IN THE SUPREME COURT OF
THE STATE OF VERMONT

SUPREME COURT DOCKET NUMBER 2013-473

DZEMILA HECO,
Plaintiff – Appellee,

v.

JOHNSON CONTROLS, INC.,
Defendant – Appellant.

ON APPEAL FROM THE VERMONT SUPERIOR COURT
CIVIL DIVISION, CHITTENDEN UNIT
DOCKET NO. S869-10-Cnc

BRIEF OF INTERNATIONAL ASSOCIATION OF DEFENSE COUNSEL AS *AMICUS CURIAE* IN SUPPORT OF APPELLANT

R. Matthew Cairns
GALLAGHER, CALLAHAN & GARTRELL, PC
214 North Main Street
Concord, NH 03302-1415
(603) 228-1181
cairns@gcglaw.com

J. Mitchell Smith
GERMER PLLC
Three Allen Center
333 Clay Street, Suite 4950
Houston, TX 77002
(713) 650-1313
jmsmith@germer.com
Pro Hac Vice

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INTEREST OF *AMICUS CURIAE*[1]

The International Association of Defense Counsel (IADC) is an association of approximately 2500 corporate and insurance attorneys from the United States and around the globe whose practice is concentrated on the defense of civil lawsuits. The IADC is dedicated to the just and efficient administration of civil justice and continual improvement of the civil justice system. The IADC supports a justice system in which plaintiffs are compensated fairly for genuine injuries, responsible defendants are held liable for appropriate damages, and non-responsible defendants are exonerated without unreasonable costs.

The IADC has a particular interest in the fair and efficient administration of the rules of evidence in all state and Federal courts, and it advocates for stability and predictability amongst the various jurisdictions in what damages evidence will be admissible or inadmissible at trial.

STATEMENT OF THE ISSUE

This appeal presents two issues for review. This brief focuses on the second issue: whether the medical damages available in a tort case should be limited to the amounts actually paid or incurred on the plaintiff's behalf, rather than the amount billed initially by the medical provider. The damages awarded a party seeking redress from a tortfeasor should be those damages actually suffered by the injured party. Evidence of past medical expenses actually paid or incurred by the plaintiff should be admissible to establish the reasonableness of said expenses and to prevent unwarranted recovery. The admission of medical expenses actually paid or incurred does not violate the collateral source rule.

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[1] This brief was authored by *amicus* and their counsel listed on the front cover, and was not authored in whole or in part by counsel for a party. No one other than *amicus* or their counsel has made any monetary contribution to the preparation or submission of this brief.

STATEMENT OF THE CASE

Amicus hereby adopts and incorporates by reference the Statement of the Case set forth in Appellant's Brief.

STATEMENT OF FACTS

Amicus hereby adopts and incorporates by reference the Statement of Facts set forth in Appellant's Brief.

SUMMARY OF THE ARGUMENT

A jury should be permitted to review the medical bills actually paid or incurred by a plaintiff. Paid medical bills are relevant evidence that assist in determining a claimant's actual damages, and should be admissible. Fairness dictates the trier of fact be allowed to consider and weigh this evidence. The jury does not see who paid the bills or the circumstances under which they were paid. The admission of paid or incurred medical bills also promotes judicial efficiency by alleviating the need for post-trial motions and appellate intervention. Here, the trial court's refusal to allow JCI to introduce evidence of the actual cost of Heco's medical treatment, as opposed to the amounts billed but unpaid, resulted in a past and future medical expenses award that was unjustly inflated. This Court should reverse, and make clear that juries in this state should be allowed to consider evidence of the amount of paid medical bills in assessing plaintiffs' damages.

ARGUMENT

I. The damages awarded a party seeking redress from a tortfeasor should be those damages actually suffered by the injured party.

A. Paid or Incurred Medical Expenses are Relevant Damages Evidence and Should be Admissible.[2]

The trial court erred in refusing to allow Johnson Controls, Inc. ("JCI") to introduce evidence of the actual cost of Plaintiff's medical treatment, as opposed to the amounts charged or billed but not paid, to establish the reasonable value for past and future medical expenses. Evidence of the amount of medical bills actually paid or incurred is relevant to the determination of the reasonableness and necessity of charges rendered for medical and hospital care. A trier of fact should be permitted to weigh the probative value of the paid or incurred evidence in order to render a verdict for past and future medical expenses that balances the complexities of today's medical care marketplace.

Tort damages are intended to "as nearly as possible . . . restore a person damaged to the position he would have been in had the wrong not been committed . . . . Consequences which are contingent, speculative, or merely possible are not entitled to consideration in ascertaining

[2] Counsel for *Amicus* studied cases from jurisdictions throughout the United States in preparing this brief. The states take positions of varying nuance on the issue of the admissibility and use at trial of billed versus paid medical bills, and many jurisdictions use a combination thereof in trial practice. In its principal brief, JCI addresses the manner in which courts in Vermont, Pennsylvania, and New York have addressed the issue. We supplement that discussion with a "snapshot" analysis of the manner in which state supreme courts have addressed the issue in different key regional areas of the country: California (well-known to be at the forefront of important legal issues, our country's most-populous state, and representing the west); Texas (a state which has experienced significant tort reform, the country's second most-populous state, and representing the south); Ohio (its Supreme Court has addressed the issue and it was selected as the representative for the midwest); and, Massachusetts (the most-populous state in New England and a state that uses a unique system for the admissibility of medical records evidence). The cases discussed below are by no means a representation of all of the evidentiary rules followed by the states on this issue, but the discussion is intended to provide the Court with sufficient guidance on the substantive law at issue without over-writing on the subject.

the damages." *My Sister's Place v. City of Burlington*, 139 Vt. 602, 612, 433 A.2d 275, 281 (1981) (citations omitted). In general, a person who undergoes necessary medical treatment for tortiously caused injuries suffers an economic loss by taking on liability for the costs of treatment. Any reasonable charges for treatment the injured person has paid, or having incurred, still owes the medical provider are recoverable as economic damages. *Howell v. Hamilton Meats & Provisions, Inc.*, 52 Cal.4th 541, 551, 257 P.3d 1130, 1135 (2011). However, it is fundamental that to recover damages, the burden is on the plaintiff to produce evidence from which the jury may reasonably infer that the damages claimed resulted from the defendant's conduct. *Haygood v. De Escabedo*, 356 S.W.3d 390, 399 (Tex. 2012).

In light of the foregoing fundamental principles, the trial court here committed reversible error when it excluded the evidence of the actual costs of Dzemila Heco's ("Heco") medical treatments and thereby prevented it from weighing the totality of the evidence to arrive at a true and reasonable amount rather than an amount predicated upon inaccurate and misleading information. By preventing the jury from reviewing all evidence relevant to Heco's medical expenses, the trial court deprived JCI from presenting its case fairly and completely to an impartial jury.

Several other state supreme courts have addressed the issue recently and concluded a paid rather than billed amount approach to recovery of medical damages is the most sensible approach. Chief among these is the California Supreme Court, which takes a more balanced approach to this issue than the trial court below and permits the admission of the paid amount to prove the plaintiff's damages for past medical expenses. *Howell* involved a motorist who was seriously injured in an automobile accident negligently caused by a driver for defendant Hamilton Meats & Provisions ("Hamilton"). *Howell*, 52 Cal.4th at 549, 257 P.3d at 1133. At

trial, Hamilton conceded liability and the necessity of the medical treatment Howell received, contesting only the amounts of Howell's economic and non-economic damages. Hamilton moved in limine to exclude evidence of medical bills that neither plaintiff nor her health insurer, PacifiCare, had paid. Hamilton asserted that PacifiCare payment records indicated significant amounts of the bills from Howell's healthcare providers had been adjusted downward before payment pursuant to agreements between those providers and PacifiCare and that, under Howell's preferred provider organization (PPO) policy with PacifiCare, plaintiff could not be billed for the balance of the original bills (beyond the amounts of agreed patient copayments). *Howell*, 52 Cal.4th at 549, 257 P.3d at 1133-1134. Hamilton argued that because only the amounts paid by Howell and her insurer could be recovered, the larger amounts billed by the providers were irrelevant and should be excluded. *Id.* The trial court denied the motion in limine, ruling that Howell could present her full medical bills to the jury and any reduction to reflect payment of reduced amounts would be handled through a post-trial motion. *Id.*

The California Supreme Court's resolution of *Howell* is illuminating on several fronts. First, the Court reiterated that "California decisions have focused on 'reasonable value' in the context of *limiting* recovery to reasonable expenditures, not expanding recovery beyond the plaintiff's actual loss or liability. To be recoverable, a medical expense must be both incurred *and* reasonable." *Howell*, 52 Cal.4th at 555, 257 P.3d at 1137 (emphasis supplied). In discussing reasonableness, the Court continued, "if the plaintiff negotiates a discount and thereby receives services for less than might reasonably be charged, the plaintiff has not suffered a pecuniary loss or other detriment in the greater amount and, therefore, cannot recover damages for that amount. The same rule applies when a collateral source, such as the plaintiff's health

insurer, has obtained a discount for its payments on the plaintiff's behalf." *Howell*, 52 Cal.4th at 555, 257 P.3d at 1138.

In discussing whether or not medical bill markdowns are a gratuitous discount and assuming California follows the Restatement's view that a plaintiff may recover the value of donated, or gratuitous, services under the collateral source rule, the Court expressed the opinion it did not believe this exception militated against applying the rule—"that only amounts paid or incurred are recoverable—to medical expenses paid by the plaintiff's insurer." *Howell*, 52 Cal.4th at 558, 257 P.3d at 1139. "Medical providers that agree to accept discounted payments by managed care organizations or other health insurers as full payment for a patient's care do so not as a gift to the patient or insurer, but for commercial reasons and as a result of negotiations." *Howell*, 52 Cal.4th at 558, 257 P.3d at 1139-1140. Where a plaintiff has incurred liability for the billed cost of services and the provider later "writes off" part of the bill because, for example, the plaintiff is unable to pay the full charge, one might argue that the amount of the write-off constitutes a gratuitous benefit the plaintiff is entitled to recover under the collateral source rule. *Howell*, 52 Cal.4th at 559, 257 P.3d at 1140.

Particularly where the medical provider has agreed, before treating the plaintiff, to accept a certain amount in exchange for its services, "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." *Id.* There remains no issue as to the amount of medical expenses as the precise amount of expenses is established by contract and satisfied, and the injured party is limited to a recovery of the amount paid for the medical services. *Id.*

The California Supreme Court concluded by holding "an injured plaintiff whose medical expenses are paid through private insurance may recover as economic damages no more than the amounts paid by the plaintiff or his or her insurer for the medical services received or still owing at the time of trial." *Howell*, 52 Cal.4th at 566, 257 P.3d at 1145. The Court continued that "when a medical care provider has, by agreement with the plaintiff's private health insurer, accepted as full payment for the plaintiff's care an amount less than the provider's full bill, evidence of that amount is relevant to prove the plaintiff's damages for past medical expenses and, assuming it satisfies other rules of evidence, is admissible at trial. Where the provider has, by prior agreement, accepted less than a billed amount as full payment, evidence of the full billed amount is not itself relevant on the issue of past medical expenses." *Howell*, 52 Cal.4th at 567, 257 P.3d at 1146. And, "where a trial jury has heard evidence of the amount accepted as full payment by the medical provider but has awarded a greater sum as damages for past medical expenses, the defendant may move for a new trial on grounds of excessive damages. *Id.*

In California, it is now clear that evidence of paid or incurred medical expenses is admissible, assuming other rules of evidence are satisfied, and a plaintiff is limited in recovery to the amount of these "paid" expenses.

The Texas Supreme Court has gone one step further than the California Supreme Court, interpreting a state statute of evidence of *only* the paid or actually incurred amount. Section 41.0105 of the Texas Civil Practice and Remedies Code provides:

> EVIDENCE RELATING TO AMOUNT
> OF ECONOMIC DAMAGES
>
> In addition to any other limitation under law, recovery of medical or healthcare expenses incurred is limited to the amount actually paid or incurred by or on behalf of the claimant.

TEX. CIV. PRAC. & REM. CODE § 41.0105 (Vernon 2008).

Despite the clear wording of section 41.0105, the Texas Supreme Court had to weigh in on the issue and clarify for all Texas trial courts the manner in which the statute should be applied at trial. In *Haygood v. De Escabedo*, Haygood sued Escabedo for injuries he sustained when the car he was driving collided with Escabedo's minivan as she was pulling out of a grocery store parking lot. Haygood's injuries required surgeries on his neck and shoulder. Both surgeries were successful, but some impairment remained. *Haygood*, 356 S.W.3d at 392. Twelve healthcare providers billed Haygood a total of $110,069.12, but he was covered by Medicare Part B, which generally "pays no more for . . . medical and other health services than the 'reasonable charge' for such service." *Id.* Accordingly, Haygood's healthcare providers adjusted their bills with credits of $82,329.69, leaving a total of $27,739.43. *Id.* At the time of trial, $13,257.41 had been paid and $14,482.02 was due. *Id.*

Invoking section 41.0105, Escabedo moved to exclude evidence of medical expenses other than those paid or owed. Haygood, asserting the collateral source rule, moved to exclude evidence of any amounts other than those billed, and any adjustments and payments. The trial court denied Escabedo's motion and granted Haygood's. *Id.* At trial, Haygood offered evidence from each of his healthcare providers that the charges billed were reasonable and necessary. The jury found Escabedo's negligence caused the accident and that Haygood's damages were $110,069.12 for past medical expenses, $7,000.00 for future medical expenses, $24,500.00 for past pain and mental anguish, and $3,000.00 for future pain and mental anguish. *Id.* The trial court overruled Escabedo's objection to an award of past medical expenses in excess of those paid or owed and rendered judgment on the verdict. *Id.*

The court of appeals reversed, holding that section 41.0105 precluded evidence of a recovery of expenses that "neither the claimant nor anyone acting on his behalf will ultimately be

liable for paying." *Id.* The court suggested a remittitur of the amount of the healthcare providers' adjustments, which Haygood did not accept, and the case was remanded for a new trial. *Id.* The appellate court noted that two other courts had reached conflicting decisions on the interpretation of Texas's paid or incurred statute. *Id.*[3]

In affirming the opinion of the appellate court, the Texas Supreme Court held that section 41.0105 "limits a claimant's recovery of medical expenses to those which have been paid or must be paid by or for the claimant." *Haygood*, 356 S.W.3d at 398. As such, only evidence of recoverable medical expenses is admissible at trial. *Haygood*, 356 S.W.3d at 399.

In arriving at its opinion, the Texas Supreme Court addressed the problems caused at trial when no bright line rule is utilized regarding the admissibility of medical expenses. In *Haygood*, the dissent argued that the jury should consider only evidence of charges billed, without adjustments or credits required by insurers, and evidence of expenses paid or to be paid should be presented to the trial court post-verdict by a defendant. *Haygood*, 356 S.W.3d at 399. In response, the Court noted that parties may dispute whether expenses are necessarily related to a plaintiff's injury and that the parties may disagree whether any part of some providers' charges is reasonable. *Id.* "If the jury awards less than the total of all charges," [for medical expense evidence submitted as billed rather than as paid] "the trial court may have no way of knowing which charges the jury found reasonable and which it did not. In all these situations, a requirement that the trial court resolve disputed facts in determining the damages to be awarded violates the constitutional right to trial by jury." *Id.*

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[3] See *Irving Holdings, Inc. v. Brown*, 274 S.W.3d 926, 931-933 (Tex. App.—Dallas 2009, pet. denied), and *Gore v. Faye*, 253 S.W.3d 785, 789-790 (Tex. App.—Amarillo 2008, no pet.). Since then, two other courts have followed *Brown*. *Arango v. Davila*, Nos. 13-09-00470-CV, 13-09-00627-CV, 2011 WL 1900189 (Tex. App.—Corpus Christi 2011, rev. denied) and *Fronter Sanitation, L.L.C. v. Cervantes*, 324 S.W.3d 135, 140 (Tex. App.--El Paso 2011, no pet. h.).

While Vermont has not enacted a "paid or incurred" statute, the *Haygood* opinion provides a strong argument for the use of a bright line admissibility rule allowing for the introduction of medical bills actually paid or incurred by the plaintiff or paid by a third-party payor on behalf of the plaintiff. A paid or incurred only admissibility rule similar to the one used in Texas gives trial courts clear guidance and a simple test to follow, which would cure the problem presented in the case below and alleviate the conflicting results (which require additional appellate intervention and interpretation) caused by trial courts having too much discretion due to the non-existence of a bright line admissibility rule. Although Vermont may not be willing to accept a paid or incurred only admissibility rule presently, at a minimum, evidence of a plaintiff's true medical expenses, i.e. what was actually paid or incurred, should be admissible at trial for a jury's consideration.

The Ohio Supreme Court similarly recognizes the admissibility of paid medical bills. "We have repeatedly recognized that 'either the bill itself or the amount actually paid can be submitted to prove the value of medical services.'" *Moretz v. Muakkassa*, 137 Ohio St.3d 171, 191, 998 N.E.2d 479, 496 (2013). Ohio takes the middle ground in refusing to adopt a categorical rule that the reasonable value of medical services is either the amount billed or the amount paid. *Moretz*, 137 Ohio St.3d at 191, 998 N.E.2d at 497. "Instead, the reasonable value of medical services is a matter for the jury to determine from **all relevant evidence**." *Id.* (emphasis added). "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. *Id.* "Evidence of 'write-offs,' reflected in medical bills and statements, is prima facie evidence of the reasonable value of medical services." *Moretz*, 137 Ohio St.3d at 192, 998 N.E.2d at 497.

While Ohio declined to set a "categorical rule" in the mode of Texas, Ohio's approach further supports the admissibility of evidence of the actual cost of a plaintiff's medical treatment; that is, those bills that were actually paid or incurred by the plaintiff herself or by a third-party payor.

Ohio, California and Texas's approaches are in contrast to that taken by the Supreme Judicial Court of Massachusetts in *Law v. Griffith*, 457 Mass. 349, 930 N.E.2d 126 (2010), which concludes that "evidence of amounts actually paid to the plaintiff's medical providers is not admissible, but evidence may be introduced concerning the *range* of payments that the providers accept for the types of medical services that the plaintiff received." *Law*, 457 Mass. at 353, 930 N.E.2d at 131 (emphasis added).[4]

Amicus herein asserts this type of admissibility rule only compounds the evidentiary problems presented in the case at hand. "Range of payments" provides little guidance for a trier of fact as to the actual amount of a plaintiff's medical damages. Further, a range of payments standard does not promote judicial economy because it requires post-trial motions and resulting appellate review to determine the sufficiency of the evidence presented regarding reasonable and necessary medical expenses, past and future. The better admissibility rule is to allow the introduction of medical bills actually paid or incurred so that a base line standard is presented for a jury's consideration. While *Amicus* argues the Texas rule would be the best rule, the California and Ohio standards are also acceptable and preferable to the exclusionary ruling provided by the trial court below. JCI is entitled to a new trial because the trial court erroneously refused to permit jury consideration of what was actually paid for Heco's medical expenses, thereby allowing inflated, unsubstantiated medical expense evidence to be considered by the jury.

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[4] Even under Massachusetts law, JCI would be entitled to a new trial because "range" evidence was prohibited by the trial court.

B. Paid or Incurred Evidence Does Not Violate the Collateral Source Rule

Evidence of amounts paid by third-party payors does not violate the collateral source rule. As a general principle, compensatory damages, like medical expenses, "are intended to make the plaintiff 'whole' for any losses resulting from the defendant's interference with the plaintiffs' rights." *Haygood*, 356 S.W.3d at 394. The collateral source rule provides an exception. Long a part of the common law of Vermont and other jurisdictions, the rule precludes any reduction in a tortfeasor's liability because of benefits received by the plaintiff from someone else—a collateral source. *Hall v. Miller*, 143 Vt. 135, 141, 465 A.2d 222, 225 (1983).[5]

"Most commonly applied where an insurance company has made a payment to compensate the plaintiff for his or her injuries, 'the collateral[-]source rule prevents the defendant wrongdoer from benefiting from the plaintiff's foresight in acquiring the insurance through any offsetting procedure.'" *Windsor School District v. State*, 183 Vt. 452, 470-471, 956 A.2d 528, 542 (2008). "While the rule may result in plaintiff's obtaining a 'double recovery,' its essential purpose is not to provide the plaintiff a windfall but to prevent the wrongdoer from escaping liability for his or her misconduct." *Windsor*, 183 Vt. at 471, 956 A.2d at 542.[6] The rule also serves as a deterrent to a tortfeasor's negligent conduct, and makes the tortfeasor fully responsible for damages caused as a result of tortious conduct. *Windsor*, 183 Vt. at 472, 956 A.2d at 543.

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[5] See also RESTATEMENT (SECOND) OF TORTS § 920A(2) (1977) ("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."), *Haygood*, 356 S.W.3d at 395. It is worth noting the RESTATEMENT is over thirty years old and the American health system has changed dramatically since that time.

[6] Double recovery is no longer the issue it once was because the common practice presently is for insurers to assert liens against tort recoveries for the amounts they have paid; the "double recovery" issue is now more theoretical than real.

Interestingly, the supreme courts of both California and Texas, representing the two most populous states in the country and states that are well-known to be on the opposite ends of the political spectrum, have each determined that evidence of medical expenses actually paid or incurred does not offend or abrogate the collateral source rule but preserves and honors its inviolate place in the rules of evidence.

As explained by the California Supreme Court, "if the jury were required to decide whether the price actually paid for medical care was lower than reasonable," [rebutting the dissent's proposal that the insured plaintiff recover the "reasonable value" of his or her care, to be proven in each case by expert testimony] "the defense could not in fairness be precluded from showing the circumstances by which that price was determined, including that it was negotiated and paid by the plaintiff's health insurer." *Howell*, 52 Cal.4th at 563, 257 P.3d at 1143. "In contrast, our conclusion, that the plaintiff may recover no more than the medical providers accepted in full payment for their services, allows for proof of the amount paid without admitting evidence of the payment's source." *Id.* Thus, if the jury is not permitted to review evidence of a payment's source, the collateral source rule is not violated.

The *Howell* Court addressed the collateral source rule further in the context of a negotiated rate differential and found no violation of the rule. In reiterating the fact that Howell 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, the Court determined:

> "The negotiated rate differential lies outside the operation of the collateral source rule because it is not primarily a benefit to the plaintiff and, to the extent it does benefit the plaintiff, it is not provided as compensation for injuries. Insurers and medical providers negotiate rates in pursuit of their own business interests, and the benefits of the bargains made accrue directly to the

> negotiating parties. The primary benefit of discounted rates for medical care goes to the payor of those rates—that is, in largest part, to the insurer."

Howell, 52 Cal.4th at 563-564, 257 P.3d at 1143-1144. The Court determined the negotiated rate differential is not a collateral payment or benefit subject to the collateral source rule and concluded, "that because the plaintiff does not incur liability in the amount of the negotiated rate differential, which also is not paid to or on behalf of the plaintiff to cover the expenses of the plaintiff's injuries, it does not come within the rule. '[A] rule limiting the measure of recovery to paid charges (where the provider is prohibited from balance billing the patient) . . . provides certainty without violating the principles protected by the collateral source rule.'" *Howell*, 52 Cal.4th at 565, 257 P.3d at 1144-1145.

The Court acknowledged there is an element of fortuity to the compensatory damages a defendant may be required to pay, but concluded that this did not counsel in favor of a different rule:

> "A tortfeasor who injures a member of a managed care organization may pay less in compensation for medical expenses than one who inflicts the same injury on an uninsured person treated at a hospital (assuming the hospital does not offer the person a discount for its charge master prices). But [and citing to the brief provided by an *amicus curiae* in the *Howell* litigation], '[f]ortuity is a fact in life and litigation.' . . . [w]hen a driver negligently injures a pedestrian, the amount of lost income the injured plaintiff can recover depends on his or her employment and income potential, a matter of complete fortuity to the negligent driver. In that situation as in this, '[i]dentical injuries may have different economic effects on different victims.' We should not order one defendant to pay damages for an economic loss the plaintiff has not suffered merely because a different defendant may have to compensate a different plaintiff who *has* suffered such a loss."

Howell, 52 Cal.4th at 566, 257 P.3d at 1145 (emphasis supplied). The Court then reiterated that an injured plaintiff whose medical expenses are paid through private insurance may recover as

economic damages no more than the amounts paid by the plaintiff or his or her insurer for the medical services received or still owing at the time of trial. In so holding, "we in no way abrogate or modify the collateral source rule as it has been recognized in California; we merely conclude the negotiated rate differential—the discount medical providers offer the insurer—is not a benefit provided to the plaintiff in compensation for his or her injuries and, therefore, does not come within the rule. *Id.*

In Texas, the *Haygood* Court held, "the common-law collateral source rule does not allow recovery as damages of medical expenses a healthcare provider is not entitled to charge." *Haygood*, 356 S.W.3d at 396. Only evidence of recoverable medical expenses should be admissible at trial but "the collateral source rule continues to apply to such expenses, and the jury should not be told that they will be covered in whole or in part by insurance. Nor should the jury be told that a healthcare provider adjusted its charges because of insurance." *Haygood*, 356 S.W.3d at 400.

Thus, the supreme courts of California and Texas have provided solid opinions on why the admission of paid or incurred medical bills does not violate the collateral source rule. Ohio is also in accord with this reasoning. "The common-law collateral source rule does not exclude evidence of write-offs of expenses that are never paid. A write-off is not a payment, and, thus, it cannot constitute payment of a benefit. Thus, evidence of write-offs can be admitted because the tortfeasor 'does not obtain a 'credit' therefrom.'" *Moretz*, 137 Ohio St.3d at 191, 998 N.E.2d at 497.

As the cases discussed herein support, the evidentiary consequences of the collateral source rule are fully satisfied by excluding the origins of third-party payments without barring

the amounts paid. JCI never sought to introduce who paid for Heco's medical care, only how much was actually paid. It was reversible error for the Court to exclude this evidence.

C. The Future Medical Expenses Award was Wrongfully Inflated

Amicus hereby adopts and incorporates by reference the arguments set forth in V-C in Appellant's Brief. The number utilized by the jury below in determining future medical expenses was an inaccurate one because the jury did not consider the medical expenses actually incurred or paid by Heco due to the trial court's erroneous exclusion of this evidence. It is in the best interest of all parties—plaintiffs and defendants—that juries consider and weigh all relevant evidence. This gives all parties a level playing field and could reduce the number of appeals required for consideration of future damages awards that are premised upon inaccurate multipliers.

D. Public Policy Considerations Support Limiting the Recovery of Medical Expenses to the Paid Rather than the Billed Amount

The California Supreme Court's opinion in *Howell* is an enlightening read that presents a detailed, balanced analysis of the myriad of public policy issues at play on the issue of the admissibility of medical bills. The medical bills of today are not the medical bills of the early 1960's, or even the medical bills of the 1970's or 1980's. The advent of Medicare and Medicaid, state-funded insurance plans, pension plans, the ever-complex insurance marketplace, and the Affordable Care Act have all made an effect upon the manner in which the healthcare industry issues and pays its bills. Indeed, it is now an "industry" and the system is in constant flux. What one healthcare provider charges for a service may differ from the amount charged by a different provider, in the same locale, for the same service.

As such, the legal system must adapt and ensure that evidentiary rules are in place that provide litigants clear guidance on what is and what is not admissible—while at the same time

safeguarding against the abuses the rules of evidence are designed to prevent and ensuring all litigants try their cases on level playing fields. *Amicus* argues the best practice is for juries to consider what a claimant actually paid or incurred in medical expenses. The use of this evidence ensures jurors are utilizing numbers that are a more accurate reflection of the actual damages (or harm) than the inflated numbers generated by the complex healthcare marketplace. This can be done without violating the sacrosanct collateral source rule.

Although *Amicus* is a defense-oriented organization, the use of paid or incurred medical bills at trial will benefit all parties—plaintiffs and defendants. Evidentiary clarity on the issue will resolve time-consuming pre-trial matters, reduce the need for post-trial motions and remittiturs, and, hopefully, reduce the need for appellate intervention on points of error regarding medical expense damages awards. A reduction in litigation costs and the saving of judicial time and resources are strong public policy factors to consider in this important debate.

CONCLUSION

It was reversible error for the trial court to prohibit relevant evidence of the actual cost of Heco's medical treatment. The error resulted in a damages award based upon inaccurate and insufficient evidence. Evidence of paid or incurred medical bills can be admitted without violating the collateral source rule. The judgment of the trial court should be reversed and a new trial on the issue of damages should be granted.

Respectfully submitted,

GALLAGHER, CALLAHAN & GARTRELL, PC
214 North Main Street
Concord, NH 03302-1415
Telephone: (603) 228-1181

By: _____
R. Matthew Cairns
Vermont Bar No. 5100
cairns@gcglaw.com

J. Mitchell Smith
GERMER PLLC
Three Allen Center
333 Clay Street, Suite 4950
Houston, Texas 77002
Telephone: (713) 650-1313
Telecopier: (713) 739-7420

ATTORNEYS FOR *AMICUS CURIAE*, INTERNATIONAL ASSOCIATION OF DEFENSE COUNSEL

RULE 32(A)(7)(D) CERTIFICATE OF COMPLIANCE

I hereby certify that this brief in its entirety contains 6021 words, was prepared using Microsoft Word 2010 and complies with the word-count limit.

_____
R. Matthew Cairns

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the above and foregoing Brief of International Association of Defense Counsel as *Amicus* Curiae in Support of Appellant has been forwarded to all counsel of record on this the 19th day of February, 2014.

_____
R. Matthew Cairns