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# Phantom Damages and the Collateral Source Rule: How Recent Hyperinflamation in Medical Costs Disturbs South Carolina's Application of the Collateral Source Rule

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# PHANTOM DAMAGES AND THE COLLATERAL SOURCE RULE: HOW RECENT HYPERINFLATION IN MEDICAL COSTS DISTURBS SOUTH CAROLINA'S APPLICATION OF THE COLLATERAL SOURCE RULE



## I. INTRODUCTION

In the determination of compensatory damages, is it proper for the court to allow the jury to consider grossly inflated medical costs that the plaintiff never actually incurred? Or rather, is the issue of whether to allow a defendant to contest the "reasonableness" of the billed amount overshadowed by the question of whether the billed amount is even an accurate indication of the value itself, given that recent medical hyperinflation has excessively influenced the "list" price of many health care providers? A growing number of jurisdictions across the country are beginning to notice this alarming trend in the health care industry and have taken action to counteract it.[1] Indeed, in light of recent medical pricing inflation, coupled with the complexities of the health care and insurance

1. *See infra* Part IV.

reimbursement systems, the time has come for South Carolina to change its current approach for determining compensatory damages.

In 2003, the South Carolina Supreme Court held in *Haselden v. Davis*[2] that evidence of the actual amount paid for health care services was admissible in determining the "reasonable" value of medical damages.[3] However, in *Covington v. George*[4]—decided just fourteen months after *Haselden*—the South Carolina Supreme Court limited itself on this very issue.[5] Although the *Covington* court never specifically overruled the *Haselden* decision, the court approached the same issue differently.[6] The court determined that this issue directly implicates the collateral source rule, holding that the actual payment amount should be excluded as evidence on the issue of reasonableness of medical expenses sought.[7] Therefore, currently in South Carolina, a jury must determine this "reasonable value" with no indication of the actual amount paid to fully satisfy these same medical bills.

Part II of this Note discusses the history and application of the collateral source rule in South Carolina and other jurisdictions. It then discusses the South Carolina Supreme Court's holdings in *Haselden* and *Covington* with respect to the application of the collateral source rule and the void created by the difference between "paid" and "billed" amounts. Part III provides an in-depth analysis of the *Covington* decision's harmful effects, particularly in light of the recent hyperinflation of medical costs. Part IV analyzes the methodologies of other jurisdictions that approach this issue differently through varying interpretations of *reasonableness*, highlighting the flaws in the current medical pricing system, discussing the varying applications of the law of damages, and considering whether an injured plaintiff ever incurred the actual medical expenses. Finally, Part V reiterates the need for change to South Carolina's current approach to this problem and posits several potential solutions.

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2. 353 S.C. 481, 579 S.E.2d 293 (2003).

3. *See id.* at 484–85, 579 S.E.2d at 295 (quoting Kashner v. Geisinger Clinic, 638 A.2d 980, 983 (Pa. Super. Ct. 1994)) (noting that the trier of fact should consider both the amount paid and the amount billed when determining damages).

4. 359 S.C. 100, 597 S.E.2d 142 (2004).

5. *See id.* at 105, 597 S.E.2d at 145 ("While a defendant is permitted to attack the necessity and reasonableness of medical care and costs, he cannot do so using evidence of payments made by a collateral source.").

6. *See id.* at 103, 597 S.E.2d at 144 (limiting the holding in *Haselden* to the facts of that case).

7. *Id.*

## II. BACKGROUND

### *A. History and Background of the Collateral Source Rule*

The collateral source rule is a rule of damages as well as a rule of evidence.[8] The rule first arose in English common law—with the inception of commercial insurance—and was adopted throughout the United States during the nineteenth century and beyond.[9]

Generally speaking, collateral source benefits are payments made by sources other than a tortfeasor, such as an insurer.[10] In short, the collateral source rule precludes a wrongdoer from "tak[ing] advantage of a contract between an injured party and a third person, no matter whether the source of the funds received is an insurance company, an employer, a family member, or other source."[11] In situations in which an injured party receives a benefit from a collateral source, this injured party may keep the benefit.[12] Thus, the rationale for this rule is that a tortfeasor should not receive a benefit, or windfall, if a plaintiff—by coordinating insurance or arranging for a gift—was responsible for the benefit.[13]

Critics of the collateral source rule, on the other hand, argue that the purpose of awarding compensatory damages is not to enable the injured party to make a profit.[14] Although these principles are at odds with each other, courts have reasoned that, if a windfall is going to occur, it should favor the innocent plaintiff as opposed to the defendant.[15]

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8. Bryce Benjet, *A Review of State Law Modifying the Collateral Source Rule: Seeking Greater Fairness in Economic Damages Awards*, 76 DEF. COUNS. J. 210, 210 (2009).

9. *Id.*; *see also* The Propeller Monticello v. Mollison, 58 U.S. (17 How.) 152, 155 (1854) (holding that tortfeasors are liable for the full value of the damages they cause and cannot use an injured party's relationship with a third party insurer as a defense).

10. RESTATEMENT (SECOND) OF TORTS § 920A cmt. b (1979).

11. *Covington*, 359 S.C. at 103, 597 S.E.2d at 144 (quoting Pustaver v. Gooden, 350 S.C. 409, 413, 566 S.E.2d 199, 201 (Ct. App. 2002)) (internal quotation marks omitted).

12. *See* RESTATEMENT (SECOND) OF TORTS § 920A cmt. b (1979) ("If the plaintiff was himself responsible for the benefit . . . the law allows him to keep it for himself. If the benefit was a gift to the plaintiff . . . he should not be deprived of the advantage that it confers.").

13. *Id.* ("[I]t is the position of the law that a benefit that is directed to the injured party should not be shifted so as to become a windfall for the tortfeasor.").

14. *See* 25 C.J.S. *Damages* § 21 (2010).

15. *See, e.g.*, Bynum v. Magno, 101 P.3d 1149, 1154, 1160 (Haw. 2004) (quoting RESTATEMENT (SECOND) OF TORTS § 920A cmt. b (1979)) (concluding that injured plaintiffs are entitled to recover the full value of medical services without consideration for the amount actually paid); Bardsley v. Gov't Emps. Ins. Co., 405 S.C. 68, 78, 747 S.E.2d 436, 441 (2013) (citation omitted) (noting that the collateral source rule exists to ensure that any windfall goes to the plaintiff).

### *B. In Certain Situations, the Collateral Source Rule Makes Sense*

Several arguments support the notion that the collateral source rule is beneficial.[16] First, as previously mentioned, a windfall may ensue in some instances.[17] In such situations, it is considered more just to have the injured person receive the windfall rather than provide relief to the tortfeasor.[18] Thus, general fairness errs on the side of providing a windfall to the innocent injured party instead of the wrongdoer.

Second, subrogation is available under health insurance contracts that expressly provide for it.[19] Thus, if damages paid by a wrongdoer are reduced by the amount paid by an insurer, a plaintiff would not be made whole if the plaintiff was required to repay the insurer.[20] When a plaintiff incurs reasonable, necessary, and customary charges by a hospital and then creates an implied contract to pay for these services, the plaintiff may become liable for the bill or liable for reimbursement to the insurer.[21] Thus, in the private market, the argument against an injured party receiving a windfall is generally nullified through an insurance company's right to recuperate the payments made on behalf of the injured party.[22]

Third, public policy encourages insurance,[23] and "the collateral source rule ensures plaintiffs will receive the benefits of their decision to carry insurance and thereby encourages them to do so."[24] More thoroughly, the collateral source rule "embodies the venerable concept that a person who has invested years of insurance premiums to assure his medical care should receive the benefits of his

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16. *See, e.g.*, Helfend v. S. Cal. Rapid Transit Dist., 465 P.2d 61, 69 (Cal. 1970) ("[T]he [collateral source] rule presently performs a number of legitimate and even indispensible functions.").

17. *See* RESTATEMENT (SECOND) OF TORTS § 920A cmt. b (1979).

18. *See id.*

19. 44A AM. JUR. 2D *Insurance* § 1787 (2013) (citing Wajnberg v. Wunglueck, 963 N.E.2d 1077 (Ill. App. Ct. 2011); Fortis Benefits v. Cantu, 234 S.W.3d 642 (Tex. 2007)).

20. *See Helfend*, 465 P.2d at 67 (noting that, when an insurance policy requires subrogation, the plaintiff receives no double recovery when the tortfeasor pays the full amount of damages); *see also id.* at 66 ("If we were to permit a tortfeasor to mitigate damages with payments from plaintiff's insurance, plaintiff would be in a position inferior to that of having bought no insurance, because his payment of premiums would have earned no benefit.").

21. *See* Haygood v. De Escabedo, 356 S.W.3d 390, 397 (Tex. 2011) (quoting Black v. Am. Bankers Ins. Co., 478 S.W.2d 434, 437 (Tex. 1972)).

22. *See Helfend*, 465 P.2d at 67 (noting that a plaintiff receives no double recovery, and thus no windfall, when an insurer has a right of subrogation).

23. *See* Howell v. Hamilton Meats & Provisions, Inc., 257 P.3d 1130, 1135 (Cal. 2011) (quoting *Helfend*, 465 P.2d at 66–67) (noting that many insurance policies are structured to allow the injured party to recover the full value of damages from the tortfeasors, while preventing double recovery from both the insurer and the tortfeasor); *see also Helfend*, 465 P.2d at 66 ("The collateral source rule expresses a policy judgment in favor of encouraging citizens to purchase and maintain insurance . . . .").

24. *Howell*, 257 P.3d at 1135 (citing *Helfend*, 465 P.2d at 66).

thrift."[25] Thus, "[t]he tortfeasor should not garner the benefits of his victim's providence."[26]

### C. *Rule 403, South Carolina Rules of Evidence*

The collateral source rule has an evidentiary aspect as well: evidence of a collateral payment is inadmissible at trial to reduce damages that are otherwise recoverable.[27] In fact, allowing evidence of collateral payments may be reversible error, even if accompanied by a limiting instruction informing the jury not to deduct the payments from its award of economic damages.[28] In *Covington*, the court noted that the proper application of Rule 403 of the South Carolina Rules of Evidence (SCRE) rendered evidence of the actual amount paid inadmissible.[29] The *Covington* court further explained that even allowing the amount to be introduced apart from the "source" would generate confusion among the jurors.[30] Thus, Rule 403 of the SCRE provides the basis for a South Carolina court to disallow evidence of the actual medical costs incurred by the plaintiff.[31]

## III. THE COLLATERAL SOURCE RULE IN SOUTH CAROLINA: THE AFTERMATH OF *COVINGTON*

### A. Haselden v. Davis

In a wrongful death and survival action brought by the decedent's estate, the plaintiff alleged that the decedent's physician negligently failed to diagnose a suspicious mammogram.[32] By the time the decedent's physician delivered the diagnosis—over two years after the mammogram—the decedent's breast cancer had spread to her lymph nodes.[33] At trial, her medical expenses, totaling $77,905.21, were presented to the jury.[34] Despite the amount billed, Medicaid fully satisfied the decedent's medical bills for a total of $24,109.04.[35] The physician unsuccessfully argued at trial that, for purposes of determining compensatory damages, the court should have admitted into evidence only the

25. *Helfend*, 465 P.2d at 66.
26. *Id.*
27. *Howell*, 257 P.3d at 1135.
28. *Id.* (citing Hrnjak v. Graymar, Inc., 484 P.2d 599, 601–02 (Cal. 1971)).
29. Covington v. George, 359 S.C. 100, 105, 597 S.E.2d 142, 145 (2004).
30. *Id.* at 104, 597 S.E.2d at 144.
31. *See id.*
32. Haselden v. Davis, 353 S.C. 481, 482–83, 579 S.E.2d 293, 294 (2003).
33. *Id.* at 483, 579 S.E.2d at 294.
34. *Id.*
35. *Id.* Therefore, Medicaid satisfied the decedent's original bill by paying only around thirty percent of the original billed amount. *See id.*

total amount actually paid by Medicaid.[36] On appeal, the South Carolina Supreme Court narrowed the issue to determine whether a plaintiff can submit evidence of the total amount of billed medical expenses when a Medicaid patient is not liable for any amounts billed in excess of the amount paid by Medicaid.[37] The *Haselden* court explained that a plaintiff is entitled to seek compensatory damages for the cost of medical services amounting to a reasonable value.[38] In doing so, the court acknowledged the relevancy of the actual amount paid in determining the reasonable value of medical services rendered, but noted that the trier of fact must look to a variety of factors to arrive at this reasonable value.[39] Further explaining the *reasonable value* criteria, the court identified the amount billed and the relative market value of services as important factors to consider.[40]

Furthermore, the *Haselden* court made reference to comment f of section 924 of the Restatement (Second) of Torts,[41] supporting the notion that an injured person should receive damages "for the value of services reasonably made necessary by the harm."[42] Recognizing that a wrongdoer would receive a windfall should the plaintiff's damages be limited to the actual paid amount, the court noted that limiting a plaintiff's damages to the amount actually paid by Medicaid would contravene the collateral source rule's underlying purpose.[43]

Accordingly, the *Haselden* court held that evidence of the fully billed amount, prior to any negotiated reduction by Medicaid, was admissible.[44] The court mentioned that limiting a plaintiff's damages to the amount Medicaid actually paid is contrary to the collateral source rule.[45] More importantly, however, the court did *not* say that allowing the actual payment amount into

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36. *Id.*

37. *Id.*

38. *Id.* at 484, 579 S.E.2d at 295 (citation omitted).

39. *Id.*

40. *Id.* (citing Kashner v. Geisinger Clinic, 638 A.2d 980, 983 (Pa. Super. Ct. 1994)). The Supreme Court of Pennsylvania later departed somewhat from the holding in *Kashner*. *See* Moorhead v. Crozer Chester Med. Ctr., 765 A.2d 786, 789–90 (Pa. 2001) (holding that, when the tortfeasor provided medical services to the injured party, the amount paid by the injured party and accepted by the tortfeasor was the proper amount of damages the plaintiff could recover and that allowing the plaintiff to recover more would result in a windfall) *abrogated on other grounds*, Northbrook Life Ins. Co. v. Commonwealth, 949 A.2d 333 (Pa. 2008).

41. *Haselden*, 353 S.C. at 484, 579 S.E.2d at 295 (citing *Kashner*, 638 A.2d at 983).

42. RESTATEMENT (SECOND) OF TORTS § 924 cmt. f (1979).

43. *Haselden*, 353 S.C. at 485, 579 S.E.2d at 295.

44. *Id.* In his dissent, Justice Burnett stated that the proper inquiry rests in the law of damages and *not* the collateral source rule. *Id.* at 486, 579 S.E.2d at 296 (Burnett, J., dissenting). Justice Burnett noted that the purpose of compensatory damages is to put an injured person in the position that person was in prior to any wrongdoing and no more. *Id.* Furthermore, Justice Burnett opined that the plaintiff never actually incurred the medical expense and, therefore, allowing the plaintiff to recover for the amount billed to Medicaid is inconsistent with this principle of law. *Id.* at 486–87, 579 S.E.2d at 296.

45. *Id.* at 485, 579 S.E.2d at 295 (majority opinion).

evidence contravened the collateral source rule.[46] This holding is consistent with the court's discussion noting that the ultimate goal is to utilize all available evidence to allow the jury to determine the reasonable value of medical services when determining compensatory damages.[47]

Therefore, after *Haselden*, a defendant cannot assert that a plaintiff's compensatory damages were limited to only the amount that Medicaid accepted as full payment.[48] In determining compensatory damages, however, a factfinder could utilize several factors—including the amount billed and the amount paid—to arrive at the reasonable value of medical services rendered.[49]

### *B.* Covington v. George

In *Covington*, the plaintiff brought an action stemming from an automobile accident with the defendant.[50] At trial, the defendant sought to introduce evidence that, despite the plaintiff's much higher original bill, her health care provider accepted, as full payment, a significantly reduced payment amount.[51] The trial judge refused to allow the defendant to show that, although the plaintiff's original medical bills totaled $3,399.00, her health care provider accepted $647.47 as payment in full.[52]

The South Carolina Supreme Court transferred this case under Rule 204(b) of the South Carolina Appellate Court Rules, thus precluding a ruling by the court of appeals on this issue.[53] Relying on the court's ruling in *Haselden v. Davis* just one year prior, the defendant argued that he was entitled to present evidence that a medical provider accepted as full payment an amount less than what this same medical provider billed for its services.[54] The defendant further argued that, to dispute the reasonableness of the medical costs sought, he should

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46. *See id.* (noting that, while the amount paid is not sufficient by itself to determine the reasonable value of medical services, it is relevant to establishing damages). This signifies the court's recognition of a clear difference between limiting a plaintiff's recovery to a certain amount and prohibiting a defendant from providing material evidence that further assists a factfinder in arriving at a reasonable value. *See id.*

47. *See id.* at 484, 579 S.E.2d at 295 (citing Kashner v. Geisinger Clinic, 638 A.2d 980, 983 (Pa. Super. Ct. 1994)).

48. *See id.* at 485, 579 S.E.2d at 295.

49. *See id.* at 484, 579 S.E.2d at 295 (citing *Kashner*, 638 A.2d at 983).

50. Covington v. George, 359 S.C. 100, 101, 597 S.E.2d 142, 143 (2004).

51. *Id.*

52. *Id.* at 102, 597 S.E.2d at 143. Therefore, Medicare fully satisfied the plaintiff's medical bills for less than twenty percent of the original price. *See id.* at 102 & n.2, 597 S.E.2d at 143 & n.2. Of note, the defendant only sought to reveal the amount paid to satisfy the plaintiff's bills, and not the source of payment. *Id.* at 102, 597 S.E.2d at 143.

53. *See id.* at 102, 597 S.E.2d at 143 ("Did the trial court err in refusing to allow George to present evidence that the amount Covington's medical provider accepted in payment was less than what it charged for its services?").

54. *Id.* (citing Haselden v. Davis, 353 S.C. 481, 484, 579 S.E.2d 293, 295 (2003)).

be able to present evidence of what the health care provider accepted as payment in full.[55]

In holding that the trial court properly excluded the defendant's evidence, the supreme court explained its decision in *Haselden*.[56] Noting that the introduction of evidence was not at issue on appeal in *Haselden*, the *Covington* court stated that the issue of whether the amount actually paid may be used to establish the reasonableness of medical expenses was "ancillary" to the main issue in *Haselden*.[57] The court explained that both the *billed* and *paid* amounts in *Haselden* were already introduced as evidence at trial.[58] Contrary to the issue statement in the *Haselden* opinion, the *Covington* court stated that the issue in *Haselden* was whether the plaintiff was entitled to recover the difference between the actual payment and the billed amount.[59]

After determining that the negotiated amounts accepted by a health care provider represent contractual negotiations, rather than the "prevailing costs" of the services rendered, the *Covington* court held—during its discussion the difference between paid and billed amounts for rendered health care services—that the collateral source rule was directly implicated in this case.[60] Therefore, the court concluded that "the actual payment amount was properly excluded" at trial.[61]

In clarifying the rule, the *Covington* court explained that "[t]he collateral source rule provides that compensation received by an injured party from a source wholly independent of the wrongdoer will not reduce the damages owed by the wrongdoer."[62] Thus, the court explained that the proper application of SCRE Rule 403 and the collateral source rule demand that trial courts exclude evidence of the actual payment amount at trial.[63]

The *Covington* court also supported its decision by citing a Florida case involving the collateral source rule and evidence of contractual "write-offs" by medical providers.[64] In that case, the court held that "the collateral source rule

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55. *Id.* at 102–03, 597 S.E.2d at 143.

56. *See id.* at 103, 597 S.E.2d at 143–44 (citing *Haselden*, 341 S.C. at 501, 534 S.E.2d 295 at 303).

57. *Id.* at 103, 597 S.E.2d at 143.

58. *Id.*

59. *Id.* at 103, 597 S.E.2d at 143–44. In the *Haselden* opinion itself, however, the South Carolina Supreme Court clearly identified the issue: "Is evidence of amounts billed by a treating physician admissible to establish a medical malpractice plaintiff's damages, where the plaintiff is a Medicaid patient who is not liable for any amounts billed in excess of the amount paid by Medicaid?" *Haselden*, 353 S.C. at 483, 579 S.E.2d at 294.

60. *Covington*, 359 S.C. at 103–04, 597 S.E.2d at 144 (citing Radvany v. Davis, 551 S.E.2d 347, 348 (Va. 2001)).

61. *Id.* at 102, 597 S.E.2d at 143.

62. *Id.* at 103, 597 S.E.2d at 144 (quoting Citizens & S. Nat'l Bank of S.C. v. Gregory, 320 S.C. 90, 92, 463 S.E.2d 317, 318 (1995)) (internal quotation marks omitted).

63. *Id.* at 105, 597 S.E.2d at 145.

64. *See id.* at 104–05, 597 S.E.2d at 144 (quoting Goble v. Frohman, 848 So. 2d 406, 409, 410 (Fla. Dist. Ct. App. 2003)).

prohibited introduction of contractual discounts that were 'written-off' by the medical providers."[65]

Therefore, just one year after *Haselden*, the Supreme Court of South Carolina executed an about-face regarding the application of the collateral source rule with respect to a defendant's ability to introduce evidence of the actual amount paid to fully satisfy a plaintiff's medical bills.[66]

### C. *Summary of Current Law in South Carolina*

After *Covington*, it is now settled law that a plaintiff can submit into evidence a "list price" medical bill of services for the purposes of allowing a jury to determine the reasonable value of those medical services, regardless of what amount was actually paid to fully satisfy these medical obligations.[67] A defendant, on the other hand, cannot produce evidence that the actual amount paid was less—or even substantially less—than the amount originally printed on the bill, even if the defendant refrains from identifying the source of the payment.[68] Therefore, even Medicaid recipients—who do not realize any personal loss for medical expenses paid—can pocket a windfall at the defendant's expense.[69]

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65. *Id.* at 104, 597 S.E.2d at 144 (quoting *Goble*, 848 So. 2d at 409). The full *Goble* opinion details how Florida's legislature enacted a statutory exception for this exact type of case, as well as how the Supreme Court of Florida refined the exception when asked whether it is appropriate to set off a plaintiff's reasonable damages when a medical provider has written off an equal portion of the medical bills pursuant to a contract with a health maintenance organization. *See Goble*, 848 So. 2d at 408–10 (citations omitted). The Supreme Court of Florida explained that it was proper for the district court to permit a setoff in damages for contractual discounts, as this setoff was consistent with the legislature's intent to reduce the litigation costs that arise when insurers are required to pay damages beyond what the injured party actually incurred. *See* Goble v. Frohman, 901 So. 2d 830, 832–33 (Fla. 2005) (quoting *Goble*, 848 So. 2d at 410).

66. *See Covington*, 359 S.C. at 105, 597 S.E.2d at 145. Of note, Justice Burnett, the author of the dissent in *Haselden*, concurred with the *Covington* opinion. *See id.*; Haselden v. Davis, 353 S.C. 481, 485, 579 S.E.2d 293, 295 (2003) (Burnett, J., dissenting). While it is not clear from the record, it appears that the plaintiff in *Covington* was a Medicare recipient, while the plaintiff in *Haselden* was a Medicaid recipient. *See Covington*, 359 S.C. at 102 n.2, 597 S.E.2d at 143 n.2; *Haselden*, 353 S.C. at 483, 579 S.E.2d at 294.

67. *See supra* Part III.B.

68. *See Covington*, 359 S.C. at 104, 105, S.E.2d at 144, 145 (holding that a defendant cannot use evidence of the actual payment amount in establishing the reasonableness of medical costs because "any attempts on the part of the plaintiff to explain the compromised payments would necessarily lead to the existence of a collateral source").

69. *See Haselden*, 353 S.C. at 485, 579 S.E.2d at 295 (recognizing, but failing to follow, a line of cases that held that "to allow a plaintiff to claim the billed amount, as opposed to the paid amount, would result in a windfall [to the plaintiff]").

## IV. ANALYTIC FRAMEWORKS OF OTHER JURISDICTIONS

While South Carolina courts currently employ the collateral source rule to prevent a defendant from introducing evidence of the amount paid to fully satisfy an injured party's medical bills, other jurisdictions have arrived at a host of different conclusions regarding the effect of the collateral source rule on a plaintiff's recovery of compensatory damages.[70] Some jurisdictions agree with South Carolina's approach as outlined in *Covington*.[71] Other jurisdictions, however, have modified the collateral source rule through common law to address the disparity between the "full" price and the actual amount paid to fully satisfy the same bill.[72] Furthermore, some states have decided to address the rising costs of insurance, the expensive costs of litigation, and the recent hyperinflation of medical costs through legislation.[73] These states are further divided on whether to address this disparity in the private insurance context, as

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70. *See, e.g.*, Lopez v. Safeway Stores, Inc., 129 P.3d 487, 495, 497 (Ariz. Ct. App. 2006) (holding that Arizona is among the majority of states that allow injured parties to recover the full, reasonable value of their medical expenses, but also noting that the collateral source rule is subject to legislative abrogation, and per Arizona statutory law, medical malpractice defendants are allowed to present evidence of collateral source payments during trial); Mitchell v. Haldar, 883 A.2d 32, 40 & n.26 (Del. 2005) (concluding that the trial judge violated the state's commitment to the collateral source rule by refusing to allow an injured party to present evidence of the full amount of that party's medical bills because nothing indicated that the plaintiff received an offset from a public source); Olariu v. Marrero, 549 S.E.2d 121, 123, 124 (Ga. Ct. App. 2001) (holding that a tortfeasor cannot use a third-party write-off of a victim's medical expenses to reduce the damages owed to the victim and that, while the plaintiff's recovery should be reduced by the amount of any medical debt discharged through bankruptcy, because of the risk of unfair prejudice, a defendant does not have an absolute right to present evidence of the discharge to the jury).

71. *See, e.g.*, Cates v. Wilson, 361 S.E.2d 734, 739 (N.C. 1987) (determining it was preferable that blameworthy defendants bear the burden of any loss caused by operation of the collateral source rule and holding that any evidence that "gratuitous public benefits served, and will serve, to mitigate plaintiff's damages violates the collateral source rule"); Fye v. Kennedy, 991 S.W.2d 754, 764 (Tenn. Ct. App. 1998) ("[T]here is no reason to differentiate between a *payment* from a collateral source and a *gratuity* from a collateral source." (emphasis added)); Ellsworth v. Schelbrock, 611 N.W.2d 764, 769 (Wis. 2000) (quoting Rixmann v. Somerset Pub. Sch., St. Croix Cnty., 266 N.W.2d 326 (Wis. 1978); McLaughlin v. Chi., Milwaukee, St. Paul & Pac. Ry. Co., 143 N.W.2d 32, 40 (Wis. 1966)) (noting that damages should be measured by their value, not by their actual cost to the injured party).

72. *See, e.g.*, Boutte v. Kelly, 863 So. 2d 530, 553 (La. Ct. App. 2003) (citing Suhor v. Lagasse, 770 So. 2d 422, 423, 425–26 (La. Ct. App. 2000); Terrell v. Nanda, 759 So. 2d 1026, 1027, 1029–30 (La. Ct. App. 2000)) (distinguishing between an amount "paid" and an amount "discounted" by Medicare and holding that the collateral source rule does not apply to evidence of the amount "written-off" by Medicare, thus allowing the plaintiffs to recover only the amount actually paid).

73. *See, e.g.*, ARK. CODE ANN. § 16-55-212(b) (2005) (limiting evidence of damages to the amount actually paid or the unpaid amount for which the plaintiff is legally responsible); CONN. GEN. STAT. ANN. § 52-225a (2013) (citations omitted) (requiring post-verdict reductions of damages for amounts received from collateral sources, unless the collateral source has a right of subrogation).

well as the Medicare and Medicaid context, or to simply modify the collateral source rule with respect to Medicare, Medicaid, or both.[74]

### *A. Policy Considerations*

Two competing policy considerations are at the heart of each jurisdiction's analysis of the rate differential with respect to the collateral source rule. The first consideration is the need to protect the tort recovery of an injured party. The second consideration involves the health care system and the economic effects of recent hyperinflation of medical costs, expensive litigation, and rising insurance premiums.

### *B. Different Jurisdictions' Analytic Frameworks*

Each jurisdiction, in its unique approach to the rate differential conundrum, focuses on at least one of several key analytic frameworks to justify its outcome. While some jurisdictions, like South Carolina, focus on allowing plaintiffs to recover the reasonable and necessary costs in computing compensatory damages,[75] other jurisdictions highlight the growing problem of hyperinflation in medical costs.[76] Also, several jurisdictions analyze the law of damages in determining whether to apply the collateral source rule to this issue.[77] Finally, several jurisdictions focus on whether the plaintiff actually incurred the substantially higher full price and, therefore, should recover.[78]

### *C. The Varying Interpretations of Reasonableness*

As previously mentioned, the *Haselden* court noted that the ultimate goal of compensatory damages for medical costs is to allow the injured party to recover the reasonable value of medical services rendered.[79] The *Covington* court further argued that, while the goal is to allow a plaintiff to recover the reasonable value

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74. *See, e.g.*, DEL. CODE ANN. tit. 18, § 6862 (1999) (allowing the introduction of public, but not private, collateral sources into evidence); Dyet v. McKinley, 81 P.3d 1236, 1238–1239 (Idaho 2003) (affirming a trial court's decision to prohibit the defendant from presenting evidence during trial of the amount of medical expenses the plaintiff actually paid, but reduced the jury award by the amount of charges "written off" by Medicare because this prevented a windfall to the plaintiff). The Supreme Court of Idaho held that "[t]he [trial] court correctly refused to allow [the defendant] to present evidence to the jury regarding the amounts actually paid to [the plaintiff's] medical providers." *Id.* at 1238.

75. *See* Haselden v. Davis, 353 S.C. 481, 484, 579 S.E.2d 293, 295 (2003) (citation omitted).

76. *See infra* notes 109–134 and accompanying text.

77. *See infra* Part IV.C.2.

78. *See infra* Part IV.C.3.

79. *See Haselden*, 353 S.C. at 484, 579 S.E.2d at 295 (citation omitted).

of damages incurred, the collateral source rule requires that the actual payment amount be excluded from the jury.[80]

Interestingly, although the Florida Supreme Court utilized the Restatement (Second) of Torts in concluding that a plaintiff should recover the reasonable value of medical costs, Florida statutes specifically limit a plaintiff's recovery in this very situation.[81] The full *Goble* opinion—partially cited in *Covington*[82]—explained that it is proper to permit a setoff in damages for contractual discounts because this setoff is "consistent with the Legislature's intent to reduce the litigation costs that arise when insurers are required to pay damages beyond what the injured party *actually incurred*."[83] Thus, through a statutory exception to the collateral source rule, a defendant in Florida may not present evidence of the actual amount paid, but may compel the court to reduce the plaintiff's damages to the amount actually paid.[84] Furthermore, Florida's analysis is not limited to government funded insurance programs, but also applies in the private insurance context as well.[85]

The Texas Supreme Court also identified the potential confusion a jury may encounter while determining the reasonable value of medical costs when given both the full amount and the actual amount paid to satisfy a plaintiff's medical bills.[86] Enacted in 2003, section 41.0105 of the Texas Civil Practice and Remedies Code provides that "recovery of medical or health care expenses incurred is limited to the amount actually paid or incurred by or on behalf of the claimant."[87] Applying this statute, the Texas Supreme Court affirmed the reduction of the plaintiff's awarded damages from $110,069.12 to $27,739.43 because "only evidence of recoverable medical expenses is admissible at trial."[88]

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80. *See* Covington v. George, 359 S.C. 100, 105, 597 S.E.2d 142, 145 (2004) (concluding that evidence of the actual payment amount is not admissible to prove the reasonableness of medical expenses).

81. *See* Goble v. Frohman, 848 So. 2d 406, 410 (Fla. Dist. Ct. App. 2003) (noting that the court's decision was consistent with an "intent to fully compensate" the plaintiff), *aff'd*, 901 So. 2d 830 (Fla. 2005); *see also* Goble v. Frohman, 901 So. 2d 830, 833 (Fla. 2005) (citing FLA. STAT. ANN. § 768.76 (West 2011)) ("[U]nder section 768.76, the amount of the contractual discount, for which no right of reimbursement or subrogation exists, is an amount that should be set off against an award of compensatory damages.").

82. *See Covington*, 359 S.C. at 104–05, 597 S.E.2d at 144 (quoting *Goble*, 848 So. 2d at 410).

83. *Goble*, 901 So. 2d at 832 (emphasis added) (quoting *Goble*, 848 So. 2d at 410) (internal quotation marks omitted).

84. *See id.* (citing FLA. STAT. ANN. § 768.76 (West 2011)) (describing a defendant who successfully argued that the court reduce a damages award by the amount the plaintiff's medical providers contractually agreed to discount).

85. *See* FLA. STAT. ANN. § 768.76(1) (providing that damages reductions apply regardless of the nature of the insurer). On the other hand, the statute states that "there shall be no reduction for collateral sources for which a subrogation or reimbursement right exists." *Id.*

86. *See* Haygood v. De Escabedo, 356 S.W.3d 390, 398 (Tex. 2011) (citing TEX. R. EVID. 403).

87. TEX. CIV. PRAC. & REM. CODE ANN. § 41.0105 (West 2008).

88. *Haygood*, 356 S.W.3d at 392, 399.

However, the court pointed out that the plaintiff, as a Medicare Part B recipient, was ultimately charged a reasonable amount because "[f]ederal law prohibits health care providers who agree to treat Medicare patients from charging more than Medicare has determined to be *reasonable*."[89] Essentially, through application of a statutory exception to the collateral source rule, the Texas Supreme Court defined *reasonable* medical bills as the amount that a health care provider customarily bills for the same or similar services.[90]

Through common law, the Pennsylvania Supreme Court settled the definition of *reasonable* in a similar situation, stating that "where, as 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."[91] Pennsylvania limits a plaintiff's recovery to the actual amount paid in both the private insurance context and the Medicare context.[92]

Applying this same analysis to arrive at the opposite conclusion with respect to a plaintiff's demand,[93] the Supreme Court of Hawaii noted that "the Restatement declares that the collateral source rule applies to 'gratuities.'"[94] Furthermore, the court specifically pointed to the Restatement's comments and explained that "social security benefits, welfare payments, [and] pensions under special requirement acts" are benefits to which the collateral source rule must apply.[95] Therefore, the court determined that the amount charged is not dispositive of the reasonable value and the collateral source rule bars a defendant from submitting the amount actually paid into evidence to reduce damages—but evidence of the amounts billed is not irrelevant or inadmissible.[96]

Reaching a similar result, the Tennessee Court of Appeals was also persuaded by the Restatement (Second) of Torts section 920A.[97] Notably, the court opined that, per comment b of section 920A, courts should apply the collateral source rule such that a tortfeasor is "responsible for all harm that he

89. *Id.* at 392 (emphasis added) (citing 42 U.S.C. § 1395cc(a)(1)–(2) (2006)).

90. *See id.* (citing 42 C.F.R. § 405.502(a) (2011)).

91. *See* Moorhead v. Crozer Chester Med. Ctr., 765 A.2d 786, 789 (Pa. 2001).

92. *See id.*

93. *See* Bynum v. Magno, 101 P.3d 1149, 1155–57 (Haw. 2004) (quoting Sam Teague, Ltd. v. Haw. Civil Rights Comm'n, 971 P.2d 1104, 1118 (Haw. 1999)); Barham *ex rel.* Barham v. Rubin, 816 P.2d 965, 967 (Haw. 1991); Cates v. Wilson, 361 S.E.2d 734, 737–38 (N.C. 1987); RESTATEMENT (SECOND) OF TORTS § 920A cmt. c(3), (4) (1979)).

94. *Id.* at 1155 (citing RESTATEMENT (SECOND) OF TORTS § 920A cmt. c (1979)) (likening a doctor not charging for all services rendered or reducing the bill based on a patient's circumstances to a gratuity).

95. *Id.* at 1156 (quoting RESTATEMENT (SECOND) OF TORTS § 920A cmt. c(4) (1979)).

96. *See id.* at 1157, 1160, 1163.

97. *See* Fye v. Kennedy, 991 S.W.2d 754, 763–64 (Tenn. Ct. App. 1998) (citing RESTATEMENT (SECOND) OF TORTS § 920A (1979)).

causes."[98] Moreover, the court saw no reason to differentiate between a payment and a gratuity if both originated from a collateral source.[99]

Also of note, Massachusetts enacted legislation to address damages reductions.[100] In *Sylvestre v. Martin*,[101] the Massachusetts Superior Court explained that section 60G is part of a "comprehensive set of reforms enacted . . . to avert a perceived crisis in the medical profession relating to the burgeoning cost of medial malpractice insurance and litigation."[102] In *Sylvestre*, the plaintiff's original medical bills totaled $260,122.25.[103] However, the MassHealth Casualty Recovery Unit paid $9,496.55 to the plaintiff's health care provider in full and final satisfaction of the original bill.[104] The court explained that the legislative intent behind section 60G was to "protect plaintiffs from a double loss of benefits by cancelling the rights of subrogation and lien perfection previously held by entities providing collateral benefits."[105] In sum, the intent was to ensure that a plaintiff could recover the reasonable expenses incurred, while preventing both losses and windfalls to the plaintiff.[106]

The *Sylvestre* court, however, explained that a Medicaid write-off is "an amount which [is] extinguished by operation of federal law and was neither paid out nor received by any entity."[107] Therefore, allowing a plaintiff to recover this Medicaid write-off would not further the Massachusetts legislature's goal of preventing excessive medical malpractice awards.[108]

### 1. *Flaws in the Current Medical Pricing System*

When a hospital bills its regular rates, or *list prices*, these rates "are at least double, and may be up to eight times what the hospital would accept as payment in full for the same services from Medicare, Medicaid, [Health Maintenance Organizations], or private insurers."[109] Furthermore, the very term *full*—or

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98. *Id.* at 764 (quoting RESTATEMENT (SECOND) OF TORTS § 920A cmt. b) (1979) (internal quotation marks omitted).

99. *Id.*

100. *See* MASS. GEN. LAWS ch. 231 § 60G (1986) (addressing reduction of damages awards and collateral sources of benefits).

101. Sylvestre v. Martin, No. SUCV200305988, 2008 WL 82631 (Mass. Dist. Ct. 2008).

102. *Id.* at *5 (citing Darviris v. Petros, 812 N.E.2d 1188, 1195 (Mass. 2004); McGuiggan v. New England Tel. & Tel. Co., 496 N.E.2d 141, 147 (Mass. 1986) (Lynch, J., concurring)).

103. *Id.* at *1.

104. *Id.*

105. *Id.* at *6 (citing MASS. GEN. LAWS ch. 231 § 60G).

106. *See* MASS. GEN. LAWS ch. 231 § 60G.

107. *Sylvestre*, 2008 WL 82631, at *5.

108. *Id.* Black's Law Dictionary defines *reasonable* as "fair, proper, or moderate under the circumstances." BLACK'S LAW DICTIONARY 1293 (8th ed. 2004). One would likely struggle to conclude that a medical bill is reasonable if $260,122.25 is fully satisfied for just 3.65% of its face value, or $9,496.55. *See Sylvestre*, 2008 WL 82631, at *1. This discrepancy certainly calls into question the pricing structure of this particular health care provider.

109. George A. Nation, III, *Obscene Contracts: The Doctrine of Unconscionability and Hospital Billing of the Uninsured*, 94 KY. L.J. 101, 104 (2006).

*list*—is fallacious when, nationally, less than five percent of patients actually pay this full amount.[110]

Hospitals establish their full prices "with the clear expectation that they will receive only a portion of these so-called 'full charges.'"[111] Because reimbursement rates are often set as a percentage of a hospital's list price, hospitals are financially pressured into establishing their full price list as high as possible.[112] Given that only the uninsured are somewhat expected to pay the full price, hospitals are extremely reluctant to discount this full price for fear that, under federal regulations for Medicare and Medicaid, their reimbursement from Medicare or Medicaid could be drastically reduced.[113] Thus, hospitals lack any incentive to reduce their full prices to more closely align with the amounts they actually receive on average for the same charge.[114]

Against a backdrop of the collateral source rule and health care pricing practices, the Texas legislature enacted legislation to address the problem discussed above.[115] In examining this legislation, the Texas Supreme Court recognized that the current health care pricing system has drastically evolved in recent years, noting that health care charges—once based on the provider's cost and profit margin—are now driven by government regulation and private insurers' negotiation efforts.[116]

Thus, "[a] two-tiered structure has evolved: 'list' or 'full' rates sometimes charged to uninsured patients, but frequently uncollected, and reimbursement rates for patients covered by government and private insurance."[117] In *Haygood v. De Escabedo*,[118] the court heard testimony from the plaintiff's health care provider arguing that the charges billed to the plaintiff were reasonable, despite the fact that the provider's "charges were *four times* the amount they were entitled to collect."[119]

The court stated that section 41.0105 of the Texas Civil Practice and Remedies Code limits the recovery of medical or health care expenses to "the amount actually paid or incurred by or on behalf of" the plaintiff.[120] In further explaining its decision, the court cast serious doubt on the congruence of the full bill amount and the actual value of the plaintiff's damages.[121] By essentially

110. *Id.*
111. *Id.* at 118.
112. *Id.* at 119.
113. *Id.* at 134–35.
114. *See id.* at 135. Professor Nation further argued that courts should hold the contract to pay for services based on this full price unenforceable, as a matter of law, because the disparity between the full price and the amounts all insurers generally accept as full payment renders the contract unconscionable. *See id* at 136–37.
115. Haygood v. De Escabedo, 356 S.W.3d 390, 392–93 (Tex. 2011).
116. *See id.* at 393.
117. *Id.*
118. 356 S.W.3d 390.
119. *Id.* at 394 (emphasis added).
120. *Id.* at 391 (citing TEX. CIV. PRAC. & REM. CODE ANN. § 41.0105 (West 2008)).
121. *See id.* at 394.

ignoring the health care provider's testimony regarding the value of the medical services rendered, the *Haygood* court held that a plaintiff may only submit "evidence at trial[] [of] expenses that the provider has a legal right to be paid."[122]

Likewise, in 2011, the California Supreme Court acknowledged the growing separation between a health care provider's full price and the amounts the provider contractually accepts as full payment.[123] In explaining its decision to part from previous precedent, the court recognized in *Howell v. Hamilton Meats & Provisions, Inc.*[124] that it had previously observed the "legitimate and even indispensible functions" of the collateral source rule.[125] The *Howell* court, however, determined that its previous ruling did not "consider *how* the collateral source rule would apply to damages for past medical expenses when the amount billed for medical services substantially exceeds the amount accepted in full payment."[126]

The *Howell* court discussed the history of changes and influences on medical costs over the past fifty years.[127] Citing to a 2005 Medicare Payment Advisory Commission study, the court explained how disparities between charges and costs have grown significantly in recent years.[128] The 2005 study discussed the competing influences of competitors, payers, regulators, and customers, concluding that a hospital's charges may not relate systematically to costs.[129] Furthermore, the *Howell* court noted that the rise of managed care organizations has led to increases in prices for the uninsured or those who are not members of a healthcare organization.[130]

To demonstrate this point, the *Howell* court explained that essentially everyone paid the same rates in 1960 because discounts negotiated by managed care were nonexistent.[131] More eloquently put, "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

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122. *Id.* at 391 (citing Garza de Escabedo v. Haygood, 283 S.W.3d 3 (Tex. App. 2009), *aff'd*, 356 S.W.3d 390 (Tex. 2011)).

123. *See* Howell v. Hamilton Meats & Provisions, Inc., 257 P.3d 1130, 1135, 1143 (Cal. 2011).

124. 257 P.3d 1130.

125. *See id.* at 1135 (internal quotation marks omitted) (quoting Helfend v. S. Cal. Rapid Transit Dist., 465 P.2d 61, 69 (Cal. 1970)).

126. *Id.*

127. *See id.* at 1141 (quoting Mark A. Hall & Carl E. Schneider, *Patients as Consumers: Courts, Contracts, and the New Medical Marketplace*, 106 MICH. L. REV. 643, 663 (2008)).

128. *See id.* (quoting ALLEN DOBSON ET AL., A STUDY OF HOSPITAL CHARGE SETTING PRACTICES, at v (2005), *available at* http://www.medpac.gov/publications/contractor_reports/Dec05_Charge_setting.pdf).

129. *See id.* (quoting DOBSON ET AL., *supra* note 128, at v)

130. *Id.* (quoting Hall & Schneider, *supra* note 127, at 663).

131. *See id.* (quoting Hall & Schneider, *supra* note 127, at 663).

would yield truly enormous profits if those prices were actually paid."[132] As this disparity continues to grow, attempting to broadly generalize the relationship between the cost of medical services and the full amount that a provider bills "would be perilous."[133]

In summarizing the difficulty of attaching a value to medical services rendered solely based on a health care provider's bill, the *Howell* court stated that "[g]iven this state of medical economics, how a market value other than that produced by negotiation between the insurer and the provider could be identified is unclear."[134] Therefore, the *Howell* court determined that the collateral source rule does not expand the scope of reasonable economic damages to include unreasonable expenses that a plaintiff has not and will not incur.[135]

Analogous to the court's chief aim of determining the reasonable value of medical services rendered—particularly amid the inconsistent and illogical pricing structure of today—the *Howell* court did note one exception to the rule.[136] The court distinguished donative gifts and discounted payments as a result of negotiations between an insurer and a health care provider.[137] In line with the holding that a plaintiff may only recover amounts paid or incurred—as this more accurately suggests the actual value—the court noted that, when a health care provider gratuitously donates services to a plaintiff, the collateral source rule will apply and the court will not limit the plaintiff's recovery.[138]

### 2. *Law of Damages*

Another area of focus that has shaped jurisdictional approaches to the rate differential in medical costs is the law of damages. For example, the Supreme Court of Wisconsin highlighted the meaning of *damages* and explained that recovery is not for the expenditures actually made or obligations incurred, but rather for the value of the medical services rendered.[139] In *Ellsworth v. Shelbrook*,[140] the court concluded that the collateral source rule barred the defendant from showing that the plaintiff's medical bills were satisfied for

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132. *Id.* at 1142 (quoting Uwe E. Reinhardt, *The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy*, HEALTH AFF., Jan.–Feb. 2006, at 57, 63) (internal quotation marks omitted).

133. *Id.*

134. *See id.*

135. *Id.* at 1133.

136. *See id.* at 1139–40 (citations omitted).

137. *See id.*

138. *See id.* at 1139.

139. *See* Ellsworth v. Shelbrock, 611 N.W.2d 764, 769 (Wis. 2000) (citation omitted) (quoting Rixmann v. Somerset Pub. Sch., St. Croix Cnty., 266 N.W.2d 326, 330–31 (Wis. 1978); McLaughlin v. Chi., Milwaukee, St. Paul & Pac. Ry., Co., 143 N.W.2d 32, 40–41 (Wis. 1966)).

140. 611 N.W.2d 764.

substantially less than what the health care provider charged, as the amount paid was not dispositive of the actual value.[141]

Conversely, the Louisiana Court of Appeals held that medical expenses contractually written off pursuant to the Medicaid program requirements are not recoverable damages.[142] In *Terrell v. Nanda*,[143] the plaintiff's medical bills totaled $1,110,922.82, but Medicaid fully satisfied the plaintiff's bills for $164,084.82.[144] Relying on the collateral source rule, the plaintiff argued that he was entitled to recover the full amount.[145] The *Terrell* court, however, reasoned that the plaintiff never became obligated to satisfy the medical expenses incurred by the health care provider.[146] Further, the court noted that the plaintiff was informed that, as a Medicaid recipient, he would have no responsibility for the bill.[147] The court also explained that the health care provider knew it would receive payment from Medicaid and that the provider was prohibited from billing or accepting payment from the plaintiff.[148] Concluding that recoverable damages require an obligation, the court stated that, "[u]nder these circumstances, the requirements for giving rise to a natural obligation are not met, and no natural obligation exists."[149]

The Hawaii Supreme Court has also discussed the law of damages and noted its concern with creating various new categories of plaintiffs based on their type of insurance, and not on the nature of their injuries, in *Bynum v. Magno*.[150] In his dissent, Justice Moon reasoned that compensatory damages seek to "compensate the injured party for the injury sustained, and nothing more."[151] Because medical expenses are recoverable as compensatory damages, allowing a plaintiff to recover more than an amount the plaintiff is legally obligated to pay would put the plaintiff in a better position than that maintained before the wrong occurred.[152]

The Supreme Court of California also discussed the law of damages in the *Howell* case, holding that a plaintiff may not recover contractually written-off amounts.[153] The court stated that, for a plaintiff's expenses to be recoverable,

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141. *See id.* at 771.

142. *See* Terrell v. Nanda, 759 So. 2d 1026, 1027 (La. Ct. App. 2000).

143. 759 So. 2d 1026.

144. *Id.* at 1028. The original medical bills were written down by $946,838. *Id.* Thus, Medicaid only paid 14.8% of the original bill. *See id.*

145. *Id.*

146. *Id.* at 1030.

147. *Id.*

148. *Id.*

149. *See id.*

150. 101 P.3d 1149, 1162 (Haw. 2004).

151. *Id.* at 1163 (Moon, J., dissenting) (quoting Kuhnert v. Allison, 868 P.2d 457, 462 (Haw. 1994)).

152. *Id.* at 1165.

153. *See* Howell v. Hamilton Meats & Provisions, Inc., 257 P.3d 1130, 1137–38, 1140–41 (Cal. 2011) (citations omitted).

the expenses "must be both incurred *and* reasonable."[154] The court further explained that if a plaintiff negotiates a discount and thereby reduces the costs incurred, the plaintiff cannot recover damages for the greater amount, as "the plaintiff has not suffered a pecuniary loss or other detriment in the greater amount."[155] According to the *Howell* court:

> While the measure of recovery for the costs of services a third party renders is ordinarily the reasonable value of those services, "[*i*]*f* . . . *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."[156]

### 3. *The Plaintiff Never Incurred the Greater Expense*

Along with the previously discussed analytic frameworks, some jurisdictions give deference to the fact that the plaintiff never actually incurred the substantially higher expense.[157] In *Howell*, the Supreme Court of California also noted that when the plaintiff actually received the medical bill, her health care provider had already agreed to the substantially lower price with the insurer.[158] Accordingly, "Having never incurred the full bill, [the] plaintiff could not recover it in damages for economic loss. For this reason alone, the collateral source rule would be inapplicable."[159]

Returning to *Goble v. Frohman*[160]—a case that the South Carolina Supreme Court cited in *Covington v. George*[161]—Justice Bell of the Florida Supreme Court, in a concurring opinion, noted that the pre-discount amount of the plaintiff's medical bills "lies wholly outside the question of 'collateral sources' either as defined by statute or at common law."[162] Justice Bell further reasoned that, because the plaintiff never paid the full medical bill and was not obligated to pay it, he could not recover any amount greater than that which he was obligated to pay.[163]

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154. *Id.* at 1138 (citing CAL. CIV. CODE § 3359 (West 1997)).

155. *Id.* (citing CAL. CIV. CODE §§ 3281, 3282 (West 1997)).

156. *Id.* (quoting RESTATEMENT (SECOND) OF TORTS § 911 cmt. h (1979)).

157. *See, e.g.*, *id.* at 1143 (concluding that a plaintiff could not recover the full bill in damages for economic loss and that the collateral source rule did not apply solely because the plaintiff never incurred the expense of the full bill).

158. *See id.*

159. *Id.*

160. 901 So. 2d 830 (Fla. 2005).

161. 359 S.C. 100, 104–05, 597 S.E.2d 142, 144 (2004) (citing Goble v. Frohman, 848 So. 2d 406, 409 (Fla. Dist. Ct. App. 2003)).

162. *Goble*, 901 So. 2d at 833 (Bell, J., concurring).

163. *Id.*

Conversely, some courts, such as the Supreme Court of North Carolina, permit plaintiffs to recover the amount of gratuitous government benefits,[164] despite other courts acknowledging that such plaintiffs were never obligated to pay for the gratuities provided by Medicaid.[165] In *Cates v. Wilson*,[166] the court reasoned that the difference between the full bill and the amount actually paid inherently created a windfall and "as between defendants who tortiously inflict injury and innocent taxpayers who fund programs such as Medicaid, we think it better that the loss fall on the tortfeasor."[167]

Other jurisdictions disagree with the rationale that because a windfall is unavoidable, it must be better for the plaintiff to receive the windfall.[168] In *Wills v. Foster*,[169] the Supreme Court of Illinois reasoned that the purpose of compensatory damages is not to punish defendants or bestow a windfall upon plaintiffs.[170] Further, the idea that the plaintiff should enjoy any windfall that may result "borders too closely on approval of unwarranted punitive damages."[171]

## V. THE CURRENT APPROACH IN SOUTH CAROLINA NEEDS CHANGE

In South Carolina, a plaintiff may recover a substantially higher amount in compensatory damages than what was actually paid to fully satisfy the billed amount.[172] In looking at how different jurisdictions have approached compensatory damages for plaintiffs, the issue of whether to allow a defendant to contest the reasonableness of the billed amount is overshadowed by the question of whether the billed amount is even an accurate indication of the value itself.[173]

The collateral source rule does serve a purpose and provides several benefits. Society clearly benefits from encouraging all citizens to procure

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164. *See, e.g.*, Cates v. Wilson, 361 S.E.2d 734, 739 (N.C. 1987).

165. *See, e.g.*, Terrell v. Nanda, 759 So. 2d 1026, 1031 (La. Ct. App. 2000) ("[W]e now hold that a plaintiff may not recover as damages that portion of medical expenses 'contractually adjusted' or 'written-off' by a healthcare provider pursuant to the requirements of the Medicaid program. Such expenses are not damages incurred by the injured plaintiff and are not subject to recovery by application of the 'collateral source' rule.").

166. 361 S.E.2d 734.

167. *See id.* at 739. This quote from the North Carolina Supreme Court seems to imply that the defendant is not a taxpayer.

168. *See, e.g.*, Wills v. Foster, 892 N.E.2d 1018, 1022 (Ill. 2008) (citing Wills v. Foster, 867 N.E.2d 1223, 1226 (Ill. App. Ct. 2007), *rev'd*, 892 N.E.2d 1018 (Ill. 2008)) (concluding that the collateral source rule prevents double recovery because a right of subrogation or a lien typically exists).

169. 892 N.E.2d 1018.

170. *Id.* at 1023 (citing RESTATEMENT (SECOND) OF TORTS § 903 cmt. a (1979)).

171. *Id.* (quoting Peterson v. Lou Bachrodt Chevrolet Co., 392 N.E.2d 1, 5 (Ill. 1979), *overruled by Wills*, 892 N.E.2d at 1031).

172. *See supra* notes 59–61, 67–69 and accompanying text.

173. *See supra* notes 81–108 and accompanying text.

insurance and be good stewards of their potential economic impact on others through tortious behavior.[174] Ensuring that plaintiffs receive the benefit of their decision to purchase and maintain insurance is also beneficial to society.[175]

However, the logical conclusions about the collateral source rule stop here. The argument that it is better to allow the plaintiff to receive a windfall because a windfall will inherently occur[176] completely lacks merit. As the *Bynum* dissent aptly explained, allowing a plaintiff to only recover the amount paid directly to satisfy the amount billed avoids a windfall to *either party*.[177] In essence, states do not have to create a windfall in compensatory damages. Furthermore, if the goal of compensatory damages is to put an injured party in the place that party was in prior to the wrongdoing, how can this be justified if the party receives far more than the exact amount paid to satisfy the medical bill?

Under the logic that "but for" the insurance payment, the plaintiff would be responsible for the bill, one can easily rationalize that the plaintiff should be obligated to pay the same amount as the insurance payment. Adhering to this logic, a plaintiff would require reimbursement simply for the amount that a health care provider receives to discharge the bill.

Moreover, the plaintiff should bear the burden of pleading all damages accurately by including loss of earning power, future medical costs, and even punitive damages. The plaintiff should account for the specific purposes of these particular damages. The focus must be on looking at damages categorically and allowing a jury to award these amounts based on the current application of the law of damages.

In light of recent hyperinflation of medical costs and the ever-evolving changes in the health care industry, how can South Carolina courts utilize a health care provider's excessively inflated list price to standardize the amount a jury will review in determining compensatory damages?[178] As the *Howell* court noted, it seems that professionals in the health insurance industry are in the strongest position to determine and negotiate the actual value of medical services rendered.[179] By simply looking at the undue influences that push health care providers to continue raising their list prices for the sole purpose of also raising the negotiated values they will undoubtedly receive from insurance companies, a prudent and reasonable person would clearly discard the list price from the analysis of what seems fair.

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174. *See supra* Part II.B.

175. *See supra* notes 24–27 and accompanying text.

176. *See* Cates v. Wilson, 361 S.E.2d 734, 739 (N.C. 1987).

177. *See* Bynum v. Magno, 101 P.3d 1149, 1167 (Haw. 2004) (Moon, J., dissenting).

178. *See supra* notes 109–14, 123–29 and accompanying text.

179. *See* Howell v. Hamilton Meats & Provisions, Inc., 257 P.3d 1130, 1142 (Cal. 2011) ("Patients individually suffer inherent disadvantages that significantly impede negotiating prices with medical care providers: difficulty in gathering information, lack of choice and bargaining power, and possible physical and emotional disabilities relating to the injury or illness.").

With many jurisdictions attempting to address the issues of rising costs in insurance premiums, litigation, and health care, it seems that these jurisdictions have identified a problem in the economics of the health care industry.[180] Because the potential economic effects of the health care industry are similar in most jurisdictions, these jurisdictions have effectively identified a cause-and-effect relationship between the net costs of insurance and litigation. As insurers calculate their risk pools based on potential payouts over a set term, these insurers are, in turn, obligated to collect premiums from all customers such that they are able to meet their payout obligations.[181]

It does not require a complex analysis to realize that, if a potential payout is eight times greater in one particular state compared to another, then an insurer will need to collect significantly higher premiums to meet its potential payment obligations from the risk pool of people residing in the state with higher payouts. Furthermore, it is certainly foreseeable that the risk of potentially higher payouts could discourage some insurers from doing business in a particular state. Courts must realize the error in assigning the title *reasonable* to a grossly inflated medical service bill.

To right this ship, South Carolina has two different options to choose from. First, the state supreme court can revive *Haselden* and allow a jury to determine the reasonable value of medical services rendered by viewing both the full bill and the amount actually paid. Second, similar to Florida and many other jurisdictions, the South Carolina General Assembly can elect to enact legislation that creates statutory exemptions to the collateral source rule.

### *A. Enforce the Restatement Approach—Revive* Haselden

While some jurisdictions, like Texas and Pennsylvania, have determined that the reasonable amount of payment for medical services is the actual amount paid to fully satisfy the medical bill,[182] other jurisdictions, such as Hawaii and Tennessee, have determined that the reasonable amount is the amount originally billed.[183] Both approaches prevent the parties from submitting evidence contrary to the prevailing view in the jurisdiction.[184] In *Haselden*, however, the court specifically noted that both amounts were certainly helpful in determining the reasonable value.[185]

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180. *See supra* notes 81–92 and accompanying text.

181. *See* 5 STEVEN PITT ET AL., COUCH ON INSURANCE 3D § 69.7 (3d ed. 2005) (citations omitted).

182. *See supra* notes 81–92 and accompanying text.

183. *See supra* notes 93–99 and accompanying text.

184. *See, e.g.*, Bynum v. Magno, 101 P.2d 1149, 1162 (Haw. 2004) (quoting Pryor v. Webber, 263 N.E.2d 235, 239 (Ohio 1970)) (holding that collateral payments should not be admitted into evidence).

185. Haselden v. Davis, 353 S.C. 481, 484, 579 S.E.2d 293, 295 (2003) (citation omitted) (citing Kashner v. Geisinger Clinic, 638 A.2d 980, 983 (Pa. 1994)) ("Among those factors to be

Likewise, in *Robinson v. Bates*,[186] the Supreme Court of Ohio determined that the correct approach is to allow the jury to see both the amount billed and the amount paid.[187] The *Robinson* court—ruling that the collateral source rule does not apply to write-offs in medical billing—reasoned that the fairest approach is to hold the defendant responsible for the reasonable value of the medical costs the plaintiff incurred.[188] The court noted the difficulties in determining what *reasonable* means due to the complexities of today's insurance and reimbursement system and held that both the original medical bill and the amount accepted as full payment were admissible.[189] Further, the court stated that "[t]he jury may decide that the reasonable value of medical care is the amount originally billed, the amount . . . accepted as payment, or some amount in between."[190]

Therefore, in keeping with the spirit of allowing a plaintiff to recover the reasonable and necessary amounts of medical services rendered, it only makes sense to allow jurors to view all helpful evidence that would assist them in arriving at this value. More importantly, this approach places the burden on both parties to convince the jurors of the actual fair and reasonable value.[191]

Moreover, the collateral source rule prohibits defendants from introducing evidence of a collateral benefit—a benefit conferred upon the plaintiff that is wholly independent of the defendant.[192] Some jurisdictions have argued that a plaintiff should be entitled to the benefit of the bargain and have noted the burden on taxpayers in cases in which the plaintiff is a Medicaid recipient.[193] However, the rationale linking taxpayers to plaintiffs who receive Medicaid is just as applicable to taxpaying defendants: If a defendant pays taxes and contributes to the Medicaid system, should this not mean that the benefit is no longer "wholly independent" of that person? Applying this logic, the collateral source rule would not even be implicated.[194]

In sum, if the goal is to allow the plaintiff to recover the reasonable and necessary value of the medical costs incurred, it seems only logical to allow a jury to view all available information and obtain the "big picture" of the health

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considered by the jury are the amount billed to the plaintiff, and the relative market value of those services.").

186. 857 N.E.2d 1195 (Ohio 2006).

187. *Id.* at 1200.

188. *Id.*

189. *Id.*

190. *Id.*

191. *See, e.g.*, *id.* (allowing the introduction of evidence of both the amount billed and the amount paid, which left the determination of reasonableness in the hands of the jury after hearing the parties' arguments on damages).

192. *See* RESTATEMENT (SECOND) OF TORTS § 920A cmt. b (1979).

193. *See, e.g.*, Cates v. Wilson, 361 S.E.2d 734, 739 (N.C. 1987) (concluding that, "as between defendants who tortiously inflict injury and innocent taxpayers who fund programs such as Medicaid, we think it better that the loss fall on the tortfeasor").

194. *Cf.* RESTATEMENT (SECOND) OF TORTS § 920A cmt. b (1979) (noting that the collateral source rule requires that the benefit "not come from the defendant or a person acting for him").

care industry's economic system. Allowing a jury to see both the full amount and the amount actually paid would negate any opposing arguments involving unjust enrichment or insufficient plaintiff compensation, as well as any arguments against the creation of multiple classes of plaintiffs.

### *B. Statutory Exception*

As previously discussed, some jurisdictions—such as Florida—have created specific statutory exceptions to the collateral source rule.[195] These jurisdictions have created exceptions as a mechanism to limit the rising costs of health insurance, expensive litigation, and the hyperinflation of health care costs.[196] South Carolina would stand to benefit in the same ways as these jurisdictions. Although courts in some jurisdictions have determined that it is improper to allow the court system to create multiple classes of plaintiffs based on their insurance coverage type,[197] this position lacks common sense. As the *Howell* court explained, some element of fortuity regarding the pre-negotiation prices for services exists among different health care providers, insurers, and the uninsured.[198] Furthermore, "identical injuries may have different economic effects on different victims."[199] In *Howell*, the court opined that it should not order one defendant to pay damages for a loss the plaintiff never incurred merely because a different defendant may have to compensate a different plaintiff who did suffer that loss in a completely separate matter.[200]

Likewise, in *Robinson*, the Supreme Court of Ohio stated that "[i]t may well be that the collateral source rule itself is out of sync with today's economic realities of managed care and insurance reimbursement for medical expenses."[201] The *Robinson* court followed this description of the collateral source rule by then seemingly encouraging the General Assembly of Ohio to craft legislation to address this problem.[202]

Creating a narrow statutory exception specifically tailored to the element of compensatory damages in health care costs is certainly in line with the purpose of compensatory damages, which is to put the injured party in the identical position that the party was in prior to the wrongdoing.[203] In a marketplace in which health care costs vary greatly for identical services, adhering to this

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195. *See* FLA. STAT. ANN. § 768.76 (West 2011).

196. *See supra* notes 81–85 and accompanying text.

197. *See, e.g.*, Bynum v. Magno, 101 P.3d 1149, 1162 (Haw. 2004) (explaining that creating multiple categories of plaintiffs would improperly focus on the type of insurance coverage instead of the nature of the injuries); Robinson v. Bates, 857 N.E.2d 1195, 1200 (Ohio 2006) (declining to adopt a categorical rule to avoid creating varying categories of plaintiffs).

198. *See* Howell v. Hamilton Meats & Provisions, Inc., 257 P.3d 1130, 1145 (Cal. 2011).

199. *Id.*

200. *Id.* (citing CAL. CIV. CODE §§ 3281, 3282 (West 1997)).

201. *Robinson*, 857 N.E.2d at 1201.

202. *See id.*

203. *See* RESTATEMENT (SECOND) OF TORTS § 903 cmt. a (1979).

purpose may be the only way to synthesize the true value without limiting the value to the amount that was paid to fully satisfy the medical bill.

## VI. CONCLUSION

When determining compensatory damages for health care costs, the collateral source rule should not apply to limit a defendant from presenting evidence of what a medical care provider actually received as full payment. In the context of recent hyperinflation, as well as the complexities of the current health care pricing and insurance reimbursement systems, the amount that a health care provider coins as its *full* or *list* price is not the true indicator of the value.[204] To fulfill the goal of compensatory damages, South Carolina must follow the spirit of the law and seek to place an injured party in the same position that person was in before the wrong occurred—not in a position that is substantially greater.

Through reviving *Haselden*, South Carolina courts can better assist juries in determining the reasonable value of medical services rendered. Allowing a jury to view all available evidence will better empower the jury to arrive at a fair value. Another alternative is for South Carolina to create a statutory exception to the collateral source rule. This exception must address the fallacy that exists in determining a health care provider's full price as the true value of medical services rendered. Legislation creating an exception to the collateral source rule would ensure that fairness is achieved in civil litigation, while helping control the negative effects of hyperinflation of medical costs, rapid increases in insurance premiums, and expensive litigation.

*Todd R. Lyle*

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204. *See Robinson*, 857 N.E.2d at 1200; Nation, *supra* note 109, at 104.

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