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Don't be chicken, keep fighting

Howell *and* Corenbaum – *what they say (and don't say) about the reasonable value for medical services*

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The sky is falling! The sky is falling! While there is cause for concern about what the future holds after the decisions in *Howell v. Hamilton Meats & Provisions, Inc.* (2011) 52 Cal.4th 541, and *Corenbaum v. Lampkin* (2013) 215 Cal.App.4th 1308 at 556, the current state of the law is not as bad as it might seem. Relying in part on Restatement of Torts, sections 911 & 924, the California Supreme Court in *Howell* limits recovery for past medical care that has been paid for (whether by an insurer or the plaintiff), to that which has been paid. While past cases have held that the maximum allowable recovery is the lesser of (a) the amount paid or incurred for medical services, and (b) the reasonable value of the services, *Howell* and *Corenbaum* seem to alter that rule. *Howell* initially reiterates this general rule as California law (*Howell, supra,* 52 Cal.4th at 556.) But the court then states that in cases where the medical services have been paid at an agreed-upon price, an analysis of whether the cost is reasonable is not considered. ("Thus, where a medical provider has agreed, before treating a plaintiff, to accept a certain amount for its services, that constitutes the provider's price and there is no need to determine a reasonable value for those services (*Corenbaum, supra,* 215 Cal.App.4th at 1326).) "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 need to determine a reasonable value of the services, as there is in the case of services gratuitously provided." (*Howell, supra,* 52 Cal.4th at 559.)

Compensation for unpaid past medical care and future medical care are not addressed directly by *Howell*.

Write offs

It is important to note the distinction that the California Supreme Court makes between what is negotiated and what is written-off. As laid out in *Howell*, when a rate is negotiated between the insurer and the medical provider, the reduction from the billed amount to the pre-negotiated rate is not considered a collateral source. As a result, payment of the lower amount is all that is compensable by a tortfeasor to the plaintiff. The court relied heavily upon the concept that this amount was all that the plaintiff was liable for, and not the greater billed amount. Conversely, it is the widely held view that gratuitous payments and services are considered a collateral source (See Restatement (Second) Torts, §920A, comment c, and as cited to in *Howell, supra,* 52 Cal.4th at 557-558.) The *Howell* court struggles with this rule as it relates to the issue of reimbursement for the reasonable cost of medical services (*Howell, supra,* 52 Cal.4th at 557-558) and specifically indicates that it does not approve or disapprove of the rule. Nonetheless, based on *Arambula v. Wells* (1999) 72 Cal.App.4th 1006, cited in *Howell, supra,* 52 Cal.4th 1006, it is still the law that in circumstances when services are written-off by a provider, the amount to be paid by a tortfeasor to the plaintiff will be determined based on the reasonable value of the service. In the context of the cost of medical services, "donated," "gratuitous," and "write-off" are all terms meaning the same thing – the patient was not held responsible for paying all or part of a bill. The court has created a divide between two types of costs for medical services – those where there is a pre-agreed negotiated rate that is paid for which the patient is liable (recovery limited to what was paid) and those where the client is not necessarily liable and the cost of services is reduced or eliminated (recovery limited to the reasonable value of the care).

Cost of medical services

Now comes *Corenbaum*. The holding of *Corenbaum* only clarifies a very narrow issue as it relates to the cost for medical services: the full amount billed for past services is not admissible as evidence of what the reasonable value of future medical services will be, nor is it relevant for purposes of determining noneconomic damages. While much has been made about how bad this ruling is for plaintiffs (and it is), the damage is limited.

Corenbaum does *not*, as has been suggested in some publications, limit the cost of future medical services to a pre-negotiated rate paid by insurance companies. It simply says that the patient's specific past costs that were billed for medical services cannot be used to determine what the reasonable value of costs will be for future medical services. While the reasoning of the court in *Corenbaum* is not clearly laid out, it is fair that the court takes issue with this approach. After all, how do we know that the billed amount for a surgery of one type in the

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past will be any indication of what the billed amount for a different type of surgery will be in the future? We don't, unless we have someone do a survey of the reasonable value of the types of medical services that a patient will need in the future.

So how do we determine the reasonable value of medical services not yet received or not yet paid? The same way that it was done before *Howell* – hire an expert who has knowledge of and can testify to the current rates billed for the services needed. The expert determines what the rates are that a medical provider contracts with patients to charge for its services. The rates that an insurer might agree with a medical provider to pay is not permissible because the rate is speculative in two ways. First, it is speculative to assume a plaintiff will have insurance in the future and, if they do, what type they will have is unknown. This is true even assuming The Affordable Care Act (ACA) continues to be the law of the land (itself a speculative proposition). ACA does not require a person to have insurance.

Second, assuming that it could be established that a plaintiff will have insurance in the future, and it could be determined what type of insurance they would have, there is still no way to determine what rates would be negotiated in the future. Wading into this discussion in a jury trial would violate the long-held and still applicable prohibition against evidence of insurance in non-medical malpractice personal injury cases. *Howell,* (*supra,* 52 Cal.4th at 567) reaffirmed the inadmissibility of insurance payments. If evidence of insurance is not permissible for past medical service payments, certainly it would be inconsistent to allow the introduction of evidence of lower payments for medical services in the future based on a presumption of the plaintiff having insurance. Conversely, what is known, regardless of what happens with our medical system and whether a plaintiff has insurance or not, is that there will always be medical care available for those who have the money to pay for it. If the medical-care provider chooses to write off some portion of their billed amount, the principle that donated, gratuitous or written-off services are compensable at their reasonable value should apply. Similarly, the amount that is billed is a liability incurred by the plaintiff and, based on the logic of *Howell,* should be compensable at that amount.

Future medical services

There are a number of experts who can do a fair market analysis and testify to the reasonable value of future medical services based on an area's healthcare providers. Typically, this will be a life-care planner who has a background in nursing, medical services administration or accounting, or a similar experience in delivery and costs of medical services. The life-care planner's opinions will be based on the future care needs of the plaintiff and utilizing a recognized, authoritative treatise such as the American Hospital Directory, Physician Fee and Coding Guide, the Hospital Cost and Utilization Project or other similar treatise that accumulates and compiles data for the cost of various medical services. This information can be affirmed by the life-care planner by asking local medical service providers as to their costs to see if those costs fall within the ranges specified by the treatises used.

The bottom line: all is not lost and the sky is not falling. The reasonable value for unpaid medical services is alive and well. The reasonable value for medical services should be determined by the cost that is incurred by a plaintiff without regard to negotiated rates between insurance companies and medical service providers. Similarly, the reasonable value for unpaid medical services should be determined without regard to the amounts that a hospital writes-off from its bills, whether in full or in part. Go forth and fight for your clients – they deserve the medical care they need and the ability to pay for those services, come what may in the uncertain future.


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