Is That Fair? Medical Expense Write-Offs and a Call for a Return to "Reasonableness" in the Context of Recovering Alleged Medical Expenses in Tort Actions

Warner S. Fox
Martin A. Levinson
HAWKINS & PARNELL, LLP
4000 SunTrust Plaza
303 Peachtree Street, N.E.
Atlanta, Georgia 30308-3243
(404) 614-7400
(404) 614-7500 (fax)
wfox@hplegal.com
mlevinson@hplegal.com

Warner S. Fox has practiced with Hawkins & Parnell, LLP for more than 20 years. His practice focuses on catastrophic accident litigation of all types, including matters arising from transportation, retail and products liability. He has tried numerous cases involving all types of tort matters and frequently is called upon to handle catastrophic cases in other jurisdictions. He also has developed a subspecialty in the handling of traumatic brain injury cases as the result of his prior experience in numerous similar cases. Mr. Fox has defended a wide variety of clients including multi-national retailers such as The Home Depot U.S.A., Inc., Toys "R" Us, Inc., The TJX Companies, CVS Pharmacy and Rite-Aid Corporation. Additionally, he represents a number of trucking/transportation companies including Marten Transport, Contract Freighters, Inc., May Trucking, Laidlaw and Greyhound Lines. He also routinely represents insureds for a number of insurers, including Zurich North America and St. Paul Travelers.

Martin Levinson is an associate in the Atlanta office of Hawkins & Parnell, LLP. Martin represents businesses and individuals in various types of liability defense and litigation, including premises liability, product liability, trucking and transportation law, and insurance and bad faith litigation. Martin handles matters in all phases of the litigation process, including advising clients on litigation avoidance, pre-suit liability and/or coverage analysis, handling matters in active litigation, mediation and settlement, trial, and appeals.

I. Introduction

One of the most talked-about issues in America today is the ready availability and affordability of quality healthcare. Few would dispute that our healthcare system is in need of reform in order to improve the quality of service provided and the affordability of those services. Unfortunately, as we search for solutions to the difficult problems that face us in reforming our healthcare system,

some of the most obvious problems and inequities go unchallenged and unchanged.

To that end, it is time that we focus on a long-standing problem in our tort system which is obviously responsible for driving up the cost of medical services. The typical situation which underlies this problem is one with which we are all familiar. A patient visits a medical provider, receives treatment for a covered injury or ailment, and is billed for that treatment. Although the patient may pay a small co-pay or office visit fee, the balance of the cost for those medical services is submitted to an insurer or other benefits provider on the patient's behalf. The insurer or benefits provider then determines how much it will pay to satisfy the covered portion of the bill, pays the medical provider that amount, and the bill is satisfied. Invariably, a portion of the amount initially billed – quite often, a significant portion – is not covered by the insurer or benefits provider and is written off by the medical provider. The patient owes nothing, the bill is satisfied by the insurer's payment, and the written-off portion of the original bill is never paid by anyone.

Where the patient is a plaintiff or a prospective plaintiff in a personal injury suit, however, this situation does not always end so simply. In many jurisdictions, under the auspices of the common-law "collateral source rule," plaintiffs are permitted to blackboard, present evidence of, and even recover the *entire* amount billed for any claimed medical expenses, notwithstanding that large portions of the amounts billed were written-off by an insurer or benefits provider, have never been paid, and *will* never be paid. In these jurisdictions, no proof of what amount was actually paid or owed for the medical services in question may be presented to or considered by the jury in determining the "reasonableness" of the plaintiff's claimed medical expenses. The result is that plaintiffs are routinely handed double, triple, or exponentially more than the amount of the medical bills actually incurred as a result of the defendant's negligence.

While many courts have acknowledged that this results in a "windfall" for the plaintiff, what it truly amounts to is judicially-sanctioned *fraud*. It is time for us, as attorneys, to examine the underpinnings of this plaintiff-friendly farce and why it is inequitable to defendants, contrary to longstanding principles of tort law, and in conflict with the widely-held goal of promoting the availability of affordable healthcare to all Americans.

II. The Collateral Source Rule

A. History and Purpose of the Collateral Source Rule

The situation at hand is largely a result of the careless extension and over-application of the collateral source rule by courts, even as the rule has become less meaningful and more out of touch with the realities of our modern healthcare system. The collateral source rule is a doctrine originating in the common law

which is "designed to strike a balance between two competing principles of tort law: (1) a plaintiff is entitled to compensation sufficient to make him whole, but no more; and (2) a defendant is liable for all damages that proximately result from his wrong." *Acuar v. Letourneau*, 531 S.E.2d 316, 323 (Va. 2000). The common-law collateral source rule is summarized by the Restatement (Second) of Torts as follows:

> Payments made to or benefits conferred on the injured party from other sources are not credited against the tortfeasor's liability, although they cover all or a part of the harm for which the tortfeasor is liable.

RESTATEMENT (SECOND) OF TORTS, § 920A(2).

Under the Restatement's version, the rule applies although "[t]he injured party's net loss may have been reduced correspondingly, and to the extent that the defendant is required to pay the total amount *there may be a double compensation* for a part of the plaintiff's injury." *Id.*, § 920A, cmt. b; *see also* Joel K. Jacobsen, *The Collateral Source Rule and the Role of the Jury*, 70 Or. L. Rev. 523, 524 (1991) ("[T]he most obvious effect of the collateral source rule is that it enables a plaintiff to reap a double recovery in certain circumstances." (internal citation omitted)).

The rationale behind such over-compensation of the plaintiff is that "a benefit that is directed to the injured party should not be shifted so as to become a windfall for the tortfeasor." *Id.*; *see also Metoyer v. Auto Club Family Ins. Co.*, 536 F. Supp. 2d 664, 667 (E.D. La. 2008) ("[T]he most common reason for the rule is that a defendant should not be allowed to benefit from the outside benefits provided for the plaintiff."). As one court recently explained,

> A plaintiff who receives a double recovery for a single tort enjoys a windfall; a defendant who escapes, in whole or in part, liability for his wrong enjoys a windfall. Because the law must sanction one windfall and deny the other, it favors the victim of the wrong rather than the wrongdoer.

Acuar, 531 S.E.2d at 323; *Mitchell v. Haldar*, 883 A.2d 32, 38 (Del. 2005). In reference to the fact that a common source of collateral source payments is private insurance benefits, some courts have reasoned that "there is no reason why a risk adverse insured may not contract for a double recovery." *Mitchell*, 883 A.2d at 38-39. Courts have also stated, however, that another rationale underlying the collateral source rule is to punish defendants for their tortious acts. *See*, *e.g.*, *Bozeman v. Louisiana*, 879 So. 2d 692 (La. 2004); *Clausen v. SEA-3, Inc.*, 21 F.3d 1181, 1192-93 (1st Cir. 1994); *Motor Vehicle Admin. of Md. Dep't of Transp. v. Seidel Chevrolet, Inc.*, 604 A.2d 473, 482 (Md. Ct. App. 1992). In any event, the collateral source rule is an exception to the general rule that the measure of damages which a plaintiff may recover in a tort action is that amount

which will make the plaintiff whole. *Robinson v. Bates*, 857 N.E.2d 1195, 1199 (Ohio 2006); *Chisholm v. UHP Projects, Inc.*, 205 F.3d 731, 744 (4th Cir. 2000); *Clausen*, 21 F.3d at 1992.

B. Recent Changes and Exceptions to the Collateral Source Rule

In recent years, however, there has been a movement across the country to bring the law into sync with the realities of the modern healthcare and insurance systems. This reform has resulted in the modification or complete abrogation of the collateral source rule in at least thirty-seven (37) states. Numerous courts have held that evidence of payments received from a collateral source may be admissible for the purposes of impeaching a witness's credibility. *See*, *e.g.*, *Cowens v. Siemens-Elema*, 837 F.2d 817, 824 (8th Cir. 1988) ("While it is true that evidence of payments received from a collateral source is ordinarily inadmissible, we have recognized that a [party's] testimony on direct examination may make evidence of payments from a collateral source relevant and necessary for purposes of rebuttal." (brackets in original)); *Lawson v. Trowbridge*, 153 F.3d 368, 379-80 (7th Cir. 1998); *Kroning v. State Farm Auto. Ins. Co.*, 567 N.W.2d 42, 46 (Minn. 1997); *Stewart v. Amer. Family Mut. Ins. Co.*, 2008 U.S. Dist. LEXIS 10288, *6 (E.D. La. 2008); *Montgomery Ward & Co. v. Anderson*, 976 S.W.2d 382, 384-85 (Ark. 1998); *Matheson v. Stilkenboom*, 555 S.E.2d 73, 75 (Ga. Ct. App. 2001); *Robinson Prop. Group, L.P. v. Mitchell*, 7 So. 3d 240, 245 (Miss. 2009). Many state legislatures, recognizing the inequity posed by the collateral source rule, have abrogated it in whole or in part in all tort actions, permitting the presentation of evidence of collateral source benefits received by the plaintiff for purposes of reducing any damage award by the amount of such benefits.

At least twenty (20) states have eliminated the collateral source rule in all tort actions, with some exceptions which vary tremendously from state to state. *See* ALASKA STAT. § 9.17.070 (excludes payments from federal, life insurance, or gratuitous benefits); COLO. REV. STAT. § 13-21-111.6; CONN. GEN. STAT. § 52-225a (excludes payments as to which right of subrogation exists); FLA. STAT. § 768.76 (excludes payments as to which right of subrogation exists, as well as federal medical services benefits and worker's compensation); HAW. REV. STAT. § 663-10 (requiring trial court to determine validity of any lien claims prior to judgment and then include in final judgment a list of any amounts due pursuant to any such valid liens); IDAHO CODE § 6-1606 (excludes payments as to which right of subrogation exists, benefits paid under federal programs, and life insurance benefits); 735 ILL. COMP. STAT. 5/2-1205 (excludes certain collateral sources and places limits on certain reductions); IND. CODE §§ 34-44-1-1, *et. seq.* (excludes payments made by state or federal government, as well as life insurance or other death or insurance policy benefits); IOWA CODE § 668.14 (excludes state or federal benefits and payments made from assets of claimant or his immediate family); KY. REV. STAT. § 411.188 (excludes known subrogation rights or life insurance policy benefits); MICH. COMP. LAWS § 600.6303; MINN. STAT. § 548.36

(excludes life insurance, social security, pension, and private disability insurance benefits); MO. REV. STAT. § 490.715; MONT. CODE ANN. § 27-1-308 (applicable only where damages awarded exceed $50,000.00); NEB. REV. STAT. § 44-2819; N.J. STAT. ANN. § 2A:15-97 (excludes worker's compensation and life insurance benefits); N.Y. C.P.L.R. § 4545 (excludes life insurance and social security benefits, as well as voluntary charitable contributions, but allows plaintiff to receive credit for health insurance premiums paid during previous two-year period plus projected future cost of maintaining such insurance); N.D. CENT. CODE § 32-03.2-06 (excludes life insurance or other death benefits, retirement benefits, and any benefit purchased by plaintiff); OHIO REV. CODE ANN. § 2315.20 (excludes payments as to which right of subrogation exists or arising from life insurance or disability payment); OR. REV. STAT. § 31.580 (excludes benefits which plaintiff is obligated to repay, life insurance or other death benefits, insurance benefits for which the injured person or his family paid, and retirement, disability, pension, and social security benefits).

At least fifteen (15) other states have abrogated the collateral source rule in medical malpractice cases. *See* ARIZ. REV. STAT. § 12-565; CAL. CIV. CODE § 3333.1; 18 DEL. C. § 6862 (applicable only to past or expected future public collateral source benefits); MD. CTS. & JUDICIAL PROCEEDINGS CODE ANN. §§ 3-2A-05, 3-2A-06; MASS. GEN. LAWS ch. 231, § 60G (excludes gratuitous payments or gifts and certain state benefits); N.H. REV. STAT. ANN. 507-C:7 (but plaintiff may present evidence amount paid to secure right to benefits at issue); 63 OKLA. STAT. § 1-1708.1D (not applicable where right of subrogation exists); 40 PENN. CONS. STAT. § 1301.602 (excludes certain types of benefits); R.I. GEN. LAWS § 9-19-34.1 (plaintiff may present evidence of amount paid to secure applicable insurance benefits); S.D. COD. LAWS § 21-3-12 (excludes benefits subject to subrogation, state or federal benefits, and insurance benefits purchased privately by claimant, his decedent, or immediate family); TENN. CODE ANN. § 29-26-119 (excludes payments from assets of claimant or his immediate family and privately-purchased insurance benefits); UTAH CODE ANN. § 78B-3-405 (excludes benefits subject to subrogation); REV. CODE WASH. (ARCW) § 7.70.080; W. VA. CODE § 55-7B-9a; WIS. STAT. § 893.55(7).

Other states have eliminated the collateral source rule in professional negligence actions generally or in product liability actions. *See* 24 ME. REV. STAT. § 2906 (applicable only to personal injury-related professional negligence cases; excludes federal benefit and life insurance benefit payments); *See* ALA. CODE § 6-5-520 (applicable only to product liability actions). At least two other state legislatures passed statutes abrogating the collateral source rule in whole or in part, only to have those statutes subsequently declared unconstitutional by their state's highest court. *See* O.C.G.A. § 51-12-1(b) (declared unconstitutional by *Denton v. Con-Way S. Express, Inc.*, 261 Ga. 41 (1991)); KAN. STAT. ANN. § 60-3802 (applicable only in cases where damages exceed $150,000.00; declared unconstitutional by *Thompson v. KFB Ins. Co.*, 850 P.2d 773 (Kan. 1993)).

In each of these states, subject to whatever restrictions may be imposed by the individual statutory schemes, plaintiffs are no longer permitted to recover any amount which has been shown to have been paid by a collateral source. These changes in the treatment of collateral sources at trial represent a larger trend toward permitting plaintiffs to recover only those economic damages actually incurred by them, rather than providing plaintiffs with a windfall in the form of double or multiple recovery of their actual, reasonable medical expenses.

III. "Reasonable Value" as the Appropriate Measure of Damages

As a general matter, reasonable medical expenses are among the types of special or compensatory damages a plaintiff may seek to recover in a tort action in which the plaintiff alleges injury to his person. RESTATEMENT (SECOND) OF TORTS, § 924(c). Generally speaking, when a plaintiff seeks to recover medical expenses in a tort action, the plaintiff must demonstrate both that the claimed value of the medical services for which the plaintiff seeks to recover is reasonable and that the plaintiff's need for the medical services in question was proximately caused by the defendant's negligence. *See Id.*, § 924, cmt. f; *Mitchell v. Haldar*, 883 A.2d 32, 37 (Del. 2005). Put another way, "a person injured by another's tortious conduct is entitled to recover the *reasonable value* of medical care and services reasonably required and attributable to the tort." *Hanif v. Hous. Auth. of Yolo Cty.*, 200 Cal. App. 3d 635, 640, 246 Cal. Rptr. 192 (1988).

Importantly, it is widely understood that the purpose of an award of compensatory damages such as reasonable medical expenses is to compensate the plaintiff. Compensatory damages "are intended to redress the concrete loss that the plaintiff has suffered by reason of the defendant's wrongful conduct." *Cooper Indus., Inc. v. Leatherman Tool Group, Inc.*, 532 U.S. 424, 432, 121 S. Ct. 1678 (2001); *see also* RESTATEMENT (SECOND) OF TORTS, § 903. Thus, unlike punitive or exemplary damages, compensatory damages are not properly awarded to a plaintiff in an effort to punish a defendant, nor should they be used to bestow a windfall upon the plaintiff. *Coop. Leasing, Inc. v. Johnson*, 872 So. 2d 956, 958 (Fla. Ct. App. 2004); *Washington v. Barnes Hosp.*, 897 S.W.2d 611, 621 (Mo. 1995); *see also* RESTATEMENT (SECOND) OF TORTS, § 908.

IV. Present Court Conflict as to Whether Write-Offs Are "Collateral Sources" and, Thus, Part of the Medical Expenses Which May Be Sought and Recovered by Plaintiffs

A. Courts Holding That the Total Amount *Billed* is the Appropriate Measure of a Plaintiff's Reasonable Medical Services

Not all jurisdictions have yet considered the specific issue of whether a plaintiff may recover the full amount *billed* for medical services, or whether the amount recoverable should be limited to the amount actually *paid* for those

services. Specifically, it is unclear in many jurisdictions whether a plaintiff may present evidence of and/or recover those portions of the plaintiff's medical bills which were written off by an insurer or other benefits provider. To date, however, courts in at least thirteen (13) states and the District of Columbia have held that a plaintiff is entitled to claim and blackboard at trial the full amount of reasonable medical expenses billed, notwithstanding that portions of the expenses billed have been written off as a result of contractual rate reductions or those required by statute (i.e., Medicare benefits). *See Lopez v. Safeway Stores, Inc.*, 129 P.3d 487 (Ariz. Ct. App. 2006); *Tucker v. Volunteers of Am. Colo. Branch*, 211 P.3d 708, 713 (Colo. Ct. App. 2008); *Mitchell v. Haldar*, 883 A.2d 32, 40 (Del. 2005); *Hardi v. Mezzanotte*, 818 A.2d 974, 985 (D.C. App. 2003); *Olariu v. Marrero*, 549 S.E.2d 121 (Ga. Ct. App. 2001); *Bynum v. Magno*, 101 P.3d 1149 (Haw. 2004); *Arthur v. Catour*, 803 N.E.2d 647 (Ill. Ct. App. 2004); *Wal-Mart Stores, Inc. v. Frierson*, 818 So. 2d 1135, 1139-40 (Miss. 2002); *Brown v. Van Noy*, 879 S.W.2d 667, 676 (Mo. Ct. App. 1994); *White v. Jubitz Corp.*, 219 P.3d 566 (Ore. 2009); *Haselden v. Davis*, 579 S.E.2d 293 (S.C. 2003); *Papke v. Harbert*, 738 N.W.2d 510, 534-36 (S.D. 2007); *Acuar v. Letourneau*, 531 S.E.2d 316 (Va. 2000); *Koffman v. Leichtfuss*, 630 N.W.2d 201 (Wis. 2001).

Although some of these decisions have dealt with private insurance benefits and others have dealt with Medicare or other public benefits, the rationale underlying such decisions is the same. Some of these courts have at least recognized a defendant's right to a post-verdict set-off in the amount of any write-offs. *See*, *e.g.*, *Candler Hosp. v. Dent*, 491 S.E.2d 868, 869 (Ga. Ct. App. 1997). Other courts, however, have permitted plaintiffs to actually *recover* the full amount billed, including any amount written off. *See*, *e.g.*, *Bozeman v. Louisiana*, 879 So. 2d 692 (La. 2004); *Lopez v. Safeway Stores, Inc.*, 129 P.3d 487 (Ariz. Ct. App. 2006). These courts have primarily relied on the rather disingenuous and illogical proposition that any portions of medical expenses written off by medical providers constitute a collateral source of compensation received by the plaintiff, notwithstanding that the very essence of a write-off is that it is not paid by anyone. *See*, *e.g.*, *Mitchell*, 883 A.2d at 40; *Hardi*, 818 A.2d at 985; *Olariu*, 549 S.E.2d at 123 ("Georgia does not permit a tortfeasor to derive any benefit from a reduction in damages for medical expenses paid by others, whether insurance companies or beneficent boss or helpful relatives. [Defendant] is not entitled to use a third party's write-off of medical expenses as a set-off against Marrero's recovery of past medical expenses." (internal citation omitted)).

Some courts, rather than argue that such write-offs actually *are* collateral sources, have acknowledged that they are creating a legal fiction in order to provide a windfall to the plaintiff:

> [T]he application of the collateral source rule makes more sense and is more appropriate. This rationale can best be understood by analyzing the write-offs in two situations: one in which a tortfeasor injures an uninsured victim and the other in which the same tortfeasor, in the same manner and

> to the same extent, injures an insured victim. Unless the write-offs are considered collateral sources, the tortfeasor would be relieved of his liability to the insured victim to the amount of the write-offs. The argument that there is no underlying obligation for plaintiff to pay the amount of the write-offs and, therefore, the plaintiff should not be allowed to benefit from a non-existent debt, falls because the effect of this reasoning results in a diminution of the tortfeasor's liability vis-a-vis an insured victim when compared with the same tortfeasor's liability vis-a-vis an uninsured victim.

Bozeman, 879 So. 2d at 703.

At least one court has held that "[t]he result is the same whether the write off is generated by cash payment…or…because of a reduction attributable to a health insurance contract for which the tortfeasor paid no compensation." *Mitchell*, 883 A.2d at 40. Such a holding is puzzling, to say the least, inasmuch as one can hardly imagine a better indication of the true reasonable value of the medical services received by a plaintiff than the actual amount accepted by the provider, in cash, *from the plaintiff himself* (with the possible exception of relative value units, as explained below).

Some of these courts have acknowledged that their holdings will result in double or multiple recovery by the plaintiff, but conclude that this is preferable to a system wherein plaintiffs would only be fully compensated once and defendants might not always have to pay the full claimed amount of plaintiffs' medical expenses. *See*, *e.g.*, *Lopez*, 129 P.3d 487; *Lettinger v. DBart, Inc.*, 736 N.W.2d 1, 10 (Wis. 2007). Some courts have even based their decisions on a stated goal of punishing defendants in tort cases. *See*, *e.g.*, *Bozeman*, 879 So. 2d 692. What makes these decisions especially troubling and inequitable is that no additional showing was required by the plaintiff, such as would normally be required for the recovery of punitive or exemplary damages.

The Virginia Supreme Court's decision in *Acuar v. Letourneau*, 531 S.E.2d 316 (Va. 2000), one of the more commonly-cited decisions permitting a plaintiff to recover written-off portions of medical bills, is illustrative of the extent of the tautological reasoning some courts have resorted to in order to reach such a conclusion. In *Acuar*, the Virginia Supreme Court went to great lengths to distinguish another decision from just two years earlier in which that court had held that the amount of medical expenses which were "incurred" by an insured and, thus, subject to reimbursement, included only "the amounts that the health-care providers accepted as full payment for their services rendered to him." *Acuar*, 531 S.E.2d at 321, *quoting State Farm Mut. Auto. Ins. Co. v. Bowers*, 500 S.E.2d 212, 214 (Va. 2000) (internal quotation omitted). The court held in *Bowers* specifically held that any amounts written off by the insured's providers were *not* considered to have been "incurred" by the insured and were not subject to reimbursement. *Id.*

The operative policy language at issue in *Bowers* defined "medical expense" as "all reasonable and necessary expenses for medical … services … incurred." *Bowers*, 500 S.E.2d at 212. Despite acknowledging that both cases involved medical expenses which had been written off by healthcare providers, and although the definition of "medical expenses" under the policy at issue in the prior case would seem to make the court's decision in that case directly on point, the *Acuar* court distinguished the prior decision simply on the basis that it involved interpretation of a provision in an insurance policy. *Acuar*, 531 S.E.2d at 321. The court reasoned that because *Acuar* dealt with a "tort claim, not a contractual one, by an injured party against a wrongdoer," its holding was not controlling or even relevant. *Id.*

This explanation is somewhat unconvincing in light of the reality that in both situations, the medical bills in question likely would be paid by someone's liability insurer. Moreover, the Court's rationale in *Acuar* leads to the inexorable but rather unsatisfying conclusion that an injured person who files suit is entitled to recover more for *the same medical treatment* than an injured person who seeks reimbursement from his insurer for the same medical bills. More than anything else, the *Acuar* opinion arguably demonstrates the relative weakness of the reasoning underlying the decisions in holding that plaintiffs should be permitted to seek and recover portions of medical bills which have been written off.

B. Courts Holding That Defendants May Present Evidence That the Reasonable Value of Plaintiff's Medical Bills is Less Than the Amount Originally Billed

Several other courts have held that a jury is entitled to hear evidence of and may decide to award only the amount of medical expenses *actually paid* by an insurer or other benefits provider. *See Stanley v. Walker*, 906 N.E.2d 852, 857 (Ind. 2009); *Robinson v. Bates*, 857 N.E.2d 1195, 1200 (Ohio 2006); *Moorhead v. Crozer Chester Med. Ctr.*, 765 A.2d 786 (Pa. 2001); *Hanif v. Hous. Auth. of Yolo Cty.*, 200 Cal. App. 3d 635, 640, 246 Cal. Rptr. 192 (1988) (holding that the reasonable value of a plaintiff's damages must be the actual amount paid for medical services or the amount for which the plaintiff incurred liability); *Dyet v. McKinley*, 81 P.3d 1236 (Idaho 2003) (holding that although a write-off technically is not a payment from a collateral source within the meaning of a statute prohibiting double recoveries from collateral sources, it is not an item of damages for which a plaintiff may recover because the plaintiff has incurred no liability for the charges); *Coop. Leasing, Inc. v. Johnson*, 872 So.2d 956, 960 (Fla. Ct. App. 2004) (holding that the amount written off by medical providers cannot be considered "benefits received" under applicable Florida statute); *Chapman v. Mazda Motor of Amer., Inc.*, 7 F. Supp. 2d 1123, 1125 (D. Mont. 2008) (holding that plaintiff could not recover from defendant those portions of plaintiff's medical expenses which had been disallowed by Medicaid).

In *Robinson v. Bates*, 857 N.E.2d 1195, 1200 (Ohio 2006), one of the leading such cases, the Supreme Court of Ohio focused on the fact that write-offs of medical expenses are never actually paid by anyone. Thus, although Ohio retains a statutory version of the collateral source rule, the court held that such write-offs did not constitute a collateral source, and evidence of such write-offs was properly presented to the jury. *Id.* As Ohio's highest court explained:

> The jury may decide that the reasonable value of medical care is the amount originally billed, the amount the medical provider accepted as payment, or some amount in between. Any difference between the original amount of a medical bill and the amount accepted as the bill's full payment is not a "benefit" under the collateral-source rule because it is not a payment, but both the original bill and the amount accepted are evidence relevant to the reasonable value of medical expenses.

Id. at 1200-01; *see also Stanley*, 906 N.E.2d at 857.

Moreover, the Ohio Supreme Court held that concerns that this would result in a "windfall" to the defendant were unfounded: "Because no one pays the negotiated reduction, admitting evidence of write-offs does not violate the purpose behind the collateral source rule." *Robinson*, 857 N.E.2d at 1200; *see also Schlegel v. Song*, 547 F. Supp. 2d 792, 798-800 (N.D. Ohio 2008). Accordingly, the Ohio Supreme Court concluded that both the original medical bill issued *and* the amount accepted by the provider as full payment for the medical care rendered to the plaintiff should be admitted into evidence. *Robinson*, 857 N.E.2d at 1197. The Supreme Court of Indiana recently adopted the reasoning and holding of *Robinson*. *Stanley v. Walker*, 906 N.E.2d 852, 857 (Ind. 2009).

Under the approach adopted by the Ohio and Indiana courts, the touchstone in determining whether a plaintiff may recover written-off portions of medical bills is once again the "reasonable value" of the medical services rendered. The jury is supplied with all of the available facts and is charged with determining what portion of the bills were reasonable and necessary. "[T]he plaintiff is only entitled to the reasonable value of his medical expenses, and the price that a medical provider is prepared to accept for the medical services rendered is highly relevant to that determination." *Scott v. Garfield*, 912 N.E.2d 1000, 1014 (Mass. 2009) (Cordy, J., concurring). This conclusion is in accord with the general rule regarding the recovery of damages for other types of services rendered to the plaintiff:

> When the plaintiff seeks to recover for expenditures made or liability incurred to third persons for services rendered, normally the amount recovered is the reasonable value of the services rather than the amount paid or charged. If, however, the injured person paid less than the

> exchange rate, he can recover no more than the amount paid, except when the low rate was intended as a gift to him.

RESTATEMENT (SECOND) OF TORTS, § 911, cmt. h.

The California Court of Appeals has also held that the "reasonable value" of medical care and services does not include any amount written off, and, thus, not actually paid by plaintiff or anyone else. *Hanif*, 200 Cal. App. 3d 635. In reaching this conclusion, the court relied on "[f]undamental principles underlying recovery of compensatory damages in tort actions" and the calculation of such damages:

> *The primary object of an award of damages* in a civil action, and the fundamental principle on which it is based, are *just compensation* or indemnity for the loss or injury sustained by the complainant, *and no more*. A plaintiff in a tort action is not, in being awarded damages, to be placed in a *better* position than he would have been had the wrong not been done.

Id. at 640-41 (emphasis in original). Accordingly, the court held that "when the evidence shows a sum certain to have been paid or incurred for past medical care and services, whether by the plaintiff or by an independent source*, that sum certain is the most the plaintiff may recover for that care* despite the fact it may have been less than the prevailing market rate." *Id.* at 641.

Similarly, the Pennsylvania Supreme Court has held that the appropriate measure of medical expenses recoverable by a plaintiff in a tort action is the amount *actually paid*, rather than the total amount initially billed. *Moorhead v. Crozer Chester Med. Ctr.*, 765 A.2d 786, 789 (Pa. 2001), *overruled in part on other grounds*, *Northbrook Life Ins. Co. v. Commonwealth*, 949 A.2d 333, 337 (2008) ("We find that the amount paid and accepted by Appellee as payment in full for the medical services is the amount Appellant is entitled to recover as compensatory damages."). Specifically, that court held that the collateral source rule did not apply to amounts written off by an insurer, since those amounts are *never* paid by any collateral source. *Id.* In so holding, the court relied heavily on the fact that the cost of the medical expenses in question had been established by contract: "[W]here…the exact amount of expenses has been established by contract and those expenses have been satisfied, there is no longer any issue as to the amount of expenses for which the plaintiff will be liable." *Id.* In that instance, the court reasoned, "the injured party should be limited to recovering the amount paid for the medical services." *Id.*

As the Pennsylvania Supreme Court explained, allowing a plaintiff to allege in a tort action and recover for portions of medical bills which have been written off by the plaintiff's insurer "would provide [the plaintiff] with a windfall and would violate fundamental tenets of just compensation." *Moorhead*, 765

A.2d at 790. Because "damages are to be compensatory to the full extent of the injury sustained, but the award should be limited to compensation and compensation alone," it would be inappropriate and inequitable to allow the plaintiff to recover for medical bills which the plaintiff "never has, and never will, incur." *Id.*

Similarly, the Florida Court of Appeals has held that the "reasonable value" of medical care resulting from a defendant's negligence does not include amounts charged off pursuant to federal Medicare payments. *Coop. Leasing, Inc. v. Johnson*, 872 So.2d 956, 959-60 (Fla. Ct. App. 2004). In so holding, the court noted that the plaintiff "never became liable" for the written-off amounts and that the federal government had no right to reimbursement for those amounts. *Id.* at 960. The court also reasoned that the Florida legislature's abrogation by statute of the common-law collateral source rule "evinces the legislature's intent to prevent plaintiffs from receiving a windfall by being compensated twice for the same medical bills by both their insurance company and by the tortfeasor." *Id.* at 959. Allowing the plaintiff to present evidence of the full amount billed by the plaintiff's medical providers, the court explained, rather than the amount of those bills actually paid by Medicare, "would result in a windfall" to the plaintiff rather than simply allowing her to recover the "reasonable value" of the plaintiff's medical care. *Id.* at 960.

V. So What's the Problem? Why the Majority Rule Does Not Hold Water

The rule embraced by such decisions as *Mitchell*, *Bozeman*, and *Acuar* results in an untenable, inequitable situation in which plaintiffs regularly recover significantly more than their actual medical expenses under the auspices of "compensatory damages," for no real reason other than to punish defendants for conduct which amounts only to mere negligence. It also results in driving up the costs of settlement because defendants may fear the amount of special damages that a plaintiff may "blackboard." In some circumstances, the "blackboarded" medical expenses may be three times or more what is actually owed or was (or will be) paid. It has long been recognized, even by courts upholding the collateral source rule, that "[i]n a day of increased insurance protection, this rule has allowed plaintiffs to effectuate double and even triple recovery as a result of the injuries received by them." *Eastin v. Broomfield*, 570 P.2d 744, 751 (Ariz. 1977). This is especially true given that the amounts paid for medical services by private insurers and public benefit programs in modern times is based primarily or wholly on predetermined, contractually agreed-upon amounts. *See generally Am Soc'y of Cataract & Refractive Surgery v. Thompson*, 279 F.3d 447 (7th Cir. 2002) (discussing use of "relative value units" mandated by Congress in determining amount of Medicare payments); see also 42 C.F.R. § 414.22. Specifically, many insurers and governmental entities adhere to the "Relative Value Units" (RVU) system, a standard approach for determining the amount to be paid by an insurer for a particular medical procedure or service. *See Frew v. Hawkins*, 2007 U.S.

Dist. LEXIS 65843, *36 (E.D. Tex. 2007); *see also Tex. Med. Ass'n v. Tex. Workers Comp. Comm'n*, 137 S.W.3d 342, 346, fn. 3 (Tex. Ct. App. 2004).

The RVU system is widely recognized in medical and insurance circles as a nationally-accepted method for calculating the amount of reimbursement for medical services and procedures. *Frew*, 2007 U.S. Dist. LEXIS 65843 at *37. Under this system, each medical procedure or service is assigned a "relative value" based on the amount of effort involved in terms of time, support staff/office/overhead expenses, and the cost of professional liability/malpractice insurance, multiplied by a "geographic adjustment factor" for the applicable geographic region. *Id.* at *36, fn. 18; Barbara J. Safriet, *Health Care Dollars and Regulatory Sense: The Role of Advanced Practice Nursing*, 9 Yale J. on Reg. 417, 474 (1992). Each RVU is then multiplied by a standard conversion factor to determine the amount to be reimbursed for the procedure or service. *Frew*, 2007 U.S. Dist. LEXIS 65843 at *37; Safriet, *supra*, at 474. While the RVU system sets in stone the amount to be reimbursed for any medical services payable by Medicare, private insurers typically contract with medical providers for a particular percentage of that amount payable under the RVU system for all services and procedures rendered to their insureds. Miriam L. Clemons, *Don't Shoot the Messenger: Independent Physicians and Joint Payment Contracting Using the Messenger Model*, 32 U. Mem. L. Rev. 927, 945, fn.105 (2002). That percentage is then applied to each charge to determine the amount to be paid by the insurer for any covered medical procedures or services by that provider. *Id.*

As a result, it is clear that in any given case, the "reasonable value" of the medical services rendered to the plaintiff cannot be determined merely by considering the amount billed by the plaintiff's medical providers. The truth is that the "reasonable value" of a medical service is the amount the provider will agree to accept in payment for that service. As the Ohio Supreme Court explained:

> Due to the realities of today's insurance and reimbursement system, in any given case, that determination is not necessarily the amount of the original bill or the amount paid. Instead, the reasonable value of medical services is a matter for the jury to determine from all relevant evidence.

Robinson, 857 N.E.2d at 1200. That relevant evidence, logically, must include both the original amount billed for the medical services in question *and* the amount accepted as full payment for those medical services. *Id.* Only upon consideration of *all* available, relevant information can it be said that a jury has been able to properly determine the "reasonableness" and "necessity" of the claimed medical expenses.

Moreover, this judicially-sanctioned system of excessive recovery cannot be justified based on a benefit-of-the-bargain rationale. Although health insurance typically covers injuries regardless of how they occur, such double or

multiple recovery is only recoverable upon the fortuitous circumstance in which the injury is negligently caused by another. As one commentator has explained:

> If the collateral source rule were abolished, the plaintiff will have paid for security and not for the opportunity of a double recovery. He has paid for more only because the law, by allowing double recovery, in effect requires him to pay for more.

Dobbs, *Law of Remedies*, § 8.6(3), at 496 (2d ed. 1993). Moreover, the cost of this unearned, undeserved double or multiple recovery is passed not only to defendants, but also to other Americans in the form of increased overall insurance premiums. Dobbs, *Law of Torts*, § 380, at 1059 (2001). At a time where the availability of affordable health care has become such a popular and important concern across the country, it is time to address this obvious inequity by employing a system wherein injured plaintiffs are fairly compensated and defendants and their insurers are fairly penalized.

All policy issues aside, the benefit-of-the-bargain argument and other policy-based arguments in favor of permitting a plaintiff to recover the portions of medical bills which have been written off inherently miss the mark. As outlined above, it has long been required that a plaintiff establish the *reasonableness* of any medical expenses before he may recover them from a defendant in tort. If the amount sought is not paid by the plaintiff's insurer or other benefit provider – and, as a practical matter, would not be paid in whole or in part by any other reasonable provider – how can it be said that the amount billed is "reasonable"? At the very least, defendants should be permitted to present all of the available evidence to the jury so that the jury can decide what is "reasonable."

It seems clear that it is time for a paradigm shift, whether by legislative action or judicial pronouncements, toward reestablishing reasonableness as the primary factor in determining whether or how much a plaintiff should be able to recover in medical expenses in each case. Rather than focusing on the *source* of each charge, courts should follow the lead of the Supreme Courts of Ohio and Indiana by providing juries with *all available evidence* regarding the reasonable value of the medical services actually rendered, including the amount actually paid in satisfaction of plaintiffs' medical bills and the fact and amount of any write-offs. Only then can we realize a system in which damages are awarded in a way which is fair and equitable – both to plaintiffs *and* defendants.

VI. Conclusion

Permitting plaintiffs to present evidence of and recover the total amount billed for medical services while preventing defendants from showing that a lesser amount was actually accepted by a medical provider in satisfaction of the bill is inequitable, unjustifiable, and not in any way calculated to facilitate an award of the reasonable value of the medical services rendered to the plaintiff. Requiring

defendants to pay the amount of such write-offs unfairly punishes defendants while bestowing a windfall upon plaintiffs because these sums were not paid by the plaintiff or his insurer and will never be paid by anyone. As a practical matter, this scheme also increases the costs which must be borne by defendants or their insurers. The fairest way to resolve this conflict is to make all evidence regarding the value of any claimed medical services, including the amount of any portions written off, available to the jury. Then the jury can decide what portions of the plaintiff's claimed medical expenses were reasonable. The end result will be the equitable treatment of all parties involved: plaintiffs will be fairly compensated, and defendants will not be unfairly penalized.