EFiled: Jan 07 2015 04:32PM EST
Filing ID 56567103
Case Number 601,2014

IN THE SUPREME COURT OF THE STATE OF DELAWARE

DIANE L. STAYTON, *Plaintiff Below*, *Appellant*, v. DELAWARE HEALTH CORPORATION, a Delaware Corporation, HARBOR HEALTHCARE CENTER COMPANY, L.L.C., a Limited Liability Company; MARY FRANCIS DRANDORFF, RN, Individually; RUTHANNE ROBERTS JACOBS, RN, Individually; and RENEE L. WOZNICKI EDGE, RN, Individually, *Defendants Below*, *Appellees*.	C.A. No. 601, 2014 ON APPEAL FROM THE SUPERIOR COURT OF THE STATE OF DELAWARE, C.A. No. K12C-04-026 RBY

BRIEF OF CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA AS *AMICUS CURIAE* IN SUPPORT OF APPELLEES AND IN SUPPORT OF AFFIRMANCE

WILLIAM B. CHANDLER III (#116)
BRADLEY D. SORRELS (#5233)
WILSON SONSINI GOODRICH & ROSATI, P.C.
222 Delaware Avenue, Suite 800
Wilmington, DE
(302) 304-7600

Attorneys for Amicus Curiae *Chamber of Commerce of the United States of America*

OF COUNSEL:

GIDEON A. SCHOR
WILSON SONSINI GOODRICH & ROSATI, P.C.
1301 Avenue of the Americas, 40th Fl.
New York, NY 10019
(212) 999-5800

KATE COMERFORD TODD
SHELDON GILBERT
U.S. CHAMBER LITIGATION CENTER, INC.
1615 H Street, N.W.
Washington, DC 20062
(202) 463-5685

Dated: January 7, 2015

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Page(s)

CASES

STATUTES

RULES

MISCELLANEOUS

INTEREST OF *AMICUS CURIAE*

Amicus curiae the Chamber of Commerce of the United States of America (the "Chamber") is the world's largest business federation, representing 300,000 direct members and indirectly representing the interests of more than 3,000,000 U.S. business and professional organizations. The Chamber's members include companies and organizations of every size, in every industry sector, and from every region of the country – including many companies that are incorporated in Delaware. The Chamber represents its members' interests by, among other activities, filing briefs in cases implicating issues of concern to the nation's business community. This is such a case.

Amicus, on behalf of its members, is greatly interested in the issue presented by this appeal – whether a personal injury plaintiff may recover, as damages for medical expenses, the total amount billed by the plaintiff's healthcare provider *where such provider has already agreed to accept as full payment the smaller amount paid by Medicare*. Here, the provider billed $3,683,797.11 but accepted Medicare's payment of $262,550.17 as full payment, and the Superior Court properly held that plaintiff's recovery of damages for medical expenses was limited to the amount of the Medicare payment. *Amicus* urges affirmance of the Superior Court's decision because a reversal will cause several problems of grave concern to the nation's business community. In particular, a reversal will vastly

increase settlement costs and insurance premiums, while *over*compensating plaintiffs and thereby contravening the tort system's purpose of making plaintiffs *whole*. The price will be paid not only by businesses and their insurers but also, ultimately, by consumers. And the additional recovery guaranteed to plaintiffs by a reversal – *i.e.*, the amount by which the billed amount exceeds the Medicare payment – will represent only phantom medical expenses that no one has paid or ever will pay.

Pursuant to Delaware Supreme Court Rule 28(b), the Chamber has contemporaneously filed a motion for leave to file this *amicus curiae* brief. Defendants-Appellees' counsel consent, and Plaintiff-Appellant's counsel do not object, to the Chamber's filing of this *amicus curiae* brief.[1]

ARGUMENT

At issue on this appeal is whether Plaintiff may recover amounts that her healthcare provider billed but did not and will never collect. The provider will never collect those amounts because the provider already accepted Medicare's – much smaller – payment as payment in full.[2] The amounts by which the billed

[1] Hereinafter, Defendants-Appellees will be referred to as "Defendants," and Plaintiff-Appellant will be referred to as "Plaintiff."

[2] It is undisputed in this case that Medicare pays providers at a discounted rate and that, by accepting a Medicare payment, a provider agrees that the payment is payment in full and that the provider cannot pursue plaintiff, as the Medicare participant, for the unpaid balance. Appellant's Opening Brief ("Br.") at 7.

amounts exceed the Medicare payment are properly viewed as phantom medical expenses.

The Superior Court ruled that Plaintiff may not recover such phantom medical expenses. That ruling should be upheld by this Court.

The ruling is sensible, avoiding windfalls to plaintiffs and their lawyers. A reversal here will create such windfalls because billed amounts in excess of Medicare payments are not paid by anyone and because those excess amounts recovered are kept by plaintiffs and lawyers rather than by the healthcare professionals who provided the medical services.

Moreover, allowing windfall payments like that which Plaintiff here seeks would cause dramatic harm. Nationwide, the difference between what healthcare providers bill and what they accept from Medicare as full payment for medical services to tortiously injured persons is without a doubt a staggering figure. Payment of that difference will not come out of thin air, but rather from liability insurers, whose inevitable rise in insurance premiums will in turn raise costs for business and, ultimately, consumers. Because imposing those societal costs is not only bad policy but also contrary to basic principles of tort compensation, the decision of the Superior Court should be affirmed.

I. The Superior Court's Decision Provided Plaintiff with *Full* Compensation, Rather Than *Over*compensation

A plaintiff who wins a personal injury suit is entitled to recover medical expenses as damages. That entitlement exists even if the medical expenses were paid not by the plaintiff but rather by the plaintiff's health insurance. The reason is the common-law collateral source rule, which provides that "a tortfeasor has no interest in, and therefore no right to benefit from, monies *received* by the injured person from sources unconnected with the defendant." *Yarrington v. Thornburg*, 205 A.2d 1, 2 (Del. 1964). The Delaware rule further provides that the tortfeasor must compensate the plaintiff for the "reasonable value" of all harm caused by the tortfeasor, *Mitchell v. Haldar*, 883 A.2d 32, 38 (Del. 2005), and that "double recovery" by the plaintiff is permissible as long as the source of the payment is not connected to the same tortfeasor, *Onusko v. Kerr*, 880 A.2d 1022, 1024 (Del. 2005) (citation and internal quotation marks omitted).

The issue in this case is whether the collateral source rule makes the defendant liable for the amount of billed medical expenses in excess of the Medicare payment – an excess amount that neither the plaintiff nor Medicare (nor anyone else) has paid or will ever pay. Plaintiff here asserts entitlement to recovery of that excess amount (which her healthcare provider had billed unilaterally), even though the provider accepted the Medicare payment as full

payment for Plaintiff's medical services. The billed charges at issue here are thus phantom medical expenses.

Venerable principles of law counsel against extending the collateral source rule to the difference between billed amounts and Medicare payments, and thus against any holding that permits Plaintiff to recover such phantom expenses. First, "the purpose of tort damages is to compensate an injured person for a loss suffered, *and only for that.*" Br. Ex. A at 10 (citation and internal quotation marks omitted) (emphasis added). That is, "the law attempts to put the plaintiff in a position as close as possible to his position before the tort." *Id.* Second, as an exception to the general tort rule barring double recovery, the collateral source rule permits double recovery (in the sense that the *same* amount is recovered once from a collateral source like insurance and once again from the defendant), but the collateral source rule has never been explicitly held by this Court to permit any multiple of recovery *beyond* double recovery. None of the cases on which Plaintiff relies has squarely addressed the issue of whether such *beyond*-double recovery – be it triple, quintuple, duodecuple, or, as here, more – is consistent with the repeated holding that the collateral source rule permits "*double* recovery," *see Onusko*, 880 A.2d at 1024 & n.7 (emphasis added). Here, contrary to both the general tort rule and even the exception embodied in Delaware's collateral source rule, a damage award for the full amount billed would give Plaintiff a *fourteen*-

fold recovery over the Medicare payment. Third, damages may not be conjectural, much less imaginary. *Coleman v. Garrison*, 349 A.2d 8, 12 (Del. 1975) (citing cases), *overruled on other grounds by Garrison v. Med. Ctr. of Del., Inc.*, 571 A.2d 786 (Del. 1989). Fourth, damages must be mitigated where reasonably possible. *Gulf Oil v. Slattery*, 172 A.2d 266, 270 (Del. 1961) (citing cases). Consistent with these principles, the Superior Court's ruling renders Defendants liable for whatever Medicare actually pays to a healthcare provider, but with the common-sense qualification that Defendants are not liable for *more* than what Medicare actually pays.

This Court has noted and rejected the "anomalous results" that may be caused by "indiscriminate application of the collateral source rule." *State Farm Mut. Auto. Ins. Co. v. Nalbone*, 569 A.2d 71, 75 (Del. 1989). To allow Plaintiff to recover *any* phantom medical expenses – let alone those that are *fourteen times* greater than the Medicare payment accepted by Plaintiff's provider as full payment – is precisely such an "anomalous result[]" and should be similarly rejected.

Contrary to Plaintiff's argument on appeal, *see* Br. at 9, the amount written off by a healthcare provider as a result of accepting a Medicare payment as payment in full is not a "benefit" for the insured under the collateral source rule.[3]

[3] *See Howell v. Hamilton Meats & Provisions, Inc.*, 257 P.3d 1130, 1144-45 (Cal. 2011) ("We conclude the negotiated rate differential is not a collateral payment or benefit subject to the

For those covered by Medicare, all that matters (in other words, the "benefit" to which that person is entitled under Medicare coverage) is that the treatment provided is being paid for; the price that Medicare pays, whether high or low, is of no meaningful consequence to the Medicare patient.

The billed amount in excess of the Medicare amount is not within the collateral source rule, which, as formulated by this Court, deprives the tortfeasor of any right "to benefit from monies *received* by the injured person from sources unconnected to the defendant." *State Farm*, 569 A.2d at 73 (emphasis added); *see also Yarrington*, 205 A.2d at 2 ("Under the collateral source rule, a tortfeasor has no right to any mitigation of damages because of payments or compensation *received* by the injured person from an independent source." (emphasis added)). The question in this case is whether the phantom medical expenses at issue were monies "received" by Plaintiff from a collateral source. Here, the only monies that Plaintiff could reasonably be considered to have "received" from a collateral source were the sums that Medicare paid her provider, which sums her provider accepted as full payment for her medical treatment. Additional amounts that the provider included in its bills over and above the sums actually paid by Medicare were not monies that Plaintiff "received." Indeed, those additional amounts were

---

collateral source rule"; "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.").

not paid or received by anyone. For this reason, the *State Farm* Court expressed its readiness to deny double recovery under the collateral source rule "for losses which did not, in fact occur, or expenses not, in fact sustained." *State Farm*, 569 A.2d at 76.

Nor did Plaintiff incur liability for any billed amount in excess of the Medicare payment accepted by Plaintiff's healthcare provider as payment in full. Plaintiff here was never obligated to pay any amount above that Medicare payment. Plaintiff's healthcare provider agreed, as part of its acceptance of the Medicare payment as payment in full, not to charge Plaintiff for any amount above the Medicare payment. Thus, the provider had no legal expectation of payment for what it billed in excess of the Medicare payment. Moreover, nothing in the record suggests that Plaintiff's healthcare provider rendered gratuitous services as a friend or relative with an expectation – actual or presumed – of later payment. Rather, the provider's acceptance of the Medicare payment as payment in full was a business decision made with full knowledge that the difference between the billed amount and the Medicare payment must be written off and is extinguished by operation of law, *see* Br. Ex. A at 13. Consequently, Plaintiff did not incur those "written off" charges for purposes of the collateral source rule.

Barring recovery of phantom medical expenses in this case is consistent with the collateral source rule's rationale, as expressed in *State Farm*. There, this

Court explained that there is "no reason why a risk-averse insured should not be permitted to contract for a double recovery." *State Farm*, 569 A.2d at 75. Thus, as the Superior Court held under *State Farm*, a plaintiff who contracted for double recovery would lose the benefit of that bargain if the amount paid to the plaintiff under the contracted-for insurance policy could be deducted from the tortfeasor's damages. Br. Ex. A at 5-6. Where, however, the plaintiff did not contract for double recovery, deducting the collateral source payment to the plaintiff from the tortfeasor's damages does not deprive the plaintiff of the benefit of any bargain – because there was no bargain – and thus the *State Farm* rationale for application of the collateral source rule is inapplicable.

Far from being an abrogation of the collateral source rule, as Plaintiff would have this Court believe, the Superior Court's decision respects the collateral source rule while simply declining an unwarranted and inequitable extension of the rule to phantom medical expenses.

II. The Amount Paid by Medicare, Not the Amount Billed by the Provider, Establishes the Reasonable Value of the Medical Services Provided

Although the measure of medical-expense damages is said to be the "reasonable value" of the medical services provided, *see, e.g.*, Br. at 6, the term

"reasonable value" is a ceiling, not a floor.[4] Just as a plaintiff should not recover a windfall for phantom medical expenses that no one has ever paid, so a plaintiff should not recover more than the reasonable value of medical services that *have* been paid for. Here, the reasonable value of Plaintiff's medical services and the amount paid by Medicare for those services are one and the same.

In practice, the amount billed by a provider is, standing alone, an inadequate indicator of reasonable value, because payment of that amount is the rare exception, not the rule. "[I]n a world in which patients are covered by Medicare and various other kinds of medical insurance schemes that negotiate rates with providers, providers' supposed ordinary and standard rates may be paid by a small minority of patients." *Vencor Inc. v. National States Ins. Co.*, 303 F.3d 1024, 1029 n.9 (9th Cir. 2002); Ireland, Thomas R., *The Concept of Reasonable Value in Recovery of Medical Expenses in Personal Injury Torts*, 14 J. Legal Econ. 87, 88 (2008) ("only a small fraction of persons receiving medical services actually pay original amounts billed for those services"). As such, the "full" price is a particularly unreliable measure of damages in a personal injury action where the plaintiff is not to be put in a better position than she would have been had she not been harmed. *See Coalition for Quality Health Care v. New Jersey Dept. of*

[4] As one court has noted, "reasonable value" is "a term of limitation, not of aggrandizement." *Hanif v. Housing Authority*, 246 Cal. Rptr. 192, 200 Cal. App. 3d 635, 641 (3d Dist. 1988).

Banking and Ins., 817 A.2d 347, 350 (N.J. App. 2003) ("if . . . providers routinely accept significantly less than . . . they purport to charge, then paid fees are a realistically more accurate measure of reasonable and prevailing fees than billed fees."). In short, where, as here, Medicare pays, and the provider accepts, a specific amount in an arms-length transaction, that amount is plainly a far better measure of reasonable value than the initial amount "billed" by the provider.

III. Plaintiff's Arguments Concerning Medicare Taxes, Differential Treatment of Tort Plaintiffs, and "Net Loss" Are Incorrect

Unavailingly, Plaintiff argues that a Medicare participant's payment of taxes for Medicare coverage essentially constitutes consideration for such coverage and thus that Plaintiff is entitled to obtain the benefit of her bargain by recovering as damages the billed amount in excess of the Medicare payment. *See* Br. at 11. The argument fails because it ignores the fact that defendants, both corporate and individual, pay Medicare taxes as well. Br. Ex. A at 16 (Medicare is "federal government program funded through taxes paid by *employers* and *employees*" (emphasis added)). If, as Plaintiff urges, the Court should take cognizance of the *plaintiff's* payment of Medicare taxes, then the Court must also take cognizance of the *defendant's* payment of Medicare taxes – with the result that the collateral source rule should be completely inapplicable to Medicare payments and that Plaintiff therefore should not recover as medical-expense damages *even the*

amounts paid to the provider by Medicare. The collateral source rule explicitly provides that "the plaintiff's damages may not be reduced because of payments for treatment paid for by medical insurance *to which the tortfeasor did not contribute.*" *Mitchell*, 883 A.2d at 38 (emphasis added) (citing *State Farm*). Correlatively, the collateral source rule "'does permit the tortfeasor to obtain the advantage of payments made by himself or from a fund created by him; in such an instance the payments come, not from a collateral source, but from the defendant himself.'" *State Farm*, 569 A.2d at 73 (quoting *Yarrington*, 205 A.2d at 2). In other words, if Plaintiff is correct that payment of Medicare taxes constitutes consideration paid for Medicare coverage, then necessarily the defendant's payment of Medicare taxes requires reduction of the plaintiff's damages even by the amount that Medicare paid to the plaintiff's provider.

Contrary to Plaintiff's argument (Br. at 11-12), there is indeed a justifiable purpose for treating damages to a plaintiff Medicare recipient differently from damages to a plaintiff who is privately insured. It is the same purpose that justifies the Delaware Medical Malpractice Act's differential treatment of public and private collateral sources, as set forth in 18 *Del. C.* § 6862.[5] As articulated by this

[5] *See* 18 *Del. C.* § 6862 ("In any medical negligence action for damages because of property damage or bodily injury, including death resulting therefrom, there may be introduced, and if introduced, the trier of facts shall consider evidence of: (a) Any and all facts available as to any *public collateral source* of compensation or benefits payable to the person seeking such damages (including all sums which will probably be paid payable to such person in the future) on account

Court, that purpose is "to prevent the collection of a loss from a collateral *public* source . . . and then for the same loss from the party or hospital being sued." *Mitchell*, 883 A.2d at 40 (emphasis in original). As the decision below recognized, this purpose has been adopted judicially and not just legislatively: "One jurisdiction has explicitly stated that it is unconscionable to allow taxpayers to bear the expense of providing free medical care to a person, and then allow that person to take the windfall of expenses from a tortfeasor." Br. Ex. A at 9-10. Although the parties and the Superior Court agreed that the terms of § 6862 do not apply in this case, *see* Br. at 7, that agreement does not and should not preclude this Court from recognizing the soundness of this purpose and from holding that it disposes of Plaintiff's differential treatment argument. Where a plaintiff has paid out of his or her own pocket for insurance coverage (as in the case of private insurance), that plaintiff's damages recovery may permissibly be different from the damages recovery of a plaintiff who has not similarly paid out of his or her own pocket for insurance coverage (as in the case of Medicare).

Plaintiff's contention that she should not be limited to her "net loss" is question-begging. *See, e.g.*, Br. at 10, 12. Because Medicare's payment was

---

of such property damage or bodily injury; and (2) any and all changes, including prospective changes, in the marital, financial or other status of any persons seeking or benefiting from such damages known to the parties at the time of trial; provided, however, *this section shall not be applicable* to life insurance or *private collateral sources* of compensation or benefits." (emphasis added)).

accepted by Plaintiff's provider as payment in full, Plaintiff never had any obligation to pay her provider any additional amount. Thus, that additional amount – the excess of the billed amount over the Medicare payment – was *never* a loss to Plaintiff. Accordingly, the amount of the Medicare payment, far from being Plaintiff's *net* loss, was rather her *full* loss. The Superior Court's decision thus did not improperly limit Plaintiff's recovery.

IV. A Reversal Would Result in a Vast and Needless Windfall Annually to Plaintiffs and Their Attorneys, at the Expense of the Liability-Insurance-Buying Public

The impact that a reversal of the Superior Court's decision would have is difficult to overstate. At issue is the difference between the amounts that healthcare providers unilaterally bill – but no one pays – and the lesser amounts that the providers accept from Medicare as full payment for plaintiffs' medical services. When deciding this issue, one must keep in mind the cumulative amount of that difference, to whom the difference would and would not go, who would pay the difference, and the effect of the payment.

The amount of money at stake is enormous. In the present case, a reversal would multiply Plaintiff's medical-expense damages *fourteen-fold*, from $262,550.17 to $3,683,797.11. Even if other cases would involve a less dramatic difference, the combined value of the differences in personal injury claims for

domestic corporations is easily tens, and quite possibly hundreds, of millions of dollars every year.

Significantly, these vast amounts of phantom medical expenses, if awarded as damages, will not actually go to the healthcare providers that billed them. Instead, the money will go only to plaintiffs and their attorneys. This is because providers do not collect any more than the amounts they have agreed to accept from Medicare as full payment. *See* Br. at 7.

If the decision below is reversed, the healthcare provider would still get no more than the amount it accepted from Medicare, but Plaintiff will recover as damages the larger amount billed by the provider – even though neither Plaintiff nor anyone else has ever paid or will ever pay that larger amount. That recovery, of course, will be on top of what Plaintiff undisputedly already recovers for the amount paid by Medicare – not by Plaintiff – to the provider.[6] The additional recovery of phantom expenses billed but never paid is a windfall *far* beyond the double recovery contemplated by conventional application of the collateral source rule.

[6] The parties do not dispute that Plaintiff is entitled to recover as medical-expense damages the $262,550.17 paid by Medicare. Thus, the only issue raised by this appeal is whether Plaintiff may recover the phantom medical expenses, *i.e.*, the amount billed in excess of the Medicare payment.

The vast increase in annual windfall payments that a reversal here would cause will be funded largely by liability insurance. These enormous new liability insurance costs will likely lead to a dramatic increase in liability insurance premiums. The cost of those increased premiums will in turn be borne by corporate insureds and, inevitably, consumers.

CONCLUSION

For the reasons stated above, the decision of the Superior Court should be affirmed.

WILSON SONSINI GOODRICH & ROSATI, P.C.

/s/ William B. Chandler III
WILLIAM B. CHANDLER III (#116)
BRADLEY D. SORRELS (#5233)
WILSON SONSINI GOODRICH & ROSATI, P.C.
222 Delaware Avenue, Suite 800
Wilmington, DE 19801

Attorneys for Amicus Curiae *Chamber of Commerce of the United States of America*

OF COUNSEL:

GIDEON A. SCHOR
WILSON SONSINI GOODRICH & ROSATI, P.C.
1301 Avenue of the Americas, 40th Fl.
New York, NY 10019
(212) 999-5800

KATE COMERFORD TODD
SHELDON GILBERT
U.S. CHAMBER LITIGATION CENTER, INC.
1615 H Street, N.W.
Washington, DC 20062
(202) 463-5685

Dated: January 7, 2015