S179115

In the Supreme Court of California

REBECCA HOWELL,

Plaintiff and Appellant,

vs.

HAMILTON MEATS & PROVISIONS, INC.,

Defendant and Respondent,

On Review of a Published Decision by the Fourth Dist. Ct. of Appeal—Div. One
Case Number D053620—Filed November 23, 2009
On Appeal from a Judgment After Jury Verdict and Postjudgment Order
San Diego County Superior Court—Hon. Adrienne Orfield—GIN053925

AMICUS CURIAE BRIEF IN SUPPORT OF PLAINTIFF/APPELLANT

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

CALIFORNIA CASES AND STATUTES

CASES

STATUTES

OUT OF STATE CASES AND STATUTES

CASES

STATUTES

STATUTES (CONT'D.)

OTHER AUTHORITIES

I. INTRODUCTION

The position asserted by Hamilton Meats in this case, and defendants generally throughout the State, punishes the millions of California consumers who strive to maintain private health insurance for their families.[1] Defendants' position conveniently ignores the economic reality that medical care providers receive significant benefits while agreeing to forego full reimbursement for services rendered when they reduce medical bills pursuant to the "negotiated rate differential." It is therefore not surprising that the position advanced by Mrs. Howell and amicus CAOC is fully consistent with the majority view adopted by the jurisdictions that have addressed the issue presented for review.

A. Health Insurance Indemnifies Patients' Debt For The Full Charges Of Their Medical Providers Through A Combination Of Cash And Non-Cash Benefits

Consumers invest inordinate amounts of time, money and effort to make certain they have health insurance in place for themselves and their families. As the cost of health insurance premiums continue to rise at rates far-outstripping inflation and cost-of-living indexes, workers are denied pay increases to cover the cost of employer-provided benefits, families and individuals have to pay higher co-payments and deductibles, and get less coverage at greater cost. At the same time, health plans have grown incredibly aggressive in pursuing reimbursement and lien claims against consumers who seek legal redress for their personal injuries.

"Patients who receive medical services incur liability for the cost of such services." (*King v. Willmett* (2010) 2010 WL 3096258 *11 citing

[1] As used in this brief, the term "defendants" refers to Hamilton Meats and all other parties who advance the same position urged by Hamilton Meats.

Holmes v. Cal. State Automobile Assn. (1982) 135 Cal. App. 3d 635, 638-39; *see also Parnell v. Adventist Health System/West* (2005) 35 Cal. 4th 595, 600-09; *Mercy Hospital & Medical Center v. Farmers Ins. Group of Companies* (1997) 15 Cal. 4th 213, 217; *City and County of San Francisco v. Sweet* (1995) 12 Cal. 4th 105, 117.) As the *King* Court explained, "[i]n the absence of other applicable contractual agreements, statutory provisions or charity, they will be billed for the services." (*King*, supra, 2010 WL 3096258 at 11.)

When health plans enter into contracts with medical providers, the plans exact a toll for making the providers part of their network. That toll is a discount to a negotiated contractual rate. "[D]iscounts reflect noncash, pecuniary savings in the cost of delivering health care services that are financed by [the plan members'] premium dollars." (*Yanez v. SOMA Environmental Engineering, Inc.* (2010) 185 Cal. App. 4th 1313, 1329.) Any negotiated discounts those providers have agreed to in contracting with a patients' health plan extinguish that portion of the patients debt (*Parnell, supra*, 35 Cal. 4th at 609), and are thus a collateral source benefit to patients insured by those plans. (*Yanez, supra*, 185 Cal. App. 4th at 1330; *King, supra*, 2010 WL 3096258 at 11-12.) As healthcare consumers, we see these negotiated terms reflected in our Explanations of Benefits (EOB's). This document reflects the medical care provider's charge for services rendered, a contractual adjustment or contractual allowance as a credit against that charge, along with a cash payment by the health plan (also appearing as a credit against the provider's charge.) Together, both payments – the contractual credit and the monetary payment – extinguish our debt as a patient.

Since the negotiated contractual credits represent a "benefit conferred on the injured party" by a source other than a defendant tortfeasor, under the laws of the State of California, a defendant is not legally entitled to a reduction of a plaintiff's damages award in an amount equal to the negotiated rate differential. (*Helfend v. Southern Cal. Rapid Transit Dist.* (1970) 2 Cal. 3d 1, 10 ("Defendant[s] 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.").)

During the past decade or so, defendants in tort cases have pushed an agenda of misrepresenting certain legal authorities (*Hanif v. Housing Authority of Yolo County* (1988) 200 Cal. App. 3d 635, and *Nishihama v. City and County of San Francisco* (2001) 93 Cal. App. 4th 298, while intentionally ignoring others (*Helfend*, supra, 2 Cal. 3d 1; *Mercy Hospital*, *supra*, 15 Cal. 4th 213; *Sweet*, *supra*, 12 Cal. 4th 105; *Arambula v. Wells* (1999) 72 Cal. App. 4th 1006. Not surprisingly, defendants utilize these tactics for the express purpose of convincing trial courts to strip successful tort plaintiffs of the collateral contractual benefits they have purchased from their health plans.

Defendants propose that a successful tort plaintiff should retain absolutely no net benefit from their investment in health insurance, but instead, that tortfeasors should garner the benefit of the service rate reductions negotiated by health plans, secured by contract, financed by the plan members' premiums, and established for them by law. (*See* Cal. Ins. Code § 10133(b).)

Because the formula defendants advance would limit tort damages for medical services to the contract rates negotiated by the plaintiff's health plan, tort plaintiffs would retain no past medical damages to compensate

them for having to use their collateral benefits. The damages a tortfeasor would pay under defendants' formula is concurrent with the amounts health plans claim in reimbursement, lien, or subrogation rights, which would leave tort plaintiffs with no net recovery of medical damages despite their investment of time, money and effort to secure and maintain health insurance. Instead, the benefit of contract agreements financed by plan members' premiums would inure to tortfeasors who have contributed nothing to secure those benefits.

Defendants' approach violates the collateral source rule, and is inconsistent with both existing legislated exceptions to the rule and with the statutory and regulatory framework governing medical providers and health insurers in California. It has also been widely rejected throughout the country.

B. Negotiated rate differentials are a benefit established by statute for consumers of health insurance

Restatement (Second) of Torts § 920A comment b provides "[i]f the benefit was a gift to the plaintiff from a third party or established for him by law, he should not be deprived of the advantage that it confers." (*Yanez*, *supra*, 185 Cal. App. 4th at 1326.) "The law does not differentiate between the nature of the benefits, so long as they did not come from the defendant or a person acting for him." (*Id.* at 1329.) Defendants' argument ignores the very principles contained in this Restatement Section: (1) that negotiated rate differentials are established by statute for the benefit of health plan members who use contracting medical providers (Ins. Code § 10133(b)), and (2) that negotiated discounts are an in-kind benefit – as opposed to "in cash" benefit – but a benefit nonetheless.

In 1985, the California Legislature found and declared "that the public interest in ensuring that citizens of this state receive high-quality health care coverage in the most efficient and cost-effective manner possible is furthered by permitting negotiations for alternative rate contracts between purchasers and payers and both institutional and professional providers." (Cal. Ins. Code § 10133.6.) Insurance Code Section 10133(b) provides that "an insurer may negotiate and enter into contracts for alternative rates of payment with institutional providers, and *offer the benefit of these alternative rates to insureds who select those providers*." (emphasis added).

These Insurance Code sections constitute a statutory framework established in the early through mid-1980s which reflect "the health care financing model that has evolved in this country, in which ... providers receive noncash, pecuniary consideration from their transactions with the patient's private insurers, which allows and induces them to accept a reduced rate for their services." (*Yanez, supra*, 185 Cal. App. 4th at 1328; *see also Prospect Medical Group, Inc. v. Northridge Emergency Medical Group* (2009) 45 Cal. 4th 497 (because of statutory and regulatory controls, providers of emergency medical services must resolve billing and payment disputes directly with HMOs and cannot "balance bill" HMO members); *see also* Cal. Ins. Code §§ 10123.12, 10133, 10133.2; Health & Safety Code §§ 1373.18 and 1395.6.)

Over the past decade, defense counsel have sought to ignore the fact that a payment may be made in ways other than cash, and that the benefits of indemnity can be conferred through arrangements that do not involve the direct monetary transfer. Defendants' contention simply misses the mark.

Justice Nares, writing the unanimous Court of Appeal in *Howell,* referred to the difference between a medical provider's charge rate and the negotiated rate under any given alternative rate contract a "negotiated rate differential." Hamilton Meats challenges the application of the collateral source rule to these "alternative rate contracts." B&P § 16770(f); H&S §§ 1373.9, 1342.6, 1373.18; Ins.§§ Code 10133(b), 10133.2, 10133.3, 10133.6. That is, Hamilton Meats asks this Court to deny application of the collateral source rule to a health insurance benefit financed with the plan members' invested premiums and established as a member's benefit by law. Defendants argue that otherwise, plaintiffs who have worked to secure health insurance for themselves and their families and who have been forced to seek medical care for injuries caused by defendants will receive a "windfall."

This position was directly refuted by the *Yanez* Court, which recently explained that "the courts apply the collateral source rule even when it unquestionably does confer a windfall benefit on the tort plaintiff. The rule reflects a policy preference favoring the tort victim over the wrongdoer since not applying the rule allows the wrongdoer to profit from the victim's investment in purchasing insurance or from the generosity of those who come to the victim's aid." (*Yanez, supra,* 185 Cal. App. 4th at 1319.)

Furthermore, "the measure of the collateral benefit Yanez purchased for her premiums includes not only the cash Aetna and Healthnet paid for her medical care but the financial, administrative, and marketing *savings* the providers obtained that induced and permitted them to accept a discounted rate of payment for their services to her." (*Id.* at 1330.) "Because of these marketplace realities, … Rate discounts negotiated

between health insurers and providers must be deemed collateral benefits which, under the collateral source rule, should accrue to the insured plaintiff, not the defendant." (*Ibid.*)

Medical patients have no personal control over the prices charged by the hospitals and doctors from whom they obtain medical care. But that has not stopped defendants from seeking to leverage a general suspicion or dissatisfaction with medical pricing and financing to profit from the financial arrangements that health plans have negotiated on behalf of their members.

As representatives of the interests of consumers throughout California, CAOC is naturally concerned that medical providers and health insurers engage in fair, honest, and legal pricing and financing practices. However, the correct legal setting in which to examine or redress perceived excesses, inadequacies, or misrepresentations in medical pricing and financing is not a personal injury tort lawsuit between an injured plaintiff and their tortfeasor. Rather, to examine the medical pricing and financing model requires jurisdiction over the players in that system – the hospitals, doctors, and health plans – either through the legislative process, or at least through lawsuits to which those participants are party.

C. The California legislature has created two limited exceptions to the majority collateral source rule for medical malpractice and public entity defendants

Yanez explains that "[t]he great majority of decisions from other jurisdictions have concluded that the collateral source rule entitles tort victims to recover the full amount of reasonable medical expenses charged, including amounts written off from their bills pursuant to contractual rate reductions or under Medicaid or Medicare." (*Id.* at 1324.)

The Virginia Supreme Court's reasoning in *Acuar,* is representative of the majority view: [Defendant] contends that the collateral source rule is not applicable ... because [plaintiff] is not, and never will be, legally obligated to pay those portions of his medical bills that were written off, nor were those amounts paid on his behalf. According to [defendant], the amounts written off ... are not benefits derived from a collateral source, and to allow [plaintiff] to recover such amounts ... would create a double recovery or windfall in his favor. [Plaintiff] maintains that, if [defendant's] position were adopted, she would derive a benefit from [plaintiff's] health insurance without having paid any consideration for [it], thereby creating a windfall for [defendant]...

[Defendant's] argument overlooks the fundamental purpose of the [collateral source] rule ... to prevent a tortfeasor from deriving any benefit from compensation or indemnity that an injured party has received from a collateral source.... [T]he focal point of the collateral source rule is not whether an injured party has 'incurred' certain medical expenses. Rather, it is whether a tort victim has received benefits from a collateral source that cannot be used to reduce the amount of damages owed by a tortfeasor ... [Plaintiff] is entitled to seek full compensation from [defendant].

[Defendant] cannot deduct from that full compensation any part of the benefits [plaintiff] received from his contractual arrangement with his health insurance carrier, whether those benefits took the form of medical expense payments or amounts written off because of agreements between his health insurance carrier and his health care providers. Those amounts written off are as much of a benefit for which [plaintiff] paid consideration as are the actual cash payments made by his health insurance carrier to the health care providers. [They] constitute 'compensation or indemnity received by a tort victim from a source collateral to the tortfeasor....' "

(*Id.* at 1325, citing *Acuar v. Letourneau* (2000) 531 S.E.2d 316, 321-323; *see also Id.*, at 1324; fn. 10.

A number of states retain the collateral source rule generally, but have statutorily modified the rule in certain specified types of suits such as medical malpractice cases.[2] California provides two examples of statutory modification of the rule with respect to certain cases – both Medical Malpractice cases (Civil Code § 3333.1) and suits against public entity defendants (Government Code § 985). These statutes do not remove these states from the majority position, but rather create limited exceptions to the rule's application only in specified kinds of cases.

Justice Cantil-Sakauye's recent opinion for the Third District Court of Appeal in *King* closely examines California's legislative abrogation of the collateral source rule "through the provisions of Civil Code section 3333.1 (section 3333.1) in actions for professional negligence against health care providers." (*King*, *supra*, 2010 WL 3096258 *7.)

Under Civil Code § 3333.1, a medical malpractice defendant can choose to introduce collateral benefits plaintiff has or will receive. (Cal. Civ. Code § 3333.1(a).) As to health insurance benefits, such defendants are not limited to introducing only the amounts of a health plan's negotiated rate cash payments. If a defendant elects to introduce evidence of plaintiff's collateral benefits, "the plaintiff may in turn introduce evidence of any amount which the plaintiff has paid to secure the insurance benefits introduced by defendant." (*King*, *supra*, 2010 WL 3096258 *7, citing Cal. Civ. Code § 3333.1(a).) Pursuant to Civil Code § 3333.1(b), where

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[2] Ariz. Rev. Stat. Ann. § 12-565; Del. Code Ann. Tit. 18, § 6862; 735 Ill. Comp. Stat. 5/2-1205; Mass. Gen. Laws ch. 231, § 60G; Me. Rev. Stat. Ann. tit. 24, § 2906 (2007); Neb. Rev. Stat. § 44-2819; Nev. Rev. Stat. Ann. § 42.021; Okla. Stat. tit. 63, § 1-1708.1D; R.I. Gen. Laws § 9-19-34.1; S.D. Codified Laws § 21-3-12; Tenn. Code Ann. § 29-26-119; Utah Code Ann. §78-14-4.5; W. Va. Code § 55-7B-9A; Wis. Stat. § 893.55.

defendant has elected to introduce such evidence, a plaintiff is relieved of any obligation to reimburse their collateral source providers.

Civil Code § 3333.1 places all this evidence in the hands of the fact finder, and permits them to decide whether or not to make a lower damages award, and whether to compensate plaintiff for the cost of obtaining collateral coverage. In any event, whatever medical damages a jury awards, plaintiff is permitted to retain those damages free from any obligation to reimburse their health plan.

The *King* decision pays especially close attention to the Legislature's limited exception to the collateral source rule provided to public entity defendants, since this exception – Government Code § 985 – expressly provides a post-verdict reduction hearing procedure, but one that is in stark contrast to the post-verdict hearing defendants ask this Court to create.

After a jury returns a verdict against a public entity including damages for which collateral source benefits have been provided, "the defendant public entity may, by a motion noticed within the time set in Section 659 of the Code of Civil Procedure, request a posttrial hearing for a reduction of the judgment ... for collateral source payments paid ... or benefits that were provided prior to the commencement of trial. (Cal. Gov. Code § 985(b).)

The language of the statute is significant both because it references collateral source payments or benefits, and because the statute also provides the trial court at such a hearing with wide discretion to "make a final determination as to any pending lien and subrogation rights, and *determine what portion of collateral source payments should be* reimbursed from the judgment to the provider of a collateral source payment, *deducted from the verdict,* or accrue to the benefit of the plaintiff." (Cal. Gov. Code § 985(f).)

Subdivision (g) of section 985 specifically provides that "the court may order no reimbursement or verdict reduction if the reimbursement or reduction would result in undue financial hardship upon the person who suffered the injury."

The Court did just that in *Joyce v. Simi Valley Unified School District* (2003) 110 Cal. App. 4th 292, a case decided after *Nishihama.*[3] In *Joyce*, a student sued a school district for dangerous condition of public property after being struck in a crosswalk adjacent to a junior high school. The trial court exercised the discretion provided by the legislature in Section 985 to deny any reduction for collateral benefits to the public entity defendant – a result permitted by statute, but inconsistent with the result Hamilton Meats seeks here.

Defendants' proposal, by stark contrast, provides no authority or jurisdiction over providers of collateral source benefits, and rather than providing discretion to the courts, would be mandatory in nature, reducing the role of trial court judges in a post-verdict setting to a clerical accounting function in favor of tortfeasors. Rather, Defendants continue to cite cases such as *Hanif* and *Nishihama,* which do not stand for the cited propositions. *King, supra*, 2010 WL 3096258 *9-10.

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[3] In *Joyce*, plaintiff incurred medical bills totaling $437,599.45, for which plaintiff's health plan paid $117,116.37. (*Id.* at 307.) Defendant brought a post-verdict motion for reduction under Government Code Section 985. (*Ibid.*) "In determining the amount to be deducted for collateral source providers, the trial court was required to consider attorney's fees and costs." (*Id.* at 308, fn. 11.) Because the case went through one appeal (from demurrer) and three trials before reaching verdict (*Id.* at 295-98), costs were $203,129.01 and counsel for the third trial, which took place after plaintiff reached majority, received a 50 percent contingency fee. (*Id.* at 308, fn. 11.)

The aspect of Government Code § 985 that most starkly illustrates the impropriety of the rule the defense has tried to impose by citing *Hanif* and *Nishihama* as authority for propositions not considered in those cases is Subsection (f)(3), which provides that where a trial court chooses to make a reduction of damages to reflect collateral source benefits received by plaintiff, "the court shall make the following adjustments:"

> (A) Where plaintiff has been found partially at fault, the reimbursement or reduction shall be decreased by the same percentage as the entire judgment is reduced to take into account the plaintiff's comparative fault.
>
> (B) The court shall deduct from the reimbursement or reduction the amount of premiums the court determines were paid by or on behalf of the plaintiff to the provider of a collateral source payment.
>
> (C) After making the adjustments described in subparagraphs (A) and (B) above, the court shall reduce that amount by a percentage equal to the percentage of the entire judgment that the plaintiff paid or owes for his or her attorney fees and costs and reasonable expenses incurred.

With the high cost of health insurance premiums, after adjusting for premiums, attorneys fees, and costs of litigation, in many cases, the reduction for public entity defendants will be eliminated under Section 985.

As observed in *King*, the net effect of the procedure set forth in Government Code § 985, which governs actions against public entity defendants, is that if defendants proposal were adopted, a plaintiff would be better off suing a public entity defendant than suing a private defendant:

> The medical expense damages of a plaintiff suing a private defendant would be limited as a matter of law to the amount ultimately paid by the plaintiff's insurer to

> plaintiff's health care providers, but a plaintiff suing a public defendant for personal injury or wrongful death may or may not be subject to any reduction of damages in the discretion of the trial court under section 985. Thus, the public defendant would not be assured of a reduced award, but a private defendant would be. It is seriously questionable whether the Legislature intended such a result.

(*King*, *supra*, 2010 WL 3096258 *8.)

The Legislature certainly did not intend such an absurd result, and CAOC agrees with Justice Cantil-Sakauye's conclusion that medical insurance benefits have become so integrated within our present tort system that its precipitous judicial nullification would work hardship and any proposed changes, if desirable, would be more effectively accomplished through legislative reform." (*King*, *supra*, 2010 WL 3096258 *12.)

II. CONCLUSION

Defendants are all too willing to ignore California law and the economic reality that medical care providers receive significant benefits in exchange for contracted negotiated rate differentials. This Court should reject Defendants' position and ensure that California remain solidly among the majority of jurisdictions where tortfeasors are not permitted to garner the benefit of the service rate reductions negotiated by health plans, which

are secured by contract, financed by the plan members' premiums, and established by law for the benefit of the consumers of health insurance.

Dated: August 25, 2010

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WORD COUNT CERTIFICATE

The foregoing brief of amicus curiae CAOC contains 3,774 words (including footnotes, but excluding tables and this Certificate). In preparing this certificate, I have relied on the word count generated by Microsoft Office Word 2003.

Executed on August 26, 2010, at Walnut Creek, California.

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PROOF OF SERVICE

I am a resident of the State of California, over the age of eighteen years, and not a party to the within action. My business address is 1646 N. California Blvd., Suite 600, Walnut Creek, California 94596. On August 26, 2010 I served the within documents:

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I am readily familiar with the business practice at my place of business for collection and processing of correspondence for mailing with the United States Postal Service. Correspondence so collected and processed is deposited with the US Postal Service that same day in the ordinary course of business.

I declare under penalty of perjury that the foregoing is true and correct, and that this declaration was executed on August 26, 2010, at Walnut Creek, California.

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