Supreme Court puts plaintiffs through the *Hamilton Meats* grinder

Many questions remain unanswered for personal-injury plaintiffs

By Gary L. Simms and Mike Danko

We all know the adage about watching law and sausages being made. Personal-injury plaintiffs became the sausages after being put through the grinder in *Howell v. Hamilton Meats & Provisions, Inc.* (2011) 52 Cal.4th 541, filed on August 18. *Howell* is the most significant decision for personal-injury plaintiffs since *Li v. Yellow Cab Co.* (1975) 13 Cal.3d 804. It is not pretty. And it did not have to be this way. As the court acknowledged, it adopted a minority view. (52 Cal.4th at p. 566, fn. 10.)

Understandably, *Howell* has already been the subject of extensive and intensive discussion among the plaintiffs' bar. One can hardly read a plaintiffs' listserv, blog or Web site without seeing questions and comments about what *Howell* means – both for now and in the future. The discussion calls to mind the process of reading entrails to divine meaning. Everyone seems to see something different, depending, it seems, on the diviner's level of optimism or pessimism. The purpose of this article is to provide our thoughts, from both a trial and appellate perspective, on *Howell* and where it may lead.

The decision

The question in *Howell* was whether an injured plaintiff could recover for past medical expenses the amount charged by her medical providers or, instead, the typically and significantly lesser amount paid by her healthcare insurer pursuant to its contract with the providers. For example, plaintiff Rebecca Howell's providers had billed her $189,978.63 for her treatment, but the defendant contended that Howell's providers had "written off" $130,286.90 and that Howell should thus recover only $59,691.73. *Howell's* core holding, which by now surely every personal-injury lawyer has pored over, is that

a plaintiff may recover only the lesser amount:

> We hold, therefore, that 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.

(52 Cal.4th at p. 566.)

This holding is a serious blow to plaintiffs. To pretend otherwise calls to mind the Black Knight's retorts as his limbs are lopped off, " 'Tis but a scratch; I've had worse . . . It's just a flesh wound . . . All right, we'll call it a draw." (John Cleese, Monty Python and the Holy Grail (1974).) We believe it is false hope to think that plaintiffs can somehow "get around" or significantly limit *Howell* with creative arguments. That may succeed, albeit rarely, in trial courts. But appellate courts, most especially the Supreme Court, will not allow *Howell* to be neutered. Take a cold shower or do whatever it takes. But we must accept this reality and move forward.

Although our task is to deal with *Howell's* aftermath, one can reasonably ask why the court ruled as it did. *First*, we cannot ignore the reality of who decided the case. All six justices in the *Howell* majority are Republican appointees. The lone dissenter is a Democratic appointee. We should not be surprised. In this respect, *Howell* is very much like landmark pro-plaintiff rulings. In *Li v. Yellow Cab*, *supra*, 13 Cal.3d 804, the majority was four Democratic appointees, plus one Republican. The dissent was two Republicans. Likewise, in *Dillon v. Legg* (1968) 68 Cal.2d 728, in which the court first allowed recovery for negligent infliction of emotional distress caused by injury to a third party, the majority was four Democratic appointees, and the dissent was three Republican appointees. The more important an issue, the more predictably partisan the result.

Second, we also must accept that *Howell* was easily viewed as a bumper-sticker case: "Plaintiffs Want Windfalls." This bumper-sticker was the beginning and the end of the analysis and the naked reason for the decision. The majority opinion was simply an attempt to clothe it. As many legal scholars have observed, with rare exception, a judge is either deliberately or subconsciously deploying judicial reasoning, or the appearance of judicial reasoning, in the service of what he or she already believes to be true. The ultimate source of judicial opinion is emotion. As political commentator and columnist David Brooks has explained,

> Supreme Court justices, like all of us, are emotional intuitionists. They begin their decision-making processes with certain models in their heads. These are models of how the world works and should work, which have been idiosyncratically ingrained by genes, culture, education, parents and events. These models shape the way judges perceive the world.

(Brooks, *The Empathy Issue*, New York Times (May 26, 2009) p. A25.)

All the law and logic in the world could not overcome this reality. Our task brings to mind the first rule of politics: "If you are explaining, you are losing." In *Howell*, we had to explain why we were right. We had statutes, cases, treatises, logic, and practical consequences on our side. The defense had a slogan: "windfall." And a slogan wins almost every time. This is not a criticism of the court. It is a reality.

The unanswered questions

Most importantly, it does not matter whether the court's holding or its reasoning was correct. What matters is where we go from here. The *Howell* court identified but intentionally declined to answer the questions of whether billed charges are admissible to show: (i) noneconomic damages or (ii) future medical expenses. (52 Cal.4th at p.567.) And the opinion necessarily raises, without acknowledging, many other questions. Indeed, the *Howell* court unfortunately did not grasp the many ramifications of its decision, including significant procedural and evidentiary issues. But that, too, is to be expected. With rare and slight exceptions, neither the justices nor their staff attorneys, who actually write the court's opinions, have any experience as litigators. As Supreme Court Justice Antonin Scalia recently told the Senate, "I have very little contact with the American people." (U. S. Senate Judiciary Committee, Oct. 5, 2011.) Likewise, California Supreme Court justices and staff have very little, if any, knowledge of personal-injury trial practice.

Whatever the reasons, though, we must work our way through the thicket created by *Howell*. We are like Our Gang's Stymie when asked, "Hey, Stymie, where ya goin'?" He responded, "I don't know, but I'm on my way." (Our Gang, *Hi, Neighbor* (MGM 1934).) So too, here. We're on our way. And we must keep in mind that, by the time the many questions raised by *Howell* come before the court in future cases, the court may have several new justices. (Three justices are in their 70's, and one is 69, so some retirements may not be too distant.) The authors, though, will venture their views on how this court will eventually decide some of these issues. We do not approach this from the perspective of what is right or fair, but only what is likely. And on some issues, we can only guess what the court might do.

• ***For* Howell *to apply, must there be a contract between the plaintiff's medical providers and her insurer?*** – A significant threshold question raised by *Howell* is the subject of the plaintiff's petition for rehearing or modification, which remains pending as of the publication deadline for this article. More specifically, the court stated that, "[A]n 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 her insurer for the medical services received or still owing at the time of trial." (52 Cal.4th at p. 566.) Because this holding is worded without limitation or condition, the holding indicates that it does

not matter *why* a portion of a plaintiff's medical bill was discounted or "written off." (Indeed, that was the trial court's view in *Howell*.) Rather, the only questions will be what amount was paid and what amount, if any, is still owed. Thus, it will arguably be irrelevant whether a plaintiff's medical provider had any pre-existing agreement with her insurer to discount or "write off" a portion of the plaintiff's bill.

The court, though, repeatedly justified its holding with the premise that the discounts in *Howell* were the result of pre-existing agreements between Mrs. Howell's insurer and her medical providers and thus that she never incurred liability in the first instance. (52 Cal.4th at pp. 557, 559 & 563.) The opinion is thus ambiguous in a crucial respect: whether a pre-existing agreement to accept less than full payment is a prerequisite for limiting recovery to the amount paid rather than the amount billed. Perhaps the court will clarify this in response to the petition for rehearing or modification. (As a practical matter, the court virtually never grants rehearing, but the court might modify its opinion.) If the court clarifies that a pre-existing contract is *not* a prerequisite, that will provide simplicity but may raise other questions, e.g., what if the plaintiff no longer owes the provider's charges because the plaintiff has been discharged in bankruptcy or has successfully negotiated with the provider to accept less than the charges as full payment? Conversely, if a pre-existing contract *is* a prerequisite, this raises the next question.

• ***How can the existence of a contract between the insurer and the provider be proven?*** – In *Howell*, as in perhaps most cases in which defendants have sought so-called *Hanif* reductions, the defendant did nothing more than submit declarations by the medical providers' billing clerks, who claimed that, pursuant to contracts between Mrs. Howell's providers and her insurer, the providers had accepted the insurer's contractual rate of payment (i.e., sometimes called the "cash payment") as full payment and that Mrs. Howell owed nothing more. Is that enough? It shouldn't be. As is typical, the billing clerks had never seen the contracts between the provider and the insurer and had no idea what the contracts provided. (If you are wondering, Mrs. Howell's counsel was not allowed to present any evidence or to object to the defendant's evidence on the *Hanif* issue. The Supreme Court remanded to the Court of Appeal to deal with that problem.)

Moreover, this approach ignores the well-established statutory rule that, "Except as otherwise provided by statute, oral evidence is not admissible to prove the content of a writing." (Evid. Code, § 1523, subd. (a).) The plaintiff has a right to demand that the contract itself be submitted into evidence unless the defendant can establish a statutory exception to section 1523, e.g., a copy of the contract is not procurable by use of judicial process such as a subpoena. But of course, the provider and the insurer will argue that the contract contains proprietary trade-secret information. The *Howell* court did not anticipate this problem.

• ***Who has the burden of proving what was paid or owing and what is reasonable?*** – A plaintiff, of course, has the burden of proof and burden of persuasion on all elements of her cause of action, including damages. *Howell* makes clear that the sole, proper measure of damages for past medical expenses is the amount paid or still owing at time of trial. Reasonable value is merely a limitation on damages. (52 Cal.4th at p. 555.) Thus, contrary to the view of some members of the plaintiffs' bar, we believe that under *Howell* a plaintiff bears the initial burden of submitting evidence of the amounts paid or owing. If she submits only evidence of reasonable value, the defendant can move for a nonsuit on the ground that the plaintiff has proven only what her damages can be, not what they actually are.

How this will work procedurally is not yet clear. A plaintiff can easily enough submit evidence of payments by her insurers. And evidence of payment has been held to be some evidence of reasonable value. (*Dewhirst v. Leopold* (1924) 194 Cal. 424, 433; *Smalley v. Baty* (2005) 128 Cal.App.4th 977, 984.) But what if the plaintiff goes further and introduces evidence that she owes the full balance, e.g., by submitting her contract with her provider, which, as in *Howell*, typically provides that the patient is responsible for the full charges?

The burden should then shift to the defendant to show that the plaintiff does not owe the remaining balance. Otherwise, the plaintiff would have to argue against herself. After submitting evidence of what was paid and what is still owing, she would then have to submit evidence that the provider is willing to accept less than full payment. That would make no sense.

Nonetheless, if the plaintiff submits evidence that she owes the full billed-amounts, she arguably will have to show that the balance owing is reasonable. Otherwise, a court may rule that the burden does not shift to the defendant to show that the provider is willing to accept less than the billed amount as full payment.

• ***Are billed charges relevant to noneconomic damages?*** – The tortfeasor bar will argue that billed charges bear no rational relationship to a plaintiff's noneconomic damages, e.g., pain and suffering. But it is equally true that a contractual amount paid by a plaintiff's insurer also provides no meaningful basis for calculating noneconomic damages. So, asking the court to choose one or the other (billed or paid) as a measure of noneconomic damages is to pose a false choice. This is because the folk wisdom that noneconomic damages bear some relationship to medical expenses lacks any real substance. (To explain the origins and reasons for the perpetuation of this misunderstanding would require a separate article.) With apologies to Oakland, the fallacy calls to mind Gertrude Stein's observation, "There is no there there."

(Stein, *Everybody's Autobiography* (1937).) For example, the medical expense to amputate a leg may be considerably lower than the expense to perform a hip replacement, but the emotional distress at losing a leg will almost certainly be far greater than a hip replacement from which the patient nicely recovers with no significant loss of function. Indeed, the proper understanding is reflected by CACI 3905A: "No fixed standard exists for deciding the amount of these noneconomic damages. You must use your judgment to decide a reasonable amount based on the evidence and your common sense."[1]

In light of this reality, the court, at least with the present justices, will likely hold that the amounts billed are *not* admissible to show noneconomic damages. *First*, the court may understand that medical expenses have no proper relationship to noneconomic damages, so there is no point in creating a rule that results in evidence of two differing amounts: the amount paid (to show past medical expenses) and the amount billed (to show noneconomic damages). Similarly, the court will likely conclude that juries may be confused if they are asked to base their awards for past medical expenses on charges paid or owing but, at the same time, to base their awards of noneconomic damages on billed charges. *Second* and alternatively, the court may conclude that juries do, at least to some degree, base their awards of noneconomic damages on the amount of medical expenses. If that is the court's view, the court will want to limit awards of noneconomic damages by preventing juries from considering evidence of billed charges, which are more than amounts paid by insurers.

• ***Are billed charges relevant to future medical expenses?*** – The tortfeasor bar will argue that, as with past medical expenses, future expenses should be based on amounts paid by the plaintiff's insurer rather than on the amounts that will be billed by her providers. That argument is founded on the premise that the plaintiff will have insurance for her future medical expenses. But that requires multiple speculation, especially for expenses that will be incurred far in the future, e.g., for a child who will need lifetime care. Will the plaintiff still be insured or even insurable? Will it be the same carrier? What will its rate of payment be years from now? When will the policy's lifetime cap be met?

Tortfeasors, though, will counter with the argument that the plaintiff is also engaging in speculation by assuming that, even if she is uninsured in the future, she will pay what her providers will bill her for services, e.g., Chargemaster rates. The defendant will show that neither private insureds, Medicare patients, Medi-Cal patient, nor indigent patients under The Hospital Fair Pricing Act (Welf. & Inst. Code, § 16900 et seq.) pay Chargemaster rates. In effect, the defendant will say, "No one pays those rates, so how can they be reasonable?" And the *Howell* court also gave those rates short shrift. (52 Cal.4th at pp. 561-562.) We believe it unlikely the court will hold that billed charges (e.g., Chargemaster rates), standing alone, are admissible to establish future medical expenses.

There thus remains the question of how to determine future medical expenses. Presumably, the court will require awards for future medical care to be based on the reasonable value of the care, not on the amounts that may or may not be paid in the future by an insurer or the amounts that may be billed. But although substantively sound, the reasonable-value approach faces analytical and practical obstacles in the court.

The analytical problem is that the *Howell* court rejected reasonable value as the measure for past medical expenses when an insurer has paid those expenses. "[T]here is no need to determine a reasonable value of the services . . . ." (52 Cal.4th at p. 559.) The court may conclude that ideological purity requires the same view of future medical expenses, so that only the amounts likely to be paid or incurred are relevant, i.e., those amounts define "reasonable value."

The practical problem is how the reasonable value of future medical care should be determined. Almost certainly, expert testimony will be required. But if the measure of reasonable value is what will be paid or incurred, rather than what will be charged, how will the expert be able to predict what a provider will accept as payment in the future? Perhaps the expert can use the average amount currently paid for a particular procedure. But providers may well resist disclosure of that amount on the ground that it is a trade secret. So, experts will have to develop some type of credible and workable methodology. But nothing seems obvious at this point.

Another practical problem is the potential discrepancy between past medical expenses and anticipated future medical expenses. For example, assume that a plaintiff had a medical procedure for which the reasonable value was $20,000, but for which her insurer paid only $10,000 and which her provider accepted as full payment. She will need the same procedure two years from now. Under *Howell*, the only relevant evidence for past medical expenses is the $10,000 paid by the insurer. But assume that evidence is admitted to show that the reasonable value of the next, identical procedure is $20,000. The jury will likely wonder why there is such a disparity in the two amounts: $10,000 for the first procedure and $20,000 for the same procedure two years from now. The jury may well conclude that the plaintiff is inflating the cost of future care and award her less than the reasonable value of that care. Depending on the respective amounts of past medical expenses and likely future medical expenses, a plaintiff's attorney may wish to waive any claim for past medical expenses to avoid this problem. (Likewise, by waiving a claim for past expenses, the plaintiff's attorney may avoid the possibility, discussed above, that evidence of a amounts paid for past expenses will artificially reduce the jury's award of noneconomic damages.) On the other hand, this potential discrepancy between any past

and future expenses may not be significant if the court defines the "reasonable value" of future medical care as being the amount that will be paid, as discussed above.

Of course, the tortfeasors will say, "What's wrong with that? If, as with the first procedure, she will actually have to pay only $10,000 for the future procedure, she should be awarded only that amount." But as explained above, it is speculation to say that the plaintiff will be insured for the second procedure, how much her insurer will pay, and whether her provider will accept that amount as full payment.

Is evidence of reasonable value necessary or admissible? – As noted above, the court stated that, when an insurer has paid the plaintiff's medical expenses, "[T]here is no need to determine a reasonable value of the services . . ." (52 Cal.4th at p. 559.) But the opinion is inconsistent on this point. Earlier in its opinion, the court stated, "[A] plaintiff may recover 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." (52 Cal.4th at p. 555.) This clearly seems to say the reasonable value is still relevant, perhaps even necessary. But how does this work procedurally? Does the plaintiff first submit evidence of reasonable value, and the tortfeasor then submit evidence that a lesser amount was paid by the plaintiff's insurer? Or instead, is the plaintiff limited to submitting evidence of the amount paid or owing and then the tortfeasor, if it chooses to do so, submits evidence that this amount exceeds reasonable value? (As a practical matter, it will be the rare case in which reasonable value is less than the amount paid by the insurer.) As explained above regarding the burden of proof, we believe the plaintiff must show both the amount paid or owing and that it is reasonable.

• ***Is evidence of billed charges admissible?*** – As noted above on another point, the *Howell* court stated that, when a medical provider "has, by prior agreement, accepted less than a billed amount as full payment, evidence of the full billed amount is not itself relevant on the issue of past medical expenses." (*Howell*, *supra*, 52 Cal.4th at p. 567.) That might seem clear enough. But how will this actually work procedurally? The court's premise is the existence of a prior agreement. But the plaintiff, of course, puts on her case first. She will have no reason to submit evidence that her provider and insurer had a prior agreement. Rather, she might wish to submit evidence of the billed amount and that she is obligated to pay that amount. Then, when the defendant puts on its case, it will try to establish the prior agreement. But even if the defendant does so (assuming there is no disputed question of fact), at that point, the plaintiff has already submitted evidence of the billed charges. How does the horse get put back into the barn? Does the judge instruct the jury to ignore evidence of the billed charges? Or is this dealt with *in limine*? Presumably, the defendant could submit evidence of the prior agreement before trial, and if the agreement is established, the plaintiff would not be allowed to submit evidence of billed charges to the jury. But what if there are questions of fact regarding the prior agreement?

• ***Is evidence of the amount paid by the insurer admissible?*** – As with evidence of the billed charges, the court's premise is that the plaintiff's provider and insurer had a prior agreement that the provider would accept the insurer's payment as full payment. So, the same procedural problems are present for this issue. But aside from procedure, will evidence of paid amounts be generally admissible? Our view is unequivocally, "Yes." Some plaintiffs' attorneys, hoping to keep amounts paid by the insurer out of evidence, have focused on the court's statement that, "evidence of that [paid] 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." (52 Cal.4th at p. 567.) Those plaintiffs' attorneys see hope in the court's phrase – i.e., "assuming it satisfies other rules of evidence" – and believe *Howell* can be severely limited by arguing that evidence of the amounts paid is unduly prejudicial under Evidence Code section 352. We respectfully disagree. The entire point of *Howell* is to limit awards of past medical expenses to amounts paid by insurers. As we explained at the beginning of this article, the court will not allow that holding to be eviscerated, certainly not by the argument that what the court wants is unduly prejudicial. The court's statement that "assuming it satisfies other rules of evidence" most certainly refers only to routine matters such as hearsay, authentication, and foundation.

• ***How is the amount paid or owing to be determined?*** – The court assumed that the amounts paid or owing are easily determined. That may generally be true for amounts already paid. But it is far from true for amounts still owed. The key question is whether a medical provider is bound by an adjudication – in a personal injury action to which the provider is not a party – of the amount owed to the provider. The court's premise was that it is fair to limit the plaintiff to the amounts paid and still owed because she will never have to pay anything more than that total. As the court put it, "Having agreed to accept the [insurer's] 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." (52 Cal.4th at p. 558.) But the court's premise is flawed in many respects.

First, the court relied on its prior decision in *Parnell v. Adventist Health System/West* (2005) 35 Cal.4th 595, in which the court held that a hospital could not assert a lien under Civil Code section 3045.1 for the hospital's full charges against a plaintiff's recovery from a third party, i.e., the hospital could not engage in balance billing unless its contract with the patient provided for balance billing. But section 3045.1 applies only to hospitals, not to other medical providers. So,

Howell is overbroad in stating that all providers' liens are governed by section 3045.1, as it was interpreted in *Parnell*.

Second, as the *Parnell* court made clear, providers are free to engage in balance billing if they wish to do so. (52 Cal.4th at p. 611.) And many providers do exactly that. Thus, if the plaintiff's provider has contracted for the right to balance bill, presumably that means the plaintiff owes the full charges. And if *Howell* means what it says, she should be able to recover the full charges. But there is a twist. What about "contingent balance-billing" in which the provider agrees to accept the insurer's payment as full payment unless the plaintiff recovers damages from a third party? Is that an amount "still owing at the time of trial?" (52 Cal.4th at p. 566.)

Third, because a provider is not a party to the plaintiff's action against the tortfeasor, a provider will not be bound by principles of res judicata or collateral estoppel. Thus, regardless of what amount the court in the personal-injury action determines is owed, the provider can presumably pursue collection efforts, including litigation, against the plaintiff for any additional amount the provider seeks to collect. So, a plaintiff may recover in the personal-injury action only a portion of what the plaintiff ultimately has to pay the provider.

The court also failed to understand that, in some situations, it is practically impossible to know what amount is "still owing at the time of trial." (52 Cal.4th at p. 566.) That is because the provider may not be willing to provide a definite figure. And as plaintiffs' attorneys know, getting such information from Medicare before trial is virtually impossible. Put simply, a plaintiff may not know until after trial how much is still owed to her providers.

• ***Do HMO patients recover nothing?*** – Also unanswered is the important question of how *Howell* applies to a plaintiff who receives her medical care from a health maintenance organization ("HMO"). Unlike a fee-for-service plan such as Mrs. Howell had, in the HMO situation, the provider is not paid anything for a particular service. Rather, the provider is paid an annual capitation-fee. For example, assume the provider renders treatment with a reasonable value of $10,000, but he received a capitation fee of $200. How does a court determine what was paid? Does the plaintiff recover nothing? Does she recover only the capitation fee? Carried to its logical conclusion, *Howell* indicates that the HMO patient recovers only the capitation fee, if even that much.

• ***Do MICRA plaintiffs recover nothing?*** – *Howell* also raises the dreadful prospect that a plaintiff in a medical malpractice action is not entitled to recover any amount for past medical expenses. The court justified its holding that an insured plaintiff is entitled to recover only the amounts paid by her insurer (or still owing) on the ground that she never incurs any damages beyond that amount. And the court claimed it was reaffirming the collateral source rule, i.e., "Plaintiff here recovers the amounts paid on her behalf by her health insurer as well as her own out-of-pocket expenses." (52 Cal.4th at p. 565.) In other words, those amounts are a collateral benefit. But under MICRA, as *Howell* acknowledged, the defendant is allowed to introduce evidence of collateral benefits, including payment by the plaintiff's health insurer, and the jury need not award any such amount. (Civ. Code, § 3333.1, subd. (a); *Howell*, *supra*, 52 Cal.4th at p. 567.) The result is that a medical malpractice plaintiff can wind-up with nothing. For example, assume her provider bills her $100,000. Her insurer pays $50,000, which the provider accepts as full payment. Under *Howell*, she can recover no more than the $50,000 because, in the court's view, that is the extent of her damages. But under MICRA, the defendant can introduce evidence of that $50,000 payment, and the jury need not award her any portion of that payment. The result? She recovers nothing for past medical expenses.

• ***Is evidence of the plaintiff's medical insurance now admissible?*** – Not in theory, but yes in practice. The *Howell* court purported to reaffirm the evidentiary prong of the collateral source rule. "Evidence that such payments [by an insurer] were made in whole or in part by an insurer remains, however, generally inadmissible under the evidentiary aspect of the collateral source rule." (52 Cal.4th at p. 566.) But the court's statement is much less helpful than it might seem.

First, as a practical matter, when jurors are told how much was "paid" for the plaintiff's medical care, rather than the reasonable value of that care, many jurors will assume the payment was by the plaintiff's insurer, especially if the plaintiff is employed or seems to have financial resources. (For example, if a plaintiff is seeking lost income of $200,000 a year, a jury may well assume that the plaintiff had purchased medical insurance.) Of course, the jury could be instructed not to consider whether the plaintiff had medical insurance, but such an instruction would merely highlight the issue.

Second, the court's opinion muddles the issue. As discussed above, the court's core premise (unless the opinion is modified) is that damages are limited to the amount paid by the insurer if there was a prior agreement for the provider to accept the insurer's payment as full payment. But of course, to establish an agreement between the provider and the insurer, there must be evidence that the plaintiff had insurance. So, the court inconsistently says there must be evidence of insurance, but there can be no evidence of insurance. How is this handled? One can only wonder.

• ***Can this be dealt with posttrial?*** – Some attorneys have suggested that the evidentiary and procedural problems raised by *Howell* might be eliminated or at least minimized by dealing with the matter posttrial, such as defendants

typically did with their so-called posttrial *Hanif* motions. For example, it has been suggested that the jury should hear evidence of reasonable value and then, after verdict, the defendant can introduce evidence of the amounts paid by the plaintiff's insurer. We doubt this will succeed. As the court made clear, "A nonstatutory '*Hanif* motion' is unnecessary." (52 Cal.4th at p. 567.) Of course, the parties could stipulate to this, but there is no reason for a defendant to do so. And absent a stipulation, the matter cannot properly be handled by a court after verdict. Indeed, plaintiffs typically objected to so-called *Hanif* hearings on the ground that they violated the plaintiff's right to a jury trial. (This was one of Mrs. Howell's arguments.) And on that point, even the *Howell* defendant's amici curiae agreed with plaintiffs. Moreover, a motion for new trial based on the ground of excessive damages can be based only on the minutes of the trial; no new evidence is permitted. (Code Civ. Proc., §§ 657 & 658.) Rather, the only proper use of a motion for new trial will be when the jury has already heard evidence of the amounts paid but has awarded a greater amount. (52 Cal.4th at p. 567.)

Well, by now you get the picture. *Howell* is a major win for tortfeasors and their insurers. And *Howell* is the beginning of a new and uncertain era. We have addressed only some of the questions *Howell* raises. Its many questions will take years to wend themselves though the trial and appellate courts. In the meantime, we, as plaintiffs' attorneys, must do our best to prevent *Howell* from becoming as bad a quagmire as it threatens to be.


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Endnote

[1] Of course, there may be cases in which billed charges are relevant to noneconomic damages even if the charges have nothing to do with the emotional distress caused by the injury. More specifically, the bills may themselves be the cause of emotional distress, e.g., the plaintiff is distressed at the prospect of a crushing financial burden. But as a practical matter, in the *Howell* context, that type of distress is unlikely to be present because the plaintiff has insurance for her medical expenses.