) 564 Pa. 156 [765 A.2d 786, 789].*)

[*560]

C. *Windfall to the Tortfeasor*

HN17[↑] ***CA(16)***[↑] **(16)** Nor does the tortfeasor obtain a "windfall" (*Arambula v. Wells, supra, 72 Cal.App.4th at p. 1013*) merely because the injured person's health insurer has negotiated a favorable rate of payment with the person's medical provider. When an injured plaintiff has received collateral compensation or benefits as a gift, allowing a deduction from damages **[31]** in that amount would result in a windfall for the tortfeasor and underpayment for the injury. Because the tortfeasor would not pay the full cost of his or her negligence or wrongdoing, the deduction would **[****1159]** distort the deterrent function of tort law. (See Katz, *Too Much of a Good Thing: When Charitable Gifts Augment Victim Compensation (2003) 53 DePaul L.Rev. 547, 564* [if a charitable gift to the plaintiff reduces the tort recovery, the defendant "pays less than the full social costs of his conduct and is underdeterred"].) Analogously, if it were established a medical provider's full bill generally represents the value of the services provided, and the discounted price negotiated with the insurer is an artificially low fraction of that true value, one could make a parallel argument that relieving the defendant of paying the full bill would result in underdeterrence. The complexities of contemporary pricing and reimbursement patterns for medical providers, however, do not support such a generalization. We briefly explore those complexities below.

A 2005 study of hospital cost setting conducted for the Medicare Payment Advisory Commission concluded: "Hospital charge setting practices are **[32]** complex and varied. Hospitals are generally faced with competing objectives of balancing budgets, remaining competitive, complying with health care and regulatory standards, and continuing to offer needed services to the community. ... [¶] Disparities between charges and costs [have] been growing over time as many existing charges were set before hospitals had a good idea of their costs and/or were set in response to budgetary and competitive considerations rather than resource consumption. Hospital charges are set within the context of hospitals' broader communities, including their competitors, payers, regulators, and customers. ... These competing influences and hospitals' efforts to address them often produce charges which may not relate systematically to costs." (Dobson et al., A Study of Hospital Charge Setting Practices (2005) p. v <*http://www.medpac.gov/documents/Dec05_Charge_setting.pdf*> [as of Aug. 18, 2011].)

The rise of managed care organizations, which typically restrict payments for services to their members, has reportedly led to increases in the prices charged to uninsured patients, who do not benefit from providers' contracts **[*561]** with the plans. As one article explains: **[33]** "Before managed care, hospitals billed insured and uninsured patients similarly. In 1960, 'there were no discounts; everyone paid the same rates'—usually cost plus ten percent. But as some insurers demanded deep discounting, hospitals vigorously shifted costs to patients with less clout." (Hall & Schneider, *Patients as Consumers: Courts, Contracts, and the New Medical* ***[***339]*** *Marketplace (2008) 106 Mich. L.Rev. 643, 663*, fns. omitted (hereafter *Patients as Consumers*).) As a consequence, "only uninsured, self-paying U.S. patients have been billed the full charges listed in hospitals' inflated chargemasters ... ," [7] so that a family might find itself "paying off over many years a hospital bill of, say, $30,000 for a procedure that Medicaid would have reimbursed at only $6,000 and **[****1160]** commercial insurers somewhere in between." (Reinhardt, *The Pricing Of U.S. Hospital Services: Chaos Behind A Veil Of Secrecy* (2006) 25 Health Affairs 57, 62 (hereafter *The Pricing of U.S. Hospital Services*).) Some physicians, too, have reportedly shifted costs to the uninsured, resulting in significant disparities between charges to uninsured patients and those with private **[**1142]** insurance or public medical benefits. (*Patients as Consumers, at pp. 661–663*.)

Nor do the chargemaster rates (see fn. 7, *ante*) necessarily represent the amount an uninsured patient will pay. In California, medical providers are expressly authorized to offer the uninsured discounts, and hospitals in particular are required to maintain a discounted payment policy for patients with high medical costs who are at or below 350 percent of the federal poverty level. (*Bus. & Prof. Code, § 657, subd. (c)*; *Health & Saf. Code, § 127405, subd. (a)(1)(A)*.) Nationally, "many hospitals now have means-tested discounts off their chargemasters for uninsured patients, which bring the prices charged the uninsured closer to those paid by commercial insurers or even below." (*The Pricing of U.S. Hospital Services, supra*, 25 Health Affairs **[35]** at p. 62.) 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. 63.)

We do not suggest hospital bills always exceed the reasonable value of the services provided. Chargemaster prices for a given service can vary tremendously, sometimes by a factor of five or more, from hospital to hospital in California. (See *The Pricing of U.S. Hospital Services, supra*, 25 Health Affairs at p. 58, exhibit No. 1 [prices for a chest X-ray at selected Cal. **[*562]** hospitals, showing low of around $200 and high of around $1,500].) [8] With so much variation, making any broad generalization about the relationship between the value or cost of medical

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[7] A **[34]** hospital charge description master, or chargemaster, is "a uniform schedule of charges represented by the hospital as its gross billed charge for a given service or item, regardless of payer type." (*Health & Saf. Code, § 1339.51, subd. (b)(1)*.) California hospitals are required to make their chargemasters public and to file them with the Office of Statewide Health Planning and Development. (*Id.*, *§§ 1339.51, subds. (a)(1), (b)(3), 1339.55, subd. (a)*.)

[8] Hospitals' chargemaster prices can be accessed on the Web site of the Office of Statewide Health Planning and Development at <*http://www.oshpd.ca.gov/Chargemaster*> (as of Aug. 18, 2011). Updating Reinhardt's 2004 survey **[36]** using 2010 data, one finds the listed price for a two-view chest X-ray was $176 at San Francisco General Hospital and $1,390 at Doctors Medical Center of Modesto.

services and the amounts providers bill for them—other than that the relationship is not always a close one—would be perilous.

Finally, private health insurers are well equipped to conduct sophisticated arm's-length price negotiations, whereas patients individually suffer inherent disadvantages that significantly impede negotiating prices with medical care providers: difficulty in gathering information, lack of choice and bargaining power, and possible physical and emotional disabilities relating to the **[***340]** injury or illness. (See *Patients as Consumers, supra, 106 Mich. L.Rev. at pp. 648–659*.) If we seek, then, the exchange value of medical services the injured plaintiff has been required to obtain (see *Rest.2d Torts, § 911 & com. h*, pp. 476–477), looking to the negotiated prices providers accept from insurers makes at least as much sense, and arguably more, than relying on chargemaster prices that are not the result of direct negotiation between buyer and seller. For this reason as well, it is not possible to **[****1161]** say generally that providers' full bills represent the real value of their services, nor that the discounted payments they accept from private **[37]** insurers are mere arbitrary reductions. Accordingly, a tortfeasor who pays only the discounted amount as damages does not generally receive a windfall and is not generally underdeterred from engaging in risky conduct.

The dissent argues that unless the insured plaintiff is permitted to recover the reasonable value or "market value" of the medical services, the tortfeasor will not pay the full cost of its negligence, "distort[ing] the deterrent function of tort law." (Dis. opn., *post*, at pp. 568, 571.) But as discussed above, pricing of medical services is highly complex and depends, to a significant extent, on the identity of the payer. In effect, there appears to be not one market for medical services but several, with the price of services depending on the category of payer and sometimes on the particular government or business entity paying for the services. Given this state of medical economics, how a market value other than that produced by negotiation between the insurer and the provider could be identified is unclear. [9]
[*563]

[1143]** The dissent's proposal that the insured plaintiff recover the "reasonable value" of his or her care, to be proven in each case by expert testimony (dis. opn., *post*, at pp. 568, 577–578), is also troubling because it would routinely involve violations of the evidentiary aspect of the collateral source rule. If the jury were required to decide whether the price actually paid for medical care was lower than reasonable, the defense could not in fairness be precluded from showing the circumstances by which that price was determined, including that it was negotiated and paid by the plaintiff's health insurer. In contrast, our conclusion, that the plaintiff may recover no more than the medical providers accepted in full payment for their services, allows for proof of the amount paid without admitting **[39]** evidence of the payment's source. (See p. 566, *post*.)

D. *The Negotiated Rate Differential as Insurance Benefit*

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[9] The Restatement (*Rest.2d Torts, § 911, com. h*, p. 476) notes the "customary rate" for services governs tort recovery "[i]f the services are rendered in a business **[38]** or profession in which there is a rate for them definitely established by custom ... ." But how may such a rate be determined when the "custom" is to bill for medical services at chargemaster rates that are paid by relatively few patients and to discount those rates to varying degrees for various government, insurance, and individual payers according to a complex system of regulation and negotiation?

If the negotiated rate differential is not a gratuitous payment by the provider to the injured plaintiff (recoverable, at least in the Restatement's view, under the collateral source rule), nor an arbitrary reduction (arguably recoverable to prevent a defense windfall and underdeterrence), is it, as plaintiff contends and the Court of Appeal held, recoverable as a benefit provided to the insured plaintiff under her **[***341]** policy? Plaintiff contends the negotiated rate differential represents the monetary value of the administrative and marketing advantages a provider obtains through its agreement with the insurer. Having incurred liability for the full price of her medical care, plaintiff maintains, she then received the benefit of having her **[****1162]** insurer extinguish that obligation through a combination of cash payments and noncash consideration in the amount of the negotiated rate differential. Both parts of this consideration being benefits accruing to her under her policy, for which she paid premiums, both parts should assertedly be recoverable under the collateral source rule.

We disagree. **[40]** As previously discussed, plaintiff did not incur liability for her providers' full bills, because at the time the charges were incurred the providers had already agreed on a different price schedule for PacifiCare's PPO members. (See *Parnell v. Adventist Health System/West, supra, 35 Cal.4th at p. 609*.) Having never incurred the full bill, plaintiff could not recover it in damages for economic loss. For this reason alone, the collateral source rule would be inapplicable. The rule provides that "if an injured party receives some compensation for his injuries from a source wholly independent of the tortfeasor, such payment should not be deducted from the *damages which the plaintiff would otherwise collect from the tortfeasor.*" **[*564]** (*Helfend, supra, 2 Cal.3d at p. 6*, italics added.) The rule does not speak to losses or liabilities the plaintiff did not incur and would not otherwise be entitled to recover. As was explained by an Oregon justice, "The collateral source doctrine does not address the amount of damages that a plaintiff can recover in the first instance." (*White v. Jubitz Corp. (2009) 347 Or. 212 [219 P.3d 566, 584]* (dis. opn. of Kistler, J.); see also *Goble v. Frohman (Fla. 2005) 901 So. 2d 830, 833* **[41]** (conc. opn. of Bell, J.) [collateral source rule has no application where plaintiff "has not paid, nor is he obligated to pay, the prediscount amount of his medical bills"].) "Certainly, the collateral source rule should not extend so far as to permit recovery for sums neither the plaintiff nor any collateral source will ever be obligated to pay." (Beard, *The Impact of Changes in Health Care Provider Reimbursement Systems on the Recovery of Damages for Medical Expenses in Personal Injury Suits* (1998) 21 Am. J. Trial Advoc. 453, 489.)

The negotiated rate differential lies outside the operation of the collateral source rule also because it is not primarily a benefit to the plaintiff and, to the extent it does benefit the plaintiff, it is not provided as "compensation **[**1144]** for [the plaintiff's] injuries." (*Helfend, supra, 2 Cal.3d at p. 6*.) Insurers and medical providers negotiate rates in pursuit of their own business interests, and the benefits of the bargains made accrue directly to the negotiating parties. The primary benefit of discounted rates for medical care goes to the payer of those rates—that is, in largest part, to the insurer.

Nor does the insurer negotiate or the medical provider **[42]** grant a discounted payment rate *as compensation for the plaintiff's injuries*. As one amicus curiae observes, sellers in almost any industry may, for a variety of reasons, discount their prices for particular buyers, "[b]ut a discounted price is not a payment. ... [¶] ... [¶] Nor has the value of damages the plaintiff *avoided* ever been the measure of tort recovery." And even when the overall savings a health

insurance organization negotiates for itself can be said to benefit an insured indirectly—through lower premiums or copayments, for example—it would be rare that these indirect benefits would **[***342]** coincidentally equal the negotiated rate differential for the medical services rendered the plaintiff.
[**1163]**

Finally, while the providers presumably did obtain some commercial advantages by virtue of their agreements with PacifiCare, plaintiff's insurer, the *global* value of those advantages cannot be equated to the amount of the negotiated rate differential for plaintiff's *individual* care. As we have seen, 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. Within a single hospital's **[43]** chargemaster, for example, "[m]ark-ups tend to vary by service line, with high cost items receiving a lower mark-up than low cost items." (Dobson et al., A Study of Hospital Charge Setting Practices, ***[*565]*** *supra*, at p. v.) The price schedules for PacifiCare members, meanwhile, were negotiated for the entire PPO membership, not individually for plaintiff, and covered a range of medical services Scripps and CORE provided, not only those rendered to plaintiff. For a given medical service to a given plaintiff, therefore, the amount of the negotiated rate differential may be higher or lower than the average discount over the range of services offered. The negotiated rate differential in a particular case thus does not necessarily reflect the commercial advantages the provider obtained in exchange for accepting a discounted payment *in that case*.

CA(17)[↑] **(17)** We conclude***HN18***[↑] the negotiated rate differential is not a collateral payment or benefit subject to the collateral source rule. We emphasize, however, that the rule applies with full force here and in similar cases. Plaintiff here recovers the amounts paid on her behalf by her health insurer as well as her own out-of-pocket expenses. No "credit[] against the **[44]** tortfeasor's liability" (*Rest.2d Torts, § 920A*, subd. (2)) and no deduction from the "damages which the plaintiff would otherwise collect from the tortfeasor" (*Helfend, supra, 2 Cal.3d at p. 6*) is allowed for the amount paid through insurance. Plaintiff thus receives the benefits of the health insurance for which she paid premiums: her medical expenses have been paid per the policy, and those payments are not deducted from her tort recovery.

Plaintiff's insurance premiums contractually guaranteed payment of her medical expenses at rates negotiated by the insurer with the providers; they did not guarantee payment of much higher rates the insurer never agreed to pay. Indeed, had her insurer not negotiated discounts from medical providers, plaintiff's premiums presumably would have been higher, not lower. In that sense, plaintiff clearly did not pay premiums for the negotiated rate differential. Recovery of the amount the medical provider agreed to accept from the insurer in full payment of her care, but no more, thus ensures plaintiff "receive[s] the benefits of [her] thrift" and the tortfeasor does not "garner the benefits of his victim's providence." (*Helfend, supra, 2 Cal.3d at p. 10*.)

In **[45]** holding plaintiff may not recover as past medical damages the amount of a negotiated rate differential, then, we do not alter the collateral source rule as articulated in *Helfend* and the Restatement. Rather, we conclude that because the plaintiff does not **[**1145]** incur liability in the amount of the negotiated rate differential, which also is not paid to or on behalf of the plaintiff to cover the expenses of the plaintiff's injuries, it simply does not come within the rule. "[A] rule limiting the measure of recovery to paid charges (where the provider is prohibited from balance

billing the patient) ... provides certainty without **[***343]** violating the principles **[****1164]** protected by the collateral source rule. Even with a limit of recovery to the net loss there is no lessening of the deterrent force of tort law, the defendant does not gain the benefit of the plaintiff's **[*566]** bargain, and the plaintiff receives full compensation for the amount of the expense he was obligated to pay." (Beard, *The Impact of Changes in Health Care Provider Reimbursement Systems on the Recovery of Damages for Medical Expenses in Personal Injury Suits, supra*, 21 Am. J. Trial Advoc. at p. 489.)

There is, to be sure, an element of fortuity **[46]** to the compensatory damages the defendant pays under the rule we articulate here. A tortfeasor who injures a member of a managed care organization may pay less in compensation for medical expenses than one who inflicts the same injury on an uninsured person treated at a hospital (assuming the hospital does not offer the person a discount from its chargemaster prices). But, as defendant notes, "[f]ortuity is a fact in life and litigation." To use an example provided by amicus curiae League of California Cities, when a driver negligently injures a pedestrian the amount of lost income the injured plaintiff can recover depends on his or her employment and income potential, a matter of complete fortuity to the negligent driver. In that situation as in this, "[i]dentical injuries may have different economic effects on different victims." We should not order one defendant to pay damages for an economic loss the plaintiff has not suffered (*Civ. Code, §§ 3281, 3282*) merely because a different defendant may have to compensate a different plaintiff who *has* suffered such a loss. [10]

CA(18)[↑] **(18)** We hold, therefore, that ***HN19***[↑] an injured plaintiff whose medical expenses are paid through private insurance may recover as economic damages **[48]** no more than the amounts paid by the plaintiff or his or her insurer for the medical services received or still owing at the time of trial. In so holding, we in no way abrogate or modify the collateral source rule as it has been recognized in California; we merely conclude the negotiated rate differential—the discount medical providers offer the insurer—is not a benefit provided to the plaintiff in compensation for his or her injuries and therefore does not come within the rule. For this reason, plaintiff's argument that any reform of the collateral source rule should come from the **[****1165]** Legislature rather **[*567]** than this court misses the mark. *Government Code section 985* and *Civil Code section 3333.1*, which limit or eliminate the collateral source rule for cases involving, respectively, public entity defendants and negligence of a health care provider, simply do not speak to the issue presented here. Our holding neither contradicts **[***344]** or undermines these statutes nor alters their operation. Trial courts continue to have authority to reduce a plaintiff's recovery against a public entity under *Government Code section 985*; in an action arising from the professional negligence of a health care provider, **[49]** evidence of

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[10] Plaintiff cites several decisions from other states in which courts have declined to follow *Hanif*, expressed the **[47]** view that a negotiated rate differential should be recoverable as a collateral source payment, or both. (See, e.g., *Lopez v. Safeway Stores, Inc. (Ct.App. 2006) 212 Ariz. 198 [129 P.3d 487, 491–497]*; *Bynum v. Magno (2004) 106 Haw. 81 [101 P.3d 1149, 1155–1162]*; *Wills v. Foster (2008) 229 Ill. 2d 393 [323 Ill. Dec. 26, 892 N.E.2d 1018, 1029–1031]*; *White v. Jubitz Corp., supra, 219 P.3d at pp. 576–583*.) By and large, however, these decisions rest on reasoning we have considered and rejected above, or on statutory provisions without California parallel. And while ours may presently be the minority view, several other courts have reached the same conclusion. (See, e.g., *Boutte v. Kelly (La.Ct.App. 2003) 863 So. 2d 530, 552–553*; *Kastick v. U-Haul Co. of Western Michigan (N.Y.App.Div. 2002) 292 A.D.2d 797 [740 N.Y.S.2d 167, 169]*; *Moorhead v. Crozer Chester Medical Center, supra, 765 A.2d at pp. 789–791*; see also *Goble v. Frohman, supra, 901 So. 2d at pp. 833–835* (conc. opn. of Bell, J.); *Robinson v. Bates (2006) 112 Ohio St.3d 17 [857 N.E.2d 1195, 1200]* [a negotiated rate differential does not come within the collateral source rule].)

indemnity payments made to the plaintiff, and premiums paid by the plaintiff, continues to be **[**1146]** admissible under the circumstances set out in *Civil Code section 3333.1*.

CA(19)[↑] **(19)** It follows from our holding that ***HN20***[↑] when a medical care provider has, by agreement with the plaintiff's private health insurer, accepted as full payment for the plaintiff's care an amount less than the provider's full bill, evidence of that amount is relevant to prove the plaintiff's damages for past medical expenses and, assuming it satisfies other rules of evidence, is admissible at trial. Evidence that such payments were made in whole or in part by an insurer remains, however, generally inadmissible under the evidentiary aspect of the collateral source rule. (*Hrnjak v. Graymar, Inc., supra, 4 Cal.3d at p. 732*.) Where the provider has, by prior agreement, accepted less than a billed amount as full payment, evidence of the full billed amount is not itself relevant on the issue of past medical expenses. We express no opinion as to its relevance or admissibility on other issues, such as noneconomic damages or future medical expenses. (The issue is not presented here because defendant, in this court, conceded it **[50]** was proper for the jury to hear evidence of plaintiff's full medical bills.)

HN21[↑] ***CA(20)***[↑] **(20)** Where a trial jury has heard evidence of the amount accepted as full payment by the medical provider but has awarded a greater sum as damages for past medical expenses, the defendant may move for a new trial on grounds of excessive damages. (*Code Civ. Proc., § 657, subd. 5*.) A nonstatutory "*Hanif* motion" is unnecessary. The trial court, if it grants the new trial motion, may permit the plaintiff to choose between accepting reduced damages or undertaking a new trial. (*Id.*, *§ 662.5, subd. (b)*.)

CA(21)[↑] **(21)** In the case at bench, the trial court correctly ruled plaintiff could recover as damages for her past medical expenses no more than her medical providers had accepted as payment in full from plaintiff and PacifiCare, her insurer. The Court of Appeal, believing incorrectly that this ruling violated the collateral source rule, reversed the trial court's ruling on the merits and thus had no occasion to resolve plaintiff's claims of procedural and evidentiary error. As these issues were not resolved in the Court of Appeal, they were not included in defendant's petition for review, and we do not address **[*568]** them. (*Cal. Rules of Court, rule 8.516(b)(1)*.) **[51]** On remand the Court of Appeal may, as appropriate, consider any remaining issues regarding the procedures and evidence on which the trial court ordered the damages reduced.
[**1166]**

DISPOSITION

The judgment of the Court of Appeal is reversed. The matter is remanded to that court for further proceedings consistent with our opinion.

Cantil-Sakauye, C. J., Kennard, J., Baxter, J., Chin, J., and Corrigan, J., concurred.

Dissent by: Klein

Dissent

KLEIN, J.,* Dissenting.—I respectfully dissent. I agree Rebecca Howell (Howell), who was insured by PacifiCare **[***345]** under a preferred provider organization (PPO) health insurance policy, is not entitled to recover the gross amount of her potentially inflated medical bills. However, I disagree with the majority insofar as it concludes **[**1147]** Howell's recovery of medical damages must be capped at the discounted amount her medical providers agreed to accept as payment in full from her insurer. Rather, Howell should be entitled to recover the *reasonable value* or market value of such services, as determined by expert testimony at trial, just as would be the case if the injured person had not purchased insurance or if the medical services had been donated.

The majority, while it states "we do not alter the collateral source rule as articulated in *Helfend [v. Southern Cal. Rapid Transit Dist. (1970) 2 Cal.3d 1 [84 Cal. Rptr. 173, 465 P.2d 61]]* and the Restatement" (maj. opn., *ante*, at p. 565), creates a significant exception to this state's long-standing collateral source rule. The majority draws a bright line and limits Howell's recovery of medical damages to "no more than the medical providers accepted in full payment for their services." (*Id.* at p. 563.) Thus, Howell is left in a worse position than an uninsured individual or one who was a donee of medical services, persons who are entitled to recover the full reasonable value of their medical care. (*Arambula v. Wells (1999) 72 Cal.App.4th 1006, 1012 [85 Cal. Rptr. 2d 584]* (*Arambula*) [tortfeasor cannot mitigate damages because of a third party's charitable gift].) Neither law nor policy supports such an anomalous outcome.

The majority holds the "negotiated rate differential" (the *difference* between the original billed amount of $189,978.63 and the lesser amount accepted by the providers as payment in full) lies outside **[53]** the operation of the collateral source rule because plaintiff did not suffer any economic loss in the amount of the negotiated rate differential and therefore said sum is not recoverable by plaintiff.
[*569]

The majority fails to recognize the difference between the *reasonable value* of Howell's care (hypothetically, $75,000) and the *lesser sum* Howell's preferred providers agreed to accept as *payment in full* ($59,691.73), did constitute a payment by others, namely, the medical providers, toward the cost of treating Howell. Howell's medical providers, as participants in PacifiCare's PPO network, *wrote off* a portion of her bills, pursuant to their agreements with PacifiCare. By acquiring the PPO policy, Howell purchased not only indemnity coverage but also access to the negotiated discounts between her health insurer and her medical **[****1167]** providers. Therefore, any difference between the *reasonable value* of Howell's treatment, and the *lesser amount* the providers agreed to accept as *payment in full*, was a benefit Howell is entitled to retain under the collateral source rule. There is little justification for allowing a defendant tortfeasor to avoid liability for the reasonable value of a plaintiff's **[54]** medical expenses, where such value exceeds the negotiated payment.

The task before this court is twofold. In the era of managed care, the court is grappling with the problem of injured plaintiffs recovering compensatory damages based on allegedly inflated

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* Presiding Justice of the Court of Appeal, Second Appellate **[52]** District, Division Three, assigned by the Chief Justice pursuant to *article VI, section 6 of the California Constitution*.

medical bills, while continuing to adhere to the collateral source rule and the policies underlying the rule.

The Court of Appeal held Howell is entitled to recover the *gross undiscounted amount* of her medical bills (i.e., $189,978.63), including the full amount of the "negotiated rate differential" (i.e., the difference between the original billed **[***346]** amount and the lesser amount accepted by the providers as payment in full).

In contrast, the majority limits Howell's recovery as economic damages for past medical expenses to "no more than the medical providers accepted in full payment for their services" (maj. opn., *ante*, at p. 563), amounting to $59,691.73.

There is an intermediate position between these two ends of the spectrum, one more consistent with both the collateral source rule and with the deterrent function of tort law: For purposes of determining the application of the collateral source rule, a plaintiff who has purchased private **[55]** health insurance, just like a plaintiff who is a donee or is uninsured, should be entitled to recover from the defendant tortfeasor economic damages for past medical expenses an amount not to exceed the *reasonable value* of medical expenses which the plaintiff incurred for tortiously caused injuries. Howell should be entitled to recover the *reasonable value* of her medical care, *no more and no less*. That the plaintiff may have purchased a negotiated rate benefit is not, for purposes of the collateral source rule, relevant.
[*570]

By limiting the plaintiff's recovery to the *reasonable value* of the treatment (an amount which the plaintiff is required to prove at trial), I would eliminate the potential mischief created by the Court of Appeal's opinion, which enables a plaintiff to recover damages for medical expenses based on potentially inflated medical bills, while still preserving the full protection of the collateral source rule for all injured plaintiffs, whether or not covered by private insurance.

Under the reasonable value approach, in the event the reasonable value of a plaintiff's **[**1148]** treatment *exceeds* the amount the medical providers have agreed to accept as payment in full from the plaintiff's **[56]** insurer, such difference would be allocated to the plaintiff, rather than to the defendant tortfeasor. This approach preserves the long-standing collateral source rule, and at the same time, prevents a plaintiff from recovering excessive damages based on potentially inflated medical bills.
[**1168]**

1. *Policy considerations underlying the collateral source rule.*

a. *The collateral source rule represents the sound policy judgment of encouraging citizens to purchase insurance and denying the tortfeasor the benefits of the victim's providence.*

It has long been settled in California that " '[d]amages recoverable for a wrong are not diminished by the fact that the party injured has been wholly or partly indemnified for his loss by insurance effected by him, and to the procurement of which the wrongdoer did not contribute ... .' " (*Loggie v. Interstate Transit Co. (1930) 108 Cal.App. 165, 169 [291 P. 618]*; accord, *Helfend*

v. Southern Cal. Rapid Transit Dist., supra, 2 Cal.3d at p. 6 (*Helfend*); *Peri v. L. A. Junction Ry. (1943) 22 Cal.2d 111, 131 [137 P.2d 441]*.)

In *Helfend*, this court engaged in an extensive review of the policy arguments for and against the collateral source rule and reaffirmed its adherence to the rule as it has **[57]** developed in California. In the context of insurance payments for medical treatment, where the rule is most frequently applied, the court stated the collateral source rule "*embodies the venerable concept that a person who has invested years of insurance premiums to assure his medical care should receive the benefits of his thrift. The tortfeasor should not garner the benefits of his victim's providence.* [¶] The collateral source rule expresses a policy judgment in favor of encouraging citizens to purchase and maintain **[***347]** insurance for personal injuries and for other eventualities. Courts consider insurance a form of investment, the benefits of which become payable without respect to any other possible source of funds. If we were to permit a tortfeasor to mitigate damages with payments from plaintiff's insurance, plaintiff would be in a position inferior to that of having **[*571]** bought no insurance, because his payment of premiums would have earned no benefit. Defendant should not be able to avoid payment of full compensation for the injury inflicted merely because the victim has had the foresight to provide himself with insurance." (*Helfend, supra, 2 Cal.3d at pp. 9–10*, italics added & fn. omitted.)

b. *Deterrence **[58]** of tortious conduct; the collateral source rule ensures the tortfeasor pays the full cost of its negligence or wrongdoing.*

When an injured plaintiff has received collateral compensation from insurance, a gift, or other sources (*such as the expense borne by the preferred providers, which wrote off a portion of their bills pursuant to the PPO contract*), allowing a deduction for damages in that amount would result in a windfall for the tortfeasor and underpayment for the injury. (*Helfend, supra, 2 Cal.3d at p. 10*; *Arambula, supra, 72 Cal.App.4th at pp. 1013–1014*.) Because the tortfeasor would not be paying the full cost of its negligence or wrongdoing, a deduction for collateral compensation would distort the deterrent function of tort law. (See Katz, *Too Much of a Good Thing: When Charitable Gifts Augment Victim Compensation (2003) 53 DePaul L.Rev. 547, 564* [if a charitable gift to the plaintiff reduces tort recovery, the defendant "pays less than the full social costs of his conduct and is underdeterred"].)
[**1169]**

2. *The difference between the reasonable value of the medical services and the lesser sum the medical provider agreed to accept as payment in full constitutes a "payment by others" **[59]** on behalf of the injured person and therefore is a benefit within the meaning of the collateral source rule.*

The majority acknowledges the negotiated rate differential is not a gift by the provider to the injured plaintiff, but it regards the negotiated rate differential as merely a price discount. However, because the issue at **[**1149]** bench is the application of the collateral source rule, involving (1) an injured party, (2) the injured party's PPO health insurance policy, and (3) a negligent tortfeasor, treating the negotiated rate differential as nothing more than a discount is, in my view, inappropriate.

The majority properly recognizes: "Medical providers that agree to accept discounted payments by managed care organizations or other health insurers as full payment for a patient's care *do*

so not as a gift to the patient or insurer, but for commercial reasons and as a result of negotiations. As **[60]** plaintiff herself explains, hospitals and medical groups obtain commercial benefits from their agreements with health insurance organizations; the agreements guarantee the providers prompt payment of the agreed rates and **[*572]** often have financial incentives for plan members to choose the providers' services." (Maj. opn., *ante,* at p. 558, italics added.)

However, the fact that Howell's medical providers, as participants in a PPO network, agreed to accept discounted payments motivated by their economic self-interest, rather than with a donative intent, should not make a difference in the analysis of the issues presented herein. **[***348]** The majority's analysis rests upon a distinction between commercial motive and donative intent, a distinction the majority has failed to explain. Had Howell been uninsured, or had Howell's providers donated their services, Howell would be entitled to recover the *reasonable cost* of her medical care. It is anomalous to limit Howell's recovery of medical damages to the deeply discounted amount her providers accepted as payment in full, merely because Howell was insured under a PPO policy, rather than being uninsured or a donee. Howell should not be penalized, nor should **[61]** the negligent tortfeasor be rewarded, based on the manner in which her PPO policy is structured.

Clearly, medical providers in a PPO network benefit from their status as preferred providers in significant ways: the preferred providers obtain access to an expanded client base; the preferred providers have greater certainty of being paid for their services; and the preferred providers can expect relatively prompt reimbursement. In return for these commercial benefits, the preferred providers agree with the insurer to accept reduced fees for their services. The insurer likewise derives a commercial benefit from the PPO system through greater cost control and reduced costs for patient care. At the same time, the PPO system has advantages for the consumer who enjoys reduced fees when obtaining care through a preferred provider.

This recognition of the existence of a tripartite negotiated relationship among the insured, the insurer, and the medical providers, informs the proper characterization of the "negotiated rate differential." It is undisputed the negotiated rate **[***1170]** differential was *not a gratuitous payment* by the providers. Nor should the negotiated rate differential be deemed a *mere price* ***[62]*** *discount* by a vendor. Rather, the negotiated rate differential was, in effect, a "payment by a third party," namely, the medical providers, which wrote off a portion of Howell's bills. It is undisputed that "[w]hen, as here, the costs of medical treatment *are paid in whole or in part by a third party* unconnected to the defendant, the collateral source rule is implicated." (Maj. opn., *ante*, at p. 551, italics added.) Accordingly, to the extent the *reasonable* value of Howell's care exceeded the amount accepted by her providers in full payment, that sum should be considered a benefit covered by the collateral source rule.

Although the majority recognizes the collateral source rule is implicated whenever the costs of medical treatment are paid in whole or in part by a **[*573]** nontortfeasor third party, it takes the position the negotiated rate differential, i.e., the discount medical providers offer the insurer, was "*never paid by or on behalf of the injured person*" (maj. opn., *ante*, at p. 548, italics added), and therefore does not come within the collateral source rule.

Said conclusion overlooks the fact the preferred providers absorbed a portion of the reasonable cost of treating Howell by *writing* ***[63]*** *off* a portion of her bills. *The fee reduction, a benefit to*

which Howell was entitled under ***[**1150]*** *the PPO policy, was purchased with costly health insurance premiums and was an essential part of the bargain between Howell and PacifiCare.* Thus, it is entirely appropriate to recognize the difference between the *reasonable value* of the medical services and the *lesser amount* the providers agreed to accept in full payment for their services, as a payment made by others, namely, the providers, on Howell's behalf. A consistent application of the collateral source rule, as it prevails in the United States, entitles **[***349]** Howell to retain that benefit. (See pt. 5., *post.*)

3. *Limiting plaintiff's recovery to the reasonable cost of care prevents a windfall recovery by the victim based on potentially inflated medical bills.*

The problem in the instant case arises due to the practice of inflating medical charges and then deeply discounting them, which has become the norm in this era of managed care.

"Before managed care, hospitals billed insured and uninsured patients similarly. In 1960, '[t]here were no discounts; everyone paid the same rates'—usually cost plus ten percent. But as some insurers demanded deep **[64]** discounting, hospitals vigorously shifted costs to patients with less clout." (Hall & Schneider, *Patients as Consumers: Courts, Contracts, and the New Medical Marketplace (2008) 106 Mich. L.Rev. 643, 663*, fns. omitted.) As a consequence, "only uninsured, self-paying U.S. patients have been billed the full charges listed in hospitals' inflated chargemasters ... ." (Reinhardt, *The Pricing Of U.S. Hospital Services: Chaos Behind A Veil Of Secrecy* (2006) 25 Health Affairs 57, 62; see *Health & Saf. Code, § 1339.51, subd. (b)(1)* [chargemaster, or hospital charge description master is "a uniform schedule of charges represented by the hospital as its gross billed charge for a given service or item, regardless of payer type"].)
[**1171]**

Therefore, to reconcile the collateral source rule with the problem posed by potentially inflated medical bills, a uniform rule should apply. Irrespective of whether a plaintiff has private health insurance, is a donee or is uninsured, the plaintiff should be entitled to recover as economic damages for past medical expenses *the reasonable value* of the medical expenses the plaintiff incurred for tortiously caused injuries.
[*574]

With this approach, in the event the reasonable value **[65]** of the plaintiff's treatment *exceeds* the amount the medical providers agreed to accept as payment in full from plaintiff's insurer, that difference is allocated to the plaintiff, rather than to the tortfeasor. This fully preserves the collateral source rule, and at the same time prevents a plaintiff from recovering excessive damages pursuant to potentially inflated medical bills.

4. *Collateral source rule does not yield a double recovery.*

Helfend observed that insurance policies increasingly provide for either subrogation or *refund of benefits* upon recovery from the tortfeasor, thus transferring the risk from the victim's insurer to the tortfeasor by way of the victim's tort recovery. (*Helfend, supra, 2 Cal.3d at pp. 10–11.*) *Helfend* explained that viewed from this perspective, the collateral source rule does not permit the plaintiff a double recovery, as critics of the rule have charged. (*Ibid.*) Further, "[t]he collateral

source rule partially serves to compensate for the attorney's share and does not actually render 'double recovery' for the plaintiff." (*Id. at p. 12.*)

Consequently, it should be recognized that where an insured plaintiff prevails and obtains an award of economic damages **[66]** for past medical expenses from a third party, the insured generally is contractually required to reimburse the health insurer to the extent the insured recovers on her judgment against the tortfeasor. In addition to having to reimburse the health insurer, the plaintiff will have incurred attorney fees to prosecute the claim for economic damages.

[*350]** Thus, because the plaintiff's award of economic damages for past medical expenses is likely to be largely transferred from the defendant (or from the defendant's insurer) to the plaintiff's insurer and to the plaintiff's attorney, the award is not likely to yield a windfall to the plaintiff.

[1151]** In addition, it should be recognized the collateral source rule serves to protect the "person who has invested years of insurance premiums to assure [her] medical care." (*Helfend, supra, 2 Cal.3d at pp. 9–10.*) However, the award of compensatory damages does not expressly include reimbursement to the plaintiff for those premiums. It is only through the application of the collateral source rule that the plaintiff is rewarded for maintaining his or her own health insurance for personal injuries.

For all these reasons, any perceived windfall to the plaintiff as **[67]** a consequence of the collateral source rule represents a relatively minor portion of plaintiff's overall recovery of economic damages. Further, as between the injured person and the tortfeasor, the equities dictate such benefit should be **[*575]** allocated to the injured party, not to the negligent tortfeasor. Indeed, it is difficult to understand just what policy **[****1172]** considerations justify denying the thrifty or prudent plaintiff who has purchased private health insurance the full benefit of his or her own foresight, and instead, transferring that benefit to the tortfeasor.

5. *This court should follow the majority rule in the United States, which is consistent with the Restatement Second of Torts.*

The majority, limiting plaintiff's recovery of medical damages to the amount her medical providers accepted as payment in full from plaintiff's insurer, has failed to explain why California should align itself with the minority view in the United States.

By way of background, courts across the country have considered the issue of whether the collateral source rule allows a plaintiff to recover insurance writeoffs. Three general approaches have emerged: (1) *the reasonable value of services*; (2) the benefit **[68]** of the bargain; and (3) the actual amounts paid. (See, e.g., *Martinez v. Milburn Enterprises, Inc. (2010) 290 Kan. 572, 591–592 [233 P.3d 205].*)

"The vast majority of courts to consider the issue follow the common-law rule articulated in *section 924 of the Restatement* and permit plaintiffs to seek the reasonable value of their expenses without limitation to the amount that they pay or that third parties pay on their behalf. *See Wills v. Foster, 229 Ill2d 393, 892 NE2d 1018, 1031 (Ill 2008)* (so stating)." (*White v. Jubitz Corp. (2009) 347 Or. 212, 237 [219 P.3d 566].*)

The *Restatement Second of Torts, section 924*, is entitled "Harm to the Person." It provides, in part, that "[o]ne whose interests of personality have been tortiously invaded is entitled to recover damages for past or prospective [¶] ... [¶] *(c) reasonable medical* and other expenses ... ." (*Ibid.*, italics added.) Comment f to that section, entitled "Expenses," provides that an "injured person is entitled to damages for all expenses and for the *value of services reasonably made necessary* by the harm." (*Rest.2d Torts, § 924, com. f*, p. 526, italics added.) Comment f then instructs that "[t]he *value of medical services made* ***[69]*** *necessary* by the tort can ordinarily be recovered although they have created no liability or expense to the injured person, as when a physician donates his services." (*Id., at p. 527*, italics added, referring to *Rest.2d Torts, § 920A*.) Thus, "the *Restatement* permits a plaintiff to recover from a tortfeasor the *reasonable* ***[***351]*** *value* of the medical treatment that **[*576]** he or she receives whether plaintiff is liable to pay or pays the medical providers' charges for that treatment, the providers waive those charges, or a third party pays or otherwise satisfies those charges." (*White v. Jubitz Corp., supra, 219 P.3d at p. 579*, second italics added.) Under the Restatement rule, "plaintiffs who incur the same injuries as a result of a defendant's tort[i]ous actions may claim and recover the same damages." (*Ibid.*; see also *Martinez v. Milburn Enterprises, Inc., supra, 290 Kan. at p. 602* [reasonable value of medical services is the fairest approach; " 'to do otherwise would create separate categories of plaintiffs based on the method used to finance medical expenses' " (italics omitted)].)

The majority's rationale for eschewing the majority rule is that those out-of-state decisions "rest on reasoning we have **[70]** considered and rejected above, *or on statutory provisions without California parallel*." (Maj. **[**1152]** opn., *ante*, at p. 566, fn. **[****1173]** 10, italics added.) However, insofar as the majority does not discuss how the statutes of our sister states differ from our damages statutes (see, e.g., *Civ. Code, §§ 3281, 3282, 3333*), it is unpersuasive.

6. *Statutory provisions in the Civil Code do not bar plaintiff's recovery of the difference between the reasonable value of the medical services and the lesser amount the providers agreed to accept as full payment.*

The majority takes the position that unlike the law of other states, California's damages statutes bar Howell from recovering as damages for medical expenses anything in excess of the amount her medical providers agreed to accept as payment in full. That conclusion is unwarranted. Our damages statutes do not preclude this court from following the majority rule and authorizing compensation to Howell for the reasonable value of her medical treatment.

The pertinent statutes are as follows: Every person "who **[71]** suffers detriment from the unlawful act or omission of another, may recover from the person in fault a compensation therefor in money, which is called damages." (*Civ. Code, § 3281*.) The measure of damages generally recoverable in tort is "the amount which will compensate for all the detriment proximately caused" by the tort. (*Id.*, *§ 3333*.) Detriment is "a loss or harm suffered in person or property." (*Id.*, *§ 3282*.)

The maxims embodied in these statutory provisions do not dictate the conclusions reached by the majority. It is undisputed that "[w]hen, as here, the costs of medical treatment *are paid in whole or in part by a third party unconnected to the defendant,* the collateral source rule is implicated." (Maj. opn., *ante*, at p. 551, italics added.)
[*577]

As this dissent has sought to explain, in the instant case the costs of Howell's medical treatment were partially borne by third parties, namely, Howell's preferred medical providers, which wrote off a significant portion of her bills pursuant to a tripartite contract for which valuable consideration was paid. Therefore, any difference between the reasonable value of Howell's care and the lesser amount the providers accepted as payment in full **[72]** constitutes *detriment,* which is recoverable by Howell from the tortfeasor.

7. Determining the reasonable value of plaintiff's medical care; procedure in future cases.

The majority precludes any inquiry into the reasonable value of the patient's care and limits the plaintiff's recovery of medical damages to the amount her preferred providers accepted as payment in full. **[***352]** The majority's bright-line approach rests on the assumption "the negotiated prices providers accept from insurers" is equivalent to the reasonable value, or "exchange value of medical services the injured plaintiff has been required to obtain." (Maj. opn., *ante*, at p. 562.)

However, the reasonable value of the patient's care is a question for the trier of fact. It may be that the sum the providers accepted in full payment is equivalent to the reasonable value of the care, or it may be that the reasonable value of the care is a higher figure. Preferred providers discount their fees to PPO members because **[****1174]** the providers "obtain commercial benefits from their agreements with health insurance organizations" (maj. opn., *ante*, at p. 558), such as an expanded clientele. This court should not speculate that the amount a preferred **[73]** provider accepts as payment in full from the insurer is equivalent to the reasonable value of the services rendered.

The inquiry at trial should be the same, irrespective of whether the injured plaintiff was covered by a PPO health insurance policy, was a donee, or was uninsured. The plaintiff's burden is to prove the *reasonable value* of the medical care needed to treat his or her tortiously caused injuries.

"Due to the realities of today's insurance and reimbursement system, in any given case, that determination is not necessarily the amount of the original bill or the amount paid. Instead, the reasonable value of medical services is a matter for the jury to determine **[**1153]** from all relevant evidence. Both the original medical bill rendered and the amount accepted as full payment are admissible to prove the reasonableness and necessity of charges rendered for medical and hospital care. [¶] The jury may decide that the reasonable value of medical care is the amount originally billed, the amount the medical provider accepted as payment, or some amount in between." (*Robinson v. **[*578]** Bates (2006) 112 Ohio St.3d 17, 23 [857 N.E.2d 1195, 1200]*.) California jurors are as capable as jurors in Ohio **[74]** or elsewhere of making that determination.

A plaintiff may attempt to rely on the undiscounted medical bills to establish economic damages, but if such billing is inflated, it would be exposed on cross-examination and through defense expert testimony. For example, if a chest X-ray was billed at $1,500 but the evidence shows the provider has rarely, if ever, obtained that sum in payment, or if the evidence shows the billed amount significantly exceeds the charges by other medical providers for such treatment, the trier of fact would take such evidence into consideration in assessing the reasonable value of the

treatment. A jury, with the help of expert opinion testimony, is capable of weighing the evidence and determining the reasonable value of the medical services provided to the plaintiff.

Finally, in the event the verdict as to past medical expenses is excessive, the defendant can move for a new trial on that basis. (*Code Civ. Proc., § 657, subd. 5.*)

8. *Any modification to the collateral source rule should be left to the Legislature.*

There is nothing unique about PPO insurance coverage that requires this court to carve out a special rule governing the negotiated rate differential in **[75]** this type of health insurance. An injured person with PPO coverage, like uninsured plaintiffs or donees, should be able to recover the reasonable value of care required to treat the tortiously caused injuries.

[*353]** Any change to the collateral source rule should be left to the Legislature. (*Olsen v. Reid (2008) 164 Cal.App.4th 200, 213–214 [79 Cal. Rptr. 3d 255]* (conc. opn. of Moore, J.).) The Legislature twice has abrogated or modified the collateral **[****1175]** source rule, in the Medical Injury Compensation Reform Act (*Civ. Code, § 3333.1, subd. (a)* [health care providers]) and in *Government Code section 985* (public entity defendants), and can do so again if it sees fit.

"It may well be that the collateral-source rule itself is out of sync with today's economic realities of managed care and insurance reimbursement for medical expenses. However, whether plaintiffs should be allowed to seek recovery for medical expenses ... only for the amount negotiated and paid by insurance is for the [Legislature] to determine." (*Robinson v. Bates, supra, 857 N.E.2d at p. 1201.*)

[*579]

9. *Proposed disposition.*

The judgment of the Court of Appeal should be reversed with directions to remand the matter to the trial court for a limited new trial **[76]** to determine, and award, the reasonable value of the medical services which Howell received for her tortiously caused injuries.

Appellant's petition for a rehearing was denied November 2, 2011.

End of Document

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1. *Ward-Conde' v. Smith, 19 F. Supp. 2d 539*

Client/Matter: 1737-10881

Search Terms: Ward-Conde' v. Smith, 19 F. Supp. 2d 539

Search Type: Natural Language

Narrowed by:

Content Type	Narrowed by
Cases	-None-

Ward-Conde' v. Smith

United States District Court for the Eastern District of Virginia, Newport News Division

September 16, 1998, Decided ; September 16, 1998, Filed

4:98CV00052

Reporter
19 F. Supp. 2d 539 *; 1998 U.S. Dist. LEXIS 19424 **

ELISA WARD-CONDE', Plaintiff, v. HANNO SMITH, and MARYLAND NATIONAL CAPITAL PARK AND PLANNING COMMISSION, Defendants.

Disposition: [1]** Defendants' motion to compel plaintiff and motion in limine GRANTED.

Core Terms

medical expenses, healthcare provider, collateral source rule, amounts, defendants', collateral, insured

Case Summary

Procedural Posture

Defendants filed a motion to compel plaintiff, injured in an automobile accident (injured party), to fully and completely answer an interrogatory seeking information as to whether any public or private insurer paid any portion of his medical expenses and whether any amount was written off by the health care provider.

Overview

The injured party brought an action against defendants following an automobile accident. Defendants filed a motion to compel the injured party to provide certain medical reimbursement information. They also filed a motion in limine limiting the amount of medical expense to be submitted in evidence by the injured party. Defendants argued that since the injured party had no liability for significant portions of the ostensible medical costs that the amount for which she is entitled to claim compensation should be correspondingly reduced. The court granted the motion. The court held that this was in compliance with the collateral source rule under which compensation or indemnity received by a tort victim from a source collateral to the tortfeasor may not applied as a credit against the damages the tortfeasor owes. The court held that defendants were protected against the injured party's windfall by permitting her only to present to the jury those expenses for which she is legally obligated.

Outcome

The court granted defendants motion to compel production and motion in limine.

LexisNexis® Headnotes

Civil Procedure > Preliminary Considerations > Federal & State Interrelationships > Erie Doctrine

Civil Procedure > Preliminary Considerations > Federal & State Interrelationships > General Overview

HN1[⬇] **Federal & State Interrelationships, Erie Doctrine**

When a case is in federal court on the basis of diversity of citizenship, the court is required to apply state substantive law and federal procedural law.

Healthcare Law > ... > Health Insurance > Reimbursement > General Overview

Torts > ... > Damages > Collateral Source Rule > General Overview

HN2[⬇] **Health Insurance, Reimbursement**

Under the collateral source doctrine, a plaintiff in a tort action is entitled to recover the value of his or her medical expenses, even though those expenses may have been paid by a third-party health care provider.

Torts > ... > Damages > Collateral Source Rule > General Overview

HN3[⬇] **Damages, Collateral Source Rule**

For the collateral source rule to be in effect under Virginia law, the injured party must be responsible for making payment, even if a collateral source actually pays.

Counsel: For ELISA WARD-CONDE', plaintiff: Kenneth Leon Roberts, Law Offices of Kenneth L. Roberts, Newport News, VA.

For HANNO SMITH, MARYLAND NATIONAL CAPITAL PARK AND PLANNING COMMISSION, defendants: Richard Joshua Cromwell, McGuire, Woods, Battle & Boothe, Norfolk, VA.

Judges: James E. Bradberry, UNITED STATES MAGISTRATE JUDGE.

Opinion by: James E. Bradberry

Opinion

[*540] ***ORDER***

This matter is before the Court on several motions, all of which will be dealt with in the chronological order in which they were filed.

The action arises out of an automobile accident which caused injury to plaintiff. The pleadings reveal that plaintiff has incurred substantial medical expenses and seeks to recover in excess of Fourteen Thousand Dollars ($ 14,000.00) in medicals.

Plaintiff has filed a motion *in limine* seeking to preclude defendants from allowing any experts to testify on behalf of either defendant based upon the nonidentification of experts on or before the discovery cut-off date of August 13, 1998, set forth in the Order on Initial Pretrial Conference entered April 22, 1998. Defendants respond that they "have not retained **[**2]** or specially employed an expert witness to provide expert testimony in this case." Instead, they merely reserve the right to call any of plaintiff's treating physicians as witnesses with regard to matters set forth in the medical records pertaining to plaintiff. Accordingly, the motion is MOOT.

Defendants have filed a motion to compel plaintiff to fully and completely answer defendants' first supplemental interrogatory to plaintiff which seeks information as to whether any public or private insurer has paid any portion of the medical expenses, the amount thereof, and whether any amount has been written off by the health care provider to which payments have been made. The motion to compel is directly related to defendants' motion *in limine* filed contemporaneously herein which seeks to limit evidence of plaintiff's medical claims to those amounts for which she is responsible, whether paid by insurance or not, and to exclude any medical expenses above payment amounts specifically negotiated by a health care provider with plaintiff's insured or written off by the health care provider.

For the reasons which follow, defendants' motion to compel plaintiff to fully and completely answer **[**3]** defendants' first supplemental interrogatory and defendants' motion *in limine*, limiting the amount of medical expenses which may be submitted in evidence by plaintiff, are GRANTED.

The issue of what medical expenses may be introduced in evidence has previously **[*541]** been addressed by this Court. *See Futrell v. Food Lion*, No. 4:97CV129 (E.D. Va. May 7, 1998). ***HN1***[↑] Because the case is before the Court on the basis of diversity of citizenship and governed by the doctrine of *Erie R.R. Co. v. Tompkins, 304 U.S. 64, 82 L. Ed. 1188, 58 S. Ct. 817 (1938)*, this Court is required to apply state substantive law and federal procedural law. *See Gasperini v. Ctr. for Humanities, Inc., 518 U.S. 415, 427, 135 L. Ed. 2d 659, 116 S. Ct. 2211 (1996)*. Because the accident occurred in Virginia, Virginia substantive law applies to plaintiff's case.

As in *Futrell*, this case arises in the context of representations by defendants that certain medical expenses for which plaintiff seeks compensation have been "written off" by her health care providers incident to the health care agreements which provide her with medical care. Defendants argue that since plaintiff has no liability for significant portions of the ostensible medical costs **[**4]** that the amount for which she is entitled to claim compensation should be correspondingly reduced.

Plaintiff vigorously opposes the motion. In an excellent brief, thoroughly attacking the various problems created by what plaintiff contends is a departure from the Virginia "collateral source"

rule, plaintiff contends that she is entitled to fully submit all of the medical expenses represented in bills provided to her, utterly without regard to whether any portion of the bill has been the subject of a negotiated fee agreement between the health care provider and her health insurance company, or whether any particular expense has been written off by her health care providers.

The Court is sensitive to the problems that are posed by defendants' motion. The Court recognizes that it may be necessary in certain cases for a plaintiff to subpoena an employee of a health care provider, or an employee of an insured, and conduct a hearing out of the presence of a jury to determine what the actual obligations of a plaintiff may be with regard to medical expenses incurred. The Court is also aware of the fact that plaintiffs with no insurance may end up being able to present to a jury evidence **[**5]** of medical care that is more expensive than the same identical care rendered to an insured plaintiff. However, all of the problems that plaintiff posits in her brief are beyond the scope of this Court's ability to resolve. If anything, a legislative resolution may be necessary should the Commonwealth of Virginia decide that the merits of the collateral source doctrine, which governs recovery in tort cases, is worthy of maintaining.

HN2[↑] Under the collateral source doctrine, a plaintiff in a tort action is entitled to recover the value of his or her medical expenses, even though those expenses may have been paid by a third-party health care provider. The theory of the recovery is admirable: A tortfeasor should not be able to avoid responsibility for his or her negligent acts and benefit form the foresight of a plaintiff who obtains insurance as a measure of protection against such acts. An insured injured party may, therefore, experience a "double" recovery. The question then arises as to whether plaintiff obtains a windfall if plaintiff is permitted to tell a jury that medical expenses are more than the amount for which plaintiff is legally obligated, the situation which defendants posit **[**6]** in this case.

Addressing the matter in *McAmis v. Wallace, 980 F. Supp. 181 (W.D. Va. 1997)*, Judge Williams Stated:

> Plaintiff's arguments rely on Virginia's collateral source rule, which Defendant asserts, does not apply to the situation at hand. Defendant correctly argues that plaintiff did not incur the Medicaid discount as an expenses and that Virginia law does not include in compensatory damages amounts for which no one is liable. "Under [the collateral source rule], compensation or indemnity received by a tort victim from a source collateral to the tortfeasor may not be applied as a credit against the quantum of damages the tortfeasor owes." *Schickling v. Aspinall, 235 Va. 472, 369 S.E.2d 172, 174 (1988)*. "The collateral source rule is designed to strike a balance between two competing principles of tort law: (1) a plaintiff is entitled to compensation sufficient to make him whole, but no more; and (2) a defendant is liable for all **[*542]** damages that proximately result from his wrong." *369 S.E.2d at 174*.

Id. at 184.

Judge Williams went on to rule against the plaintiff and in favor of the defendant, stating:

> ***HN3***[↑] For the collateral source rule to be **[**7]** in effect under Virginia law, the injured party must be responsible for making payment, even if a collateral source actually pays. The

> present case is not a situation where Plaintiff avoided personally paying a bill because a collateral source stepped in. Here, no one paid the written off amount and as a result, under Virginia law, Plaintiff has not incurred this fee. While it is true that Plaintiff would have been liable for these fees if she had not qualified for Medicaid, this distant liability is not enough to trigger the collateral source rule because Plaintiff has neither paid these write-offs nor become legally obligated to pay them. . . . Since no one incurred the fees at issue, the collateral source rule does not require that Plaintiff be permitted to recover the write off.

Id. (citations omitted).

Judge Williams correctly anticipated the position of the Virginia Supreme Court as reflected in State Farm Mutual Automobile Insurance Co. v. Bowers, 255 Va. 581, 500 S.E.2d 212 (1998). In a comparable case, addressing the collateral source rule as it applied to Bowers, Justice Kinser said:

> The evidence in the instant case was that Bowers would never be **[**8]** liable for any amount greater than that which the various health care providers accepted as full payment for their services based on the Blue Cross fee schedule. Stated differently, the health care providers' agreements with Blue Cross prevented them from collecting more than the scheduled fee and any required co-payment. Therefore, we conclude that the medical expenses Bowers "incurred" were the amounts that the health care providers accepted as full payment for their services rendered to him. Bowers has not paid nor is he "legally obligated to pay" the amounts written off by the providers. To decide otherwise would be to grant Bowers a windfall because he would be receiving an amount greater than that which he would ever be legally obligated to pay.

Bowers, 255 Va. at 585 (citations omitted).

Plaintiff argues that *Bowers* is a contract case, not a tort case, and the principal articulated by Judge Kinser in the *Bowers* opinion has no applicability. This Court disagrees.

Judge Kinser had to address the issue of when a medical expense is "incurred" under Virginia law. Like Judge Williams, she found that the amounts that *Bowers* "incurred" were the "amounts that **[**9]** the health care providers accepted as full payment for their services rendered to him." That is precisely the issue raised in this case. It is not a question of coverage, and it is not a question of the amount of medicals; it is the amount of the medical expenses for which plaintiff is actually responsible that plaintiff is entitled to seek recovery.

Contrary to the position taken by plaintiff's counsel, his client suffers no adverse consequences by the enforcement of the rule limiting the medical claims to those for which plaintiff is obligated because plaintiff is still permitted to recover one hundred percent of all expenses which must be paid. The operative words are "must be paid," whether those are paid in a negotiated fee agreement between a health care provider and an insurance company or through plaintiff's co-payment obligation. The collateral source rule is fully honored by the court's decision in that a defendant is denied the windfall of an insured plaintiff, protected against catastrophic loss, and defendants are protected against plaintiff's windfall by permitting plaintiff only to present to the jury those expenses for which she is legally obligated, or, as stated **[**10]** in *Bowers*, which have been "incurred."

The Clerk shall mail a copy of this Order to all counsel of record.

James E. Bradberry

UNITED STATES MAGISTRATE JUDGE

Newport News, Virginia

September 16, 1998

End of Document

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Attorneys for Plaintiffs

DISTRICT COURT

CLARK COUNTY, NEVADA

TITINA FARRIS and PATRICK FARRIS, Plaintiffs, vs. BARRY RIVES, M.D.; LAPAROSCOPIC SURGERY OF NEVADA, LLC et al., Defendants.	CASE NO.: A-16-739464-C DEPT. NO.: XXXI **HEARING REQUESTED**

PLAINTIFFS' RENEWED MOTION TO STRIKE DEFENDANTS' ANSWER FOR RULE 37 VIOLATIONS, INCLUDING PERJURY AND DISCOVERY VIOLATIONS ON AN ORDER SHORTENING TIME

Plaintiffs PATRICK FARRIS and TITINA FARRIS, by and through their attorneys of record, KIMBALL JONES, ESQ. and JACOB G. LEAVITT, ESQ., with the Law Offices of **BIGHORN LAW** and GEORGE F. HAND, ESQ., with the Law Offices of **HAND & SULLIVAN**, LLC, and hereby submit this Renewed Motion to Strike Defendants' Answer for Rule 37 Violations, Including Perjury and Discovery Violations on an Order Shortening Time ("Motion").

This Motion is made and based upon all of the pleadings and papers on file herein and the attached Memorandum of Points and Authorities.

DATED this 19th day of October, 2019.

BIGHORN LAW

By: */s/ Kimball Jones*
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Attorneys for Plaintiffs

NOTICE OF MOTION ON ORDER SHORTENING TIME

TO: All INTERESTED PARTIES, AND THEIR ATTORNEYS OF RECORD

It appearing to the satisfaction of this Court, and good cause appearing therefore, IT IS HEREBY ORDERED that the foregoing **MOTION** shall be heard on the _____ day of _____, 2019 at the hour of _____ a.m. in the above-noted Courtroom.

DATED this _____ day of _____, 2019.

_____
DISTRICT COURT JUDGE

Respectfully submitted by:

BIGHORN LAW

By: */s/ Kimball Jones*
KIMBALL JONES, ESQ.
Nevada Bar.: 12982
JACOB G. LEAVITT, ESQ.
Nevada Bar no.: 12608
Attorneys for Plaintiffs

DECLARATION OF KIMBALL JONES, ESQ. IN SUPPORT OF PLAINTIFF'S MOTION AND DECLARATION FOR AN ORDER SHORTENING TIME

KIMBALL JONES, ESQ., being first duly sworn, under oath deposes and says:

1. That I am an attorney duly licensed to practice law in the State of Nevada and a partner with the Law Offices of Bighorn Law.
2. That I am personally familiar with the facts and circumstances surrounding this matter and am competent to testify hereto.
3. There is good cause to hear this Motion on an Order Shortening Time as all parties are in the midst of trial and further delay may result in prejudice to the moving party.
4. That at trial, on October 17, 2019, I questioned Defendant Rives. I asked, in sum and substance, "Doctor, the woman sitting next to you the last few days, she is a consultant hired to help on your case?"[1]
5. That Defense Counsel, Thomas Doyle, Esq., objected and a bench conference was held. My recollection is that Defense Counsel objected to the question on grounds that it was privileged (perhaps among other objections). I argued that the question was proper, that it did not violate attorney/client privilege because she was a consultant, not Defendants' attorney. Moreover, I argued that it did not even need to get to the attorney-client privilege inquiry, because I was not seeking to ask about the content of any conversations. I then informed Defense Counsel and the Court that my intention was simply to ask Dr. Rives a follow-up question along the lines of, "Did the consultant help you prepare for your testimony in this case?"
6. That to my best recollection, Mr. Doyle then noted, that **yes, the consultant did help prepare Dr. Rives to testify, but that it was protected under attorney/client privilege.**

[1] I have not reviewed the transcript and I am not claiming these were the exact words used. I believe this is a fair approximation of my question.

7. That the Court overruled Defendant's objection and allowed me to continue.
8. That I then asked Dr. Rives if the consultant helped him prepare to testify in this case.
9. That Defendant Rives answered, "no."
10. That to my best recollection I asked a confirming question along the same lines and Dr. Rives again denied that the consultant had assisted in the preparation of his testimony.
11. That I later asked if Dr. Rives understood that Interrogatories are made under oath and under penalty of perjury.
12. That Dr. Rives initially vacillated and acted as though he did not understand whether or not Interrogatories are made under oath and under penalty of perjury.
13. That this testimony appeared to lack candor as Dr. Rives is an experienced litigant that has answered interrogatories many times, seven (7) times by his own sworn estimate. Moreover, Dr. Rives' position appears to conflict with his recent testimony given in the Evidentiary Hearing on October 7, 2019 on this same topic.
14. The motive for Dr. Rives' lack of candor appeared to be to trick the jury into believing that he was less than certain about the gravity of verifying false answers to interrogatories without reading them, a known issue in this case.
15. Thereafter, on October 18, 2019, during the cross-examination of Plaintiffs' medical expert, Dr. Michael Hurwitz, M.D., Mr. Doyle violated the Court's verbal order, in front of the jury, regarding the use of Dr. Hurwitz's deposition testimony, which had not been timely disclosed to the Court or to Plaintiffs.
16. Thomas Doyle, Esq., was then admonished by the court.

///

///

///

17. That this Declaration is made in good faith, and not for the purposes of delay.

FURTHER YOUR DECLARANT SAYETH NAUGHT.

/s/ Kimball Jones
KIMBALL JONES, ESQ.

4A.App.896

MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

The Court is well aware of the discovery abuses committed by Defendants in this matter. As a result of Plaintiffs' prior Motion to Strike Defendants' Answer, this Court, in an effort to balance the prejudice against Plaintiffs and to sanction Defendants' discovery violations, Ordered sanctions against Defendants, including monetary sanctions and a jury instruction noting Defendants' failure to properly disclose Defendant Rives' litigation history.

As a result of further violations by Defendants, including committing perjury while testifying under oath and violating this Court's verbal Order in the presence of the jury, Plaintiffs herein renew their Motion to Strike Defendants' Answer as a result of Defendants' flagrant and repeated discovery abuses and egregious conduct during litigation.

Testimony in Discovery Hearing:

On September 26, 2019, the Court heard arguments by counsel for Plaintiffs and Defendants on Plaintiffs' Motion for Case Terminating Sanctions. The Court was prepared to rule on the same, however, one of Defendants' arguments was that Defendants' counsel had erred and that the alleged omissions by Defendant Rives were unintentional. Defendants did not provide any affidavit or other evidentiary support for their position, but the parties did request an evidentiary hearing for the purpose of permitting Defendant Rives an opportunity to explain his acts/omissions. The parties specifically requested one (1) hour for the evidentiary hearing, which was ultimately held on October 7, 2019. See *Transcript of Dr. Rives Evidentiary Hearing Testimony*, p. 29:2 – 75:24, attached hereto as **Exhibit "1."**

Additionally, Defendant Rives lacks credibility when testifying of his prior knowledge of written discovery. Specifically, Defendant Rives testified he had never seen Defendant Rives' Answers to Interrogatories or Defendant Laparoscopic Surgery of Nevada, LLC's Answers to

Interrogatories, including the "Answers," "Supplemental Answers," and "First Supplemental Answers," until sometime in September 2019. *Id.* at 43:17 – 50:9. This question was asked numerous times and Defendant Rives did not waiver through several denials. *Id.* However, Defendant Rives' testimony regarding whether he had seen the documents prior to September 2019 became muddled after he was shown a verification signed on April 27, 2017. See *April 27, 2017 Notarized Verification*, attached hereto as **Exhibit "2."**

First, Defendant Rives again insisted he had never seen the documents. *Exhibit 1*, at 53:23 – 54:1. He then acknowledged he had at least "...pulled up..." the documents in an email and "...read it as a bunch of legalese." *Id.* at 54:6-7. When further pressed on the issue that he had not verified the statements were true, Defendant Rives claims only, "I did not review them sentence by sentence, no." The gap between "never seen" and "I did not review them sentence by sentence, no," creates a serious gap in credibility for Defendant Rives.

Moreover, in that same line of questioning Defendant Rives essentially admits to perjury:

> Q. Dr. Rives, what is this document that I've just handed you?
> A. It's a verification regarding Laparoscopic Surgery of Nevada's response to Plaintiff Titina Farris' first set of interrogatories.
> Q. All right. And can you read -- it says verification. And can you please read what it says below that?
> A. "I, the undersigned, **declare I have read the foregoing document**, and know the contents thereof. **I am informed and believe that the matters stated therein are true**. And on that ground, I allege that the matters stated therein are true. **I declare under penalty of perjury that the foregoing is true and correct.** Executed on the 27th of 2017 at Henderson, Nevada."
> Q. Is that your signature, Doctor?
> A. That is.
> ...
> Q. Okay. All right. And you did so. It says, **"I have read the foregoing document and know the contents thereof." That was not true when you signed this?**
> A. **No**.

Id. at 53:3 – 54:22. (Modified).

Thereafter, Defendant Rives acknowledged being an experienced litigant that understood and appreciated the rules related to sworn testimony and sworn interrogatories:

Q And you've answered interrogatories in numerous cases, and you would know that you -- that those are under penalty of perjury as well, correct, when you answered those?
A My counsel has answered those interrogatories for me, yes.
Q But you knew -- but you signed verifications for those interrogatories, correct?
A I believe so, yes.
Q And the verifications to those interrogatories were sworn under penalty of perjury, were they not?
A I believe so, yes.
Q And you're the one swearing under penalty of perjury that they're true, aren't you?
A Yeah, I guess. Yeah.

Id. at 57:10-57:22. (Emphasis added).

Defendant Rives then verified directly to this Court that he had verified past interrogatory responses. *Id.* at 74:24 – 75:20.

In determining whether to order case terminating sanctions, this Court acknowledged that some of the sanctionable conduct in this case would penalize Defendants for the actions that seem to be attributable to Defense Counsel. The Court ordered that a jury instruction be created and read to the jury to balance the prejudice caused by Defendants' and Defense Counsel's actions.

Rives Commits Perjury in Trial:

At trial, on October 17, 2019, Defendant Rives was questioned by Plaintiffs' Counsel, Kimball Jones, Esq. Counsel asked Defendant Rives, in sum and substance, "Doctor, the woman sitting next to you the last few days, she is a consultant hired to help on your case?"

Defense Counsel objected and a bench conference was held. Defense Counsel objected to the question on grounds that it was privileged (perhaps among other things). Plaintiffs' Counsel argued that the question was proper, that it did not violate attorney/client privilege because the woman was a consultant and not Defendants' attorney. Moreover, Plaintiffs' Counsel argued that it did not even need to get to the attorney-client privilege inquiry, because Plaintiffs were not seeking to ask about the content of any conversations. Plaintiffs' Counsel then informed Defense Counsel and this Court

that the intention was simply to ask Dr. Rives a follow-up question along the lines of, "Did the consultant help you prepare for your testimony in this case?"

Defense Counsel then noted, that **yes, the consultant did help prepare Dr. Rives, but that it was protected under attorney/client privilege.**

This Court overruled Defendant's objection and allowed Plaintiffs to proceed with the question.

Plaintiffs asked the question which was, in sum and substance, "Did the woman beside you help prepare you to give testimony in this matter?" Defendant Rives then answered, "no." Plaintiffs' Counsel, taken aback that Rives' testimony conflicted with the information that his counsel gave just seconds before and asked a confirmatory question, to which Defendant Rives emphatically denied that the consultant had not helped prepare his testimony.

This statement violated Dr. Rives' oath to give honest answers in this matter, thereby committing perjury.

Upon further questioning, Plaintiffs' Counsel asked, in both sum and substance, whether Dr. Rives was aware that Interrogatory answers are sworn and verified under oath. Dr. Rives expressed hesitation, refusing to note whether he understood that these answers are given under oath. This answer directly conflicts with his sworn answer to this Court not more than ten (10) days prior, where he noted:

> Q And you've answered interrogatories in numerous cases, and you would know that you -- that those are under penalty of perjury as well, correct, when you answered those?
> A My counsel has answered those interrogatories for me, yes.
> Q But you knew -- but you signed verifications for those interrogatories, correct?
> A I believe so, yes.
> **Q And the verifications to those interrogatories were sworn under penalty of perjury, were they not?**
> **A I believe so, yes.**
> **Q And you're the one swearing under penalty of perjury that they're true, aren't you?**
> **A Yeah, I guess. Yeah.**

Exhibit 1, at 57:10-57:22. (Emphasis added).

Defendant Rives committed perjury twice on the stand during his trial testimony. His testimony conflicted with the answer his attorney had just given the Court, and conflicted with testimony which he had sworn to ten (10) days prior.

This further discovery abuse and egregious conduct violates the very fundamentals upon which the justice system relies. Perjury, whether in court testimony, an evidentiary hearing, in sworn affidavits, or deposition, is not tolerated by the Court. "False testimony in a formal proceeding is intolerable." *ABF Freight System, Inc. v. N.L.R.B.*, 510 U.S. 317, 323 (1994). "Our legal system is dependent on the willingness of the litigants to allow an honest and true airing of the real facts." *Quela v. Payco-General Amer. Credits, Inc.*, 2000 WL 656681, at *7 (N.D.Ill. May 18, 2000).[1] Thus, "[p]arties who wish to use the judicial system to settle disputes have certain obligations and responsibilities" and "[o]ne of those responsibilities is to tell the truth" *Id.* quoting *Rodriguez v. M & M/Mars*, 1997 WL 349989, *2 (N.D. Ill. June 23, 1997). In *Rodriguez*, the Court dismissed plaintiff's case for lying about her prior criminal record in a deposition. (An offense similar to the violations which occurred in this matter). Finally, "[P]erjury strikes at the heart of the integrity of the judicial system....'" *United States v. Stokes*, 211 F.3d 1039, 1046 (7th Cir.2000

Defendant Rives' acts of perjury undermine the entirety of the proceedings which Plaintiffs have brought. These final acts of perjury, in combination with Defendant Rives' prior discovery violations, show that he was every bit as culpable as his attorney in engaging in egregious conduct.

[1] Plaintiffs note that it is citing to Federal Court authority throughout this Motion. As the Nevada Supreme Court stated in *Executive Mgmt. Ltd.*, "[f]ederal cases interpreting the Federal Rules of Civil Procedure are strong persuasive authority because the Nevada Rules of Civil Procedure are based in large part upon their federal counterparts." *Executive Mgmt. Ltd. v. Ticor Title Insur. Co.*, 118 Nev. 46, 38 P.3d 872 (2002). As Plaintiffs are seeking sanctions under Rule 37, Plaintiffs argue that the Federal Court authority cited herein is particularly authoritative.

The Court has inherent authority to strike Defendants' Answer for this perjury, particularly as it was accompanied by prejudicial discovery abuses:

> A district court may dismiss a case for discovery violations or other egregious conduct in litigation under Federal Rule of Civil Procedure 37 or under the inherent authority of the district court. See *Greviskes v. Univ. Research Assoc., Inc.*, 417 F.3d 752, 758–59 (7th Cir.2005) (citations omitted). Although Rule 37 requires violation of a judicial order before a court imposes sanctions, "[c]ourts can broadly interpret what constitutes an order for purposes of imposing sanctions" and a formal order is not required. *Quela v. Payco–General Amer. Credits, Inc.*, No. 99 C 1904, 2000 WL 656681, at *6 (N.D.Ill. May 18, 2000) (collecting cases). This broad latitude "stems from the presumption that all litigants ... are reasonably deemed to understand that fabricating evidence and committing perjury is conduct of the sort that 'is absolutely unacceptable.'

JFB Hart Coatings, Inc. v. AM Gen. LLC, 764 F. Supp. 2d 974, 981–82 (N.D. Ill. 2011)

As Defendant Rives has continued to taint these proceedings by perjuring himself, nothing less than the Striking of Defendants' Answer will serve as a proper sanction for Defendants' conduct.

Additionally, on October 8, 2019 the parties met for calendar call. Among other tasks, the parties were required to provide the original deposition transcripts for any witness deposed in this case. It was well understood that any transcript of a deposition taken in this matter that was not provided at the calendar call could not be used for any purpose at trial. Both parties turned in their transcripts. No party requested an extension, nor did any party mention that they lacked any transcript at that time.

Thereafter, after trial commenced, Defendants attempted to submit an additional transcript for the deposition of Michael Hurwitz, M.D. Plaintiffs objected. Defendants did not demonstrate any good cause or excusable neglect related to their failure to obey this Court's Order regarding original deposition transcripts. As a result, the transcript was not accepted. Defendants took no further action to submit the transcript.

On October 18, 2019, during the cross examination of Dr. Hurwitz, Defense Counsel attempted to impeach Dr. Hurwitz through the use of his deposition transcript. Plaintiffs objected and this Court sustained the objection. After numerous questions and objections by Plaintiffs related to Dr. Hurwitz

deposition transcript, this Court made it clear that questioning along these lines was improper and must cease.

Thereafter, Defense Counsel, with a defiant tone in the presence of the jury, asked additional questions that appeared to be either verbatim from the deposition or very close to the words in the deposition, and did so in a way that the jury likely would have concluded that Defense Counsel was reading from Dr. Hurwitz deposition for the purposes of impeachment.

II. LEGAL ARGUMENT AND ANALYSIS

A. DEFENDANTS' PRIOR DISCOVERY ABUSES WERE EGREGIOUS AND WARRANTED SANCTION

Defendants have violated established discovery rules and have committed offenses specifically forbidden by the Court in statute.

As the Court noted in *Young v. Johnny Ribeiro Bldg., Inc.*:

> Two sources of authority support the district court's judgment of sanctions. First, NRCP 37(b)(2) authorizes as discovery sanctions dismissal of a complaint, entry of default judgment, and awards of fees and costs.
> ...
> Second, courts have "inherent equitable powers to dismiss actions or enter default judgments for ... abusive litigation practices." *TeleVideo Systems, Inc. v. Heidenthal,* 826 F.2d 915, 916 (9th Cir.1987) (citations omitted). Litigants and attorneys alike should be aware that these powers may permit sanctions for discovery and other litigation abuses not specifically proscribed by statute.

Young v. Johnny Ribeiro Bldg., Inc., 106 Nev. 88, 92, 787 P.2d 777, 779 (1990)

The Supreme Court has enumerated numerous factors for the trial Court to utilize to determine an appropriate sanction based upon a party's behavior.

> Under NRCP 37(b)(2)(C), when a party fails to make a discovery disclosure pursuant to NRCP 16.1, the district court may make "[a]n order striking out pleadings or parts thereof ... or dismissing the action or proceeding or any part thereof, or rendering a judgment by default against the disobedient party."
>
> In *Young,* we articulated the abuse-of-discretion standard with regard to discovery sanctions:
>
> The factors a court may properly consider include, but are not limited to, the degree of willfulness of the offending party, the extent to which the non-offending party would be

> prejudiced by a lesser sanction, the severity of the sanction of dismissal relative to the severity of the discovery abuse, whether any evidence has been irreparably lost, the feasibility and fairness of alternative, less severe sanctions, such as an order deeming facts relating to improperly withheld or destroyed evidence to be admitted by the offending party, the policy favoring adjudication on the merits, whether sanctions unfairly operate to penalize a party for the misconduct of his or her attorney, and the need to deter both the parties and future litigants from similar abuses.
>
> *Valley Health Sys., LLC v. Estate of Doe by & through Peterson*, 134 Nev. 634, 639, 427 P.3d 1021, 1027 (2018), as corrected (Oct. 1, 2018).

Defendants' Degree of Willfulness is egregious. Plaintiffs directly requested the discovery answers. Both Defendant Rives and his attorney worked to obfuscate the answer and hide Rives' similar treatment of Center.

A Lesser Sanction helps balance, but fails to fully cure the damage done to Plaintiffs' case in this matter as Plaintiffs were unable to uncover the notice that Rives had of the danger of Rives "wait and see" approach while discovery was open.

Striking of Defendants' Answer is proportional to not only the discovery violations committed by Defendants, but also his flagrant disregard for the law as he has demonstrated to this Court his WILLINGNESS to deceive to this Court and the jury. Clearly, Dr. Rives' motive is to deceive to prevent a verdict against him. This is demonstrated in his willingness to commit perjury, even when this Court heard his testimony the week prior.

Dr. Rives has been present in his evidentiary hearing, most times when the jury was not present and this Court provided ample instructions and warnings to parties. **Dr. Rives cannot now claim he did not know what he was doing when he committed perjury and try and now argue that he mysteriously forgot what happened the prior week in his evidentiary hearing. Dr. Rives mocks this Court, the jury and the law as shown now two (2) times he cannot tell the truth.**

As the Court noted in *Valley*, striking an answer is not "case terminating" and is not subject to a heightened standard of review—because the issue of damages still remains:

> When a district court imposes case-ending sanctions, we apply "a somewhat heightened standard of review." *Id.* However, sanctions are not considered case ending when, as here, the district court strikes a party's answer thereby establishing liability, but allows the party to defend on the amount of damages. *Bahena v. Goodyear Tire & Rubber Co.,* 126 Nev. 243, 249, 235 P.3d 592, 596 (2010).
>
> *Valley Health Sys., LLC v. Estate of Doe by & through Peterson*, 134 Nev. 634, 638–39, 427 P.3d 1021, 1027 (2018), as corrected (Oct. 1, 2018)

Evidence Was Conveniently Forgotten By Both Defense Counsel and Dr. Rives.

Evidence was Lost as a result of Defendants' actions. There was no opportunity to request this information while discovery was ongoing.

Lesser alternatives are feasible, but not fair to Plaintiffs. The Rebuttable Presumption granted in this matter balances, but fails to fully cure the full amount of ongoing prejudice to Plaintiffs' case.

This Court, as well as Plaintiffs, would have liked to have seen Adjudication on the Merits in this case—but only if it was a fair fight. Defendants actions in this matter altered the case to such a degree that a fair, impartial finding could not be awarded in this matter on the merits.

This Court has noted it does not wish to punish Defendants for their Attorney's conduct. However, Defendants are as culpable as their Counsel in their obfuscation of litigation history. Defendant Rives failed under oath in deposition to note the Center case, where he clearly had his Interrogatory responses in front of him. Then, during the evidentiary hearing he created an odd and simply incredible story—claiming an active memory of the moment—to suggest the Interrogatory responses were not available for his review. The discovery violations in this case are simply not all attributable to Defense Counsel. Moreover, Defendant is well aware of his Counsel's actions and has the ability to choose and/or replace his attorney. Nevertheless, Defendant has stuck with his attorney despite the conduct.

Moreover, Defendant Rives' continued conduct demonstrates that Rives, more than his attorney, was culpable and acted to subvert the Court's rules.

///

B. STRIKING OF DEFENDANTS' ANSWER IS PROPER DUE TO RIVES' CONTINUED CONDUCT, INCLUDING PERJURY AND SUBVERTING THE INTEGRITY OF THE COURT

As noted above, ten (10) days prior to testifying in open Court, Dr. Rives testified that he understood that Interrogatory answers are verified and given under oath:

> Q And you've answered interrogatories in numerous cases, and you would know that you -- that those are under penalty of perjury as well, correct, when you answered those?
> A My counsel has answered those interrogatories for me, yes.
> Q But you knew -- but you signed verifications for those interrogatories, correct?
> A I believe so, yes.
> **Q And the verifications to those interrogatories were sworn under penalty of perjury, were they not?**
> **A I believe so, yes.**
> **Q And you're the one swearing under penalty of perjury that they're true, aren't you?**
> **A Yeah, I guess. Yeah.**

Exhibit 1, at 57:10-57:22. (Emphasis added).

Yet, in trial on October 17, 2019, Dr. Rives vacillated and tried to not admit to the jury that he understood that answers to discovery responses are given under oath. See *Declaration of Kimball Jones*, above.

Furthermore, in the opening question from Plaintiffs' Counsel, Dr. Rives could not help but give false testimony.

Defense Counsel immediately objected and a bench conference was held. Defense Counsel objected to the question on grounds that it was privileged. Plaintiffs' Counsel argued that the question was proper, that it did not violate attorney/client privilege, and that Counsel was not seeking to ask about the content of any conversations. Rather, Plaintiffs' Counsel insisted, he was merely seeking to ask Dr. Rives if the woman had helped him prepare his testimony. Defense Counsel then noted, that **yes, the consultant did help prepare Dr. Rives, but that it was protected under attorney/client privilege**.

The Court overruled Defendants' objection and allowed Plaintiffs to proceed.

Plaintiffs asked if the consultant had assisted Dr. Rives to prepare his testimony. Defendant Rives then answered, "**no**." Plaintiffs' Counsel, taken aback that Rives' testimony conflicted with the answer which his counsel gave just seconds before again asked, if the consultant sitting beside him helped prepare his testimony in this matter and Dr. Rives emphatically again answered that she had not helped prepare his testimony.

Then, on October 18, 2019, during the cross examination of Dr. Hurwitz, Defense Counsel attempted to impeach Dr. Hurwitz through the use of his deposition transcript. Plaintiffs objected and this Court sustained the objection. After numerous questions and objections by Plaintiffs related to Dr. Hurwitz deposition transcript, this Court made it perfectly clear that questioning along these lines was improper and must cease. Thereafter, Defense Counsel, with a defiant tone in the presence of the jury, asked additional questions that appeared to be either verbatim from the deposition or very close to the words in the deposition, and did so in a way that the jury likely would have concluded that Defense Counsel was reading directly from Dr. Hurwitz deposition transcript for the purposes of impeachment.

It appears that Dr. Rives and his Counsel will continue to contemptuously violate the rules of discovery, violate the oath to provide truthful testimony, and this Court's Orders in this case, as well as the very rules upon which our justice system is built upon.

The United States Supreme Court has noted in no uncertain terms that perjury merits case terminating sanctions. "**Lawyers and litigants who decide that they will play by rules of their own invention will find that the game cannot be won.**" *United States v. Golden Elevator, Inc.*, 27 F.3d 301, 302 (7th Cir.1994)(emphasis added).

This Court is well aware of the prior offenses committed by Defendants in this matter. Furthermore, this Court witnessed with its own eyes the false statements given under oath by Defendant on the stand as well as Defense Counsel's defiant violation of this Court's Orders. Substantial Evidence exists of their commission, and of their prejudicial impact on Plaintiffs' case. As

such, striking of Defendants' Answer is a fair, proportional sanction, which will serve to ensure that Plaintiffs' case is made whole and that this type of willful misconduct is discouraged in the future.

III. CONCLUSION

Based on the above, Plaintiffs respectfully requests that this Court GRANT Plaintiffs' Motion and Strike Defendants' Answer.

DATED this 19th day of October, 2019.

BIGHORN LAW

By: */s/ Kimball Jones*
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3442 N. Buffalo Drive
Las Vegas, Nevada 89129

Attorneys for Plaintiffs

CERTIFICATE OF SERVICE

Pursuant to NRCP 5, NEFCR 9 and EDCR 8.05, I hereby certify that I am an employee of **BIGHORN LAW**, and on the 19th day of October, 2019, I served the foregoing ***PLAINTIFFS' RENEWED MOTION TO STRIKE DEFENDANTS' ANSWER FOR RULE 37 VIOLATIONS INCLUDING PERJURY AND DISCOVERY VIOLATIONS ON AN ORDER SHORTENING TIME*** as follows:

☒ Electronic Service – By serving a copy thereof through the Court's electronic service system; and/or

☐ U.S. Mail—By depositing a true copy thereof in the U.S. mail, first class postage prepaid and addressed as listed below:

Kim Mandelbaum, Esq.
MANDELBAUM ELLERTON & ASSOCIATES
2012 Hamilton Lane
Las Vegas, Nevada 89106
&
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Chad C. Couchot, Esq.
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/s/ Erickson Finch
An employee of **BIGHORN LAW**