# SHOULD AN ALABAMA PLAINTIFF BE ALLOWED TO INTRODUCE EVIDENCE OF THE RETAIL COSTS OF MEDICAL CARE WHEN THE BILLS HAVE BEEN SATISFIED BY INSURANCE FOR A REDUCED AMOUNT?

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Here is an issue that I have been struggling with for a long time. Suppose the plaintiff in a personal injury lawsuit in Alabama state court is covered by Medicaid. The "billed" or "retail" price of his medical care from the hospital who treated him after the accident is $30,000. Medicaid paid the hospital $2,000 on behalf of the plaintiff. Pursuant to Medicaid laws, the hospital accepted that $2,000 as "payment in full" for the plaintiff's medical bills, and the hospital wrote off the $28,000 difference.

Under that scenario, presumably no one will ever be obligated to pay the $28,000 that the hospital wrote off, even if the plaintiff recovers hundreds of thousands of dollars in his lawsuit against the defendant tortfeasor. Instead, Medicaid would have a $2,000 lien or subrogation interest as to any recovery the plaintiff may have against the defendant tortfeasor. If the plaintiff obtains a judgment, no matter how large, he would never be required to pay Medicaid more than $2,000. He would never be obligated to pay the hospital anything.

Here is how the above scenario typically plays out in the plaintiff's personal injury action against the tortfeasor in Alabama state court: assuming the proper foundation is established, the plaintiff has historically been allowed to introduce into evidence the $30,000 in medical bills and claim the $30,000 as damages. The defendant, in turn, is permitted by Alabama statute to inform the jury that the plaintiff's medical

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bills have been paid by a third party. The plaintiff is then entitled to inform the jury that he would be obligated to repay Medicaid the $2,000 if he recovers in the lawsuit. The jury is then usually instructed that they can do what they choose with this evidence.[1] That instruction would permit the jury to award the plaintiff $30,000 in damages even though the plaintiff, at most, would be out of pocket only $2,000.

This scenario bothers some, as it arguably seems unfair to allow the plaintiff to receive that $28,000 windfall. On the other hand, for many years, Alabama courts have routinely admitted the retail costs of medical services, so this scenario has ample support. At the end of the day, the collateral source rule and the law of compensatory damages butt heads. The question I have is this: is there a sufficient legal basis under Alabama damages law to allow a plaintiff to introduce evidence of the retail costs of medical care when those bills have been satisfied by a third-party payor (e.g., Blue Cross, Medicaid) for a reduced amount? To be clear, courts have been admitting this evidence for decades (often without objection), but is there a sufficient legal basis for those decisions? As addressed below, at least some courts have suggested that the answer to my question should be no. The Alabama appellate courts, however, apparently have not addressed this question head on, at least as of the time this article was written.

## I. A LOOK AT THE COLLATERAL SOURCE RULE

The logical starting point for this issue seems to be the collateral source rule. The Alabama Supreme Court has explained the collateral source rule as follows: "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."[2]

The collateral source rule has been around in Alabama since at least 1910 when the Alabama Supreme Court addressed it in the property insurance context in *Long v. Kansas City, Memphis & Birmingham Railroad Co*.[3] The court illustrated the collateral source rule with the following hypothetical: "If A negligently or intentionally burns B's house, and B sues him for damages, surely A cannot defeat this action

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[1] *See* ALABAMA PATTERN JURY INSTRUCTIONS—CIVIL 11.15 (3rd ed. 2009).

[2] Marsh v. Green, 782 So. 2d 223, 230 (Ala. 2000).

[3] Long v. Kansas City, Memphis & Birmingham Railroad Co., 54 So. 62, 63–64 (Ala. 1910). *See also*, *Marsh*, 782 So. 2d at 230 ("This Court first articulated the collateral-source rule in *Long v. Kansas City, M. & B. R.R.*, 170 Ala. 635, 54 So. 62 (1910), and it thereafter consistently held collateral-source evidence inadmissible.").

by pleading and showing that C had paid B the full value of his house under a contract of insurance between B and C, as to which A is a perfect stranger."[4] The court went on to say that "[t]he mere fact that the insurer has paid the insured cannot affect the action against the wrongdoer who has destroyed or injured the property, the subject of the insurance."[5]

Here is the example I typically use when I explain the collateral source rule in evidence classes that I teach: suppose George Costanza is in a car accident and the other party, Kramer, is at fault. It costs $20,000 to repair George's car. George's insurer, Vandalay Insurance Company, pays for it to be fixed. George can sue Kramer for that $20,000, and the collateral source rule would prohibit Kramer from introducing evidence that Vandalay Insurance paid to have the car repaired.

I must admit, when I first learned about the collateral source rule, it made little sense to me. It seemed like double recovery, and indeed that view is shared by some critics of the rule.[6] But proponents of the rule respond by arguing that a defendant tortfeasor should not profit from the plaintiff's decision to purchase insurance. Indeed, perhaps the most commonly cited policy rationale for the collateral source rule is that "[r]educing recovery by the amount of the benefits received by the plaintiff would be, according to most courts, granting a 'windfall' to the defendant by allowing him a credit for the reasonable value of those benefits. . . . If there must be a windfall, it is usually considered more just that the injured person should profit, rather than let the wrongdoer be relieved of full responsibility for his wrongdoing."[7]

The rule, however, still did not make a lot of sense to me for a long time. The collateral source rule did not really make sense to me until I thought about how things usually play out in the real world—namely subrogation. In the hypothetical involving George Costanza and Kramer described above, Vandalay Insurance would typically have a lien or subrogation interest on the $20,000 it paid to fix George's car.

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4 *Long*, 54 So. at 63–64.

5 *Id.* at 64.

6 The Alabama Supreme Court has stated that "[t]he rule against double recoveries bars a plaintiff from recovering more than her full damages when payments have been made by a tortfeasor or on behalf of a tortfeasor. . . . 'The collateral-source rule is an exception to the general rule of damages preventing a double recovery by an injured party.'" *Ex parte Barnett*, 978 So. 2d 729, 732–33 (Ala. 2007) (quoting Willis v. Foster, 372 Ill. App. 3d 670, 673 (Ill. App. Ct. 2007)).

7 American Legion Post No. 57 v. Leahey, 681 So. 2d 1337, 1338 (Ala. 1996).

Therefore, if George wins his lawsuit against Kramer, George would be required to reimburse Vandalay Insurance for that $20,000. So, when the dust settles, everyone winds up in the right position. George is made whole with his repaired car, Vandalay Insurance is made whole when it is repaid its $20,000, and the person at fault, Kramer, is the one who pays for the harm that he caused. That makes sense, and the law should make sense. Under that scenario, the collateral source rule works.

Over the years, the collateral source rule has been applied in various contexts to exclude evidence of third-party payments for property damage, medical expenses, and other contexts. And again, I think the collateral source rule normally makes sense. But it arguably makes less sense when viewed in the context of modern-day health insurance.

## II. HEALTH INSURANCE

Health insurance as we know it today did not exist in 1910 when the collateral source rule was first established by the Alabama Supreme Court. Rather, health insurance as we know it today really did not come to be until around the 1930s.[8] Today, it is no secret that the retail cost for medical treatment and the amount actually paid by insurance, Medicaid, or some other third-party payor are two different numbers. Often, the two numbers do not even resemble each other.

For example, as I write this, I am looking at a medical bill that shows the patient was billed $33,000.00 for medical services. The third-party payor paid approximately $500 to the medical provider, and the medical provider wrote off the remaining $32,500.00. Suppose the plaintiff were permitted to recover the full $33,000.00 in retail costs as damages in his trial against the defendant tortfeasor. He would then likely reimburse the third-party payor $500 to cover the lien, and he and his attorneys would keep the $32,500. In that scenario, the third-

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[8] MICHAEL A. MORRISEY, HEALTH INSURANCE 3 (2nd ed. 2014). *See also* 2 HEALTH L. PRAC. GUIDE § 18:1 (2019) ("It is generally accepted that the beginning of health insurance as we know it took place at Baylor University Hospital in 1929. . . . In 1933, the American Hospital Association (AHA) established requirements that an organization had to meet for recognition as a group hospital association."); Elizabeth Y. McCuskey, *Body of Preemption: Health Law Traditions and the Presumption Against Preemption*, 89 TEMP. L. REV. 95, 136 (2016) ("The first two categories of true health insurance sprung up in the early 1930s . . . ."); Kenneth Shuster, *Because of History, Philosophy, the Constitution, Fairness & Need: Why Americans Have a Right to National Health Care*, 10 IND. HEALTH L. REV. 75, 79 (2013) ("Throughout the 1930s, such prepaid plans were popular with the public who saw them as protection from ever-increasing bills, and with hospitals, which viewed them as a much-needed source of revenue.").

party payor is "made whole," as it recoups the $500 payment it made on the plaintiff's behalf. The plaintiff is "made more than whole," as he gets what essentially amounts to a $32,500 windfall. The defendant tortfeasor is arguably punished, as he pays damages that were never incurred. Lastly, the medical provider provided $32,500 of services that the plaintiff did not have to pay for even though the plaintiff was awarded damages for those services. That scenario bothers some people.

We have not always had this issue. It presumably did not really become an issue until insurance companies and third-party payors started paying rates for medical services that were a fraction of the retail costs of medical care.

In 1940, only nine percent of the United States population had health insurance.[9] During and after World War II, there was a dramatic increase in this figure, as nearly twenty-three percent of Americans had health insurance in 1945 and over fifty percent in 1950.[10] It was close to seventy percent by 1960, close to eighty percent in 1970, and it hovered around the eighty percent figure for many years that followed.[11] Medicaid and Medicare did not exist until they were signed into law as part of Title XIX of the Social Security Act in 1965.[12]

So, here is what I take away from this: when the collateral source rule was first established in Alabama in 1910, health insurance as we know it today, Medicaid, and Medicare did not exist, and presumably whatever the doctor or hospital charged was the amount the patient was obligated to pay. Under that scenario, the collateral source rule made perfect sense. At some point along the way, more people obtained health insurance, Medicaid and Medicare were implemented, and medical providers routinely started accepting less than the retail costs of medical services from these third-party payors and writing off the difference. At that point, the collateral source rule did not make as much sense, at least in the eyes of some.

## III. THE LANDSCAPE CHANGES WITH THE PASSAGE OF ALA. CODE § 12-21-45

So, for several years before the genesis of health insurance as we

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[9] MORRISEY, *supra* note 8, at 11–12.
[10] *Id.*
[11] *Id.*
[12] *Program History*, MEDICAID.GOV, https://www.medicaid.gov/about-us/program-history/index.html (last visited Feb. 4, 2019).

know it today, Medicaid, and Medicare, all was right in the collateral source rule world. Plaintiffs in personal injury cases introduced their medical bills into evidence, and the amounts reflected in those bills were presumably the amounts the plaintiffs had actually paid or were legally obligated to pay the medical providers. When the plaintiffs prevailed in those lawsuits, those plaintiffs were made whole, the medical providers were paid what they were owed (whether that was because the plaintiff already paid them pre-lawsuit or through a subrogation interest paid post-lawsuit), and the defendant tortfeasors paid for the damage that they caused. Again, all seemed right with the collateral source rule world.

At some point along the way, things got out of whack when health insurance, Medicaid, and Medicare came to be, and medical providers began accepting less than what they billed for their services from these third parties. Plaintiffs introduced the full retail amounts into evidence, and the defendant tortfeasors, because of the collateral source rule, were prohibited from telling the jury that those bills had been paid by a third party. As a result, plaintiffs could recover more than what they ever owed.

In 1987, things changed in Alabama, and while this change leveled the playing field somewhat for the defendant tortfeasors, it did not resolve the issue completely, and it actually made some things more confusing. In 1987, the Alabama legislature passed Ala. Code § 12-21-45, which abolished the collateral source rule for medical and hospital expenses for all civil actions in Alabama filed after June 11, 1987.[13] The statute provides as follows:

> (a) In all civil actions where damages for any medical or hospital expenses are claimed and are legally recoverable for personal injury or death, evidence that the plaintiff's medical or hospital expenses have been or will be paid or reimbursed shall be admissible as competent evidence. In such actions upon admission of evidence respecting reimbursement or payment of medical or hospital expenses, the plaintiff shall be entitled to introduce evidence of the cost of obtaining reimbursement or payment of medical or hospital expenses.
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> (b) In such civil actions, information respecting such reimbursement or payment obtained or such

[13] ALA. CODE § 12-21-45 (2012).

> reimbursement or payment which may be obtained by the plaintiff for medical or hospital expenses shall be subject to discovery.
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> (c) Upon proof by the plaintiff to the court that the plaintiff is obligated to repay the medical or hospital expenses which have been or will be paid or reimbursed, evidence relating to such reimbursement or payment shall be admissible.
>
> (d) This section shall not apply to any civil action pending on June 11, 1987.[14]

After the passage of Section 12-21-45, here is how things typically began to play out in Alabama state courts: a plaintiff, assuming all foundations were established, would, as had always been the case, introduce into evidence the retail costs of the medical services provided. For cases filed after June 11, 1987, the defendant would then introduce evidence that those medical expenses had been paid by a third party, such as Blue Cross Blue Shield or Medicaid.[15] The plaintiff, in turn, was then entitled to do two things.[16] First, the plaintiff could show that he would be obligated to repay the third party.[17] For example, if the lien or subrogation interest of Blue Cross was $25,000, the plaintiff could inform the jury that he would be obligated to repay Blue Cross $25,000 out of any recovery. Second, the plaintiff could present evidence of the cost of obtaining reimbursement, which is typically in the form of insurance premiums.[18]

Notably, Section 12-21-45 does not address the issue of what medical expenses a plaintiff is entitled to recover; it does not address whether a plaintiff has the right to introduce the retail costs of medical care when the plaintiff is insured; and it does not address how the jury is to be instructed. The statute simply abolished the collateral source rule for medical and hospital expenses.

## IV. The Aftermath of the Passage of Section 12-21-45

After Section 12-21-45 became effective, plaintiffs continued to introduce the retail costs of their medical bills into evidence, and

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[14] *Id.*
[15] Ala. Code § 12-21-45(a), (d) (2012).
[16] Ala. Code § 12-21-45(a), (c) (2012).
[17] Ala. Code § 12-21-45(c) (2012).
[18] Ala. Code § 12-21-45(a) (2012).

defendants were then entitled to introduce evidence that the bills were paid by a collateral source. But Section 12-21-45 also created a lot of confusion among Alabama lawyers and judges about how to instruct the jury on damages and what damages were recoverable.

A pivotal post-Section 12-21-45 decision on this issue is *Senn v. Alabama Gas Corp*.[19] In *Senn*, the plaintiff argued that the trial court erred in refusing to instruct the jury that he was entitled to recover damages for his medical expenses, even if those medical expenses had been paid by a collateral source.[20] One of the requested jury charges the trial court refused to give was the following: "Under the 'collateral source doctrine' the amount paid by an insurer to its insured for the latter's personal injuries or medical bills does not affect the individual's measure of recovery against the wrongdoer."[21]

The Alabama Supreme Court held that the requested jury charges were erroneous as a matter of law and were properly rejected by the trial court.[22] In a concurring opinion, Chief Justice Hornsby clarified that

> under [Section] 12-21-45, a plaintiff is not entitled, necessarily, to fully recover medical or hospital expenses, as Senn's requested jury charges indicate. Instead, in such cases a jury must consider all of the evidence introduced at trial regarding payments from collateral sources and determine to what extent the plaintiff is entitled to recover his medical or hospital expenses, and the trial court should instruct the jury that it has this duty.[23]

In other words, Chief Justice Hornsby clarified in his concurring opinion that a jury could still award the retail costs of medical care even when evidence was presented that the bills were paid by a collateral source. Or the jury could choose to reduce the award.

Three years after *Senn* came *AMF Bowling Centers, Inc. v. Dearman*,[24] a case which highlighted some of the confusion on how to apply

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[19] *See* Senn v. Alabama Gas Corp., 619 So. 2d 1320 (Ala. 1993).
[20] *Id.* at 1325.
[21] *Id.*
[22] *Id.*
[23] *Id.* at 1326 (Hornsby, C.J., concurring specially).
[24] AMF Bowling Ctrs., Inc. v. Dearman, 683 So. 2d 436 (Ala. Civ. App. 1996).

Section 12-21-45. In that case, the plaintiff at trial introduced evidence of $18,577.35 in total medical bills.[25] On cross-examination, she testified that her insurer paid eighty percent of those medical bills.[26] The jury returned a plaintiff's verdict and awarded $5,000 in compensatory damages.[27] The trial court instructed the jury that the damage award was inadequate, and ordered them to deliberate again and instructed them "'you have got to compensate the plaintiff for all damages that were proven,'" and the judge stated that there were at least eighteen thousand dollars in medical expenses.[28] The judge later instructed the jury that "'[y]ou're not allowed to reduce a plaintiff's verdict by what was paid by the insurance company.'"[29] The jury returned with an $18,577.35 award, and a final judgment was entered.[30] The Alabama Court of Civil Appeals ruled that "[t]he trial court committed reversible error by wrongly instructing the jury on the measure of damages."[31] Again, as the concurring opinion in *Senn* instructed, the jury can consider all the evidence and award damages accordingly.[32]

The *Senn* holding was further reinforced by the Alabama Court of Civil Appeals several years later in *Melvin v. Loats*.[33] In that car wreck case, there was evidence that the plaintiff incurred $14,713.36 in medical expenses that were paid by insurance, as well as $1,700 in "out of pocket" medical expenses.[34] The trial court granted judgment as a matter of law in favor of the plaintiff on the negligence claim, and the jury returned a verdict of $5,100.[35] The trial court then granted the plaintiff's motion for a new trial, reasoning that the damages were insufficient under the longstanding principle that "'where liability is established, the jury's assessment of damages must include, at the least, an amount sufficient to compensate the plaintiff for his or her uncontradicted special damages, as well as a reasonable amount of

[25] *Id*. at 437.
[26] *Id.*
[27] *Id.*
[28] *Id.*
[29] *Id.*
[30] *Dearman*, 683 So. 2d at 437–38.
[31] *Id*. at 438.
[32] Senn v. Alabama Gas Corp., 619 So. 2d 1320, 1236 (Ala. 1993) (Hornsby, C.J., concurring specially).
[33] *See* Melvin v. Loats, 23 So. 3d 666 (Ala. Civ. App. 2009).
[34] *Id.* at 668.
[35] *Id.* at 667.

compensation for pain and suffering.'"[36]

Relying on Section 12-21-45, *Senn*, and Section 11.09 of the Alabama Pattern Jury Instructions ("APJI") as it existed at that time, the Alabama Court of Civil Appeals reversed the trial court's decision.[37] The court ruled that it was entirely proper for the jury to award $5,100 in damages, which would have compensated the plaintiff for the $1,700 in out of pocket medical expenses plus an additional $3,400 in pain and suffering.[38]

Speaking to APJI Section 11.09, the court also ruled that the trial court erred in determining

> that the jury . . . had no authority to find, in the words of APJI 11.09 as recited to the jury, that the only 'reasonable expenses necessarily incurred for doctors' and medical bills which the plaintiff has paid or become obligated to pay' were those paid out of [the plaintiff's] own pocket rather than those paid by third parties.[39]

The trial court had ruled in its order granting the plaintiff's motion for a new trial that the court had erred in giving the APJI Section 11.09 instruction verbatim.[40] The plaintiff had actually requested the trial court to instruct the jury that the measure of damages for medical expenses was "reasonable expenses necessarily incurred for doctors' and medical bills which the plaintiff has paid or become obligated to pay *or has been paid on his behalf*."[41] The "or has been paid on his behalf" part at the end of the plaintiff's proposed instruction was not part of APJI Section 11.09, and the Alabama Court of Civil Appeals ruled the instruction was proper without this addition.[42]

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[36] *Id*. at 667, 668–69 (citing *Ex parte Courtney*, 937 So. 2d 1060, 1062 (Ala. 2006) and *Williston v. Ard*, 611 So. 2d 274, 278 (Ala. 1992)).

[37] *Id.* at 670–71.

[38] *Id*. at 670.

[39] *Id.* The entire APJI 11.09 instruction at that time provided as follows: "The measure of damages for medical expenses is all reasonable expenses necessarily incurred for doctors' and medical bills which the plaintiff has paid or become obligated to pay [and the amount of the reasonable expenses of medical care, treatment and services reasonably certain to be required in the future]. The reasonableness of, and the necessity for, such expenses are matters for your determination from the evidence." ALABAMA PATTERN JURY INSTRUCTIONS—CIVIL 11.09 (2nd ed. 1993).

[40] *Id.*

[41] *Melvin*, 23 So. 3d at 670.

[42] *Id.*

While the passage of Section 12-21-45 brought about some confusion in many Alabama trial courts, perhaps the best explanation of its effect came from the federal case from the Southern District of Alabama applying Alabama damages law. In *Washington v. United States*,[43] substantial portions of the plaintiff's medical bills had been paid by Medicare or the Department of Veterans Affairs ("VA").[44] The defendant argued the plaintiff should not be permitted to recover those amounts as damages, and the sole issue in the case was whether the plaintiff was barred from recovering those medical expenses that Medicare and the VA paid on his behalf.[45] In rejecting the defendant's argument, Chief Judge William Steele summarized the effect of Section 12-21-45 as follows:

> As Alabama appellate courts, commentators, and pattern jury charges all recognize, [Section] 12-21-45 did abrogate the common-law evidentiary prohibition against introducing evidence of collateral source payments for medical care in the personal injury context; however, *it left open the question of whether and to what extent a damages recovery in a particular case could or should be reduced to account for those payments*. That question is reserved for the fact finder's discretion, based on the unique facts and circumstances of the case.[46]

Again, the *Washington* case is another example of a court confirming that a jury can choose to award a personal injury plaintiff the retail medical costs or a reduced amount. It is the jury's choice after considering all of the evidence, including evidence of payments from a collateral source.

## V. LOOKING AT MEDICAL EXPENSES THROUGH THE LENS OF THE PLAINTIFF'S BURDEN, THE PURPOSE OF COMPENSATORY DAMAGES, THE SUBSTANTIVE LAW OF DAMAGES, AND RELEVANCE

So far, this article has focused on the defendant's perspective and the collateral source rule. That is, the article has discussed what

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[43] *See* Washington v. United States, 17 F. Supp. 3d 1154 (S.D. Ala. 2014).
[44] *Id.* at 1156.
[45] *Id.*
[46] *Id.* at 1159–60 (emphasis added).

evidence the defendant tortfeasor can or cannot offer. For decades, the defendant was prohibited by the collateral source rule from introducing evidence that the plaintiff's medical bills had been paid by insurance or some other collateral source. With the passage of Section 12-21-45 in 1987, the law changed, and the defendant was then permitted to introduce collateral source evidence on medical expenses. And the cases construing Section 12-21-45 have been clear that its passage did not take away the jury's right to determine the amount of damages to award.

The rest of this article will view these issues from the perspective of the injured plaintiff. Specifically, is there a legal basis for allowing a plaintiff to introduce evidence of and recover the retail costs of medical care when insurance or some other third-party payor has paid a drastically reduced amount and written off the remainder? To use another *Seinfeld* example: suppose George Costanza receives $100,000 in medical treatment as a result of a car wreck where Kramer is at fault. Suppose further that Blue Cross pays his doctor $25,000, and the doctor writes off the remaining $75,000. Is there a basis under the law for allowing George to introduce evidence of the $100,000 and recover that $100,000 as damages? As previously discussed, plaintiffs have routinely been permitted to introduce the full retail costs of their medical bills into evidence even after it became well known and established that doctors and hospitals would typically accept some fraction of those bills as payment in full from insurance companies, Medicaid, and Medicare. But is there a basis in the law for that?

### *A. Plaintiff's Burden and the Purpose of Compensatory Damages*

A logical starting point for this analysis is the long-standing Alabama rule "'that the party claiming damages has the burden of establishing the existence of and amount of those damages by competent evidence.'"[47] In looking at that issue, we should also consider that "the purpose of compensatory damages in Alabama is to 'make the [injured party] whole *by reimbursing him or her for the loss or harm suffered*.'"[48] Under the hypothetical used above, George Costanza arguably did not have a "loss" of $100,000, nor did he "suffer[]" $100,000 in damages. At most, he would be required to reimburse Blue Cross

[47] Jerkins v. Lincoln Elec. Co., 103 So. 3d 1, 10 (Ala. 2011) (quoting Johnson v. Harrison, 404 So. 2d 337, 340 (Ala. 1981)).

[48] *Ex parte S & M, LLC*, 120 So. 3d 509, 516 (Ala. 2012) (quoting *Ex parte Goldsen*, 783 So. 2d 53, 56 (Ala. 2000)) (emphasis added).

$25,000 through a subrogation interest, and the purpose of compensatory damages arguably would be served by reimbursing Costanza that $25,000.

*B. The Substantive Law of Alabama on Recovering Medical Expenses*

It is also helpful to the analysis to look at what the substantive law of Alabama says about what medical expenses may be recovered as damages. For more than a century, Alabama appellate courts have indicated that, in the context of medical expenses, a plaintiff must prove that he has paid the medical expenses he is claiming, or if the expenses have not been paid, the expenses are due and the plaintiff is obligated to pay them. In *Birmingham Railway, Light & Power Co. v. Humphries*,[49] for example, the Alabama Supreme Court observed that "the defendant is not liable for any more than the reasonable value of the services of a physician, *yet neither is it liable for any more than has actually been paid or is due*."[50]

The substantive law of damages for medical expenses was crystalized on April 19, 1973, when the first version of the ALABAMA PATTERN JURY INSTRUCTIONS—CIVIL was formally approved.[51] Section 11.09 of those pattern jury instructions provided the following instruction on medical expenses in a personal injury case:

> The measure of damages for medical expenses is all reasonable expenses necessarily incurred for doctors' and medical bills *which the plaintiff has paid or become obligated to pay* [and the amount of the reasonable expenses of medical care, treatment and services reasonably certain to be required in the future]. The reasonableness of, and the necessity for, such expenses are for your determination from the evidence.[52]

The Second Edition of the *Alabama Pattern Jury Instructions—Civil* was published in 1993, and the pattern jury instruction for medical expenses in a personal injury case did not change from the first edition.[53] Thus, according to the instruction, a plaintiff could only recover

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[49] Birmingham Ry., Light & Power Co. v. Humphries, 55 So. 307 (Ala. 1911).
[50] *Id.* at 308 (emphasis added).
[51] ALABAMA PATTERN JURY INSTRUCTIONS—CIVIL, pp. iii, ix-xii (1st ed. 1974).
[52] ALABAMA PATTERN JURY INSTRUCTIONS—CIVIL 11.09 (1st ed. 1974) (emphasis added).
[53] ALABAMA PATTERN JURY INSTRUCTIONS—CIVIL 11.09 (2nd ed. 1993).

for "*medical bills which the plaintiff has paid or become obligated to pay*."[54]

In 2009, a new pattern instruction on the recovery of medical expenses in a personal injury case was published as part of the Third Edition of the *Alabama Pattern Jury Instructions—Civil*.[55] This

[54] ALABAMA PATTERN JURY INSTRUCTIONS—CIVIL 11.09 (2nd ed. 1993) (emphasis added).

[55] ALABAMA PATTERN JURY INSTRUCTIONS—CIVIL 11.15 (3rd ed. 2009). This instruction was amended twice since 2009, and the latest version, revised on May 6, 2016, provides as follows:

> (Name of plaintiff) says that (name of defendant)'s conduct caused (him/her) expenses for medical care, treatment, and services.
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> The measure of damages for medical expenses is all reasonable expenses for medical care, treatment, and services caused by (name of defendant)'s conduct, (and the amount of reasonable expenses for medical care, treatment and services that (name of plaintiff) is reasonably certain to need in the future.)
>
> You must decide if the treatment was reasonably necessary, that the expenses for it were reasonable in amount, and that the need for the treatment was caused by (name of defendant)'s conduct.
>
> (When there is evidence of third party payment of medical expenses, give the following as appropriate.)
>
> There is evidence that a third party (satisfied) (paid) (name of plaintiff)'s medical expenses, and (name of defendant) asks that you reduce the amount of any award for medical expenses.
>
> (When there is evidence of cost of obtaining reimbursement, give the following as appropriate.)
>
> There is also evidence of the cost of obtaining reimbursement or payment of medical expenses.
>
> (When there is evidence of subrogation, give the following as appropriate.)
>
> There is also evidence that (name of plaintiff) will have to pay back from any award the money (name of third party provider) paid for (name of plaintiff)'s medical expenses.
>
> (When any of the above additional paragraphs are given, give the following also.)

instruction changed significantly from the instruction in the First and Second Editions, as a substantial portion of it tracks Section 12-21-45 and suggests how the jury should be instructed if there is evidence that payments were made by a collateral source.[56] Interestingly, and without explanation, this new pattern instruction eliminated language from the prior editions that said that a plaintiff could only recover for "medical bills which the plaintiff has paid or become obligated to pay."[57]

Notwithstanding the significant changes to the pattern jury instruction on medical expenses, Alabama courts have never overturned the longstanding rule that a plaintiff may only recover medical bills that he has paid or has become obligated to pay.[58] Nor have Alabama courts strayed from recognizing that "the purpose of compensatory damages in Alabama is to 'make the [injured party] whole *by reimbursing him or her for the loss or harm suffered*.'"[59]

### *C. Relevancy under the Alabama Rules of Evidence*

If the Alabama law of substantive damages does indeed say that a

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> You may consider all this evidence in determining the amount of your award.

[56] *Id.*

[57] *Compare* ALABAMA PATTERN JURY INSTRUCTIONS—CIVIL 11.15 (3rd ed. 2009), *with* ALABAMA PATTERN JURY INSTRUCTIONS – CIVIL 11.09 (1st ed. 1973), *and* ALABAMA PATTERN JURY INSTRUCTIONS – CIVIL 11.09 (2nd ed. 1993).

[58] *See* Costa v. Sam's East, Inc., Civ. Act. No. 11-0297-WS-N, 2012 WL 3206362, 14–15 (S.D. Ala. Aug. 6, 2012) ("To the extent that plaintiff seeks to present evidence of medical expenses that Costa (or his estate) either did not pay or is not obligated to pay, such evidence is not relevant to any triable issue, and is substantially likely to cause unfair prejudice or unnecessary confusion."); Shelley v. White, 711 F. Supp. 2d 1295, 1297–98 (M.D. Ala. 2010) ("Consistent with this collateral source rule application is the Alabama rule that medical expense damages are to be allowed only for doctor's and medical bills which the plaintiff has paid or has become obligated to pay. . . . On proper proof, Plaintiff's measure of damages for medical expenses will be based on what Plaintiff is obligated to reimburse, any additional expenses he is legally obligated to pay, and any costs to him for applicable coverage."); Melvin v. Loats, 23 So. 3d 666, 671 (Ala. Civ. App. 2009) ("[W]e perceive no legal error in instructing the jury that it should award reasonable and necessary expenses for doctors' and medical bills 'which the plaintiff has paid or become obligated to pay' without referring to expenses paid by third parties."); Jones v. Crawford, 361 So. 2d 518, 521 (Ala. 1978) (noting the context of medical expenses that "[t]he general rule is that damages are unrecoverable where the plaintiff has not paid or is not liable for such items") (citing Alabama Farm Bureau Mut. Cas. Ins. Co. v. Smelley, 329 So. 2d 544, 546 (Ala. 1976) and Jones v. Keith, 134 So. 630, 633–634 (Ala. 1931)).

[59] Ex parte S&M, LLC v. Burchel, 120 So. 3d 509, 516 (Ala. 2012) (quoting Ex parte Goldsen, 783 So. 2d 53, 56 (Ala. 2000)) (emphasis added).

plaintiff may only recover medical expenses that he has paid or is obligated to pay, the next step in the analysis is to look to the rules of relevance under the Alabama Rules of Evidence.[60] Rule 401 of the Alabama Rules of Evidence provides that "'[r]elevant evidence' means evidence having any tendency to make the existence of any fact that is *of consequence* to the determination of the action more probable or less probable than it would be without the evidence."[61] "Rule 401 includes, by use of the phrase 'of consequence,' [the] historic materiality requirement as part of the definition of 'relevant evidence.'"[62]

Typically, the way to determine whether a piece of evidence is "of consequence" to the case (i.e., material) is to look to the substantive law of the tort or crime at issue in the case.[63] For example, is the evidence at issue pertinent to an element or defense to the crime or cause of action at issue?[64] Evidence offered on the element of damages that are recoverable under the substantive law, of course, is evidence that would be "of consequence" to the case.[65]

When all of these principles are combined—the purpose of compensatory damages, the substantive law of recoverable medical expenses, and the rules of relevancy—one can logically make the argument that the retail costs of medical care should be inadmissible when a third-party payor paid a reduced rate in full satisfaction of the bills. The argument is simple: a plaintiff is only entitled to recover medical bills that he has paid or is obligated to pay. Therefore, anything above the subrogation amount is irrelevant and inadmissible. I have never seen an Alabama appellate case where this argument was made, but as demonstrated in the next section, the argument has gained traction in federal cases applying Alabama damages law.

## VI. FEDERAL CASES APPLYING ALABAMA DAMAGES LAW

In the fairly recent case of *Bobo v. Tennessee Valley Authority*,[66] the Eleventh Circuit addressed a similar issue applying Alabama damages law. In that case, the trial court allowed the plaintiffs to recover

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[60] ALA. R. EVID. 401.
[61] *Id*. (emphasis added).
[62] CHARLES W. GAMBLE, TERRENCE W. MCCARTHY, & ROBERT J. GOODWIN, GAMBLE'S ALABAMA RULES OF EVIDENCE § 401(a) (3rd ed. 2014).
[63] *See* CHARLES W. GAMBLE & ROBERT J. GOODWIN, MCELROY'S ALABAMA EVIDENCE § 20.01(3)(a) (6th ed. 2009).
[64] *Id*.
[65] *Id.* at § 20.01(3)(e).
[66] Bobo v. Tennessee Valley Authority, 855 F.3d 1294 (11th Cir. 2017).

$537,131.82, the "retail" cost of the medical expenses, even though the insurers paid a fraction of that amount to the providers.[67] On appeal, the Eleventh Circuit considered "whether the plaintiffs are entitled to recover the portion of that amount of medical expenses that she was billed but which neither she nor her insurers paid the providers because through agreements with the insurers the providers agreed 'to adjust, reduce, write down, or accept a reduced portion in satisfaction of [the] billed amounts.'"[68] The defendant contended that the plaintiffs were not entitled to recover any amount that had been written off by the providers, while the plaintiffs contended they were entitled to recover all amounts that were initially billed, even the written off amounts.[69]

The Eleventh Circuit began by stating that "[u]nder Alabama law, the party seeking damages bears the burden of showing that they exist and the amount of them."[70] Further, "[m]edical expenses 'damages are unrecoverable where the plaintiff has not paid or is not liable [to pay] such items.'"[71] The Eleventh Circuit sided with the defendant, holding "that amounts that were written off by providers under contractual agreements with insurers are *not* amounts that a plaintiff has paid or is obligated to pay within the meaning of the Alabama Supreme Court's decisions."[72] The case was then reversed and remanded for the district court "to recalculate the damages award in order to exclude from it any amounts that were written off by [the decedent's] providers."[73]

The Eleventh Circuit found that Alabama law precluded the *Bobo* plaintiffs from recovering the "retail" cost of medical expenses when the "actual" cost of that medical care was covered by third parties for an amount significantly lower than the "retail" cost.[74] Under Alabama law, as explained by the *Bobo* decision, a plaintiff is only "legally obligated to pay" the amount that is actually paid to providers on his behalf, which is why the court did not allow the plaintiff to recover the

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[67] *Id.* at 1310.
[68] *Id.* at 1310–11.
[69] *Id.* at 1311.
[70] *Id.* (citing Jerkins v. Lincoln Elec. Co., 103 So. 3d 1, 10 (Ala. 2011)).
[71] *Bobo*, 855 F.3d at 1311 (quoting Jones v. Crawford, 361 So. 2d 518, 521 (Ala. 1978)); *see also* Alabama Farm Bureau Mut. Cas. Ins. Co. v. Smelley, 329 So. 2d 544, 546 ("[D]amages for medical expenses are to be allowed only 'for doctor's and medical bills which the plaintiff has paid or has become obligated to pay.'").
[72] *Bobo*, 855 F.3d at 1311 (emphasis added).
[73] *Id.*
[74] *Id.*

retail costs.[75]

Even before *Bobo*, some federal district courts, applying Alabama law, ruled that plaintiffs were prohibited from introducing retail medical costs when the bills were satisfied by a third-party payor for a discounted amount. For example, in *Portis v. Wal-Mart Stores East, Ltd. Partnership*,[76] the defendant filed a motion *in limine* seeking to limit evidence of medical expenses to the amounts that were actually required to be paid:

> [P]laintiffs should not be allowed to submit all of their medical bills to the jury, inasmuch as the billed amounts exceed $60,000 but those amounts were marked down to approximately $20,000 pursuant to contractual relationships between the medical providers and Portis's insurance company, such that plaintiffs have no exposure or responsibility for the difference.[77]

Applying Alabama damages law, United States District Court Judge Steele granted the motion and excluded from evidence the discounted portion of the medical bills, holding that the discounted portion was not recoverable.[78]

Judge Steele specifically rejected the plaintiff's argument that even discounted and written-off medical bills should be admitted into evidence for consideration by the jury "to show the extent and nature of the injury."[79] The opinion stated that evidence of the full amount, as opposed to the amount actually paid, is minimally probative and poses a great risk of confusing the jury.[80] Thus, according to Judge Steele, the amount actually paid, after write-offs were deducted, was probative on the issue of damages actually sustained by the plaintiff; the retail cost, however, was inadmissible.[81]

The *Portis* decision is not alone. For example, as stated in a subsequent case relying on *Portis*, allowing the jury to hear "evidence of medical expenses that [a plaintiff] (or [a plaintiff's] estate) either did

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[75] *Id.*

[76] Portis v. Wal-Mart Stores East, Ltd. P'ship, No. 07-0557-WS-C, 2008 WL 2959879 (S.D. Ala. Jul. 30, 2008).

[77] *Id.* at *8.

[78] *Id.*

[79] *Id.* at *8 n.13.

[80] *Id.*

[81] *Id.*

not pay or is not obligated to pay . . . is not relevant to any triable issue, and is substantially likely to cause unfair prejudice or unnecessary confusion."[82]

Research has not revealed any cases from the Alabama Supreme Court or the Alabama Court of Civil Appeals that have squarely addressed this issue. However, *Margrinat v. Maddox*,[83] which addressed an issue of first impression in Alabama and involved a different issue, can provide some guidance. In that case, the plaintiff, who did not have health insurance, was injured in a car accident and required surgery.[84] The plaintiff's surgeon billed the plaintiff $9,281 for his services.[85] A third party, OrthoUSA, purchased the plaintiff's debt from the surgeon for $3,200.[86] The surgeon then "wrote off" the approximately $6,000 remaining on the total debt and waived the right to attempt to collect the remainder of the debt from the plaintiff.[87] OrthoUSA, as the owner of the debt, then had the right to attempt to collect the entire $9,281 from the plaintiff.[88]

After a bench trial, the judge awarded the plaintiff $42,000 in compensatory damages.[89] The trial judge, however, only awarded him $3,200 in damages for the surgery bill, as opposed to $9,281.[90] The plaintiff appealed, contending that he was entitled to recover as damages the entire $9,281 cost of the surgery.[91] More specifically, the plaintiff argued that he was entitled to recover the full amount of the surgeon's bill for which he is liable, not just the amount for which the surgeon agreed to sell the debt to OrthoUSA.[92] In response, the

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[82] Costa v. Sam's East, Inc., Civ. Act. No. 11-0297-WS-N, 2012 WL 3206362, at *4 (S.D. Ala. Aug. 6, 2012). *See also* Shelley v. White, 711 F. Supp. 2d 1295, 1297–98 (M.D. Ala. 2010) ("Consistent with this collateral source rule application is the Alabama rule that medical expense damages 'are to be allowed only for doctor's and medical bills which the plaintiff has paid or has become obligated to pay. . . . ' On proper proof, Plaintiff's measure of damages for medical expenses will be based on what Plaintiff is obligated to reimburse, any additional expense he is legally obligated to pay, and any cost to him for applicable coverage.").

[83] Marginat v. Maddox, 220 So. 3d 1081 (Ala. Civ. App. 2016).

[84] *Id.* at 1082–83.

[85] *Id.* at 1083.

[86] *Id.*

[87] *Id.*

[88] *Id.*

[89] *Maddox*, 220 So. 3d. at 1083.

[90] *Id.*

[91] *Id.* at 1084.

[92] *Id.*

defendant cited the collateral source rule, contending that the trial court properly "determined that the proper measure of damages was 'the collateral source "lower" amount.'"[93]

The Alabama Court of Civil Appeals ruled in favor of the plaintiff, holding that the plaintiff incurred a debt of $9,281, and the trial court erred in awarding him only $3,200.[94] Importantly, for purposes of this article, the court observed that "[t]here is no evidence indicating that OrthoUSA purchased [the plaintiff's] debt to [the surgeon] on behalf of [the plaintiff] or to extinguish or satisfy [the plaintiff's] debt, *as would have been the case if [the surgeon] had accepted a lower payment for his services from an insurance company or an agency like Medicare or Medicaid*."[95] The plaintiff was still liable for the entire bill.[96] The only thing that changed is he became obligated to pay OrthoUSA rather than the surgeon.[97]

The language from the *Margrinat* decision emphasized above does not answer the question of how an Alabama appellate court would rule when presented with the issue of whether a plaintiff is entitled to recover the billed costs of his medical care when a third-party payor paid a discounted amount. But it does provide an opening to argue that there is a difference when a medical provider writes off debt because it received payment from a third-party payor, as opposed to writing off debt because the entire debt was sold to a third party. This distinction, in conjunction with the *Bobo* and *Portis* decisions, provides persuasive authority to argue that the retail costs of medical care are inadmissible and not recoverable when the third-party payor pays the medical provider a reduced rate.

But again, the response to this argument is that Alabama courts have long permitted personal injury plaintiffs to introduce evidence of the retail costs of medical care and for juries to award such costs should they choose to do so. But would Alabama courts reach the same conclusion if the defense argues that such a result is inconsistent with Alabama's substantive law of damages? Federal decisions applying Alabama substantive law indicate that a different result is possible.

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[93] *Id.* at 1085.
[94] *Id.* at 1087.
[95] *Maddox*, 220 So. 3d. at 1085 (emphasis added).
[96] *Id.*
[97] *Id.*

## VII. CONCLUSION

This issue fascinates me. For decades, insured plaintiffs have introduced the retail costs of medical care, often without objection by the defendant. This made perfect sense before health insurance companies began negotiating discounted rates with third-party payors. But since health insurance, Medicaid, Medicare, and Section 12-21-45 came to be, it arguably stopped making sense, at least in the minds of some people. When this scenario is presented, it seems like one question for a court to ask is this: is there any way that the insured plaintiff will ever be obligated to pay the retail costs of the medical bills? If the answer is yes, admitting evidence of the retail amount into evidence makes sense. If the answer is no, admitting evidence of the retail amount would arguably be contrary to Alabama's substantive law of damages on medical expenses and the rules of relevance. It will be interesting to see how the Alabama appellate courts resolve this issue if it is ever placed before them.