

INSURANCE WRITE-OFFS AND THE COLLATERAL SOURCE RULE

By Douglas Rallo

In contracts between health care providers and health insurance carriers, providers often agree to certain fee schedules by which they accept as full payment less than the amount billed to the patient. The difference between the amount charged and the amount accepted is "written off" by the provider. In such cases, may a tort plaintiff recover the full amount of billed medical expenses, or is recovery limited to the amount paid?

The answer depends on judicial application of the collateral source rule, which has been explained as follows:

The courts generally held that benefits received by the plaintiff from a source wholly independent of and collateral to the wrongdoer will not diminish the damages otherwise recoverable from the wrongdoer...[T]he wrongdoer cannot take advantage of the contracts or other relationships that may exist between the injured person and third persons. Thus, while a plaintiff's recovery under the ordinary negligence rule is limited to damages which will make him whole, the collateral source rule allows a plaintiff further recovery under certain circumstances even though he suffered no loss.[1]

Helfend v. Southern California Rapid Transit District provides a thorough examination of the history and application of the collateral source rule, as well as academic comment on and legislative responses to it. [2] In Helfend, the plaintiff was injured when the defendant bus driver sideswiped the plaintiff's vehicle, crushing his arm, which had been hanging down at the side of his car in the stopping-signal position. The plaintiff sued the bus driver and his employer, the Southern California Rapid Transit District, a public entity.

At trial, the defendants asked to show that about 80 percent of the plaintiff's hospital bill had been paid by the plaintiff's Blue Cross insurance carrier and that some other medical expenses had been paid by other insurance. The trial court denied the request, and the jury awarded the plaintiff \$16,300.

The defendant appealed, arguing that the collateral source rule does not apply to tort actions involving public entities and employees in which the plaintiff has received medical insurance benefits.

The court first noted that although the rule remains generally accepted in the United States, many jurisdictions have restricted or repealed it.[3] Similarly, commentators have criticized and opposed the rule, but at least one has written that "the rule seems to perform a needed function. At the very least, it removes some complex issues from the trial scene ...[and] in some cases it operates as an instrument of what most of us would be willing to call justice.[4]

As to objections that the collateral source rule is punitive to defendants, the California Supreme Court disagreed, finding that:

Courts consider insurance a form of investment, the benefits of which become payable without respect to any other possible source of funds. If we were to permit a tortfeasor to mitigate damages with payments from plaintiff's insurance plaintiff would be in a position inferior to that of having bought no insurance, because his payment of premiums would have earned no benefit Defendant should not be able to avoid payment of full compensation for the injury inflicted merely because the victim has had the foresight to provide himself with insurance.[5]

Regarding the popular contention that the collateral source rule gives plaintiff's a double recovery, the court pointed out that since juries are not informed that a plaintiff's attorney will receive a significant portion of the recovery under the typical contingent fee agreement, the plaintiff would rarely actually receive full compensation for injuries. According to Helfend, the collateral source rule "partially serves to compensate for the attorney's share and does not actually render a 'double recovery' for the plaintiff." By allowing recovery for medical expenses from both the tortfeasor and the plaintiff's medical insurance program, the collateral source rule "provides a somewhat closer approximation to full compensation for the plaintiff's injuries.[6]

The Helfend court also relied on the concept of subrogation to dispute the notion of a double recovery:

[I]nsurance policies increasingly provide for either subrogation or refund of benefits upon a tort recovery ... Hence, the plaintiff receives no double recovery; the collateral source rule simply serves as a means of bypassing the antiquated doctrine of nonassignment of tortious action and permits a proper transfer of risk from the plaintiff's insurer to the tortfeasor by way of the victim's tort recovery. The double shift from the tortfeasor to the victim and then from the victim to his insurance carrier can normally occur with little cost in that the insurance carrier is often intimately involved in the initial litigation and quite automatically receives its part of the tort settlement or verdict.[7]

Turning to the specific issue before it, the Helfend court applied the collateral source rule to tortfeasors who are public entities or public employees. To do otherwise, the court held, would create myriad problems in the common situation where a public entity is required by law or contract to indemnify and defend its employees against civil liability for their official acts in the scope of their employment. It would also provide an unwarranted sovereign immunity where no such special treatment is justified.

Similarly, nullification of the rule for public entities and employees would frustrate the transfer of medical costs from the plaintiff's medical insurer. Blue Cross, to the public-entity tortfeasor which is in at least as advantageous a position as Blue Cross to spread the risk of loss. Finally, the court noted, depriving Blue Cross of repayment for its expenditures on the plaintiff's behalf would constitute an arbitrary discrimination against tort victims who happen to be injured by public entities rather than private individuals.

Three concepts

In a Wisconsin case, *Koffman v. Leichtfuss*, the plaintiff received treatment from numerous health care providers for a spine injury, which he claimed to have suffered in a car crash.[8] The amount billed for those services was \$187,932. His employer, Wisconsin Central Transportation Co., provided the plaintiff with health care insurance through a self-funded plan.

Through certain contractual relationships with the plaintiff's health care providers, Wisconsin Central received the benefit of reduced "contracted rates" and was able to satisfy its liability for the amounts billed by those providers with total payments of \$62,324. The plaintiff's auto insurance carrier, Farmers Automobile Insurance Association, paid \$1,869 in medical expenses. The plaintiff paid \$1,869 in deductibles, co-payments, and out-of-pocket expenses.

The plaintiff's lawsuit named Wisconsin Central and Farmers as defendants. In answering the complaint, these defendants asserted their subrogation interests in the amounts paid on the plaintiff's behalf.

In a pretrial stipulation, the defendants agreed that the amounts billed by the plaintiff's health care providers were reasonable. However, the defendants filed a motion in limine seeking exclusion of those bills; the proposed justification for the motion was that the collateral source rule does not apply where subrogated carriers have paid medical expense.

Initially, the trial court concluded that the collateral source rule was inapplicable and limited evidence of medical expenses to the amount paid by the subrogated insurers. However, after the close of the evidence, the court reconsidered its decision; the plaintiff was allowed to argue for recovery of only the amount paid. The jury awarded \$98,664, which the trial court reduced to \$66,063, the amount actually paid by the plaintiff and his insurers.

The Wisconsin Supreme Court acknowledged that the issue before it involved three concepts: valuation of medical expense damages, the collateral source rule, and subrogation. On the first matter, the court noted that a tortiously injured plaintiff is entitled to recover the reasonable value of medical services rendered and that the focus of the law is on the reasonable value, not the actual charge.

With respect to the collateral source rule, the court reasoned that a tortfeasor should:

not be relieved of his obligation to the victim simply because the victim had the foresight to arrange, or good fortune to receive, benefits from a collateral source for injuries and expenses... Applying the

collateral source rule to payments that have been reduced by contractual arrangements between insurers and health care providers assures that the liability of similarly situated defendants is not dependent on the relative fortuity of the manner in which each plaintiff's medical expenses are financed. One plaintiff may be uninsured and recover the benefit of medical assistance, another's insurer may have paid full value for the treatment, and yet another's insurer may have received the benefit of reduced contractual rates. Despite the various insurance arrangements that exist in each case, the factor controlling a defendant's liability for medical expenses is the reasonable value of the treatment rendered...Where the plaintiff's health care providers settle the plaintiff's medical bills with the plaintiff's insurers at reduced rates, the collateral source rule dictates that the defendant-tortfeasor not receive the benefit of the written-off amount. The benefit of the reduced payments insures solely to the plaintiff.[9]

The court noted that any windfall created by this scenario should go to the person who was injured, not the person who caused the injury. The court also explained that the collateral source rule prevents the discounted rates paid on the insurers' behalf from affecting a plaintiff's recovery of the reasonable value of medical services rendered. In other words, the rule renders the amounts of the collateral source payments irrelevant and precludes a reduction in medical expense damages based on those payments.

The court also noted that the purpose of subrogation is to ensure that the loss is ultimately placed on the wrongdoer and to prevent the insured plaintiff from being unjustly enriched through a double recovery – namely, from the subrogated insurer and the liable third party.

The defendants argued that when the insurers made payments on the plaintiff's behalf, they extinguished the plaintiff's liability for medical expenses and that the plaintiff's claim for medical expenses became vested in the subrogated insurers. Because a subrogate carrier has a claim only to the extent that it made payments, the defendants argued, a medical expense claim is limited to the amount actually paid.

The Wisconsin Supreme Court disagreed: The creation of a subrogation interest in the insurer does not vest the entire medical expense claim in the insurer. Nor does it extinguish the insured's right to recover amounts above and beyond those paid by the insurer. The court held that when a plaintiff's medical expenses have been paid by a health care insurer:

- * the plaintiff's entitled to seek recovery for the reasonable value of medical services rendered in treating claimed injury
- * the collateral source rule allows the plaintiff to seek this recovery without consideration of, or limitation to, the amount of payments made by the insurer
- * the insurer's subrogation rights entitle it to recoup the amounts it paid on the plaintiff's behalf.

Fair winds

In a similar case in Virginia, *Acuar v. Letourneau*, the plaintiff also suffered injuries in a motor vehicle crash.[10] The defendant admitted liability, and the case proceeded to trial solely on the issue of damages. On the morning of trial, the defendant made a motion to exclude the amount of the plaintiff's medical bills that had been written off by his health care providers under their contractual agreements with his insurance carriers.

The Virginia Supreme Court noted that a tort claim was involved, implicating Virginia's tort law policies and the collateral source rule.[11] Rejecting the defendant's argument that the write-offs should be excluded from damages, the court wrote that "the focal point of the collateral source rule is not whether an injured party has incurred certain medical expense. Rather, it is whether a tort victim has received benefits from a collateral source that cannot be used to reduce the amount of damages owed by a tortfeasor." [12] It concluded that "those amounts written off are as much of a benefit for which [the plaintiff] paid consideration as are the actual cash payments made by his health insurance carrier to the health care providers." [13]

The court found this conclusion to be consistent with the purpose of compensatory damages, which is that the tortfeasor should compensate the injured party for all harm caused, not just the net loss suffered. And, under Virginia tort policy, if this provides a windfall, it is better that the victim receive it rather than the wrongdoer.

The Virginia court further explained Acuar in *Radvany v. Davis*.^[14] There, the plaintiff's medical bills were \$19,220; however, the plaintiff's health care providers accepted \$7,820 as payment in full for their services. The trial court barred the defendant from introduction into evidence the amounts paid by the defendant's medical insurance carrier and accepted by the plaintiff's health care providers.

The plaintiff received a verdict in his favor. On appeal, the defendant argued that the trial court's medical bill ruling was erroneous because Acuar only addressed whether amounts written off by health care providers could be claimed as damages, not whether the amounts accepted by health care providers as payment in full for medical services rendered were evidence of the reasonable value of those services.

The Virginia Supreme Court disagreed with that argument. It explained that in Acuar, the benefits that the plaintiff received from his contractual health insurance arrangements, which were subject to the collateral source rule,

included not only the amounts written off by the health care providers but also the actual payments made by the health insurance carrier...Payments made to a medical provider by an insurance carrier on behalf of an insured and amounts accepted by medical providers are one and the same. Regardless of the label used, they are payments made by a collateral source and thus, are not admissible in evidence for that reason... Furthermore, such amounts are not evidence of whether the medical bills are "reasonable, i.e. not excessive in amount, considering the prevailing cost of such services...The amounts accepted by [the plaintiff's] health care providers represent amounts agreed upon pursuant to contracted negotiations undertaken in conjunction with [the plaintiff's] health insurance policy. Such negotiated amounts, presumably inuring to the benefit of the medical providers, the insurance carrier, and [the plaintiff] do not reflect the "prevailing cost" of those services to other patients.^[15]

The court ruled that the trial court had not erred in barring the defendant from introducing into evidence the amounts that the medical service providers accepted as payment in full.

In *Griffin v. Louisiana Sheriff's Auto Risk Association*, the plaintiff was injured in a collision with a sheriff's vehicle that was being driven on official business.^[16] The plaintiff was also an employee of a state agency and was insured through the State Employee Group Benefits plan (SEGB).

SEGB had established a fee schedule for medical services provided by participating hospitals and other health care providers. If the participant accepted an assignment of benefits from SEGB it was prohibited from collecting from the insured the difference between the plan amount and the amount charged by the provider. The court noted that this difference is commonly referred to as the contractual adjustment or write-off.

The plaintiff's stipulated medical expenses were \$89,909. Under the SEGB fee schedule, only \$42,170 was paid to the providers. The contractual adjustment was \$47,739. The plaintiff filed a motion in limine, based on the collateral source rule, to keep the jury from considering that her medical bills were paid by insurance, that certain unpaid charges were written off, and that she was not legally responsible to the providers for any amount beyond what was allowed by the fee schedule.

The trial court denied the motion and found the collateral source rule inapplicable. The court concluded that allowing the plaintiff to collect the amount of the write-offs, which she was not obligated to pay, would be akin to awarding punitive damages where none was allowed. The plaintiff cross-appealed from a judgment in her favor, seeking reversal of the trial court's ruling on her motion.

Although the Louisiana Court of Appeal did not address the punitive damages argument, it reversed the denial of the motion in limine. The court found that the collateral source rule is best understood by focusing on its effect on the tortfeasor, not the plaintiff...and that failure to apply it to insurance contract write-offs would provide a windfall to the tortfeasor.

Although the rule's application would have no effect on the contractual agreement between medical providers and medical insurers, the court said, "it would be in furtherance of deceased, more affordable medical costs for all society; it would deter tortuous conduct rather than inure to the benefit of a tortfeasor,

and it would encourage individuals to obtain and secure health insurance coverage. "[17] The court adjusted the jury's award of medical expenses to the full \$89,909 in medical charges.

In an earlier case, the Louisiana Court of Appeal had ruled that a plaintiff could recover the full billed amount for medical expenses, although his private insurance paid significantly less and the hospital that provided treatment took a "contractual adjustment" for the difference. In *Leblanc v. Acadian Ambulance Service, Inc.*, the plaintiff suffered extensive injuries, requiring six surgeries, when his vehicle was stuck by an ambulance owned by the defendant.[18] The plaintiff's medical expenses were \$219,900. Preferred provider organization (PPO) discounts of \$42,215 were applied, leaving \$184,920 as the net amount of the plaintiff's paid medical expenses.

In closing statements, the plaintiff's counsel showed the jury a calculation with the full amount of the medical expenses. Then the jurors were shown the amount after PPO credits, \$184,920. Finally, the jury was shown the plaintiff's medical expenses as \$142,705, calculated after a further reduction for a credit for the defendant's prior partial payment of some of the plaintiff's charges.

The trial judge instructed the jury not to make an award for medical expenses merely because they were incurred, but to first determine whether the expenses were associated with injuries caused by the accident. However, the jury received no information about how to apply the PPO discount or credit for the defendant's prior partial payments. The jury awarded an even \$100,000 for the plaintiff's past medical expenses.

On appeal, the court could not harmonize the award with the various medical expenses submissions. It also could not decipher whether the jury applied any credits or discounts, or which of the plaintiff's six surgeries the jury had attributed to the defendant.

The court concluded that the trial judge had erred by failing to instruct the jury on how the discounts and credits should be applied, if at all, and that the probative value of the medical expense write-offs was substantially outweighed by the dangers of unfair prejudice, confusion of the issues, and misleading the jury.

Beyond that, the court found that the issue of the plaintiff's PPO discount never should have gone to the jury; according to the collateral source rule, the defendant should not benefit from lower prices contracted for by its insurer.

In *Brannon v. Shelter Mutual Insurance Co.*, another Louisiana case, the plaintiff received severe injuries when the car she was riding in ran off the highway and crashed into a tree.[19] Her medical expenses at the time of trial totaled \$135,929. The plaintiff's health insurer, Provident Life and Casualty Insurance Co., paid \$52,382 of her expenses for hospital treatment. This payment exceeded the amount that she would have received from Medicaid if her private insurance had not been available.

The remainder of the debt was taken as a write-off by the hospital under its policy of taking a loss for any amount under its policy of taking a loss for any amount not covered by Medicaid in order to continue participation in that program. The court applied the collateral source rule and wrote that "even if the hospital regularly writes off as 'contractual adjustments' these types of losses in order to participate in the Medicaid program, we do not feel that the defendants should benefit from a policy which is intended to afford medical treatment to those in need." [20] Accordingly, the defendant's request to benefit from the write-off was denied, and the plaintiff was allowed to recover \$135,929.
Capitation and discharged debts

In Illinois, no appellate court has directly ruled on conventional insurance policy write-offs. However, the court of appeals has discussed the propriety of reducing a plaintiff's medical expense recovery for HMO capitation arrangements and indicated that the result would be the same in a case involving conventional insurance write-offs.[21]

With capitation, a fixed amount per person is paid to the provider, which is obligated to cover all services for no additional compensation:

capitated payments usually come in one of two forms: either a fixed fee for each member of the plan or an amount based on the percentage of premiums paid to the health plan. The fixed payment is calculated in dollars per month per member based on actual factors such as the age and health, status of membership, the extent of covered services, and the level of the patient's financial contribution.[22]

In *First Midwest Trust Co. v. Rogers* the plaintiff was injured in a collision with a snowplow and received treatment at Covenant Medical Center and Christie Clinic Association hospitals. The plaintiff was a member of PersonalCare, an HMO. His membership agreement provided that he would receive certain health care benefits in exchange for paying the HMO a monthly premium. The HMO was owned by a company affiliated with Christie and a company that is part of the hospital system that owns Covenant.

Under the HMO system, PersonalCare would have paid Covenant hospital a capitation payment whether or not the hospital treated the plaintiff. However, when he did obtain treatment at the hospital, that capitation payment was allocated to his treatment.

The plaintiff received services from Christie amounting to \$28,009. Because of his HMO membership, he was responsible for only \$6,081 of that amount. Similarly, he was responsible for only \$14,746 of the total amount--\$410,107-- for services he received at Covenant. After a jury trial, the plaintiff received an award of \$774,354.

On appeal, the defendant argued that this award should be reduced by the amount of medical expenses for which the plaintiff bore no liability—namely, \$377,583 worth of benefits covered by the plaintiff's HMO—even though the HMO did not actually pay Covenant any money for the plaintiff's treatment, but merely made accounting adjustments.

The appellate court noted that HMOs differ from insurance companies in significant ways. It explained that an insurance policyholder who receives medical services is liable to the medical care provider and, in turn, the insurance company is obligated to reimburse the policyholder for covered expenses. Nonetheless, the court found that under the collateral source rule, benefits received by an injured party from a source wholly independent of, and collateral to, a tortfeasor will not diminish damages otherwise recoverable from the tortfeasor.[23]

In this analysis, the court found that the rule's rationale applies to an injured party who contracts with an HMO for medical benefits. From the plaintiff's point of view, "the contract he entered into with PersonalCare was equivalent to an insurance policy. He did not care what sort of accounting methods his HMO used or whether the providers of his medical care were business partners or owners of the HMO." [24]

The court said:

To reduce the damages awarded in this case would allow defendants to benefit from [the plaintiff's] decision to purchase health coverage from an HMO rather than from a conventional insurance company. The fact remains that the benefits plaintiff received as a result of his PersonalCare membership are collateral to defendants. Accordingly, we conclude that the collateral source rule applies to the medical expenses, covered by [the plaintiff's] HMO.[25]

The court would probably apply the collateral source rule to conventional insurance policy write-offs given its finding that "although HMOs differ from insurance companies in significant ways, those differences do not subvert the philosophical foundation of the collateral source rule." It would, therefore, "reject defendant's attempt to distinguish HMO benefits from insurance benefits." [26]

The Georgia Court of Appeals has also ruled that write-offs are equivalent to recovery from a collateral source and should be excluded from evidence at trial. In *Olariu v. Marrero*, the plaintiff was injured in a car crash and was treated at the Gwinnett County Medical Center. Before trial, the defendant deposed a medical center employee who testified that part of the plaintiff's \$21,770 bill had been written off.[27] The court's opinion does not state whether that amount was written off under an insurance company contract or was a voluntary concession by the hospital. Nonetheless, the plaintiff filed a motion to exclude the deposition.

The trial court found that the reduction of the plaintiff's hospital bill was equivalent to a recovery from a collateral source and excluded from evidence any reference to that write-off. The plaintiff was awarded \$21,770.

On appeal, the defendant argued that the plaintiff would benefit unjustly from an award of medical expenses and asked the court to either allow evidence of the write-off or prohibit the plaintiff from recovering that amount. The Georgia Court of Appeals held that the trial court had not erred in granting the plaintiff's motion, finding that the defendant's argument ran "counter to the general rule that a defendant is not entitled to a credit for collateral payments to the plaintiff." [28]

Another issue on appeal was whether the collateral source rule allowed the plaintiff to recover the portion of her medical bills that had been discharged in bankruptcy. The trial court had held that it did, but the appellate court reversed. That court reasoned that "the effects of a bankruptcy do not constitute a 'collateral source' at all. There is no third party acting as an additional source of recovery." [29]

The court also noted that debts in bankruptcy become unrecoverable by operation of law, [30] and that extending the collateral source rule to medical expenses discharged in bankruptcy might encourage bankruptcy filings, which is not consistent with public policy. [31]

Strategies and solutions

At trial, plaintiff counsel should attempt to provide evidence of the full amount of billed expenses, supported by an opinion that they are reasonable. If the defendant seeks to exclude that evidence and to limit recovery by the amount of insurance write-offs or by the amount the plaintiff did not pay under an HMO capitation arrangement, the plaintiff may oppose that effort by citing the holdings discussed above.

Counsel should also argue that simply because medical providers and insurance companies negotiate a fee schedule that is acceptable to them, this does not necessarily set the standard for what constitutes a "reasonable" medical expense for judicial purposes. Plaintiffs should not be punished or discriminated against because they purchased a specific type of insurance policy or had no insurance at all.

Submitting to the jury the full value of the plaintiff's reasonable medical services enables the jurors to properly assess fair compensation for pain and suffering because the ratio of special damages to the total verdict is a consideration in determining whether that verdict is fair or excessive. [32] With proof of little or no medical charges, the jury would be invited to take a diminished view of the plaintiff's injuries and award less for pain and suffering than would otherwise be justified, denying the plaintiff a fair trial. [33]

Nonetheless, if the court seems inclined to exclude the unpaid portion of the bill, the plaintiff may be able to blunt the defendant's efforts procedurally. For example, the general rule in civil cases is that the plaintiff has the burden of producing evidence to establish the elements of a claim. This burden is met when there is some evidence that, when viewed most favorably to the plaintiff's position, would allow a reasonable trier of fact to conclude the element to be proven.

However, this burden of producing evidence, sometimes also called the "burden of going forward," shifts from party to party during the course of a trial. Once the plaintiff has met this burden with testimony of the amount billed and an opinion that it is reasonable, the burden shifts to the defendant to come forward with evidence that the unpaid portion of the bill has been extinguished and is no longer a debt or liability of the plaintiff.

Plaintiff counsel should require the defense to produce the properly authenticated contract showing the medical provider's agreement to accept a stated amount in full payment for the services provided, as well as testimony that such payment was made and received. Several witnesses may be necessary.

Unless the defendant has pursued this issue in discovery and made proper pretrial disclosures of witnesses and the subject matter of their testimony, the defendant may be unable to sustain its burden. [34] If the defendant produces no evidence that contradicts or impeaches the plaintiff's evidence, and the plaintiff's evidence is not otherwise rendered inherently improbable, it cannot arbitrarily be disregarded. The admission of the bills and an award of medical expenses should follow. [35]

So far, the courts have unanimously held that the collateral source rule applies to private insurance contract write-offs and that personal injury plaintiff's may introduce into evidence and recover the full reasonable amount of their medical expenses at trial. While the reasoning of the courts may vary slightly, the main focus is that the defendant tortfeasor should not benefit from the plaintiff's insurance contract even if the plaintiff is deemed to receive a windfall. Principles of subrogation prevent double recoveries, and application of the collateral source rule results in verdicts that best approximate full compensation for plaintiffs.

Notes

[1] 22AM.Jur.2d Damages§ 566 (1988).

[2] 465 P.2d 61 (Cal. 1970).

[3] See *Marsh v. Green*, 782 So. 2d 223 (Ala. 2000).

[4] See Helfend. 465 P.2d 61. 64 n.6 (quoting Richard C. Maxwell, *The Collateral Source Rule in the American Law of Damages*, 46 Minn. L. Rev. 669, 695 (1962).

[5] *Id.* at 66-67.

[6] *Id.* at 68.

[7] *Id.* at 67. See also *Falconer v. Adams*, 974 P.2d 406 (Alaska 1999); *Riley v. Frantz*, 253 So. 2d 237 (La. Ct. app. 1971); John C. Fleming, *The Collateral Source Rule and Loss Allocation in Tort Law*, 54 CAL. I. REV. 1478, 1479 (1966).

[8] 630 N. W.2d 201 (Wis 2001).

[9] *Id.* at 209-10.

[10] 531 S.E.2d 316 (Va. 2000).

[11] It is the tort context that differentiates *Acuar* from the same court's earlier opinion in *State Farm Mutual Auto Insurance Co. v. Bowers*, 500 S.E.2d 212 (Va. 1998). *Bowers* involved a contractual dispute between an insured and his automobile liability insurance carrier regarding coverage under the medical payment provisions of the policy at issue. The court held that "incurred" expenses were only those amounts that the claimant's health care providers accepted as full payment for their services, and that *Bowers* was not "legally obligated to pay" the amounts written off by those providers. Two federal district courts in Virginia, sitting in diversity jurisdiction, have relied on *Bowers* to limit personal injury plaintiffs' medical expense recoveries to the amounts actually paid after negotiated contractual discounts between the health care providers and the plaintiffs' health insurance companies. *Ward-Conde v. Smith*, 19 F. Supp. 2d 539 (E.D. Va. 1998); *Mitchell v. Hayes*, 72 F. Supp 2d 635 (W.D. Va. 1999). However, both cases predated *Acuar* and now appear to be no longer good law.

[12] See *Acuar*, 531 S.E. 2d 316, 322.

[13] *Id.*

[14] 551 S.E. 2d 347 (Va. 2001).

[15] *Id.* at 348.

[16] 802 So. 2d 691 (La. Ct. App. 2001).

[17] *Id.* at 715.

[18] 746 So. 2d 665 (La. Ct. App. 1999).

[19] 520 So. 2d 984 (La. Ct. App. 1987).

[20] *Id.* at 986.

[21] *First Midwest Trust Co., v. Rogers*, 701 N.E.2d 1107 (Ill. App. Ct. 1998).

[22] Michael K. Beard, *The Impact of Changes in Health Care Provider Reimbursement Systems on the Recovery of Damages for Medical Expenses in Personal Injury Suits*, 21 AM J TRIAL ADVOC 453. 469-70 (1998).

[23] The collateral source rule does not apply if the plaintiff has been reimbursed by the tortfeasor's insurance carrier. In such cases, the plaintiff's recovery is subject to a setoff for the amounts received, and the defendant may introduce evidence of payments at trial. *Scott v. County of Los Angeles*, 32 Cal. Rptr. 2d 643 (Ct. App. 1994).

[24] See *Rogers*, 701 N.E.2d 1107, 1118.

[25] *Id.*

[26] *Id.*

[27] 549 S.E.2d 121 (Ga. Ct. App. 2001).

[28] *Id.* at 123

[29] *Id.*

[30] *Id.* at 124 (citing 11 U.S.C. §524(a)(2) (1993)).

[31] See also *Oliver v. Heritage Mut. Ins. Co.* 505 N.W.2d 452 (Wis. Ct. App. 1993) (holding that a plaintiff whose medical bills were discharged in bankruptcy could not recover those medical expense damages). On a related subject, where a plaintiff received free services at a veterans hospital, the court in *Texas Power & Light Co., v. Jacobs*, 353 S.W.2d 483 (1959), held that "the Appellee...is entitled to recover for the medical services and hospitalization rendered to him by the veterans hospital," reasoning that "Medical and hospital services supplied by government to these members of the United States Navy were part of the compensation to them for services rendered."

Regarding similar free services at a charitable Shriners' Hospital for Children, the Illinois Supreme Court has specifically refused to allow plaintiffs to recover for the reasonable value of those free services. (*Peterson v. Lou Bachrodt Chevrolet Co.*, 392 N.E.2d) (1979) ("An individual is not entitled to recover the value of services that he has obtained without expense, obligation or liability.")). But see *Montgomery Ward & Co., Inc. v. Anderson*, 976 S.W.2d 382 (Ark. 1998), where the issue was defined as whether the gratuitous forgiveness of a debt for medical services is a collateral source to be sheltered by the rule. The court found guidance in the Restatement (Second) of Torts §920A(2), comments (b) and (c)(3) which indicate that gifts from third parties, gratuities of cash or services, are collateral sources that are not subtracted from a plaintiff's recovery. The Arkansas Supreme Court specifically considered and rejected the Illinois decision in *Peterson* and ruled instead that "gratuitous or discounted medical services are a collateral source not to be considered in assessing the damages due a personal injury plaintiff.."

[32] *Lapidus v. Hahan*, 450 N.E.2d 824 (Ill. App. Ct. 1983).

[33] See *Helfend*, 465 P2 61, 68.

[34] See, e.g., *Thompson v. Mills*, 432 S.W.2d 448 (Ky. Ct. App. 1965).

[35] *Texas Axles. Inc. v. Vailie*, 489 N.E.2d 16 (Ill App. Ct. 1956).