

IN THE SUPREME COURT

On Appeal from the Michigan Court of Appeals
Hoekstra, PJ, and Markey and Krause, JJ

MAKENZIE GREER, Minor,
KENNETH GREER, Individually and
as Conservator for MAKENZIE
GREER, and ELIZABETH GREER,

Plaintiffs/Appellees/Cross-Appellants,

vs.

ADVANTAGE HEALTH and
ANITA R. AVERY, MD,

Defendants/Appellants/ Cross-Appellees,

-and-

TRINITY HEALTH-MICHIGAN,
d/b/a ST. MARY'S HOSPITAL, and
KRISTINA MIXER, MD,

Defendants.

Supreme Court Case No. 149494

Court of Appeals Docket No: 312655

Kent County Circuit Court
File No. 10-09033-NH

**BRIEF OF AMICUS CURIAE MICHIGAN
PROFESSIONAL INSURANCE
EXCHANGE IN SUPPORT OF
DEFENDANT-APPELLANTS'
APPLICATION FOR LEAVE TO APPEAL**

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TABLE OF CONTENTS

STATEMENT OF INTEREST OF AMICUS CURIAE AND THE ORDER APPEALED FROM AND RELIEF SOUGHT 1

STATEMENT OF QUESTIONS PRESENTED 3

SUMMARY OF THE ARGUMENT 4

STATEMENT OF MATERIAL FACTS AND PROCEEDINGS 7

ARGUMENT 7

 I. STANDARD OF REVIEW 7

 II. THE TRIAL COURT AND COURT OF APPEALS ERRED IN HOLDING THAT A PLAINTIFF CAN RECOVER, AS AN ELEMENT OF PAST ECONOMIC DAMAGES, THE AMOUNT OF A NEGOTIATED DIFFERENTIAL WHEN (1) THE PLAINTIFF DID NOT INCUR THE AMOUNT OF THE DIFFERENTIAL AS A MEDICAL EXPENSE AND (2) TO THE EXTENT THE DIFFERENTIAL CAN BE CONSIDERED A “BENEFIT” FOR PURPOSES OF THE COLLATERAL SOURCE RULE, IT IS A SEPARATE BENEFIT THAN THAT OVER WHICH A LIEN IS ASSERTED. 8

 A. The amount of the negotiated differential is not a loss that is incurred by a plaintiff, and therefore, not collectable as an element of damages. 8

 1. At common law, economic damages were limited to those actually paid. 9

 2. The common law collateral source rule did not affect the measure of damages. 12

 3. The current statutory collateral source rule, which abrogated the common law collateral source rule, does not alter the common law pertaining to the appropriate measure of damages for medical expenses. 13

 a. The expense or loss must first be identified..... 15

 b. The expense must be paid or payable. 15

4.	Two approaches demonstrating the practical effect of the rule.	16
a.	Irrelevance and inapplicability of insurance discounts in establishing economic loss.	16
b.	Alternatively, if a plaintiff may introduce the amount billed, a defendant should be able to introduce evidence of the discounted amount paid.	22
B.	If the negotiated discount falls within the definition of “collateral source”, the amount of the negotiated discount falls within the exception to the collateral source rule, allowing that amount to be deducted from the verdict.	24
	RELIEF REQUESTED.....	27

INDEX OF AUTHORITIES

Cases

<i>Adams v Auto Club Ins. Ass'n</i> , 154 Mich App 186; 397 NW2d 262 (1986).....	14
<i>Alt v Konkle</i> , 237 Mich 264; 211 NW 661 (1927).....	4, 8, 9
<i>Apsey v Memorial Hosp.</i> , 477 Mich 120; 730 NW2d 695 (2007).....	7
<i>Blanch v Gagnon</i> , 47 Mich App 168; 209 NW2d 292 (1973).....	12, 13
<i>Board of Rd. Com'rs of Lapeer County v Markley</i> , 260 Mich 455, 245 NW 496 (1932).....	10
<i>Bombalski v Auto Club Insurance Association</i> , 247 Mich App 536; 637 NW2d 251 (2001).....	10, 12
<i>Bourdon v Read</i> , 30 Mich App 681, 186 NW2d 737 (1971).....	13
<i>Cook v. Whitsell-Sherman</i> , 796 N.E.2d 271, 277 (Ind.1003).....	23, 24
<i>DiCarlo v St. Mary's Hosp.</i> , unpublished opinion of the United States District Court, July 19, 2006 (D. New Jersey, Docket No. 05-1665-DRD-SDW).....	6
<i>Driver v Naini</i> , 490 Mich 239; 802 NW2d 311 (2011).....	7
<i>Fogel v Sinai Hosp. of Detroit</i> , 2 Mich App 99; 138 NW2d 503 (1966).....	10
<i>Foley v Detroit & M. Ry. Co.</i> , 193 Mich 233; 159 NW 506 (1916).....	9
<i>Greer v Advantage Health</i> , 305 Mich App 192, 852 NW2d 198 (2014).....	7, 25
<i>Hanif v Housing Authority</i> , 200 Cal App 3d 635 (1988).....	18, 19
<i>Hayes-Albion Corp. v. Kuberski</i> , 421 Mich. 170, 187, 364 N.W.2d 609 (1984).....	4
<i>Heinz v Chicago Road Inv. Co.</i> , 216 Mich App 289; 549 NW2d 47 (1996).....	14, 25
<i>Herter v City of Detroit</i> , 245 Mich 425; 222 NW 774 (1929).....	9
<i>Hicks v. Ottewell</i> , 174 Mich.App. 750; 436 N.W.2d 453 (1989).....	4
<i>Howell v Hamilton Meats & Provisions, Inc.</i> , 52 Cal 4th 541, 257 P3d 1130.....	19
<i>In re Disaster at Detroit Metropolitan Airport on August 16, 1987</i> , 750 F.Supp. 793, 805 (E.D.Mich., 1989).....	4
<i>Jenkins v Patel</i> , 471 Mich 158, 167; 684 NW2d 346 (2004).....	26

<i>Kewin v. Massachusetts Mut. Life Ins. Co.</i> , 409 Mich. 401, 419, 295 N.W.2d 50 (1980)	4
<i>Kinney v Folkerts</i> , 78 Mich 687, 44 NW 152 (1889)	9
<i>Lee v Detroit Medical Center</i> , 285 Mich App 51, 67; 775 NW2d 326 (2009).....	14
<i>McAuley v General Motors Corp.</i> , 457 Mich 513; 578 NW2d 282 (1998).....	4, 8
<i>McNeil v Charlevoix County</i> , 484 Mich 69, fn 8; 772 NW2d 18 (2009)	2
<i>Moghis v Citizens Inc. Co. of America</i> , 187 Mich App 245; 466 NW2d 290 (1990).....	11
<i>Moorehead v Crozer Chester Medical Center</i> (2001) 564 Pa. 156, 765 A.2d 786, 789	20
<i>Nishihama v City and County of San Francisco</i> , 93 Cal App 4th 298 (2001).....	18, 19
<i>Perrott v Shearer</i> , 17 Mich 48 (Mich 1868).....	12
<i>Rafferty v Markovitz</i> , 461 Mich 265; 602 NW2d 367 (1999).....	8
<i>Robinson v Bates</i> , 112 Ohio St 3d 17, 23; 857 NW2d 1195 (2006).....	24
<i>Shanafelt [v Allstate Ins. Co.]</i> , 217 Mich App 625; 552 N.W.2d 671 (1996)]	11
<i>Sherwood v Railway Co.</i> , 82 Mich 374, 46 NW 773 (1890)	9
<i>Smith v Foerster-Bolser Const., Inc.</i> , 269 Mich App 424, 711 NW2d 421 (2006).....	2
<i>Stanley v Walker</i> , 906 NE2d 852 (2009)	23
<i>State Farm fire & Cas. Co. v Old Republic Ins. Co.</i> , 466 Mich 142; 644 NW2d 715 (2002).....	26
<i>Stillson v Gibbs</i> , 53 Mich 280; 18 NW 815 (1884)	4
<i>Taylor v Kent Radiology</i> , 286 Mich App 490; 780 NW2d 900 (2009).....	10
<i>Tebo v Havlik</i> , 418 Mich 350, 343 NW2d 181 (1984)	13, 20, 21, 22
<i>Thorn v Mercy Memorial Hosp. Corp.</i> , 281 Mich App 644; 761 NW2d 414 (2008)	10
<i>Velez v Tuma</i> , 492 Mich 1, 821, NW2d 432 (2012).....	13, 26
<i>Zdrowjewski v Murphy</i> , 254 Mich App 50, 657 NW2d 721 (2002).....	27
Statutes	
MCL 500.3107.....	11, 12
MCL 600.1483(3).....	10

MCL 600.2945(c)	10
MCL 600.6303(1)	15
MCL 600.6303(4)	26
MCL 600.6305(1)	10

Other Authorities

106 Mich. L.Rev. 643, 662-663	5
106 Mich. L.Rev. 643, 687	6
22 Am.Jur. 2d, Damages, § 27	4
Black's Law Dictionary	11

**STATEMENT OF INTEREST OF AMICUS CURIAE AND THE
ORDER APPEALED FROM AND RELIEF SOUGHT**

Michigan Professional Insurance Exchange ("MPIE") is an insurance exchange that provides medical professional liability insurance to health care providers and hospitals throughout Michigan. As a medical malpractice liability insurer, MPIE pays settlements and judgments incurred by its insureds.

The Appeal is of significant interest to MPIE because this Court's decision will have a substantial impact on the amounts of those settlements and judgments. Specifically, the resolution of this case will result either in (1) insured plaintiffs being able to collect, as damages for medical expenses, the full amount identified on an invoice but never incurred or (2) limiting plaintiffs to collecting the amount for which there was a legal obligation to pay or that actually was paid.

In this case, a jury awarded Plaintiff-Appellee Makenzie Greer the full amount of medical expenses identified on invoices rather than the amount that was paid pursuant to a pre-negotiated discounted rate agreed to between the insurance company and the health care provider. The difference between the amount identified on an invoice and the amount actually paid (or payable) to the provider per the pre-care negotiated contract with the insurance company will be referred to in this Brief as the "differential". The trial court denied Defendant-Appellants' post-trial Motion for Reduction in Judgment, which sought to reduce the amount awarded for medical expenses to the amount actually paid. The Opinion and Order denying that Motion was entered on August 8, 2012. Judgment entered on September 14, 2012. Defendant-Appellants' timely filed a claim of appeal from that Judgment, and the Court of Appeals affirmed the trial court in an Opinion entered on May 13, 2014. Both parties have addressed the issue in terms of whether a collateral source deduction in the amount of the negotiated differential is appropriate.

MPIE offers a third position not presented by the parties, and thus requests leave to appear as Amicus Curiae.¹ Quite simply, economic damages do not include money that the plaintiff (or her insurer) never paid and will never have to pay. The differential is not a proper measure of economic damages for medical expenses. The collateral source rule does not come into play because the negotiated differential is not an element of damages in the first instance. (In the event this Court disagrees, however, the negotiated discount would be subject to a collateral source deduction. The negotiated differential is a separate benefit than that over which a lien is asserted. Therefore, a collateral source setoff would be required.)

For the reasons set forth in this Brief, MPIE requests that this Court (1) GRANT Defendant-Appellants' Application for Leave to Appeal and ultimately (2) REVERSE the Court of Appeals Opinion to the extent it declined to reduce the award of past medical expenses.

¹ The ultimate issue in this case – how to treat negotiated differentials – has been preserved. To the extent MPIE's may not have been presented at the trial court level, and thus the more narrow issue how to treat negotiated differentials pre- or during trial was not raised, this Court can still resolve the issue because it is a question of law for which the necessary facts for resolution have been presented, *McNeil v Charlevoix County*, 484 Mich 69, fn 8; 772 NW2d 18 (2009) and consideration is necessary for proper determination of the case, *Smith v Foerster-Bolser Const., Inc.*, 269 Mich App 424, 711 NW2d 421 (2006). In the event this Court does not address MPIE's argument, MPIE requests that this Court's Opinion expressly leave open the issue for another day.

STATEMENT OF QUESTIONS PRESENTED

- I. DID THE TRIAL COURT AND COURT OF APPEALS ERR IN HOLDING THAT A PLAINTIFF CAN RECOVER, AS AN ELEMENT OF PAST ECONOMIC DAMAGES, THE AMOUNT OF A NEGOTIATED DIFFERENTIAL BETWEEN THE INSURER AND THE HEALTH CARE PROVIDER WHEN (1) THE PLAINTIFF DID NOT INCUR THE AMOUNT OF THE DIFFERENTIAL AS A MEDICAL EXPENSE AND (2) TO THE EXTENT THE DIFFERENTIAL CAN BE CONSIDERED A "BENEFIT" FOR PURPOSES OF THE COLLATERAL SOURCE RULE, IT IS A SEPARATE BENEFIT THAN THAT OVER WHICH A LIEN IS ASSERTED?**

Defendant-Appellants answer, "Yes."

Plaintiff-Appellees answer, "No."

The trial court answered, "No."

The Court of Appeals answered, "No."

Amicus Curiae Michigan Professional Insurance Exchange answers, "Yes."

SUMMARY OF THE ARGUMENT

The law differentiates between (1) the measure of economic damages for medical expenses and (2) the determination of a collateral source setoff *after* those particular damages have been established. The appropriate measure of damages is (and has always been) the “reasonable value” of medical expenses, limited to the amount actually paid. See *Alt v Konkle*, 237 Mich 264, 269; 211 NW 661 (1927). The “reasonableness” requirement is *limitation* on recoverable damages – not an aggrandizement. “The purpose of an action for tort is to recover the damages which the plaintiff has sustained from an injury done him by the defendant.” *Stillson v Gibbs*, 53 Mich 280, 284; 18 NW 815 (1884). A plaintiff cannot receive a higher amount for reimbursement of medical expenses than that which was incurred:

It is well established that generally only compensatory damages are available in Michigan and that punitive sanctions may not be imposed. See *Hayes-Albion Corp. v. Kuberski*, 421 Mich. 170, 187, 364 N.W.2d 609 (1984), *Kewin v. Massachusetts Mut. Life Ins. Co.*, 409 Mich. 401, 419, 295 N.W.2d 50 (1980), *Hicks v. Ottewell*, 174 Mich.App. 750, 755, 436 N.W.2d 453 (1989), and *In re Disaster at Detroit Metropolitan Airport on August 16, 1987*, 750 F.Supp. 793, 805 (E.D.Mich., 1989). **Because the purpose of compensatory damages is to make the injured party whole for the losses actually suffered, the amount of recovery for such damages is inherently limited by the amount of the loss; the party may not make a profit or obtain more than one recovery.** *Stillson v. Gibbs*, 53 Mich. 280, 284, 18 N.W. 815 (1884); 22 Am.Jur. 2d, Damages, § 27, pp. 54–56; 4 Restatement Torts, 2d, §§ 903, 906, 908, pp. 453, 460, 464

McAuley v General Motors Corp., 457 Mich 513, 519-520; 578 NW2d 282 (1998) (emphasis added).

A plaintiff should not profit from litigation, but rather only made whole. While a prevailing plaintiff is entitled to reimbursement for sums paid for reasonable and necessary medical care, paid either by the plaintiff or his or her insurance company, there is no entitlement beyond that amount paid. Yet that is what the plaintiff seeks in this case.

The medical “bills” in this case were fictitious. This is because the provider had an arrangement with the insurance company prior to the care provided wherein those parties agreed to a certain fee for

service. There was no expectation by the health care provider that the plaintiff would pay the differential, nor any obligation by the plaintiff to do so. In fact, the provider is prohibited by contract from “balance billing” the insured.

In the overwhelming majority of cases, allowing plaintiffs to collect the full, billed amount of a medical charge – especially with no setoff for the insurance discount rate - results in a significant windfall. Michigan has a relatively low uninsured population – 12.8% in 2009-2011 compared to a national average of 16%. See “The Uninsured in Michigan – A Profile”, issued by the Michigan Department of Community Health, December 2013, p 2. **Exhibit 1.** And, that percentage is expected to decrease with the implementation of the Affordable Care Act.

The health insurance providers or payers that insure 77% of Michigan’s population have negotiated discounts with insurers, sometimes as high as a 79% discount and generally between 33-50%. See “Patients as Consumers: Courts, Contracts, and the New Medical Marketplace”, 106 Mich. L.Rev. 643, 662-663, **Exhibit 2.** With the overwhelming majority of medical expenses being billed at almost twice the rate that the healthcare provider knows will be paid pursuant to a contractual arrangement with the insurer, the billed amount cannot *carte blanche* be considered the “reasonable value” of the medical services for an insured individual. Rather, the paid or collectable amount represents the *actual* reasonable value of the medical expense for an insured individual – it represents the market value of the services.

Although these medical billing complexities were not as prevalent when the common law was developing, the rationale behind using the amount paid is equally applicable today. The original rationale for using the amount paid to determine the reasonable value of medical expenses was that a plaintiff would not pay (or agree to pay) an amount that was unreasonable. The same is true today – an insurance company will not agree to pay an amount it deems to be unreasonable:

As health economist Gerard Anderson told Congress, for “a price list to be reasonable it needs to reflect what is actually being charged in the market place.” And since “virtually no public or private insurer actually pays full charges, charges are an unrealistic standard of comparison. **A more realistic standard is what insurers actually pay and what the hospitals have been willing to accept.**”

See “Patients as Consumers: Courts, Contracts, and the New Medical Marketplace”, 106 Mich. L.Rev. 643, 687 (Ex. 2).

In today’s health care system, attempting to litigate the “reasonable value” of medical expenses without a limitation on the amount to that which was actually paid would be so complex as to consume an entire trial. See *DiCarlo v St. Mary’s Hosp.*, unpublished opinion of the United States District Court, July 19, 2006 (D. New Jersey, Docket No. 05-1665-DRD-SDW)(“A court could not possibly determine what a ‘reasonable charge’ for hospital services would be without wading into the entire structure of providing hospital care and the means of dealing with hospital solvency.”) (affirmed by 530 F3d 255 (2008)) (Exhibit 3).

Using an amount deemed reasonable by both the provider and the payer results in the most certain and reasonable value being used and allows the plaintiff to be made whole, without requiring courts and jurors to wade into the structure of health care in this Country, preserving judicial economy. Further, limiting medical expense damages to the amount actually paid (or to be paid) results in both insured and uninsured individuals being treated fairly. Undoubtedly, both will pay different amounts for medical expenses. However, limiting both to being reimbursed for the amount actually paid (or to be paid) results in both insured and uninsured individuals being made whole (which is the goal) without insured individuals receiving an unfair windfall.

STATEMENT OF MATERIAL FACTS AND PROCEEDINGS

MPIE defers to the factual statements and procedural histories set forth in *Greer v Advantage Health*, 305 Mich App 192, 852 NW2d 198 (2014) and the Briefs of the primary parties to this Appeal.

The only facts necessary to resolve this issue, however, are these:

- (1) a plaintiff or a plaintiff's insurance company received an invoice of charges for medical services;
- (2) less than the total amount of that bill was paid pursuant to a negotiated agreement between the insurance company and the health care provider;
- (3) the plaintiff was not obligated to pay the difference between the amount identified on the invoice and the amount paid by the insurer to the provider;
- (4) despite never having incurred the billed amount, the plaintiff recovered the full amount of the medical bill as an element of past economic damages.

ARGUMENT

I. STANDARD OF REVIEW

This appeal involves an issue of law: whether a plaintiff can recover medical expenses that were never incurred or whether those amounts (i) were not awardable or (ii) if awardable, that award should have been reduced pursuant to the collateral source rule.

Issues of law and issues of statutory interpretation are reviewed de novo. See *Apsey v Memorial Hosp.*, 477 Mich 120, 127; 730 NW2d 695 (2007); *Driver v Naini*, 490 Mich 239, 246; 802 NW2d 311 (2011).

II. THE TRIAL COURT AND COURT OF APPEALS ERRED IN HOLDING THAT A PLAINTIFF CAN RECOVER, AS AN ELEMENT OF PAST ECONOMIC DAMAGES, THE AMOUNT OF A NEGOTIATED DIFFERENTIAL WHEN (1) THE PLAINTIFF DID NOT INCUR THE AMOUNT OF THE DIFFERENTIAL AS A MEDICAL EXPENSE AND (2) TO THE EXTENT THE DIFFERENTIAL CAN BE CONSIDERED A "BENEFIT" FOR PURPOSES OF THE COLLATERAL SOURCE RULE, IT IS A SEPARATE BENEFIT THAN THAT OVER WHICH A LIEN IS ASSERTED.

"Because the purpose of compensatory damages is to make the injured party whole for the losses actually suffered, **the amount of recovery for such damages is inherently limited by the amount of the loss**; the party may not make a profit or obtain more than one recovery." *McAuley v General Motors Corporation*, 457 Mich 513, 520; 578 NW2d 282 (1998) (emphasis added). See also *Rafferty v Markovitz*, 461 Mich 265, 270-271; 602 NW2d 367 (1999).

Allowing a plaintiff to collect the full billed amount of medical expenses, when that amount was never incurred as a liability and a significantly lesser amount satisfied the amount actually incurred for medical expenses, violates this long-standing rule of policy. Presented here are two analytical models pursuant to which medical expense damages can properly be limited.

The first is by ratifying the common law rule that damages for medical expenses is limited to the amount that was actually paid or for which there is an obligation to pay. The second, if this Court allows a plaintiff to receive a verdict in an amount of the medical expense invoices before the negotiated differential is applied, is to allow a collateral source set off in the amount of the differential.

A. The amount of the negotiated differential is not a loss that is incurred by a plaintiff, and therefore, not collectable as an element of damages.

A plaintiff is entitled only to the "reasonable value" of medical expenses, and at common law, the amount actually paid was evidence of reasonableness. *Alt v Konkle*, 237 Mich 264, 269; 211 NW 661 (1927). The common law collateral source rule, while prohibiting evidence of payments made by a third party, co-existed with this rule governing the measure of damages. The current collateral source

rule also should not affect the standard by which medical expenses are proven at trial. In other words, the collateral source rule does not come in to play. The issue is not whether evidence that a third party has paid expenses is admissible at trial to prove that expenses were paid by that third party. Rather, the issue is the appropriate method of valuating medical expenses.

1. **At common law, economic damages were limited to those actually paid.**

Historically, the measure of economic damages for medical expenses was the amount paid. See *Foley v Detroit & M. Ry. Co.*, 193 Mich 233, 236-237; 159 NW 506 (1916) (jury instruction indicating the plaintiff should be awarded “what he has been **compelled to pay out** for doctors, nursing, medicines, and hospital bills” was proper). See also, *Kinney v Folkerts*, 78 Mich 687, 44 NW 152 (1889) (instruction to jury that “the amount of the actual expense he has been to” for medical expenses was an appropriate instruction on the measure of damages). Simply introducing the amount billed was insufficient to establish the amount of economic damages from medical expenses. *Herter v City of Detroit*, 245 Mich 425, 428; 222 NW 774 (1929).

Rather, the plaintiff was required to establish his or her “reasonable and necessary outlays”. *Alt v Konkle*, 237 Mich 264, 269; 211 NW 661 (1927) (“A plaintiff in a negligence case is entitled to recover, as part of his damages, his reasonable and necessary outlays in an attempt to be cured of the injuries resulting from the negligence of the defendants”) quoting *Sherwood v Railway Co.*, 82 Mich 374, 46 NW 773 (1890).

The Court in *Alt* explained that the plaintiff must prove (1) the amount *actually* paid or to be paid, (2) the reasonableness of the amount and (3) that the expenditure was necessary. *Alt, supra* at 270. When the medical bill has been paid, the jury analyzes whether that amount paid was reasonable; where a bill has not yet been paid, the amount of damages is determined by “reasonable value”. *Id.* Further, a proper foundation must be laid establishing the reasonableness of the medical bills *before* they could be

introduced as evidence. *Fogel v Sinai Hosp. of Detroit*, 2 Mich App 99, 103; 138 NW2d 503 (1966). Stated another way, the amount actually paid is evidence that the amount sought is reasonable. See *Board of Rd. Com'rs of Lapeer County v Markley*, 260 Mich 455, 245 NW 496 (1932).

The common law rule finds continued support in the current statutory structure. In a medical malpractice action, an award of damages must be divided into the following categories: (i) past economic, (ii) past non-economic, (iii) future economic, and (iv) future non-economic. MCL 600.1483(3); MCL 600.6305(1). The Court of Appeals has adopted the definition of "economic loss" applicable to product liability actions and applied it to medical malpractice actions. See *Thorn v Mercy Memorial Hosp. Corp.*, 281 Mich App 644, 664-665; 761 NW2d 414 (2008) and *Taylor v Kent Radiology*, 286 Mich App 490, 519-520; 780 NW2d 900 (2009). That definition reads:

"Economic loss" means **objectively verifiable pecuniary damages** arising from medical expenses or medical care...or other objectively verifiable **monetary losses**.

MCL 600.2945(c) (emphasis added).

Similarly, the no-fault act definition requires personal protection insurance benefits to be payable for:

Allowable expenses consisting of all reasonable charges incurred for reasonably necessary...services...for an injured person's care....

MCL 500.3107. The Court of Appeals has determined that this definition does **not** allow a plaintiff to recover a health care provider's billed amount, but rather, only the amount paid by an insurer. See *Bombalski v Auto Club Insurance Association*, 247 Mich App 536, 540-541; 637 NW2d 251 (2001). Just as at common law, the no-fault definition requires "that (1) the expense must be incurred, (2) the expense must have been for a...service...reasonably necessary for the injured person's care,...and (3) the amount of the expense must have been reasonable." See *Bombalski*, supra quoting *Moghis v Citizens*

Inc. Co. of America, 187 Mich App 245, 247; 466 NW2d 290 (1990). In concluding that the differential amount was not collectable, the Court reasoned as follows:

This Court in *Shanafelt* [*v Allstate Ins. Co.*, 217 Mich App 625, 636–638; 552 N.W.2d 671 (1996)], addressed the defendant's arguments that certain medical expenses were never incurred as contemplated by subsection 3107(1)(a). The Court noted that Random House Webster's College Dictionary (1995) defined "incur" as " 'to become liable for.' " *Shanafelt*, *supra* at 638, 552 N.W.2d 671. See also Black's Law Dictionary (7th ed), p. 771, which similarly defines "incur" as "[t]o suffer or bring on oneself (a liability or expense)." The Court rejected the defendant's suggestion that the plaintiff never incurred medical expenses because the plaintiff's health insurer directly paid her medical bills. *Shanafelt*, *supra* at 636–637, 552 N.W.2d 671. After quoting the definition of incur found in Random House Webster's, the Court reasoned that "[o]bviously, plaintiff became liable for her medical expenses when she accepted medical treatment." *Id.* at 638, 552 N.W.2d 671.

Plaintiff submits that he likewise became liable for the amounts charged by his health care providers when he accepted their services and that consequently he incurred the full amounts charged. Plaintiff's claim does not persuade us, however, because plaintiff overlooks the significance of "liable," which means "[r]esponsible or answerable in law; legally obligated." Black's Law Dictionary, *supra* at 927. **The satisfaction of plaintiff's medical bills by BCBSM through payment of less than the amounts charged by the providers relieved plaintiff of any responsibility or legal obligation to pay the providers further amounts exceeding those proffered by BCBSM and accepted by plaintiff's health care providers. Because plaintiff bears no liability for the full medical service amounts initially charged by his health care providers, he has not incurred these full charges.**

* * *

Our adoption in this case of plaintiff's suggested interpretation of what are incurred charges within subsection 3107(1)(a), which proposed interpretation encompasses not only the amounts BCBSM paid in full satisfaction for the health care services plaintiff received but also the amounts of the providers' initial charges above the rates paid by BCBSM, plainly would frustrate the legislative purpose underlying the no-fault act to check skyrocketing health care costs and **would afford plaintiff a windfall** above his entitlement to uncoordinated, double benefits for any inflated medical charges he received.

We therefore conclude that in light of the ordinary meaning of incurred and the public policy behind the no-fault act, incurred charges within

M.C.L. § 500.3107(1)(a) do not encompass any amounts (1) exceeding those that plaintiff's health insurer actually paid in satisfaction of plaintiff's medical bills and (2) for which plaintiff no longer bears legal responsibility.

Bombalski, supra at 542-546 (emphasis added). (Just as in *Bombalski*, and as discussed below, allowing a plaintiff to collect amounts never incurred would frustrate the legislative intent behind the medical malpractice tort reform statutes.)

These definitions, which merely reflect the common law, limit the amount of economic loss to that which was *actually incurred* – not a fictitious amount. The definitions support the interpretation of “reasonable” medical expenses as a *limitation* on the medical expenses that can be recovered. In other words, not only must those expenses be *actually incurred*, they must also be reasonable.

When a plaintiff's health insurer has negotiated prices with a health care provider, that is the amount for which liability may be incurred. In this regard, the billed amount is a fictitious amount – there is no legal obligation to pay it, so it was never “incurred”. Since damages must be “incurred” to be collectable, the difference between the amount “billed” and the amount paid pursuant to the negotiated discounted rate is not a collectable element of damages.

2. **The common law collateral source rule did not affect the measure of damages.**

The common law collateral source rule is completely unrelated to the appropriate measure of economic damages – i.e., how a plaintiff proves the amount of medical expenses incurred. Rather, that rule prohibited a tortfeasor from mitigating the damages already proven by the standards set forth above by reference to an insurance policy. See *Perrott v Shearer*, 17 Mich 48 (Mich 1868). “The collateral source rule provides that compensation due an injured party from an independent source other than the wrongdoer does not operate to lessen damages recoverable from the wrongdoer.” *Blanch v Gagnon*, 47 Mich App 168, 171; 209 NW2d 292 (1973). In other words, once the plaintiff proves the

amount of economic loss (i.e., through admission of the amounts paid), that amount could not be reduced for the sole reason that all or some of that loss was already compensated by insurance.

The public policy reasoning behind the common law collateral source rule, which has been obviated by tort reform, was that the plaintiff gave up consideration and contracted for a benefit; the tortfeasor should not be able to benefit from the plaintiff's foresight. *Tebo v Havlik*, 418 Mich 350, 343 NW2d 181 (1984). Once again, the policy rationale pertains to a set-off *after* the plaintiff has already proven the amount of the damages. A plaintiff must first prove the amount of damages – only then does the question of a collateral source set off get evaluated. *Bourdon v Read*, 30 Mich App 681, 186 NW2d 737 (1971) (“a plaintiff who receives benefits...from a source independent of the wrong-doer does not thereby diminish the damages **otherwise recoverable** from the tort-feasor.”) (emphasis added) citing 22 Am. Jur. 2d, Damages, ss 206-211, pp. 286-298.

The collateral source rule also did not bar evidence that a plaintiff received compensation for injuries from a third party, if that evidence was introduced for a purpose other than mitigation, particularly where a limiting instruction was provided to the jury. See *Blacha v Gagnon*, 47 Mich App 168, 173-174; 209 NW2d 292 (1973) (evidence that employer continued to pay plaintiff's salary was admissible as evidence of an incentive not to return to work where the jury was instructed not to deduct any amount from damages based on that compensation).

3. **The current statutory collateral source rule, which abrogated the common law collateral source rule, does not alter the common law pertaining to the appropriate measure of damages for medical expenses.**

Just as the common law collateral source rule did not affect the measure of damages, neither does the statutory collateral source rule. “The common law remains in force until ‘changed, amended or repealed.’” *Velez v Tuma*, 492 Mich 1, 821, NW2d 432 (2012).

Whether the Legislature has abrogated, amended, or preempted the common law is a question of legislative intent. We will not lightly presume that the Legislature

has abrogated the common law. Nor will we extend a statute by implication to abrogate established rules of common law. "Rather, the Legislature 'should speak in no uncertain terms' when it exercises its authority to modify the common law."

Id. at 11-12 (footnote citations omitted).

Common law doctrines covering a subject not addressed in the statute are not extinguished by enactment of the statute. *Lee v Detroit Medical Center*, 285 Mich App 51, 67; 775 NW2d 326 (2009). citing *Adams v Auto Club Ins. Ass'n*, 154 Mich App 186, 194-195; 397 NW2d 262 (1986). There is no doubt that the statutory collateral source rule abrogated the common law collateral source rule. See *Heinz v Chicago Road Inv. Co.*, 216 Mich App 289, 194; 549 NW2d 47 (1996).

However, the statutory collateral source rule makes no reference to the manner in which *the plaintiff* may prove the reasonableness of medical expenses at trial. The substantive portion of the rule, and the part that abrogates the common law rule, reads:

In a personal injury action in which the plaintiff seeks to recover for the expense of medical care, rehabilitation services, loss of earnings, loss of earning capacity, or other economic loss, evidence to establish that the expense or loss was paid or is payable, in whole or in part, by a collateral source shall be admissible to the court in which the action was brought after a verdict for the plaintiff and before a judgment is entered on the verdict....

MCL 600.6303(1) (emphasis added).

The rule only pertains to evidence being used to establish that the expense or loss (which has already been proved at trial) was paid or is payable. It has nothing to do with the manner in which that expense or loss is established during trial. Therefore, the common law rule that the reasonableness of a medical expense is established by evidence of the amount actually paid remains controlling.

In fact, the language of the statutory collateral source rule supports that negotiated differentials are not an element of damages. In analyzing a negotiated differential, the differential must be addressed separately from the amount paid by the insurer. Those are two different types of "benefits". The Court

of Appeals recognized this, analyzing the insurance payments separately from the negotiated differential, but then erroneously failed to complete the full analysis as to the negotiated differential.

The statute requires (1) that an expense or loss be identified, (2) a determination that the identified expense was paid or payable, and (3) that the payment was made by (or could be made by) a collateral source. It is only the third step that requires consideration of the definition of “collateral source”. Until the first two steps are completed, the definition does not matter.

a. The expense or loss must first be identified.

The “expense” or “loss” is the amount *actually incurred* by the insured and insured – i.e., the **amount for the services that the health care provider and insured agreed upon**. For the reasons set forth above, the fictitious amount appearing on the plaintiff’s bill is not an amount actually incurred by the plaintiff; it is not an expense or loss. It simply does not make sense that a plaintiff can incur an “expense” or “loss” in an amount for which she was never liable. The common definitions of these words support this interpretation. An “expense” is “the amount of money that is needed to pay for or buy something.”² No money is needed to pay for the amount listed on the bill by the provider but not actually being charged. “Loss” has several definitions, including “the act of losing possession”, “decrease in amount”, and “the amount of an insured’s financial detriment by death or damage that the insurer is liable for”. An amount on a bill that is not actually incurred by a plaintiff does not fall within any of the definitions of “loss”.

b. The expense must be paid or payable.

The second prong of the analysis, that the expense or loss was “paid” or “is payable” supports that the collateral source statute does not apply to differentials. A negotiated differential is not “paid” nor is it “payable”. Rather, it is nothing more than a reflection of a different price charged for services.

² <http://www.merriam-webster.com/dictionary/expense>, accessed October 8, 2014.

In fact, most insurance company contracts preclude a health care provider from recouping additional charges from the insured.³

Since a negotiated discount is not an “expense” or “loss” suffered by a plaintiff, and since it cannot be paid (because it is not an expense or loss), it is not necessary to go any farther. The collateral source statute has no applicability; it does not say whether evidence of the discount is, or is not, admissible. It simply does not apply. In this manner, the statutory collateral source rule supports that the common law measure of damages still controls, and that amount does not include the negotiated differential amount.

4. Two approaches demonstrating the practical effect of the rule.

There are two primary methods by which medical expenses can be limited to the amount actually paid. The first is the simplest, and best aligns with Michigan’s common law. It has been in place in California since the 1980’s. Quite simply, the plaintiff is limited to the amount paid with the amount of the unadjusted medical invoice deemed irrelevant. At trial, a plaintiff introduces the amount paid or the amount for which he or she is legally liable. The negotiated differential never comes into play. With this type of certainty in the law, stipulations regarding the amount of medical expenses would increase, improving judicial economy and limiting the issue to whether care was reasonable and necessary.

The alternative approach allows a defendant to present evidence of the negotiated discount in response to a plaintiff arguing that the “reasonable value” of medical services is the billed amount.

a. Irrelevance and inapplicability of insurance discounts in establishing economic loss.

Since the common law rules governing the manner in which a plaintiff must establish economic damages for medical expenses have not been abrogated, the evidence used to establish those damages

³ In the rare event a health care provider does charge the insured the amount not paid by insurance, then that medical expense has actually been incurred. A plaintiff would be able to present the amount for which he or she is legally liable to the jury as a measure of damages.

today is the same as before the enactment of the collateral source rule. The collateral source rule does not come into play until after trial – i.e., after a plaintiff has already submitted proofs of the actual economic loss. The amount of an insurance discount has no relevance to establishing the amount that was actually paid.

In fact, the amount “billed” is not related to the issue of whether the amount actually paid is reasonable. Any issues regarding practical application can be resolved by applying the common law rules – a plaintiff establishes economic loss for medical expenses by introducing evidence of the amount actually paid, and that payment supports the reasonableness of the expense.⁴

This approach is not only the simplest, but also the one that most promotes the public policy of this State, balancing the need to wholly compensate an injured party without providing that party with a profit. A plaintiff is only entitled to be made whole, and is made whole when the amounts that have been paid to satisfy a medical expense have been reimbursed. It is only after a verdict reflecting this paid amount that the statutory collateral source rule comes into play. When a collateral source provides the funds, the plaintiff has not incurred a loss, and therefore, remains whole. When, however, that collateral source asserts a lien over the amount paid, requiring the plaintiff to repay the funds with sums collected from the defendant, it makes sense that the sum should include the amount that the plaintiff must turn over to the collateral source (and no more). In this manner, the plaintiff is whole without receiving a profit.⁵

This simplistic and easy-to-apply rule has been the rule in California for over twenty-five years. In *Hanif v Housing Authority*, 200 Cal App 3d 635 (1988), the amount plaintiff introduced as evidence

⁴ With confirmation of this black-letter rule, stipulations regarding the amount of medical expenses paid would be common, avoiding any concern of insurance benefits being mentioned to the jury, and increasing judicial efficiency.

⁵ In practice, plaintiffs will still receive a windfall, as they frequently negotiate a discounted lien settlement amount with the collateral source.

of the “reasonable value” of medical expenses was significantly more than the amount paid by the insurer,⁶ and the trial court ultimately awarded an amount much higher than the amount paid. *Id.* at 639.

The Court held this was error:

There was no evidence, however, that plaintiff was or would become liable for the difference [between the amount billed and the amount paid]. And the balance between the amount billed to Medi-Cal and the amount paid was “written off” by the hospital. Nevertheless, the court awarded, as special damages, the reasonable value of the medical services rendered. On appeal, defendant contends the court erred in its application of the controlling measure of damages in this regard, arguing that plaintiff’s recovery is limited to the amount actually paid. We agree that the trial court’s award over-compensated plaintiff for this item of damages.

Id.

The Court first confirmed that the plaintiff was entitled to damages for medical expenses despite insurance having covered the bills. It also confirmed the common law rule, which is the same in Michigan, that the appropriate measure of recovery was “the reasonable value of medical care and services reasonably required and attributable to the tort.” *Id.* at 640.

That reasonable value, however, is limited to the amount actually paid:

The question here involves the application of that measure, i.e., whether the “reasonable value” measure of recovery means that an injured plaintiff may recover from the tortfeasor more than the actual amount he paid or for which he incurred liability for pay medical care and services. **Fundamental principles underlying recovery of compensatory damages in tort actions compel the following answer: no.**

In tort actions damages are normally awarded for the purpose of *compensating* the plaintiff for injury suffered, i.e., restoring him as nearly as possible to his former positions, or giving him some pecuniary equivalent.... The primary object of an award of damages in a civil action, and the fundamental principle on which it is based, are *just compensation*

⁶ The insured in that case was Medi-Cal, a state program. However, the “benefit of the bargain” analysis does not apply (i.e., a Medicaid v Medicare / no premium v premium analysis) because, as discussed in the case analysis, the issue was not analyzed under the collateral source rule. In fact, the *Hanif* holding was later applied in the context of private insurance. See *Nishihama v City and County of San Francisco*, 93 Cal App 4th 298 (2001).

or indemnity for the loss or injury sustained by the complainant, *and no more....* A plaintiff in a tort action is not, in being awarded damages, to be placed in a better position than he would have been had the wrong not been done.

In tort actions, medical expenses fall generally into the category of economic damages, representing actual pecuniary loss caused by the defendant's wrong. Applying the above principles, it follows that an award of damages for past medical expenses in excess of what the medical care and services actually cost constitutes over-compensation.

Id. at 640-641 (numerous citations and quotations omitted).

The California court also held that the "reasonable value" was determined without consideration of the collateral source rule. *Id.* at 641. It also noted that the phrase "reasonable value" *limited* damages and did not allow excess damages:

"Reasonable value" is a term of limitation, not of aggrandizement. (See Civ.Code, §3359.) Thus, when the evidence shows a sum certain to have been paid or incurred for past medical care and services, whether by the plaintiff or by an independent source, that sum certain is the most the plaintiff may recover for that care despite the fact that it may have been less than the prevailing market rate.

Id. at 641 (emphasis added).

This rule was recently confirmed by the California Supreme Court in *Howell v Hamilton Meats & Provisions, Inc.*, 52 Cal 4th 541, 257 P3d 1130. In affirming *Hanif*, the Court relied on the Restatement 2d, Torts, § 911, comment h, pp 476-477: "[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." *Id.* at 556. "Thus, the general rule under the Restatement, as well as California law, is that a personal injury plaintiff may recover *the lesser* of (a) the amount paid or incurred for medical services, and (b) the reasonable value of services." *Id.* at 556 (emphasis in original). "[P]laintiff did not incur liability for her providers' full bills, because at the time the charges were incurred the providers had already agreed on a different price schedule for PacifiCare's PPO members. Having never incurred the

full bill, plaintiff could not recover it in damages for economic loss. For this reason alone, the collateral source rule would be inapplicable.” *Id.* at 563 (citation omitted).

The value is pre-defined by the insurer and the health care provider as the amount the health care provider will accept from the insurer as full satisfaction of the health care provided:

That amount constitutes the provider’s price, which the plaintiff and health insurer are obligated to pay without any write-off. There is no need to determine a reasonable value of the services, as there is in the case of services gratuitously provided. “[W]here, 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. In the latter case, the injured party should be limited to recovering the amount paid for the medical services.” (*Moorehead v Crozer Chester Medical Center* (2001) 564 Pa. 156, 765 A.2d 786, 789.)

Id. at 559.

The Court also addressed the practical and policy implications, concluding that tortfeasors do not receive a windfall⁷ by limiting plaintiffs to recovering only the amount actually paid. The Court actually

⁷ This Court has reached a similar conclusion:

The Court [of Appeals] said that the rationale for the [collateral source] rule is that it would constitute an “unjust enrichment” of the tortfeasor to allow him to reduce his liability because plaintiffs, exercising “a contract right of recovery against their insurer” for which they had paid consideration in the form of premiums, had already been reimbursed for their loss. *Tebo v. Havlik*, [109 Mich App 413, 415; 311 NW2d 372 (1981)]. Commentators have countered that insurance is generally purchased to assure prompt payment and to cover many perils so that only a fraction of the premium is paid to cover the peril which occurs, and that **any unjust enrichment could be avoided by requiring the tortfeasor to reimburse or contribute to the loss of the insurer.** Professor Dobbs has written:

“Perhaps the weakest argument made in support of the collateral source rule is the one that has been most mentioned in the courts – the wrongdoing defendant should not get the benefit of any reduction in the plaintiff’s damages by a collateral source, since this would be a ‘windfall’ and since a windfall should be given to the plaintiff rather than the wrongdoer. There are many answering arguments. It is possible to regard anything that diminishes or prevents a tortfeasor’s potential liability as a windfall, but since there is no standard amount

relied on the University of Michigan law review article above, and explained that with the modern complexity of health care economics, the price charged to a patient is not necessarily the “reasonable value”. Rather, the negotiated amount is a better gauge of the reasonable value. *Id.* at 560-562.

This is because there are multiple markets. The market between a health care provider and a patient with insurance is a different market than that of a health care provider and an uninsured individual. “In effect, there appears to be not one market for medical services but several, with the price of services depending on the category of payer and sometimes on the particular government or business entity paying for the services. Given 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.”⁸ *Id.* at 562.

payable for a tort, and since some torts involving little fault are costly while others involving much fault cause little or no harm, it does not seem very meaningful to refer to diminished liability as a windfall.

Furthermore, no one has suggested that the collateral source rule should be adjusted as fault increases or decreases, and in fact it is applied without regard to the tortfeasor’s fault at all, and even in cases where liability is strict and there is no fault. It is now widely agreed, in addition, that many tort cases based on ‘fault’ involve no moral fault at all and that liability in a substantial number of cases is in fact strict liability, scantily clad in the rhetoric of negligence. To whatever extent this may be so, the ‘wrongdoer’ argument for the collateral source rule fails. Finally, whatever may be said of the individual defendant as a wrongdoer, the truth is that in most cases a collectible judgment is insured against and it is the insured, not the individual defendant, who pays. Not only does this deprive the ‘wrongdoer’ thesis of any support where there is insurance, it also means that the collateral source rule is responsible for higher insurance premium costs.” Dobbs, [Remedies,] fn. 24, *supra* § 8.10, pp 586-587.

Tebo v Havlik, 418 Mich 350, n 25; 343 NW2d 181 (1984) (emphasis added).

⁸ As discussed elsewhere in this Brief, all plaintiffs remain on equal footing, regardless of whether they are insured. By limiting the amount collectable to the amount paid (or the amount for which one has liability to pay), all plaintiffs receive an amount equal to that which is owed, regardless of whether one amount is a negotiated discount and the other a higher amount. Confirming that the measure of damages does not include a negotiated differential prevents insured plaintiffs from receiving a windfall that

Finally, the Court concluded that the collateral source rule did not apply because the negotiated rate differential was not a gratuitous payment by the provider. *Id.* at 563-564. Further, “it is not primarily a benefit to the plaintiff...” *Id.* at 564. “Insurers and medical providers negotiate rates in pursuance of their own business interests, and the benefits of the bargains made accrue directly to the negotiating parties.” The discount is not compensation for the particular plaintiff’s injuries. *Id.* “[A] discounted price is not a payment....Nor has the value of damages the plaintiff *avoided* ever been the measure of tort recovery.” *Id.* at 565. (And in fact, this would run counter to the rule on mitigation of damages.)

This approach, declaring the negotiated differential to be irrelevant to the measure of damages and limiting a plaintiff to the amount actually paid, is most in line with Michigan common law and public policy. It promotes the tort reform measures found in the medical malpractice statutes and the statutory collateral source rule. It prevents plaintiffs from receiving a windfall without providing the defendants with one. And, it maintains common law principles that have not been abrogated by statute, thus promoting consistency and predictability in the law. As such, MPIE asks that this Court confirm that this is the applicable rule.

b. Alternatively, if a plaintiff may introduce the amount billed, a defendant should be able to introduce evidence of the discounted amount paid.

At the very least, if a plaintiff may introduce evidence of the full billed amount as an economic loss – despite having no legal liability to pay that amount – a defendant should be able to introduce evidence of the amount that was actually accepted by the health care provider. This is the approach taken in Indiana.

uninsured individuals would not. While this difference in treatment was justifiable under the common law collateral source rule because we were rewarding individuals for obtaining insurance, that policy underpinning was renounced by enactment of the current collateral source rule, which allows for a reduction of damages in the amount paid by insurance for which there is no right to subrogation.

Indiana allows evidence of the discounted amounts “to determine the reasonable value of medical services”. *Stanley v Walker*, 906 NE2d 852 (2009). In *Stanley*, the plaintiff introduced his medical bills as evidence of medical expenses. *Id.* at 854. The defendant sought to introduce evidence that almost half of the amount of those medical bills was a negotiated discount between the plaintiff’s health insurance company and the health care provider. *Id.* The trial court did not allow that evidence, holding that introduction of the negotiated discount amount would violate the collateral source rule. (Like Michigan, Indiana has abrogated the common law collateral source rule by statute. See I.C. § 34-44-1-2.)

The Indiana Supreme Court phrased the issue in this way:

An injured plaintiff is entitled to recover damages for medical expenses that were both necessary and reasonable. See *Cook v. Whitsell-Sherman*, 796 N.E.2d 271, 277 (Ind.1003). Thus we are confronted with the question of how to determine the reasonable value of medical services when an injured plaintiff’s medical treatment is paid from a collateral source at a discounted rate.

Id. at 855. Under Indiana law, where the plaintiff introduces their medical bills as evidence of medical expenses, the defendant can introduce evidence of the amount that was actually paid to challenge the reasonableness of the amount the plaintiff claimed.

In sum, the proper measure of medical expenses in Indiana is the reasonable value of such expenses. This measure of damages cannot be read as permitting only full recovery of medical expenses billed to a plaintiff. [Citation omitted.] Nor can the proper measure of medical expenses be read as permitting only the recovery of the amount actually paid. [Citation omitted]. The focus is on the reasonable value, not the actual charge. This is especially true given the current state of health care pricing.

Id. at 856-857.

After reviewing several sources discussing the complexity of the billing and accepting of payment in the health care system, the Court in Indiana concluded: “Thus, based on the realities of

health care finance, we are unconvinced that the reasonable value of medical services is necessarily represented by either the amount actually paid or the amount stated in the original medical bill.” *Id.* at 857.

So, the courts and juries in Indiana must wade into the complexities of the current health care structure to determine the reasonable amount of medical expenses, adopting the same position as Ohio courts:

[T]he 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...both the original bill and the amount accepted are evidence relevant to the reasonable value of medical expenses.

Id. at 857 quoting *Robinson v Bates*, 112 Ohio St 3d 17, 23; 857 NW2d 1195 (2006).

While this may be an arduous task (that can be avoided by limiting the “reasonable value” of services to the amount paid), it is fair and promotes the public policy of making a plaintiff whole without allowing a windfall. Those goals are not met by allowing the billed amount to be declared the reasonable amount in every case (especially without allowing a collateral source setoff).

B. If the negotiated discount falls within the definition of “collateral source”, the amount of the negotiated discount falls within the exception to the collateral source rule, allowing that amount to be deducted from the verdict.

The legislative intent in enacting the statutory collateral source rule was “to promote fairness, i.e., to prevent personal injury plaintiffs from being compensated twice for the same injury.” *Heinz, supra* at 301.

It is only fair that if the amount on the face of an invoice can be introduced at trial by the plaintiff to establish the measure of economic damages, but the amount of the negotiated discount

cannot be introduced by the defendant under the collateral source rule, then the extent of that differential should be reduced post-verdict as a collateral source set off.

The Court of Appeals held that the negotiated differential (which it erroneously referred to as a discount on an incurred medical expense⁹) was a collateral source under the statute. But it went on to hold that the “benefit” could not be exercised as a setoff because a lien was asserted over the medical expenses that were actually incurred. The result is an affront to common sense and equity – the Court of Appeals rule allows a plaintiff to collect a fictitious expense and would not allow a collateral source setoff to reign the amount into one that was actually incurred.

The error in the Court of Appeals opinion occurred because, despite at first properly separating the monetary benefits paid from the negotiated differential, it then combined those separate items when it considered the effect of the lien.

Again, the proper analysis is: (1) an expense or loss is identified, (2) a determination is made that the identified expense was paid or payable, and (3) that the payment was made by (or could be made by) a collateral source. Only the third prong requires an analysis of the definition of collateral source, and that definition must be considered in the context of the expense or loss and the benefit.

“Collateral source” is defined as follows:

As used in this section, “collateral source” means **benefits received or receivable** from an insurance policy; **benefits payable** pursuant to a contract with a health care corporation, dental care corporation, or health maintenance organization; **employee benefits**; **social security benefits**; **worker’s compensation benefits**; or **medicare benefits**. Collateral source does not include life insurance benefits or benefits paid by a person, partnership, association, corporation, or other legal entity entitled by law to a

⁹ See 305 Mich App 192, 206; 852 NW2d 198 (2014). The full amount “charged” was not actually incurred by the plaintiff because the discounted rate was already in effect at the time the services were provided. Therefore, the amount paid by the insurance company represented the full amount charged by that health care provider pursuant to its contract with the insurance company.

lien against the proceeds of a recovery by a plaintiff in a civil action for damages. Collateral source does not include **benefits paid or payable** by a person, partnership, association, corporation, or other legal entity entitled by contract to a lien against the proceeds of a recovery by a plaintiff in a civil action for damages, if the contractual lien has been exercised pursuant to subsection (3).

MCL 600.6303(4) (emphasis added).

“Plain and clear language is the best indicator of [legislative] intent, and such statutory language must be enforced as written.” *Velez v Tuma*, 492 Mich 1, 16-17; 821 NW2d 432 (2012). “[C]ourts must give effect to every word, phrase, and clause in a statute and avoid an interpretation that would render any part of the statute surplusage or nugatory.” *Jenkins v Patel*, 471 Mich 158, 167; 684 NW2d 346 (2004) quoting *State Farm fire & Cas. Co. v Old Republic Ins. Co.*, 466 Mich 142, 146; 644 NW2d 715 (2002).

If the collateral source statute is deemed to apply, the “expense” or “loss” could only be the amount of the differential. Again, that amount is not “paid” or “payable”, but even if it was (i.e., the “payment” was the contractual agreement between the insurer and the provider not to charge the balance to the patient), it is *that* payment that must be made by the collateral source. So then, the *lien* must also pertain to *that benefit*. The Court of Appeals identified the differential as the collateral source “benefit”, but used the lien over the actual payment benefit to remove the negotiated discount benefit from a collateral source deduction. Using a lien over one benefit to avoid applying a setoff for a separate benefit over which no lien is asserted is error.

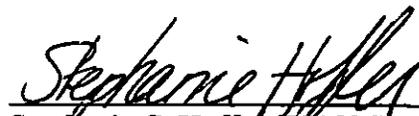
Since no lien is asserted over the negotiated discount, to the extent the collateral source rule is held to apply, that “benefit” would be deducted as a collateral source “payment”.¹⁰

¹⁰ This Brief is not intended to address the issue of when a lien is asserted over actually incurred and paid medical expenses, but for an amount less than that which was paid. See *Zdrowjewski v Murphy*, 254 Mich App 50, 657 NW2d 721 (2002). That issue does not need to be addressed in order to resolve

RELIEF REQUESTED

For the reasons set forth above, MPIE requests that this Court (1) GRANT Defendant-Appellants' Application for Leave to Appeal and ultimately (2) adopt MPIE's argument and REVERSE the Court of Appeals Opinion to the extent it declined to reduce the award of past medical expenses to only those expenses that were actually paid.

DATED: November 5, 2014



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the question presented. It is MPIE's position, however, that *Zdrowjewski* was decided in error. To the extent a collateral source discount is not permitted even when a lien is for a significantly less amount violates public policy. The purpose of the collateral source rule is to make a plaintiff whole without granting him or her a windfall. It makes sense to compensate a plaintiff for amounts that can then be recouped by the insurer. It does not make sense to allow the plaintiff to profit by pocketing the excess.