Ripe For Litigation

Using the New Federal Healthcare Act to Limit Future Damages

By H. Thomas Watson and Wesley T. Shih

The California Supreme Court recently granted review in *Howell v. Hamilton Meats & Provisions Co.* (case no. S179115) to decide the scope of the collateral source rule. Specifically, the court will decide whether the collateral source rule allows a plaintiff in a personal injury action to recover as economic damages the full amount her health care providers nominally billed for their services even though the providers agreed to accept as payment in full much smaller amounts paid by the plaintiff's health insurer. In other words, the Supreme Court will decide whether to disapprove the common-sense rule stated in *Hanif v. Housing Authority* (1988) 200 Cal.App.3d 635 that "a sum certain . . . paid or incurred . . . , whether by the plaintiff or by an independent source, . . . is the most the plaintiff may recover for [medical] care despite the fact it may have been less than the prevailing market rate." (*Id.* at p. 641; accord, *Nishihama v. City and County of San Francisco* (2001) 93 Cal.App.4th 298, 306 [applying the *Hanif* rule in the context of private health insurance]; *People v. Millard* (2009) 175 Cal.App.4th 7 [applying the *Hanif* rule in the context of a crime victim restitution action].)

The difference between a healthcare provider's schedule of listed rates (sometimes dubbed the "usual and customary" rates) and the negotiated rates they typically accept as payment in full for their services can be quite significant. For example, in *Nishihama*, the court reduced a $17,168 damages awarded based on the hospital's full "billed" rate to $3,600, the amount the hospital had accepted as payment in full for its services pursuant to its agreement with the plaintiff's health insurer—reflecting an 80 percent reduction in damages. In *Howell* and *Millard*, the difference between the listed rate and the actually paid rates was a factor of three.

Thus, the Supreme Court's decision in *Howell*, no matter what measure of damages the court announces, will significantly impact the amount of medical damages that may be recovered. To date, however, the debate over what figure to use has concentrated on the measure of recovery for *past* medical damages. This is because litigants know (or can know with appropriate discovery) whether past medical expenses were paid at the healthcare providers' full rate or a lower negotiated rate that was accepted pursuant to a healthcare contract. The parties can thus frame the difference in their positions

with respect to past damages in concrete dollar terms.

On the other hand, there has not been a reliable way to establish, by a preponderance of the evidence, that future medical care will be provided at a lower negotiated rate rather than the full rate listed by healthcare providers. This is because existing health insurance is generally subject to annual and lifetime caps on benefits, and new insurance has not been available to cover the cost of treating "preexisting" conditions. Thus, tort cases seeking large recovery of future medical expenses to treat a severe injury (e.g., brain damage, quadriplegia, etc.) have generally based those future damages on the healthcare providers' full listed rates. But that may now change.

On March 23, 2010, President Obama signed into law the Patient Protection and Accountable Care Act of 2010 (PPAC). The PPAC dramatically alters the current medical insurance regime. Under PPAC section 1200, beginning January 1, 2014, insurers are prohibited from discriminating against individuals or participants on the basis of health status, including pre-existing conditions. Moreover, to fill the gap between the date of PPAC's enactment and January 1, 2014, PPAC section 1101 mandates the creation of a temporary high risk insurance pool program by June 21, 2010. This program will provide access to health care coverage for those who are particularly costly to insurers or cannot secure coverage from private insurers due to pre-existing conditions.

Justice Stephen Breyer recently observed that litigation concerning "this 2,400-page bill" that became the PPAC will likely consume the U.S. Supreme Court's docket for years to come. (Mauro, *Breyer and Thomas Discuss High Court Docket, Clerks, Cameras*, The National Law Journal (Apr. 6, 2010).) The impact of the PPAC will likewise be felt on state court dockets. One important question that will need to be resolved (assuming *Howell* affirms the *Hanif* rule) is how the PPAC bears on a tort plaintiff's duty to mitigate their future medical expense damages.

Under the common law doctrine of mitigation of damages, "[a] plaintiff who suffers damage as a result of either a breach of contract or a tort has a duty to take reasonable steps to mitigate those damages and *will not be able to recover for any losses which could have been thus avoided.*" (*Shaffer v. Debbas* (1993) 17 Cal. App.4th 33, 41, emphasis added; accord, *Valle de Oro Bank v. Gamboa* (1994) 26 Cal.App.4th 1686, 1691 ["A plaintiff may not recover for damages avoidable through ordinary care and reasonable exertion"]; 6 Witkin, Summary of Cal. Law (10th ed. 2005) Torts, § 1624, p. 1138; Rest.2d Torts, § 918.) Moreover, the duty to mitigate applies to plaintiffs seeking personal injury damages. For example, tort plaintiffs are under an obligation to seek medical care to mitigate their damages. (See, e.g., *Withrow v. Becker* (1935) 6 Cal. App.2d 723 [plaintiff not allowed to recover pain and suffering damages resulting from a hernia he sustained

in an automobile accident for which he did not seek treatment].)

Typically, "the rule of mitigation of damages comes into play when the event producing injury or damage has already occurred and it then has become the obligation of the injured or damaged party to avoid continuing or enhanced damages through reasonable efforts." (*Valle de Oro Bank, supra,* 26 Cal.App.4th at p. 1691.) However, "[t]he duty to mitigate damages does not require an injured person to do what is unreasonable or impracticable." (*Valencia v. Shell Oil Co.* (1944) 23 Cal.2d 840, 846.) The question then, is whether the PPAC provides tort plaintiffs seeking damages for future medical care a reasonable and practicable means of fulfilling their duty to mitigate damages. Arguably, it does—at least in part.

A tort plaintiff seeking to recover damages for future medical care can now procure medical insurance covering those future needs. (Indeed, tort plaintiffs are *required* by federal law to purchase healthcare insurance starting in 2014.) And, in cases of significant injury, the premiums that the plaintiff will pay will likely be far less than the differential between a health care provider's full listed charge for uninsured patients, and the reduced rate that heathcare insurers will be able to pay for their insureds' care.

Thus, in anticipation of a Supreme Court opinion in *Howell* affirming the *Hanif* line of cases, defense counsel should ensure that their expert witnesses are prepared to testify how a plaintiff's future medical care needs will likely be met at the lower negotiated rate for medical services rather than the higher "usual and customary" (actually, unusual and non-customary) rates nominally billed by healthcare providers. Similarly, counsel should be prepared to cross-examine the plaintiff's experts regarding the costs included in their proposed life care plans to ensure they have assumed negotiated rather than full rates as the basis for the cost of the plaintiff's future medical care. And defense counsel should be prepared to argue why the mitigation of damages doctrine prevents tort plaintiffs from recovering damages for medical expenses at rates that would apply only if the plaintiff failed to take reasonable steps to minimize those charges.

There is always the possibility that, in *Howell*, the Supreme Court will overrule the *Hanif* line of cases (at least in the context of private health insurance), and hold that that the collateral source rule applies to allow a plaintiff to recover damages based on the healthcare provider's full listed rate, even though neither the plaintiff nor his or her insurer will ever have to pay that rate. The plaintiff's argument in *Howell* is that this difference between the list rate and the negotiated rate is a collateral source benefit that exists by virtue of their foresight in purchasing health insurance, and therefore it is the plaintiff, not the defendant, who should receive the benefit of this rate differential. (The defense position is that the collateral source rule only allows the plaintiff to pocket sums

based on the negotiated amounts the insurer ends up paying for care; allowing the plaintiff to collect sums that even the insurer did not have to pay would be an unprecedented expansion of the collateral source rule.) If the Supreme Court accepts the plaintiff's argument in *Howell*, it will likely need to confront the same issue again in a case where the PPAC applies, since once again the PPAC significantly alters these circumstances.

The collateral source rule holds 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." (*Helfend v. Southern Cal. Rapid Transit Dist.* (1970) 2 Cal.3d 1, 6.) *Helfend* was the last time the Supreme Court examined the validity of the collateral source rule as it applies to medical insurance. In *Helfend*, the Supreme Court acknowledged that "the collateral source rule provides plaintiff with a 'double recovery,' rewards him for the injury, and defeats the principle that damages should compensate the victim but not punish the tortfeasor." (*Id.* at p. 10.) However, the court explained that "[c]ourts consider insurance a form of investment" and that the rule "expresses a policy judgment in favor of encouraging citizens to purchase and maintain insurance." (*Ibid.*)

Insofar as courts could view insurance as something *optional or voluntary* for both insureds and providers—i.e., something individuals could choose to have and something insurance companies could refuse to give—there was some sense to the Supreme Court's reasoning in *Helfend* that "[d]efendant 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 p. 10.) Under this rationale, the court apparently viewed the collateral source rule as creating an incentive for individuals to obtain insurance. That rationale no longer applies.

PPAC's enactment vitiates *Helfend's* cornerstone justification for the collateral source rule in the medical insurance context because medical insurance is no longer optional—for insureds or providers. As mentioned above, PPAC section 1201 prohibits insurers from denying insurance coverage on the basis of pre-existing conditions as of January 1, 2014. And on that same date, PPAC sections 1501-1502 mandate that all individuals must obtain and have medical insurance. Regardless of anyone's personal preferences, medical insurance is now required by federal law. Accordingly, in the event the Supreme Court decides in *Howell* that the collateral source rule applies to the difference between the full rate for healthcare services and the negotiated rate charges pursuant to a healthcare agreement, the court will likely need to reexamine that decision in a case where the PPAC applies.

Justice Breyer predicted that the PPAC will soon increase the case load for the U.S. Supreme Court. In fact, it appears that the PPAC should increase the number of legal issues confronting many state courts as well, and many of those issues are already ripe for litigation.

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