# CASENOTE

**COURT ALLOWS UNINSURED PLAINTIFF TO INTRODUCE INTO EVIDENCE FULL AMOUNT IF MEDICAL BILLS CHARGED**

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Another case where the court has allowed the full amount of an uninsured's medical bills to be admitted -- and another case where the defense did not properly challenge the admission of such bills.

In this ***unpublished*** case of Nekrawesh v. Arno [11/18/15] the court of appeal has held that the trial court erred in:

1. Granting defense motion to exclude medical bills. The plaintiff was uninsured and under the case of ***Bermudez v. Ciolek*** (2015) 237 Cal.App.4th 1311, the entire amount of medical bills are admissible [However, note that in ***Bermudez*** defendant stipulated to the reasonableness of the medical bills and there was no pre-trial challenge as to the foundation for such opinions]. Further, the court rejected the defense contention that treating doctors were not declared as experts and therefore they could not testify as to the reasonableness of the medical bills. A treating Doctor can testify without being designated as to what he/she learns in the course of treating the plaintiff and not from outside matters strictly for the purposes of litigation. The court held that since there was no request by the defense for a pre-trial hearing to ascertain the foundation of the doctor's expected testimony it was error to exclude. The Fourth District, affirmed the holding in Ochoa that treating physicians are entitled to testify regarding the reasonable value of medical services he or she provided. ***Bermudez***, supra, 237 Cal.App.4th at 1339. As ***Ochoa*** pointed out, a physician may have "gained special knowledge concerning the market value of medical services through his or her own practice..." (***Ochoa***, supra, 228 Cal.App.4th at 140; also see ***Bermudez***, supra, 237 Cal.App.4th at 1339.)

No expert witness declaration is required for treating physicians to the extent that their opinion testimony is based on facts acquired independently of the litigation, that is, facts acquired in the course of the physician-patient relationship and any other facts independently acquired. (Citation omitted), ***Dozier v. Shapiro*** (2011) 199 Cal.App.4th 1509, 1520.) We conclude that this includes an opinion as to the reasonable value of services that the treating physician either provided to the plaintiff or became familiar with independently of the litigation, assuming that the treating physician is qualified to offer an expert opinion on reasonable value. A treating physician who has gained special knowledge concerning the market value of medical services through his or her own practice or other means independent of the litigation may testify on the reasonable value of services that he or she provided or became familiar with as a treating physician, rather than as a litigation consultant, without the necessity of an expert witness declaration. To the extent that a treating physician became familiar with services provided to the plaintiff or other facts for the purpose of forming and expressing an opinion in anticipation of litigation or in preparation for trial, however, he or she acts as a retained expert. An expert witness declaration is required for such a treating physician to the extent that he or she testifies as a retained expert. (§ 2034.210, subd. (b)). ***Ochoa v. Dorado*** (2014) 228 Cal.App.4th 120, 140.

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**NOTE**: Further it must be pointed out that some courts have recognized actions by uninsured patients who are required to sign agreements obligating them to pay the full amounts billed by the hospital. In ***Saran v. Dignity Health*** (2014) 232 Cal.App.4th 1159, 1162, plaintiff, an uninsured patient taken to the hospital by ambulance after an accident, filed a putative class action complaint asserting claims including unfair and/or deceptive business practices under Business and Professions Code section 17200 et seq. (UCL) and violation of the Consumers Legal Remedies Act (CLRA) (Civ. Code, § 1750 et seq.) against the hospital. The complaint alleged Dignity had failed to disclose uninsured patients would be required to pay several times more than other patients receiving the same services, the charges set forth on the invoice were not readily available or discernable from the agreement, and the invoiced charges exceeded the reasonable value of the services. The court allowed the case to proceed. "Full charges" was defined as "the Hospital's published rates (called the chargemaster), prior to any discounts or reductions.

However, as the California Supreme Court recognized in ***Howell v. Hamilton Meats & Provisions, Inc***. (2011) 52 Cal.4th 541, 561-62:

> "As one article explains: "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 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 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 California *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 services and the amounts providers bill for them—other than that the relationship is not always a close one—would be perilous."

2. Further, the trial court erred in precluding any claim of general damages based on the defense claim that the plaintiff was uninsured when involved in the automobile accident. CC 3333.4. While plaintiff was driving a car he had bought and had not notified his carrier, no notification was required. This was a replacement vehicle for the inoperable vehicle listed in the policy. See: ***Birch v. Harbor Ins. Co***. (1954) 126 Cal.App.2d 714. Birch made it clear that when an insurance policy includes an automatic coverage clause, no notice is required. Birch correctly pointed out that the notice is simply a condition subsequent in order to keep the policy beyond the 14-day period given in the policy.