

## Who's Swallowing the "Bitter Pill"?: Reforming Write-Offs in the State of Washington

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### I. INTRODUCTION

Washington's application of the collateral source rule permits recovery for medical expenses that were never incurred and have no relationship to their market value. This application is set forth in *Hayes v. Wieber Enterprises, Inc.*, where the plaintiff sued a restaurant for injuries she sustained from falling down the restaurant's basement stairs.<sup>1</sup> At trial, the plaintiff introduced evidence that her physician billed \$5,800 for medical services even though he had accepted \$3,300 from her health insurer as payment in full.<sup>2</sup> The trial court refused to admit evidence that her physician had accepted \$3,300 as payment in full because the \$3,300 was from a collateral source.<sup>3</sup> Accordingly, the plaintiff was allowed to recover the \$1,500 "written off" by her physician.

The court of appeals affirmed, holding the trial court did not abuse its discretion when it refused to admit evidence the physician had accepted \$3,300 as payment in full.<sup>4</sup> The court, however, did not address whether evidence the physician had accepted the \$3,300 as payment in full was barred by the collateral source rule.<sup>5</sup> Instead, the court relied on the physician's testimony that his \$5,800 bill was reasonable and that the defendant did not present testimony the bill was unreasonable.<sup>6</sup> The appellate court, therefore, having decided the case on an evidentiary issue, did not disturb the trial court's application of the collateral source rule.

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1. *Hayes v. Wieber Enterprises, Inc.*, 20 P.3d 496 (Wash. Ct. App. 2001).

2. *Id.* at 498.

3. *Id.*

4. *Id.*

5. *Id.* at 499.

6. *Id.*

The collateral source rule is set forth in the Restatement Second of Torts: “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.”<sup>7</sup> The collateral source rule is also set forth in the Washington Practice Series (WAPRAC) § 6.35: “Under the collateral source rule, a tortfeasor may not reduce damages, otherwise recoverable, to reflect payments received by a plaintiff from a collateral source. A collateral source is a source independent of one of the tortfeasors.”<sup>8</sup> WAPRAC notes the majority of cases applying the collateral source rule in Washington are cases in which the collateral payment consisted of Medicare benefits; social security and veterans’ pension benefits; disability pension benefits; workers’ compensation benefits; unemployment compensation benefits; or where a plaintiff received payments from his insurer covered all or part of the loss.<sup>9</sup>

The reasoning behind the collateral source rule is to ensure justice and deterrence. When a tortfeasor is not obliged to correct the wrong she caused, then the victim never receives what is due from the tortfeasor—justice. The collateral source rule, therefore, ensures that a tortfeasor fully pays for the damages he commits. The collateral source rule is also necessary to preserve the deterrence function of tort law by not allowing a tortfeasor to avoid liability because a plaintiff had the foresight to purchase insurance. Whether because of justice or deterrence, at common law the collateral source rule makes certain that a jury will not reduce a plaintiff’s award because he received compensation from a third party.

Why should the collateral source rule compel the defendant in *Hayes* to pay the original amount billed, \$5,800, when the physician accepted \$3,300 as payment in full? Is not \$3,300 the reasonable or market value of the medical services provided to the plaintiff? This Comment discusses whether Washington should amend its application of the collateral source rule to disallow the recovery of write-offs and whether the amount accepted as payment in full by a medical provider is the reasonable or market value of the services provided. Part II of this Comment explores the collateral source rule and the development of the “reasonable and necessary” requirement in Washington. Part III discusses the impact of the California Supreme Court’s recent decision in *Howell v. Hamilton Meats & Provisions, Inc.* and its progeny.<sup>10</sup> Part IV explores the resurgence of tort reform throughout the country while providing an

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

8. 16 WASH. PRAC., TORT LAW AND PRACTICE § 6:35 (3d ed).

9. *Id.*

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

assessment of other state court rulings on write-offs including the issues of subrogation and contractual agreements. Part V concludes with why Washington should revisit the issues raised in *Hayes v. Wieber Enterprises, Inc.* and no longer permit the amount written off to be inadmissible under the collateral source rule.

## II. THE COLLATERAL SOURCE RULE AND THE DEVELOPMENT OF “REASONABLE AND NECESSARY” IN WASHINGTON

A 1913 civil suit involving injuries sustained by a police officer is the earliest Washington State case that discusses the collateral source rule.<sup>11</sup> In *Heath v. Seattle Taxicab Co.*, the plaintiff police officer witnessed a cab driving south on Fremont Avenue at a high speed.<sup>12</sup> When the cab was within about seventy-five feet of him, the officer stepped in the street on Fremont Avenue and signaled to the cab to stop, intending to arrest the driver.<sup>13</sup> Instead of stopping, the driver of the cab increased its speed, hitting the plaintiff.<sup>14</sup> The evidence showed that the police officer suffered a partial dislocation of the right shoulder, an injury to the right knee, and that his back was severely bruised.<sup>15</sup>

Prior to the accident, the police officer had contributed 1.5% of his monthly income to the police pension fund provided by the Police Pension Act.<sup>16</sup> The taxicab company argued that the trial court erred by refusing to give the following instruction:

[I]f you believe from the evidence that the plaintiff was reimbursed from his lost wages out of the police pension fund of the city of Seattle and was reimbursed, wholly or in part, for his hospital and medical bills, then the plaintiff is not entitled to recover the sums for which he has been reimbursed out of said fund, and you shall allow plaintiff only such sums as he actually lost by reason of loss of time and wages and hospital and medical services.<sup>17</sup>

The Washington State Supreme Court held there was no error in this refusal.<sup>18</sup>

The *Heath* court explained that the pension fund was no different in principle from ordinary accident insurance where a person is reimbursed

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11. *Heath v. Seattle Taxicab Co.*, 131 P. 843 (Wash. 1913).

12. *Id.* at 844.

13. *Id.*

14. *Id.*

15. *Id.* at 847.

16. *Id.* at 846.

17. *Id.*

18. *Id.* at 187.

by an insurance company.<sup>19</sup> A person reimbursed by an insurance company for his loss of time and expenses caused by his injury is not precluded from maintaining an action for those same items against the person who caused the injury.<sup>20</sup> The court stated that it would be

contrary to public policy and shocking to the sense of justice to hold that the proceeds of insurance paid for by the injured person for his benefit . . . should inure to the benefit of and grant immunity to the person whose negligence, willful or otherwise, injured him or caused his death.<sup>21</sup>

This rule was reaffirmed in *Engstrom v. City of Seattle*, where city employee Mr. Oscar Engstrom was injured while working on the streets and sewer system.<sup>22</sup> His injury was caused by the negligence of the Puget Sound Electric Railway Company.<sup>23</sup> Due to his injury, Mr. Engstrom was incapacitated for a period of thirteen months and subsequently recovered \$4,000 from the railway company on the account of his injuries and for loss of time.<sup>24</sup> However, article 16, § 32 of the Seattle City Charter contained a provision that stated, “Any person in the service of the city under civil service appointment who shall be disabled in the discharge of his duties, shall receive full pay during such disability not to exceed thirty days, and half pay not to exceed six months . . . .”<sup>25</sup> Mr. Engstrom consequently brought an action against the city to recover the \$288 due from the charter provision.<sup>26</sup> The Washington State Supreme Court reversed the lower court’s opinion relying on the arguments set forth in *Heath*.<sup>27</sup> The court held that even though Mr. Engstrom collected damages from the railway company, it did not relieve the city from reimbursing Mr. Engstrom for his injuries or complying with its employment contract.<sup>28</sup>

The collateral source rule was also applied in *Stone v. City of Seattle*, where the plaintiff was injured when he fell into a hole on a public sidewalk in front of an apartment building.<sup>29</sup> The plaintiff brought an action against the city and the owner of the apartment complex for negli-

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19. *Id.* at 186.

20. *Id.*

21. *Id.*

22. *Engstrom v. City of Seattle*, 159 P. 816 (Wash. 1916).

23. *Id.*

24. *Id.*

25. *Id.*

26. *Id.*

27. *Id.* at 817.

28. *Id.*

29. *Stone v. City of Seattle*, 391 P.2d 179, 180 (Wash. 1964).

gently failing to maintain the sidewalk.<sup>30</sup> The trial court's instructions to the jury mentioned that the plaintiff was collecting social security benefits at the time of the accident, and on review, the Washington State Supreme Court stated,

It is well established that the fact a plaintiff receives, from a collateral source, payments of this nature which have a tendency to mitigate the consequences of the injury that he otherwise would have suffered, may not be taken into consideration when assessing the damages that the defendant must pay.<sup>31</sup>

The Washington State Supreme Court reversed because of the trial court's error with the jury instructions, stating that the social security benefits should have had no bearing on the jury deliberation.<sup>32</sup>

In *Ciminski v. SCI Corp.*, the plaintiff fell in the defendant's restaurant and sustained severe hip injuries.<sup>33</sup> The jury returned a verdict of \$79,000, which included \$14,000 paid by Medicare under the plaintiff's Part A coverage.<sup>34</sup> The defendant moved to reduce the verdict by the amount paid by Medicare, but the trial court denied the motion on the grounds that the payments were from a collateral source.<sup>35</sup> The defendant appealed the denial and the Washington State Supreme Court granted review.<sup>36</sup> The appellant argued that the collateral source rule applies only to benefits that the plaintiff "has previously extended consideration," such as health insurance.<sup>37</sup> The appellant contended that because the respondent's wages were not taxed to finance Medicare, she did not pay for the Part A coverage, but the appellant was compelled to pay taxes for Medicare and thus should not have to pay twice.<sup>38</sup> The Washington State Supreme Court did not agree and held that the "application of the collateral source rule need not be conditioned on some payment by the plaintiff for the benefit received. To so limit the doctrine would be contrary to the policy that the wrongdoer should not benefit from collateral payments made to the person he has wronged."<sup>39</sup>

There are a few exceptions to the collateral source rule in Washington. First, the collateral source rule does not apply to sources of compen-

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30. *Id.*

31. *Id.* at 183.

32. *Id.*

33. *Ciminski v. SCI Corp.*, 585 P.2d 1182 (Wash. 1978).

34. *Id.*

35. *Id.*

36. *Id.*

37. *Id.* at 1183.

38. *Id.*

39. *Id.*

sation that are not independent of the tortfeasor.<sup>40</sup> In *Maziarski v. Bair*, for example, the plaintiff was riding his bicycle when a car driven by the defendant struck him.<sup>41</sup> At the time of the accident, the defendant was insured by the Hartford Insurance Company, and her policy provided both liability coverage and Personal Injury Protection (PIP) coverage.<sup>42</sup> The plaintiff incurred medical bills in the amount of \$7,753, which Hartford fully paid under the PIP coverage before any determination of fault had been made.<sup>43</sup> The collateral source rule did not apply because the payments at issue came from the defendant's PIP coverage, which was a fund she created and thus not a collateral source.<sup>44</sup>

Second, the collateral source rule does not apply if the compensation is for a different injury.<sup>45</sup> In *Wheeler v. Catholic Archdiocese of Seattle*, the plaintiff started to have problems with her supervisor in April 1984.<sup>46</sup> Then in May 1984, the plaintiff injured her hand while working and took a three-month leave to recuperate.<sup>47</sup> The plaintiff spent three weeks of her three-month leave in an inpatient treatment facility after attempting suicide because of her health and problems at work.<sup>48</sup> The plaintiff subsequently took additional leave for surgeries to repair her hand.<sup>49</sup> During these absences, the plaintiff received workers' compensation benefits.<sup>50</sup> After the plaintiff's job was filled while she was on leave for her second surgery, the plaintiff sued her employer for handicap discrimination, among other claims.<sup>51</sup> In a pretrial ruling, the trial court ruled the employer was not entitled to an offset of the plaintiff's workers' compensation benefits.<sup>52</sup> The jury returned a general verdict of \$150,000.<sup>53</sup> On appeal, the court of appeals held that the trial court erred in refusing to offset the plaintiff's damages award by the amount of her workers' compensation benefits representing replacement for lost wages.<sup>54</sup> The Washington State Supreme Court affirmed because the collat-

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40. *Maziarski v. Bair*, 924 P.2d 409 (Wash. Ct. App. 1996).

41. *Id.* at 410.

42. *Id.* at 411.

43. *Id.*

44. *Id.* at 413.

45. *Wheeler v. Catholic Archdiocese of Seattle*, 880 P.2d 29 (Wash. 1994).

46. *Id.* at 30.

47. *Id.*

48. *Id.*

49. *Id.*

50. *Id.*

51. *Id.* at 30-31.

52. *Id.* at 31.

53. *Id.*

54. *Id.*

eral source rule had no application where the plaintiff was compensated for two different injuries.<sup>55</sup>

While the collateral source rule precludes a defendant from introducing evidence that a plaintiff has already been compensated for her injuries, a defendant is only liable for the reasonable value of the medical services received by a plaintiff, even if the bills for the medical services have been paid in full.<sup>56</sup> A plaintiff's burden to prove the reasonable value of medical services was set forth in *Torgeson v. Hanford*, where the Washington State Supreme Court held that the trial court erred when it submitted the plaintiff's claims for medical services and hospital fees to the jury without evidence of their reasonable value.<sup>57</sup> The court stated,

One who is injured as the plaintiff claims to have been, if entitled to recover against the party charged with the negligence which caused the injury, is entitled to judgment for his expenses necessarily incurred in the treatment of the injuries sustained by him, but he cannot recover what he may agree to pay the physician for his services, because the other party is not bound by such agreement. Under such circumstances the injured party must prove what would be reasonable compensation to the physician for the services rendered, and would be entitled to recover that amount if he had paid or was liable to pay the same.<sup>58</sup>

A plaintiff's burden to prove the reasonable value of medical services was affirmed in *Patterson v. Horton*, where the Washington Court of Appeals concluded that the trial court erred in relying on medical bills as proof of medical costs without requiring the plaintiff to show that the bills were reasonable and that the treatment was necessary.<sup>59</sup> The trial court adopted the plaintiff's argument that payment of the bills created a presumption that they were reasonable and necessary.<sup>60</sup> The court of appeals, however, ruled that medical records and bills are relevant to prove past medical expenses only if supported by additional evidence that the treatment and bills were both necessary and reasonable.<sup>61</sup> The Washington Pattern Instructions further explain that plaintiffs in negligence cases are permitted to recover the reasonable value of the medical services they receive—not the total of all bills paid.<sup>62</sup> The amount actually billed or

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55. *Id.* at 32.

56. See *Torgeson v. Hanford*, 139 P. 648 (Wash. 1914); *Patterson v. Horton*, 929 P.2d 1125 (Wash. Ct. App. 1997).

57. *Torgeson*, 139 P. at 649.

58. *Id.* (quoting *Wheeler v. Tyler S. E. R. Co.*, 43 S.W. 876, 877 (Tex. Sup. Ct. 1898)).

59. *Patterson v. Horton*, 929 P.2d 1125, 1127 (Wash. Ct. App. 1997).

60. *Id.* at 1130.

61. *Id.*

62. 6 WASH. PRAC., WASH. PATTERN JURY INSTR. CIV. WPI 30.07.01 (6th ed.).

paid is not determinative; rather, the question is whether the sums requested for medical services are reasonable.<sup>63</sup>

The formation of the collateral source rule and the requirement that medical bills must be reasonable and necessary culminated in *Hayes v. Wieber Enterprises, Inc.* In *Hayes*, the plaintiff's physician billed the plaintiff approximately \$5,800 for medical services<sup>64</sup> and testified at trial that the bill was reasonable.<sup>65</sup> The plaintiff's physician, however, had accepted approximately \$3,300 from the plaintiff's health insurer as payment in full.<sup>66</sup> At trial, the defendant sought to question the plaintiff's physician on the difference between the amount he accepted as payment for his services and the amount he billed for these same services.<sup>67</sup> The trial court concluded the difference was a collateral source and refused the offered proof on the difference between the amount accepted and the amount billed.<sup>68</sup>

On appeal, the defendant argued that the \$3,300 was the appropriate evidence of the market value of the medical care received by the plaintiff.<sup>69</sup> The defendant also argued that the collateral source rule only applied to actual amounts paid on the plaintiff's behalf.<sup>70</sup> The court of appeals did not explicitly address the defendant's arguments; instead, the court focused on whether the amount requested by the plaintiff was reasonable: "Plaintiffs in negligence cases are permitted to recover the reasonable value of the medical services they receive, not the total of all bills paid. And the amount actually billed or paid is not itself determinative. The question is whether the sums requested for medical services are reasonable."<sup>71</sup>

The court's focus on reasonableness led to the crux of its opinion:

Wieber could have challenged the reasonableness of Ms. Hayes' medical bills by presenting testimony that the charges were unreasonable. The fact that the doctor accepted the first party insurance carrier's limit for his services does not tend to prove his charge for these services was unreasonable. Dr. Oakley testified the bill was reasonable. Wieber presented no evidence to the contrary. The trial judge did not abuse his discretion by refusing to admit evidence that

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63. *Id.*

64. *Hayes v. Wieber Enterprises, Inc.*, 20 P.3d 496, 498 (Wash. Ct. App. 2001).

65. *Id.* at 499.

66. *Id.* at 498.

67. *Id.*

68. *Id.*

69. *Id.*

70. *Id.* at 498–99.

71. *Id.* at 499.



Ms. Hayes' physician accepted what her insurance company paid, as payment in full.<sup>72</sup>

The court's decision, in short, rested on the defendant not calling an expert witness to testify that the plaintiff's physician's bill was unreasonable. Given the plaintiff's physician's full bill was approximately \$5,800 and he accepted approximately \$3,300 from the plaintiff's health insurer as payment in full—a difference of only \$1,500—it should come as no surprise that the defendant did not hire an expert witness to testify on this issue. Nevertheless, the trial court ruled that the collateral source rule disallowed testimony of the discrepancy between the amount the plaintiff's physician billed and the amount he actually accepted as payment in full.<sup>73</sup> If the defendant had retained an expert witness to testify that the \$3,300 accepted from the plaintiff's health insurer as payment in full was the reasonable or market value of the services provided by the plaintiff's physician, is such testimony barred by the collateral source rule? The California Supreme Court's recent decision in *Howell v. Hamilton Meats & Provisions, Inc.* provides a jurisprudential blueprint for how Washington could amend its application of the collateral source rule.

### III. THE IMPACT OF *HOWELL V. HAMILTON MEATS & PROVISIONS, INC.*

In *Howell*, the plaintiff was seriously injured in an automobile accident negligently caused by a driver who was working for the defendant.<sup>74</sup> At trial, the defendant conceded liability and the necessity of the plaintiff's medical treatment, only contesting the amounts of the plaintiff's economic and noneconomic damages.<sup>75</sup>

The defendant moved to exclude evidence of medical bills that neither the plaintiff nor her health insurer, PacifiCare, had paid.<sup>76</sup> The defendant's motion was based on PacifiCare records, which indicated the plaintiff's medical bills had been adjusted downward pursuant to an agreement between the medical providers and PacifiCare.<sup>77</sup> The agreement also provided that the plaintiff could not be billed for the balance of the original bills beyond agreed-upon patient co-payments.<sup>78</sup> The trial court denied the motion, ruling that the plaintiff could present her full

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72. *Id.*

73. *Id.*

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

75. *Id.* at 1133.

76. *Id.*

77. *Id.* at 1133–34.

78. *Id.* at 1134.

bills to the jury and any reduction to reflect payment of reduced amounts in a post-trial motion.<sup>79</sup>

The plaintiff presented testimony that the total amount billed for her medical care up to the time of trial was \$189,978, and the jury returned a verdict awarding the same amount as damages for the plaintiff's past medical expenses.<sup>80</sup> The defendant then made a post-trial motion to reduce past medical damages, pursuant to *Hanif v. Housing Authority of Yolo County*,<sup>81</sup> seeking a reduction of \$130,286—the amount assertedly written off by the plaintiff's medical care providers.<sup>82</sup> The defendant's motion was supported by two declarations that stated the difference between the amount billed by the plaintiff's medical providers and the amount accepted by them as payment in full was written off pursuant to an agreement between them and the plaintiff's private healthcare insurer, PacifiCare.<sup>83</sup> Both declarations stated that the providers had not filed liens for, and would not pursue collection of, the written-off amounts.<sup>84</sup>

In opposition, the plaintiff argued that the reduction of the medical damages would violate the collateral source rule.<sup>85</sup> The plaintiff supported her opposition with patient agreements she had signed agreeing to pay "usual and customary charges" and any physician's fee her insurance did not pay.<sup>86</sup> The trial court granted the defendant's motion, reducing past medical damages to reflect the amount medical providers accepted as payment in full.<sup>87</sup> The California Court of Appeals reversed the reduction order, holding that it violated the collateral source rule.<sup>88</sup> The California Supreme Court reversed the judgment of the court of appeals, holding that an injured person could not recover the amount of a medical provider's bill when the provider accepted as full payment, pursuant to a preexisting contract with the injured person's health insurer, an amount less than the provider's bill.<sup>89</sup> The court ruled that the collateral source rule had no bearing because the differential between the amount billed and the amount accepted as full payment were not damages the plaintiff would have otherwise collected from the defendant.<sup>90</sup>

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79. *Id.*

80. *Id.*

81. *Hanif v. Hous. Auth.*, 246 Cal. Rptr. 192 (Cal. Ct. App. 1988).

82. *Howell*, 257 P.3d at 1134.

83. *Id.*

84. *Id.*

85. *Id.*

86. *Id.*

87. *Id.*

88. *Id.*

89. *Id.* at 1133.

90. *Id.*

The *Howell* court began its analysis with an earlier California appellate court case, *Hanif v. Housing Authority*.<sup>91</sup> In *Hanif*, the state insurance program, Medi-Cal, allegedly paid less than the reasonable value of the plaintiff's medical treatment.<sup>92</sup> The plaintiff's medical providers then wrote off the difference between what it billed and what it was paid by Medi-Cal.<sup>93</sup> While the trial court awarded the plaintiff the larger "reasonable value" amount, the appellate court held that the trial court overcompensated the plaintiff for his past medical expenses, and recovery should have been limited to the amount Medi-Cal had actually paid on the plaintiff's behalf.<sup>94</sup>

The *Hanif* court reasoned that reasonable value is a term of limitation, not aggrandizement.<sup>95</sup> The *Hanif* court also found that the only "detriment" or pecuniary "loss" suffered by the plaintiff was what Medi-Cal had paid on his behalf, and to award him more was to place him in a better financial position than he was in before the tort was committed.<sup>96</sup> *Hanif*, therefore, limited a tort plaintiff's recovery to the amount paid or incurred for past medical care and services whether it was paid by the plaintiff or by an independent source.<sup>97</sup>

*Hanif* and the California courts' earlier decisions, however, did not discuss the central arguments before the court in *Howell*; namely, whether restricting recovery to amounts actually paid by a plaintiff or on his or her behalf contravenes the collateral source rule.<sup>98</sup> The *Howell* court reduced the arguments to four central disputed issues:

- (1) Was *Hanif* correct that a tort plaintiff can recover only what has been paid or incurred for medical care, even if that is less than the reasonable value of the services rendered?
- (2) Even if *Hanif*, which involved Medi-Cal payments, reached the right result on its facts, does its logic extend to plaintiffs covered by private insurance?
- (3) Does limiting the plaintiff's recovery to the amounts paid and owed on his or her behalf confer a windfall on the tortfeasor, defeating the policy goals of the collateral source rule?
- (4) Is the difference between the providers' full billings and the amounts they have agreed to accept from a patient's insurer as full payment—what the appellate court below called the "negotiated rate differential"—a benefit

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91. *Hanif v. Hous. Auth.*, 246 Cal. Rptr. 192 (Cal. Ct. App. 1988).

92. *Id.* at 194.

93. *Id.*

94. *Id.* at 197.

95. *Id.* at 195.

96. *Id.* at 194–95.

97. *Id.* at 195.

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

the patient receives from his or her health insurance policy subject to the collateral source rule?<sup>99</sup>

The *Howell* court agreed with *Hanif* that a plaintiff may recover as economic damages no more than the reasonable value of the medical services received and is not entitled to recover the reasonable value if her actual loss was less.<sup>100</sup> A plaintiff could not recover more than his actual loss because under California law, a medical expense had to be incurred to be recoverable.<sup>101</sup> The *Howell* court relied in part on §§ 3281 and 3282 of the California Civil Code, which provide that a plaintiff cannot recover for a service that might have reasonably been charged if she negotiated a discount.<sup>102</sup> The court reasoned that the same rule applies when the plaintiff's health insurer has obtained a discount.<sup>103</sup>

The *Howell* court noted that the Restatement rule had the same effect.<sup>104</sup> The Restatement specifies that the measure of recovery for the costs of services that a third party renders is ordinarily the reasonable value of those services; if a person paid less than the exchange rate, then he can recover no more than the amount paid, except when the low rate was intended as a gift.<sup>105</sup> And while the expenses of medical care are not specifically mentioned in § 911 of the Restatement, the court found that they were logically included in the rule articulated.<sup>106</sup> The *Howell* court also found that § 924 of the Restatement—which provides that medical and other expenses must be reasonable—did not alter the general rule that the expense must be incurred.<sup>107</sup>

The *Howell* court found *Hanif*'s limitation of recovery for Medi-Cal recipients applied to plaintiffs with private medical insurance.<sup>108</sup> The court rejected the plaintiff's argument that she incurred liability for the full amount of her medical providers' bills when she signed their patient agreements and accepted their services.<sup>109</sup> Because of the preexisting agreement between her health insurer and the medical providers, the court reasoned it could not meaningfully be said that the plaintiff ever

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99. *Id.* at 1137.

100. *Id.*

101. *Id.*

102. *Id.*; CAL. CIV. CODE §§ 3281, 3282 (1872).

103. See *Howell*, 257 P.3d at 1138.

104. *Id.*

105. *Id.*; RESTATEMENT (SECOND) OF TORTS § 911. cmt. h (1979).

106. *Howell*, 257 P.3d at 1138.

107. *Id.*

108. *Id.*

109. *Id.*

incurred the full charges.<sup>110</sup> As in *Hanif*, the plaintiff in *Howell* bore no personal responsibility for the providers' charges.<sup>111</sup>

One exception noted in *Hanif* is that a plaintiff could recover for medical services gratuitously provided or discounted by his medical care providers.<sup>112</sup> This exception—that the collateral source rule applies to gratuitous payments and services—is supported by the Restatement.<sup>113</sup> The rationale for the exception is to encourage charitable action and preclude a tortfeasor from gaining the benefit of charity.<sup>114</sup> The exception raises the question that if the amount of gratuitous discount is considered a collateral source payment, should the amount of a negotiated discount be treated the same way?

The *Howell* court found that the exception for gratuitous discounts did not apply to medical providers who agreed to accept discounted payment because they did so “not as a gift to the patient or insurer, but for commercial reasons as a result of negotiations.”<sup>115</sup> The agreement guarantees prompt payment along with other administrative and marketing advantages.<sup>116</sup> Additionally, there is no danger the agreements will disappear if plaintiffs are not allowed to recover the full amount billed because medical providers have no financial reason to care if plaintiffs recover the negotiated rate differential.<sup>117</sup>

The *Howell* court determined that a tortfeasor does not obtain a “windfall” because the injured party’s health insurer negotiated a favorable rate of payment with the medical provider.<sup>118</sup> The rationale behind not allowing a tortfeasor to deduct from damages the benefits received from a collateral source or gift is that a tortfeasor would not be paying the full cost of her negligence or wrongdoing, which would distort the deterrence function of tort law.<sup>119</sup> The court found that this rationale did not apply to a plaintiff only paying the discounted price negotiated by a health insurer because of the complexities of pricing and reimbursement patterns for medical providers.<sup>120</sup>

The *Howell* court relied, in part, on the observation that because so many patients—insured, uninsured, and recipients under government health care programs—pay discounted rates, hospital bills have been

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110. *Id.* at 1138–39.

111. *Id.* at 1139.

112. *Id.*

113. *Id.*; RESTATEMENT (SECOND) OF TORTS § 920A. cmt. c(3) (1979).

114. *Id.* at 1140.

115. *Howell*, 257 P.3d at 1139–40.

116. *Id.* at 1140.

117. *Id.*

118. *Id.* at 1141.

119. *Id.*

120. *Id.*

called “insincere, in the sense that they would yield truly enormous profits if those prices were actually paid.”<sup>121</sup> The court noted that it is not possible to say generally that medical providers’ full bills represent the real value of their services, nor that the discounted payments they accept from private insurers are mere arbitrary reductions.<sup>122</sup> “Accordingly, a tortfeasor who pays only the discounted amount of damages does not generally receive a windfall and is not generally undeterred from engaging in risky conduct.”<sup>123</sup>

Finally, the *Howell* court determined that the negotiated rate differential was not a benefit accruing to the plaintiff under her policy for which she paid premiums.<sup>124</sup> The *Howell* court noted that health insurers and medical providers negotiate rates in pursuit of their own business interests and that the benefits of the bargains made accrue directly to them, with the primary benefit going to the medical insurer.<sup>125</sup> In addition, the negotiated rate differential did not necessarily reflect the commercial advantage the medical providers obtained in exchange for accepting a discounted payment in a particular case.<sup>126</sup> In other words, the global value of the negotiated rate to the medical provider cannot be equated to the plaintiff’s individual case.

The *Howell* court ruled that where a medical care provider accepted as full payment a sum less than the provider’s full bill, then it is evidence of the amount paid that is relevant at trial to prove the plaintiff’s damages.<sup>127</sup> Evidence that the medical bills were paid by an insurer would remain inadmissible under the collateral source rule.<sup>128</sup> The effect of the *Howell* court’s ruling is that evidence of the full-billed amount is not itself relevant on the issue of past medical expense where the provider has by prior agreement accepted less than the billed amount.<sup>129</sup> The *Howell* court, however, expressed no opinion about the relevance or admissibility of the full-billed amount on other issues such as noneconomic damages of future medical expenses.<sup>130</sup>

In *Corenbaum v. Lampkin*, the California Court of Appeals picked up where the *Howell* court left off and concluded that evidence of the full amount billed for the plaintiff’s medical care was not relevant to the

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121. *Id.* at 1142 (quoting Uwe E. Reinhardt, *The Pricing of U.S. Hospital Services: Chaos Behind the Veil of Secrecy*, 25 HEALTH AFF. 57, 63 (2006)) (internal quotation marks omitted).

122. *Id.*

123. *Id.*

124. *Id.* at 1143.

125. *Id.* at 1143–44.

126. *Id.* at 1144.

127. *Id.*

128. *See id.* at 1143.

129. *Id.*

130. *Id.* at 1146.

amount of damages for past medical services, damages for future medical care, or noneconomic damages.<sup>131</sup> In *Corenbaum*, the plaintiffs suffered serious injuries in a motor vehicle accident while they were passengers in a taxicab.<sup>132</sup> The plaintiffs brought separate actions against the defendant, which were consolidated before trial.<sup>133</sup> Prior to the May 2011 jury trial, the plaintiffs filed a motion in limine to exclude any evidence of the payment of plaintiffs' medical bills by a collateral source.<sup>134</sup> The defendant requested a post-verdict hearing in the event that the jury verdict included damages for past medical expenses in an amount exceeding the amount paid for those medical services.<sup>135</sup>

In accordance with the trial court's ruling on the motion in limine, the jury heard evidence of the full amount billed for the plaintiffs' medical care and heard no evidence of the lesser amounts accepted by their medical providers as full payment pursuant to prior agreement with the plaintiffs' private insurers.<sup>136</sup> The jury returned a verdict on June 3, 2011, awarding the plaintiffs past and future economic damages and noneconomic damages.<sup>137</sup> The defendant's June 24, 2011 motion to reduce the compensatory damage awards was continued to August 23, 2011, and then to September 6, 2011.<sup>138</sup> On July 5, 2011, the trial court entered separate judgments against the defendant, and on August 17, 2011, the trial court denied the defendant's motions for a new trial and for a judgment notwithstanding the verdict on the issue of punitive damages.<sup>139</sup>

The next day, on August 18, 2011, the California court filed its opinion in *Howell*.<sup>140</sup> The *Corenbaum* trial court subsequently denied the defendant's motion to reduce the compensatory damage awards on September 6, 2011, finding it did not have jurisdiction to reduce the awards because it had already denied the defendant's motion for a new trial.<sup>141</sup> The defendant appealed, contending the trial court erred by admitting evidence of the full amount billed for plaintiffs' medical care when the amounts accepted by their medical providers as full payment were less than the amounts billed.<sup>142</sup>

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131. *Corenbaum v. Lampkin*, 156 Cal. Rptr. 3d 347 (Cal. Ct. App. 2013).

132. *Id.* at 353–54.

133. *Id.* at 354.

134. *Id.* at 355.

135. *Id.*

136. *Id.*

137. *Id.*

138. *Id.* at 356.

139. *Id.*

140. *Id.*

141. *Id.*

142. *Id.* at 357.

After considering the reasoning in *Howell*, the *Corenbaum* court held that evidence of the full amount billed for a plaintiff's medical care is not relevant to the determination of a plaintiff's damages for past medical expenses and is therefore inadmissible for that purpose if the plaintiffs' medical providers, by prior agreement, had contracted to accept a lesser amount as full payment for the services provided.<sup>143</sup>

The *Corenbaum* court rejected the argument that a plaintiff seeking damages for past medical expenses should be able to present evidence of not only the amount accepted as full payment for past medical services provided, but also the reasonable value of those services.<sup>144</sup> The court rejected this argument because a plaintiff can recover as damages no more than the amount incurred for past medical services; therefore, evidence of the reasonable value of said services that exceed the amount paid is irrelevant and inadmissible.<sup>145</sup> The court also noted that the evidence would likely confuse the jury, suggest the existence of a collateral source of payment, and lead to a showing that the lesser amount was negotiated and paid by the plaintiffs' health insurers.<sup>146</sup>

The *Corenbaum* court then held that the full amount billed for past medical services is not relevant to the amount of future medical expenses and thus inadmissible for that purpose.<sup>147</sup> The court relied upon the statement in *Howell* that the full amount billed is not an accurate measure of the value of medical services: "a medical provider's billed price for particular services is not necessarily representative of either the cost of providing those services or their market value."<sup>148</sup> The court also determined that for a jury to consider evidence of the amount accepted as full payment, for the purpose of determining the amount of past economic damages, and the full amount billed, for some other purpose, would most certainly cause jury confusion and suggest the existence of a collateral source payment.<sup>149</sup>

The *Corenbaum* court further held that any expert who testified on remand with respect to the reasonable value of future medical services the plaintiffs are reasonably likely to require may not rely on the full amounts billed for the plaintiffs' past medical expenses.<sup>150</sup> The court concluded that evidence of the full amount billed cannot support an expert opinion or the reasonable value of future medical services because

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143. *Id.* at 360.

144. *Id.* at 361.

145. *Id.* (citing *Howell v. Hamilton Meats & Provisions, Inc.*, 257 P.3d 1130 (Cal. 2011)).

146. *Id.*

147. *Id.* at 363.

148. *Id.* at 362.

149. *Id.* at 363.

150. *Id.* at 364.



the full amount billed for past medical services is not relevant to the value of those services and that expert opinion based on speculation or conjecture is inadmissible.<sup>151</sup> In addition, expert testimony based on the full amount billed would lead to the introduction of evidence concerning the lower negotiated price, thus violating the evidentiary aspect of the collateral source rule.<sup>152</sup>

The Corenbaum court also held that evidence of the full amount billed is not relevant to the amount of noneconomic damages.<sup>153</sup> The court noted that the determination of noneconomic damages was subjective and committed to the discretion of the trier of fact.<sup>154</sup> The court observed that lawyers have used the amount of economic damages as a point of reference in their arguments to juries as a means to help determine the amount of noneconomic damages.<sup>155</sup> The court, however, found the practice could provide no justification for the admission of evidence that is otherwise irrelevant and inadmissible.<sup>156</sup> Accordingly, the court concluded evidence of the full amount billed is inadmissible for purposes of proving noneconomic damages.<sup>157</sup>

The dissenting opinion in *Howell* proposed a third alternative: evidence of payment, including acceptance of a lesser amount, is barred by the collateral source rule, and when a medical provider, by prior agreement, accepts less than the full billed amount as full payment, then evidence of the full billed amount is not relevant and inadmissible on the issue of past medical expenses.<sup>158</sup> Under this third alternative, a plaintiff could recover the reasonable value or market value of medical services as determined by expert testimony at trial.<sup>159</sup>

The dissent agreed that a plaintiff is not entitled to recover the gross amount of potentially inflated medical bills, but it rejected a bright-line rule limiting recovery to no more than the amount medical providers accepted in full payment for their services.<sup>160</sup> The dissent believed such a limitation left an insured plaintiff in a worse position than an uninsured plaintiff.<sup>161</sup> The dissent, however, did not consider the impact that a subrogation clause has on a plaintiff's recovery. The dissent further believed

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151. *Id.* at 363.

152. *Id.* at 363–64.

153. *Id.* at 364.

154. *Id.*

155. *Id.* at 364–65.

156. *Id.* at 365.

157. *Id.*

158. *Howell v. Hamilton Meats & Provisions, Inc.*, 257 P.3d 1130, 1146 (Cal. 2011).

159. *See id.* This is the only time that the dissent says “market value,” implying reasonable value and market value are the same.

160. *Id.* at 1146–47.

161. *Id.* at 1147.

that an insured individual purchased “not only indemnity coverage but also access to the negotiated discounts between her health insurer” and medical providers.<sup>162</sup> Therefore, an uninsured individual is entitled to retain any difference between the reasonable value of her treatment and the lesser amount the providers agreed to accept as payment in full.<sup>163</sup> The dissent also failed to address a plaintiff’s recovery when she had no choice but to pay more than the reasonable value of the medical services received.

The dissent observed that the majority of states follow § 924 of the Restatement Second of Torts, which permits plaintiffs to seek the reasonable value of their expenses without limitation to the amount that they pay or that third parties pay on their behalf.<sup>164</sup> The dissent believed that permitting recovery for the reasonable value of medical services is the fairest approach because to do otherwise would create separate categories of plaintiffs based on the method used to finance medical expenses.<sup>165</sup> The dissent did not acknowledge that the method used to finance medical expenses dictated the amount of those medical expenses.

The dissent believed both the original medical bill rendered and the amount accepted as full payment should be admissible to prove the reasonable value of a plaintiff’s medical care.<sup>166</sup> “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.”<sup>167</sup> The jury would weigh the evidence and determine the reasonable value of treatment with the help of expert opinion testimony.<sup>168</sup>

In *McConnell v. Wal-Mart Stores Inc.*, a Nevada district court rejected the *Howell* court’s ruling that a medical provider accepting less than the full amount billed pursuant to a preexisting contract is not the forgiveness of a debt.<sup>169</sup> The court predicted that the dissenting opinion in *Howell* accurately reflected how the Nevada Supreme Court would address the issue.<sup>170</sup> Accordingly, the court ruled:

[The] defendant may attempt to prove at trial that the amounts billed by Plaintiff’s medical providers were unreasonable in-and-of themselves—assuming Defendant has experts to provide such testimo-

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162. *Id.*

163. *Id.*

164. *Id.* at 1151.

165. *Id.* (citing *Martiney v. Milburn Enterprises, Inc.*, 233 P.3d 205 (Kan. 2009)).

166. *Id.* at 1153 (citing *Robinson v. Bates*, 857 N.E.2d 1195, 1200 (Ohio 2006)).

167. *Id.* (citing *Robinson*, 857 N.E.2d at 1200).

168. *Id.*

169. *McConnell v. Wal-Mart Stores, Inc.*, No. 2:12-CV-01601-RCJ, 2014 WL 464799, at \*4 (D. Nev. Feb. 5, 2014).

170. *Id.*

ny—but Defendant may not under the collateral source rule argue that any amount written down is necessarily unreasonable by the very fact that the amount was written down.<sup>171</sup>

The court apparently departed from the dissent in *Howell* on the admissibility of the amount accepted as full payment. The court also did not rule on what facts the defendant’s expert witness could use to support his opinion. Finally, the court buttressed its ruling by stating it encouraged the purchase of insurance,<sup>172</sup> although the primary beneficiaries under its ruling arguably are people on Medicaid.

In *Luttrell v. Island Pacific Supermarkets, Inc.*, a California appellate court held that “*Howell* governs where past medical expenses have been paid by Medicare, and the *Howell* cap should be imposed before any reduction for failure to mitigate damages.”<sup>173</sup> And in *Sanchez v. Brooke*, a separate California appellate court held that an injured employee’s recovery is limited to amounts paid to medical providers by one’s employer under workers’ compensation law.<sup>174</sup>

California’s recent leading decision on write-offs provides a jurisprudential framework for a Washington could revisit its application of the collateral source rule. Whether Washington should amend its application per *Howell*’s majority opinion or dissent will be further discussed. But first, reviewing the current political and economic environment surrounding tort reform and the collateral source rule is pivotal.

#### IV. FROM MICHIGAN TO PENNSYLVANIA: TORT REFORM, MEDICAL BILLING, AND THE DIFFERENCES IN STATE SUPREME COURT RULINGS

When considering whether Washington should revisit *Hayes v. Wieber Enterprises, Inc.* and amend its application of the collateral source rule, it is imperative to assess the current health care environment and reflect on how other state courts are ruling on write-offs per the collateral source rule. This Part summarizes the overwhelming rise in cost of the original amount billed for medical services and how “reasonableness” or “unreasonableness” is determined. This Part also explores the tort reform movement and how other states are modifying or maintaining their rulings on write-offs. Lastly, this Part examines contractual agreements and, specifically, subrogation clauses.

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171. *Id.* at \*5.

172. *Id.* at \*6.

173. *Luttrell v. Island Pac. Supermarkets, Inc.*, 155 Cal. Rptr. 3d 273, 274 (Cal. Ct. App. 2013).

174. *Sanchez v. Brooke*, 138 Cal. Rptr. 3d 507 (Cal. Ct. App. 2012).

*A. Outrageous Medical Bills in the United States and  
Determining Their “Reasonableness”*

In 1960, “there were no discounts, everyone paid the same rates” for medical care, which was usually the actual cost of the medical care plus 10%.<sup>175</sup> The rise of managed care organizations, which typically restrict payments for services to their members, has led to increases in the prices charged to uninsured patients, who do not benefit from providers’ contracts with the plans.<sup>176</sup> As some insurers demanded deep discounting, hospitals vigorously “shifted costs to patients with less clout.”<sup>177</sup> “Some physicians, too, have reportedly shifted costs to the uninsured, resulting in significant disparities between charges to uninsured patients and those with private insurance or public medical benefits.”<sup>178</sup>

As a consequence of shifting costs, “[o]nly uninsured, self-paying U.S. patients have been billed the full charges listed in hospitals’ inflated chargemasters.”<sup>179</sup> A chargemaster is an internal price list that every hospital uses, although no hospital’s chargemaster prices are consistent with those of any other hospital.<sup>180</sup> Insurers negotiate prices by a percentage above the Medicare rates or below the chargemaster price.<sup>181</sup> Stamford Hospital spokesman Scott Orstad commented, “[V]ery few people actually pay [chargemaster] rates.”<sup>182</sup> However, due to the collateral source rule applying to write-offs, defendants are required to pay this original invoiced amount for the medical services provided before the insured discounted price.

For example, a California family might find itself “paying off over many years a hospital bill of, say, \$30,000 for a procedure that Medicaid would have reimbursed at only \$6,000 and commercial insurers some-

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175. Mark A. Hall & Carl E. Schneider, *Patients As Consumers: Courts, Contracts, and the New Medical Marketplace*, 106 MICH. L. REV. 643, 663 (2008); see also *A Review of Hospital Billing and Collection Practices, Hearing Before the Subcomm. on Oversight and Investigations of the H. Comm. on Energy and Com.*, 108th Cong. 18 (2004) (testimony of Gerard F. Anderson, Director, Johns Hopkins Center for Health Finance and Management) [hereinafter Anderson Testimony 2004], available at <http://www.gpo.gov/fdsys/pkg/CHRG-108hrg95446/pdf/CHRG-108hrg95446.pdf>; Paul B. Ginsburg, *Shopping for Price in Medical Care*, 26 HEALTH AFF. 208 (2009), available at <http://content.healthaffairs.org/content/26/2/w208.full>. Important exceptions include specialists who provide discrete or limited services, such as a diagnostic service done at a separate facility (e.g., MRIs) or a fairly simple surgery for a condition handled in a standardized way (e.g., a vasectomy or an uncomplicated childbirth).

176. *Howell v. Hamilton Meats & Provisions, Inc.*, 257 P.3d 1130, 1141 (Cal. 2011).

177. Hall & Schneider, *supra* note 179, at 662.

178. *Howell*, 257 P.3d at 1141–42.

179. *Id.* at 1141.

180. Steven Brill, *Bitter Pill: How Outrageous Pricing and Egregious Profits Are Destroying Our Health Care*, TIME MAG., Mar. 2013, at 1, 22.

181. *Id.* at 23.

182. *Id.*

where in between.”<sup>183</sup> As explained in *Howell*’s majority opinion, “because so many patients, insured, uninsured, and recipients under government health care programs, pay discounted rates, hospital bills have been called ‘insincere, in the sense that they would yield truly enormous profits if those prices were actually paid.’”<sup>184</sup>

According to the Kaiser Family Foundation, the portion of the economy devoted to health care has risen steadily for at least fifty years, rising from 5.2% of Gross Domestic Product (GDP) in 1960 to 17.9% of GDP in 2010.<sup>185</sup> In only the last ten years, U.S. spending on health care doubled, from \$1.3 trillion to \$2.6 trillion a year, which is suspected to reach \$4.6 trillion in 2020.<sup>186</sup> In addition, the Center for Medicare & Medicaid Services (CMS) estimates that nearly one-fifth (19.8%) of GDP will be devoted to health care by the year 2020.<sup>187</sup> This amounts to per capita spending on health care that exceeds \$13,000 a year.<sup>188</sup> This is thousands more spent than any other developed or industrialized country.<sup>189</sup>

Health care costs associated with medical services are slated to rise drastically during the next ten years,<sup>190</sup> which will have serious implications for write-offs because as health care costs rise chargemaster prices will undoubtedly become even more inflated. The question is whether Washington should continue accepting the original amount billed as “reasonable” when it is inflated and rarely paid.

### 1. Assessing “Reasonableness”

The amount accepted by the medical provider as payment in full is by definition the market value of the services provided. This is the amount negotiated by a willing buyer to a willing seller, *i.e.*, the amount a private health insurance company or government agency agreed to pay a medical provider for a particular service. These types of agreements were unknown in 1914 when the court in *Torgeson v. Han-*

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183. *Howell*, 257 P.3d at 1141.

184. *Id.* (quoting Uwe E. Reinhardt, *The Pricing of U.S. Hospital Services: Chaos Behind the Veil of Secrecy*, 25 HEALTH AFF. 57, 63 (2006)).

185. HENRY J. KAISER FAM. FOUND., HEALTH CARE COSTS: A PRIMER 4 (2012) [hereinafter KAISER FOUND. REPORT], available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7670-03.pdf>.

186. Arthur Kellermann, *Time to Focus on Healthcare Costs*, U.S. NEWS & WORLD REP. (June 29, 2012), <http://www.usnews.com/opinion/articles/2012/06/29/time-to-focus-on-healthcare-costs>.

187. KAISER FOUND. REPORT, *supra* note 189, at 4.

188. *See* Kellermann, *supra* note 190.

189. KAISER FOUND. REPORT, *supra* note 189, at 7.

190. *Infographic: Why America Must Address the Rising Costs of Healthcare*, HEALTHCARE FIN. NEWS (Aug. 21, 2012), <http://www.healthcarefinancenews.com/infographic/infographic-why-america-must-address-rising-costs-healthcare>.

*ford* held a plaintiff had to establish he paid the reasonable value of medical services. People no longer travel by horse and buggy, and the amount paid for medical services is no longer determined by an agreement between patient and provider. Instead, as noted above, a hospital's chargemaster determines the invoiced price of all medical services.<sup>191</sup> Chargemaster prices are not based on anything objective, and as noted by Brill, "[w]ere set in cement a long time ago and just keep going up almost automatically."<sup>192</sup>

The invoiced price is simply the beginning figure in a transaction process, and it can be argued that the amount accepted as payment in full represents the reasonable value of those services. A defendant seeking to limit recovery to the amount accepted as payment in full would not be arguing that a plaintiff may not recover for medical bills paid by a collateral source. Rather, the defendant would be arguing that a plaintiff may only recover the full amount of her medical costs—not the amount billed. For example, three CT scans at Yale New Haven Health System cost an insured patient \$6,538, but Medicare would have only paid \$825 for all three.<sup>193</sup> "By law, Medicare's payments approximate a hospital's cost of providing a service, including overhead, equipment, and salaries."<sup>194</sup> In this instance, Medicare's payment could be seen as the "reasonable" cost of the service—not the amount initially billed.

The above argument is similar to a case recently decided in Pennsylvania. In *Moorhead v. Crozer Chester Medical Center*, the appellant's decedent fell and injured herself, requiring medical services provided by the appellee.<sup>195</sup> The appellant was covered under Medicare as well as a "Blue Cross 65" supplemental plan, for which she paid premiums.<sup>196</sup> The "fair and reasonable value" of the medical services rendered to the appellant was \$108,668, but Medicare's allowance for those services was \$12,167.<sup>197</sup> The issue on appeal was whether the appellant was entitled to collect the additional amount of \$96,501 as an expense even though the appellant did not pay the \$96,501, nor did Medicare or Blue Cross 65 pay that amount on her behalf.<sup>198</sup> The court affirmed that Pennsylvania case law allows a plaintiff to recover the reasonable value of medical services.<sup>199</sup> However, the court held that the collateral source rule did not

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191. See Brill, *supra* note 184, at 22.

192. *Id.*

193. *Id.* at 28.

194. *Id.* at 18.

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

196. *Id.* at 788.

197. *Id.*

198. *Id.*

199. *Id.* at 789.

apply to the illusory charge of \$96,501 because that amount was not paid by any collateral source.<sup>200</sup>

Another example is from the Indiana Supreme Court where in *Butler v. Indiana Department of Insurance*, the plaintiff filed a claim for medical negligence against Clarian Health Partners, Inc. and several individual health care providers.<sup>201</sup> The plaintiff died before the claim was resolved, but her estate continued with the claim and later settled with Clarian.<sup>202</sup> The plaintiff's estate also proceeded with its claim against the other insurer, the Indiana Patient Compensation Fund (Fund).<sup>203</sup> The Fund sought partial summary judgment, claiming the plaintiff's estate was entitled to recovery, but only for the expenses the plaintiff actually incurred for medical services and not the total amount of medical bills received.<sup>204</sup>

The Fund relied on its interpretation of Indiana Code § 34-23-1-1, which governs actions for the wrongful death of unmarried adult persons without dependents. The court held:

With respect to damages pursuant to Indiana Code § 34-23-1-2(c)(3)(A), when medical providers provide statements of charges for health care services to the decedent but thereafter accept a reduced amount adjusted due to contractual arrangements with the insurers or government benefit providers, in full satisfaction the charges, the amount recoverable under the statute for the '[r]easonable medical . . . expenses necessitated' by the wrongful act is the portion of the billed charges ultimately accepted pursuant to such contractual adjustments.<sup>205</sup>

And in *Kastick v. U-Haul Co. of Western Michigan*, the plaintiff was making a left turn from State Route 38 into his daughter's driveway in the city of Auburn when a U-Haul truck leased by the defendant struck his vehicle on the driver's side.<sup>206</sup> The plaintiff was unable to take in enough oxygen due to his injuries and became dependent on a respirator.<sup>207</sup> The plaintiff died only five months after the accident.<sup>208</sup> The New York Supreme Court, Appellate Division, stated the following:

Defendants contend that plaintiff may not recover from them an amount for which she never became obligated. We agree with de-

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200. *Id.* at 791.

201. *Butler v. Ind. Dep't of Ins.*, 904 N.E.2d 198, 199 (Ind. 2009).

202. *Id.*

203. *Id.*

204. *Id.*

205. *Id.* at 202.

206. *Kastick v. U-Haul Co. of W. Mich.*, 292 A.D.2d 797 (N.Y. App. Div. 2002).

207. *Id.*

208. *Id.*

defendants. Although the write-off technically is not a payment from a collateral source . . . it is not an item of damages for which plaintiff may recover because plaintiff has incurred no liability.<sup>209</sup>

Not all state courts use similar reasoning; for example, the Wisconsin Supreme Court did not permit the amount paid to be accepted as the recovery under the reasonable expense doctrine—even though the plaintiff, like in *Kastick*, incurred no liability for the full amount billed. In *Leitinger v. DBart, Inc.*, the plaintiff was injured at a construction site and brought a personal injury action against the property owner, subcontractor, health insurer, and liability insurers.<sup>210</sup> The plaintiff's health care provider billed the plaintiff \$154,819 for the treatment of her injuries caused by the defendant's negligent actions, but as a result of the negotiated discounts, the health care provider accepted \$111,395 from the plaintiff's insurance company.<sup>211</sup> This amounted to a difference of \$43,424.<sup>212</sup> Since the jury awards the "reasonable value" of the plaintiff's medical treatment, the defendant argued that the collateral source rule should not apply because the jury should know the amount the plaintiff's health insurance company actually paid for the medical treatment, not the amount billed, as that would aid in their computation of what the reasonable value of the medical treatment was.<sup>213</sup>

The court held that "the collateral source rule prohibits parties in a personal injury action from introducing evidence of the amount actually paid by . . . a collateral source for medical treatment rendered to prove the reasonable value of the medical treatment."<sup>214</sup> To reach its conclusion, the court reasoned that it "might bring complex, confusing side issues before the fact-finder that are not necessarily related to the value of the medical services rendered."<sup>215</sup> In addition, the court explained that one issue of confusion would be the reimbursement rate because it was decided based on the contractual agreement between the plaintiff and his insurance carrier, and is not solely based on the reasonable value of medical services.<sup>216</sup> The cost of the plaintiff's medical treatment, therefore, would vary depending on different contractual agreements.

The court's ruling in *Leitinger* is similar to the South Carolina Supreme Court decision in *Covington v. George*. In *Covington*, the defend-

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209. *Id.* at 798.

210. *Leitinger v. DBart, Inc.*, 736 N.W.2d 1 (Wis. 2007).

211. *Id.*

212. *Id.*

213. *Id.* at 3–4.

214. *Id.* at 4.

215. *Id.*

216. *Id.* at 18.



ant rear-ended the plaintiff when the plaintiff stopped for a school bus.<sup>217</sup> The defendant admitted his liability for the accident but contested the amount of damages.<sup>218</sup> The plaintiff was billed \$1,430 for services performed after the accident, but the health care provider accepted \$277 as full payment for the services.<sup>219</sup> The plaintiff was then billed \$1,969 for additional services and the health care provider again accepted the lower rate of \$371 with \$58 still owed.<sup>220</sup> The defendant sought to introduce evidence of the actual payment accepted by the health care provider in order to challenge the “reasonableness of the medical expenses sought by the plaintiff.”<sup>221</sup>

According to the court, a tortfeasor cannot “take 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.’”<sup>222</sup> The court held that while the defendant was permitted to attack the “necessity and reasonableness” of the medical care and costs, the defendant could not do so by utilizing evidence of payments made by a collateral source.<sup>223</sup>

Some states, moreover, are aware of the windfall of benefits associated with the adherence to the collateral source rule and still permit the plaintiff’s double recovery. For example, the Virginia Supreme Court recently reaffirmed the collateral source rule in *Acuar v. Letourneau* by stating,

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.<sup>224</sup>

As previously discussed, states differ on their application of the collateral source rule, with one extreme being New Hampshire. New Hampshire has eliminated the collateral source rule—including to allow the introduction of evidence of government benefits such as Medicare, Medicaid, or Social Security.<sup>225</sup> This frustration is exemplified in the court’s opinion in *Gordon v. Forsyth County Hospital Authority, Inc.*, where the

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217. *Covington v. George*, 597 S.E.2d 142, 143 (S.C. 2004).

218. *Id.*

219. *Id.*

220. *Id.*

221. *Id.* at 144.

222. *Id.* (internal citation omitted).

223. *Id.* at 145.

224. *Acuar v. Letourneau*, 531 S.E.2d 316, 323 (Va. 2000).

225. Melissa Young, *Tort Reform and the Collateral Source Rule*, AM. ACAD. OF ORTHOPAEDIC SURGEONS (Mar. 2009), <http://www.aaos.org/news/aaosnow/mar09/managing4.asp>.

judge noted, “it would be unconscionable to permit the taxpayers to bear the expense of providing free medical care to a person and then allow that person to recover damages for medical services from a tort-feasor and pocket the windfall.”<sup>226</sup>

When confronted with the issue of ruling on the reasonableness of write-offs, state courts have either maintained their coverage under the collateral source rule or held the defendant should only be responsible for the actual amount paid. In connection with the rising cost of the original amount billed for medical services, the current tort reform environment encourages modification of the collateral source rule.

Washington should abolish its requirement that a plaintiff must establish that the amount paid for past medical expenses was reasonable when the plaintiff or a third party has paid the market value of the services provided. While the requirement might have made sense when it was adopted in *Torgeson v. Hanford* in 1914, its continued use is unwarranted because medical bills are no longer agreements between plaintiffs and providers. The requirement is also impractical. The reasonableness of medical expenses can be established by the testimony of the medical provider. This is how the plaintiff in *Hayes* established the reasonableness of the full amount billed for the services provided to her. Has a medical provider in Washington ever testified that the amount she billed was not reasonable?

*B. How Does Tort Reform Impact the Write-Offs and the Collateral Source Rule?*

The tort reform movement has actively targeted the collateral source rule and focused on preventing the overcompensation of plaintiffs. In a 2006 survey of state statutes exploring the collateral source rule, Professors David Schap and Andrew Feeley discovered the following:

[Thirty-eight] states modified the rule in some form to allow the introduction of collateral source evidence in medical liability cases. Twenty states permitted consideration of collateral source offsets during trial, while [fourteen] states required consideration of such offsets after the judgment or award. Six states required the offset to be taken after the jury’s verdict but before entry of judgment by the court.<sup>227</sup>

The American Tort Reform Association (ATRA) “supports permitting the admissibility of evidence of collateral source payments at trial or

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226. *Gordon v. Forsyth Cnty. Hosp. Auth., Inc.*, 409 F. Supp. 708, 719 (M.D.N.C. 1975).

227. *See Young*, *supra* note 229.

requiring awards to be offset by the amount paid to plaintiffs by collateral sources, less the amount paid by the plaintiff to secure the benefit.”<sup>228</sup> The ATRA supports eliminating the collateral source rule specifically because it prevents relevant information used to determine damages from reaching the jury, and it allows the plaintiffs to be compensated twice for the same injury.<sup>229</sup>

In addition, the American Academy of Orthopaedic Surgeons (AAOS) issued a position statement supporting the enactment of federal tort reform legislation, including, but not limited to, a specific cap on noneconomic damages and mandatory offset of collateral sources of payment.<sup>230</sup> The AAOS argued that allowing plaintiffs to recover the undiscounted price for medical services when there is ample evidence to show that they paid less will have the net effect of increasing societal costs through higher insurance premiums.<sup>231</sup>

Would tort reform laws, such as one modifying the collateral source rule, have a substantial impact on lowering health care costs in Washington? Because Washington is one of the few states that modified its collateral source rule in medical liability cases, modifying the collateral source rule would most likely not have an impact on health care costs. The Revised Code of Washington (RCW) § 7.70.080 supersedes the common law collateral source rule in regards to health care lawsuits. Under this statute,

Any party may present evidence to the trier of fact that the plaintiff has already been compensated for the injury complained of from any source except the assets of the plaintiff, the plaintiff’s representative, or the plaintiff’s immediate family. In the event such evidence is admitted, the plaintiff may present evidence of an obligation to repay such compensation and evidence of any amount paid by the plaintiff, or his or her representative or immediate family, to secure the right to the compensation. Compensation as used in this section shall mean payment of money or other property to or on behalf of the plaintiff, rendering of services to the plaintiff free of charge to the plaintiff, or indemnification of expenses incurred by or on behalf of the plaintiff. Notwithstanding this section, evidence of compensation by a defendant health care provider may be offered only by that provider.<sup>232</sup>

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228. *Collateral Source Rule Reform*, AM. TORT REFORM ASS’N, <http://www.atra.org/issues/collateral-source-rule-reform> (last visited Apr. 6, 2014).

229. *Id.*

230. *Position Statement: Medical Liability Reform*, AM. ACAD. OF ORTHOPAEDIC SURGEONS, <http://www.aaos.org/about/papers/position/11118.asp> (last visited Apr. 6, 2014).

231. *See id.*

232. WASH. REV. CODE § 7.70.080 (2006).

The statute clearly establishes that in medical malpractice actions, either party can introduce evidence that a plaintiff has already been compensated from a third party, such as an insurance payout.<sup>233</sup>

Dr. Glenn D. Braunstein, chairman of the Department of Medicine at Cedars-Sinai, specifically addressed whether medical malpractice and tort reform would have an effect on total health care costs. Dr. Braunstein contends that the “direct costs in 2009 to providers of medical malpractice liability insurance, costs including insurance premiums, settlements, awards and administrative costs, totaled \$35 billion, according to the Congressional Budget Office.”<sup>234</sup> Therefore, even “if those costs were reduced by 10 percent, it would only reduce the national health expenditures by 0.2 percent. Even if reforms resulted in less use of health care services driven by fear of lawsuits, savings to the system would be about 0.5 percent or \$11 billion in 2009.”<sup>235</sup> This malpractice reform proposal would not limit awards for victims, but it would allow doctors to use a “safe harbor defense.”<sup>236</sup> Under a safe harbor defense, a defendant doctor or hospital can argue that the care it provided was within “the bounds of what peers have established as reasonable under the circumstances.”<sup>237</sup>

Dr. Braunstein, however, notes that tort reform could save the federal government’s Medicare, Medicaid, and other federal health insurance programs \$54 billion over ten years, or \$5.4 billion annually.<sup>238</sup> Obviously, tort reform would have an effect on health care costs, but when it currently costs \$2.6 trillion<sup>239</sup> per year, the claim that tort reform would substantially reduce the government’s cost is arguably unsubstantiated.

### *C. Contractual Agreements and Subrogation Clauses: The Argument*

Many states distinguish between collateral source payments made by a private third party, such as personal health insurance, and those made by a public source, such as Medicaid, Medicare, or Social Security. This is because a plaintiff with private insurance has a prior contractual agreement with the insurance company, *i.e.*, the plaintiff may have bargained for a specific rate and has paid into the insurance. This is different from public sources of insurance because public sources are not paid by a

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233. *See id.*

234. Glenn D. Braunstein, *Medical Malpractice and Tort Reform*, HUFFINGTON POST (Aug. 13, 2012, 11:17 AM), [http://www.huffingtonpost.com/glenn-d-braunstein-md/medical-malpractice\\_b\\_1761443.html](http://www.huffingtonpost.com/glenn-d-braunstein-md/medical-malpractice_b_1761443.html).

235. *Id.*

236. *See Brill, supra* note 184, at 24.

237. Braunstein, *supra* note 238.

238. *Id.*

239. *Id.*

plaintiff or bargained for between a plaintiff and the plaintiff's employer; instead, they are based on federal eligibility guidelines.<sup>240</sup> Thus, these "write-offs" between the plaintiff's damages and the amount paid through a public source are "phantom" benefits awarded to the plaintiff.<sup>241</sup>

This application of the collateral source rule is made in *Tucker v. Volunteers of America Colorado Branch*. In *Tucker*, the plaintiff-invitee brought a premises liability action against the defendant landowner, Volunteers of America Colorado Branch.<sup>242</sup> The district court reduced the plaintiff's award by the difference between the full amount of his medical bills and the amount paid by his medical insurer.<sup>243</sup> The Colorado Court of Appeals concluded that the contract between the plaintiff's insurer and plaintiff's health care providers, which decreased the amount actually paid for his medical care, inured to his benefit and fell within the contractual exception to Colorado's collateral source rule, codified in the Colorado Revised Statute § 13-21-111.6.<sup>244</sup> The Colorado Supreme Court affirmed when it stated the following statutory interpretation:

In any action by any person or his legal representative to recover damages for a tort resulting in death or injury to person or property, the court, after the finder of fact has returned its verdict stating the amount of damages to be awarded, shall reduce the amount of the verdict by the amount by which such person, his estate, or his personal representative has been or will be wholly or partially indemnified or compensated for his loss by any other person, corporation, insurance company, or fund in relation to the injury, damage, or death sustained; except that the verdict shall not be reduced by the amount by which such person, his estate, or his personal representative has been or will be wholly or partially indemnified or compensated by a benefit paid as a result of a contract entered into and paid for by or on behalf of such person. The court shall enter judgment on such reduced amount.<sup>245</sup>

The court clarified that this statute requires trial courts to set off any payment received by a tort plaintiff, his estate, or personal representative that was intended to indemnify or compensate such plaintiffs; however, it exempts this setoff if the payment was made "as a result of a contract entered into and paid for by or on behalf of such person."<sup>246</sup> Thus, the

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240. See Young, *supra* note 229.

241. See *id.*

242. *Tucker v. Volunteers of Am. Colo. Branch*, 211 P.3d 708, 709 (Colo. App. 2008).

243. *Id.*

244. *Id.*

245. COL. REV. STAT. § 13-21-111.6 (1986).

246. *Tucker*, 211 P.3d at 712.

court concluded that the contract between plaintiff's insurer and the health care providers, which decreased the amount actually paid for plaintiff's medical care, resulted in plaintiff's benefit and falls within the contract exception outlined in the statute.<sup>247</sup>

And in *Windsor School District v. State*, the plaintiff school district sued the state of Vermont and the Vermont Department of Corrections for expenses related to an environmental cleanup of school district property formerly owned by the state.<sup>248</sup> On appeal, the Department of Corrections argued that the trial court erroneously invoked the collateral source rule when it declined to reduce the plaintiff's damages by the amount it had been paid by its insurance company, which was acknowledged to be in excess of \$470,000.<sup>249</sup> The main basis of this argument was that because the Department of Corrections gave grants to the plaintiff under applicable state aid, "the insurance policies from which [the plaintiff] received payments were not a source 'wholly independent from the defendants.'"<sup>250</sup>

The court disagreed with the Department of Corrections because even though it may have subsidized the operating expenses of the school district, it could not definitively state that the insurance was purchased *because* of the subsidization.<sup>251</sup> The court agreed with the trial court that the plaintiff's insurance proceeds were a collateral source and, under the collateral source rule, the state's liability could not be reduced by the amount the plaintiff received from its insurance company.<sup>252</sup>

However, in *Papke v. Harbert*, where the plaintiff filed a medical malpractice suit as a result of both her legs being amputated,<sup>253</sup> the South Dakota Supreme Court prohibited evidence of the amount paid by public sources as payment in full for the plaintiff's medical care. The plaintiff was billed \$429,531 for her medical care; Medicare paid \$79,412 and Medicaid paid \$133,874.<sup>254</sup> "The remaining \$216,874.03 was written off and will never be paid by anyone."<sup>255</sup> The defendants argued that the plaintiff's right to recover the "reasonable value" of medical services as a measure of damages does not include amounts "written off" by the medical care provider because of a contractual agreement between the provid-

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247. *Id.*

248. *Windsor Sch. Dist. v. State*, 956 A.2d 528, 532 (Vt. 2008).

249. *Id.* at 542.

250. *Id.* at 544 (internal citation omitted).

251. *Id.*

252. *Id.*

253. *Papke v. Harbert*, 738 N.W.2d 510, 512 (S.D. 2007).

254. *Id.* at 530.

255. *Id.*

er, Medicare, and Medicaid.<sup>256</sup> The court nevertheless held that when establishing the reasonable value of medical services, defendants in South Dakota are prohibited from introducing evidence that a plaintiff's award should be reduced because of a benefit received wholly independent of the defendant.<sup>257</sup> The court readily admitted that this might result in a "windfall to the injured plaintiff," but that it is better than letting a "windfall go to an injured party [rather] than to a tortfeasor."<sup>258</sup>

### Subrogation Clauses

Black's Law Dictionary defines subrogation as "the principle under which an insurer that has paid a loss under an insurance policy is entitled to all the rights and remedies belonging to the insured against a third party with respect to any loss covered by the policy."<sup>259</sup> Subrogation gives an insurer the opportunity to recover the value of the benefits once paid to the plaintiff.<sup>260</sup> Upon payment for a loss, an insurer's right to subrogate arises, assuming that the right has not been waived by contract or conduct, or extinguished by applicable state or federal laws.<sup>261</sup> Under the "make whole doctrine," an insurer generally cannot seek subrogation until the insured has been fully compensated for any compensable injuries she sustained.<sup>262</sup>

At one time, the collateral source rule may have commonly resulted in defendants receiving compensation from both their health insurer and a tortfeasor whenever the defendant had health insurance at the time of an injury. Today, however, private health insurance companies and government agencies seek reimbursement for the medical bills that have been paid through contractual subrogation or by statute.<sup>263</sup> It has been only in the last 30 to 40 years that subrogation disputes regarding personal injury cases have arisen. "During this period, subrogation clauses have been inserted in first party medical payments coverage in automobile policies, uninsured and underinsured motorist coverage, and medical and hospitalization coverages."<sup>264</sup>

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256. *Id.*

257. *Id.* at 536.

258. *Id.*

259. BLACK'S LAW DICTIONARY 1563–64 (9th ed. 2009).

260. Jamie L. Wershbale, *Tort Reform in America: Abrogating the Collateral Source Rule Across the States*, 75 DEF. COUNSEL J. 346, 349 (2008).

261. *Id.*

262. *Id.*

263. *Mahler v. Szucs*, 957 P.2d 632, 641 (Wash. 1998).

264. *Id.* at 641 (citing Roger M. Baron, *Subrogation on Medical Expense Claims: The "Double Recovery" Myth and the Feasibility of Anti-Subrogation Laws*, 96 DICK. L. REV. 581, 583 (1992)).

In addition, Congress amended the Social Security Act in 1980 to add the Medicare Secondary Payer Act, which effectively created Medicare “liens.” Congress amended the Social Security Act again in 2003 to clarify its position that self-insured entities were included in the Medicare Secondary Payer Act. So after the 2003 amendment, it became clear that all third-party recoveries were subject to reimbursement on the Medicare Secondary Payer Act.<sup>265</sup>

#### V. CONCLUSION

The common law in Washington now permits recovery for medical expenses that were never incurred and have no relationship to their market value. Washington, therefore, should amend the common law application of the collateral source rule to disallow the recovery of write-offs. The common law in Washington was adopted when medical providers billed patients the same amount regardless of whether they were uninsured, had private insurance, or were covered by a government program, and when subrogation clauses were virtually unknown.

Washington courts should adopt the California court’s ruling in *Howell* that an injured plaintiff whose medical expenses are paid by a private insurance plan can recover damages for past medical expenses in an amount no greater than the amount that the plaintiff’s medical providers, pursuant to prior agreement, accepted as full payment or, to the extent that payment is still owed, the amount that the medical providers have agreed to accept as full payment for the services provided.<sup>266</sup> In short, the plaintiff may only recover the market value of the services provided.

Disallowing the recovery of write-offs does not violate Washington’s collateral source rule, and it still permits a plaintiff to recover the reasonable value of necessary medical services caused by a defendant. The collateral source rule is not violated because evidence of payment remains inadmissible. The plaintiff is permitted to recover the reasonable value of the medical services provided because recovery is permitted for the market value of those services. After all, market value is the amount paid by a willing buyer to a willing seller.

Write-offs would be eliminated if private health insurers and government agencies simply required medical care providers to bill only the amount the health insurer contracted to pay or the amount allowed by statute. Medical bills are elaborately coded, so it would be convenient for medical providers to only bill health insurers and government agencies

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265. 42 U.S.C. §§ 1395–1395b-10 (2012); 42 C.F.R. §§ 411.1–411.15 (2014).

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



for the amount that they are contracted to pay or will pay by statute. This requirement would result in the full amount billed also being the amount paid on the plaintiff's behalf. Adopting California's ruling in *Howell* would preclude recovery for damages essentially caused by a billing procedure.

Adopting the California court's ruling in *Howell* would also ensure all plaintiffs full recovery for their injuries, preclude using injuries as economic opportunities, and reduce the cost of litigation. Allowing plaintiffs to recover the amount actually paid for medical services permits plaintiffs to recover the market value of the medical services received while avoiding the risk that a trier of fact might determine the reasonable value of the medical services was less than the amount paid because others are billed less for the services provided to the plaintiffs.

It is repugnant for certain plaintiffs to receive a greater recovery for the same injuries as other plaintiffs simply because they are on Medicaid and not covered by private insurance. Limiting recovery to the actual amount paid will undoubtedly have an impact on a jury's determination of noneconomic damages, but plaintiffs should not be allowed to recover noneconomic damages based on an economic loss that they never incurred.

Finally, allowing recovery for the amount actually paid avoids the cost of expert witnesses to battle the reasonable value of the medical services received by plaintiffs, as suggested by the dissent in *Howell*—particularly when the market value can be readily obtained by ascertaining the amount actually paid for the medical services. In short, the trial court in *Patterson v. Horton* got it right.

Washington's adherence to laws that were handed down a century ago, mixed with modern medical billing practices that include rarely paid inflated invoices, has resulted in the recovery of medical expenses that were never incurred and have no relationship to their market value. Washington, therefore, should amend its common law application of the collateral source rule to disallow the recovery of write-offs. By amending its application, Washington would ensure that plaintiffs only recover the market value of medical services in a cost effective manner.