Is *Abbott v. Banner Health* the Win that Signals the Loss?: Rethinking Medical Damages in Arizona

By Amanda Heitz, Esq. and Travis Wheeler, Esq.

Bowman and Brooke, LLP

Amanda Heitz, Esq.

Travis Wheeler, Esq.

Late last year, the plaintiffs' bar was cheering the Arizona Court of Appeals' decision in *Abbott v. Banner Health Network*, 236 Ariz. 436, 341 P.3d 478 (Ct. App. 2014). It arises from the situation where a medical provider "bills" one amount for care, but then accepts a much lower amount as payment from the Arizona Health Care Cost Containment System (AHCCCS). Plaintiffs argued, and the Court of Appeals agreed, that federal preemption precludes AHCCCS-participating medical providers from asserting "balance billing" liens for amounts in excess of what they agreed to accept as payment in full by participating in the Medicaid program. As a consequence of the Abbott decision, after satisfying any AHCCCS liens against the amount actually paid for their care, AHCCCS plaintiffs can keep the sum of any verdict or settlement without worrying about liens from their medical providers.

At first blush, this dispute between plaintiffs and their medical providers does not seem to have much application to the personal injury defense bar. However, when it comes to medical bills, plaintiffs want to have it both ways. Although they do not want to be liable for balance billing liens that cut into their recoveries, they do want to include the balance billing amount as recoverable damages in personal injury suits against alleged third-party tortfeasors. This is untenable. *Abbott* means that the health care providers, in seeking reimbursement for their services, are limited to what AHCCCS paid. So too should plaintiffs, in seeking recovery of medical expenses in a personal injury suit, be limited to what AHCCCS paid. The larger, unpaid, unenforceable "bills" should be disregarded. Thus, *Abbott* plays into the ongoing dispute in Arizona, and across the country, concerning "billed versus paid" past medical expenses and the amount of damages claimed in personal injury cases.

Lopez v. Superior Court and the Billed Versus Paid Issue in Arizona

When plaintiffs argue they are entitled in personal injury cases to the full amount of their medical providers' "bills," and not merely the amount paid by government programs or insurance, they rely on the collateral source rule as interpreted by a 2006 Arizona Court of Appeals case, *Lopez v. Safeway Stores, Inc.*, 212 Ariz. 198, 129 P.3d 487 (App. 2006). The collateral source rule is a hoary damages doctrine meant to prevent windfalls to defendants. In short, the rule provides that when a plaintiff receives compensation from a source other than the defendant, the defendant is still responsible for the entire value of the damages. For example, let's say that a plaintiff breaks her arm when she is hit by a car while on her bicycle. In response, members of her cycling club raise money to cover her medical bills. When the plaintiff sues the driver who hit her, the collateral source rule prevents the driver from arguing that he is not liable for her medical bills because the plaintiff had no out-of-pocket loss.

Lopez was a slip and fall case, where the plaintiff's medical "bills" totaled approximately $60,000. The provider accepted about 1/3 of that amount from insurance and "wrote off" the remaining 2/3. *Id.* at 199, 129 P.3d at 488. The defendant argued that the plaintiff should have been permitted to present only evidence of the amount actually paid for her care, not the larger billed amount. *Id.* The court of appeals disagreed, finding that the plaintiff was entitled to recover both the full "charged" amount, not just the amount that her care providers agreed to accept from insurance. *Id.* at 207, 129 P.3d at 496. The reasoning of *Lopez* tracks a traditional

Is *Abbott v. Banner Health* the Win that Signals the Loss? *(continued)*

view that both the amount paid by insurance and the amount "written off" by the provider are "benefits" of insurance. The idea is that the insured plaintiff pays her insurance company to negotiate down the medical bills below the market rate, as well as to pay the remaining amount, so both amounts should be excluded by the collateral source rule.

Challenging the Result of *Lopez* and How *Abbott* Can Help

Although *Lopez* is something of a stumbling block to challenging a plaintiff's medical damages, it is not the insurmountable obstacle that some defense attorneys and nearly all plaintiffs' attorneys assume that it is. *Lopez* does *not* mean that a plaintiff is automatically entitled to the amount reflected on a hospital bill. One important, and often overlooked, aspect of *Lopez* is that the defendant stipulated that if it was not permitted to present the lesser "paid" amount, then the full "billed" amount would be deemed "reasonable and customary." *Id.* at 202 & n.4, 129 P.3d at 491 & n.4. Accordingly, the court of appeals did not address whether the full billed amount was in fact reasonable. *Id.* No defendant ever needs to make the *Lopez* stipulation, which relieves the plaintiff of his or her burden of proof.

Reasonableness is the ultimate challenge to any "billed" medical claim. Plaintiffs are entitled to recover only the "reasonable expenses" of their past medical care. RAJI (Civil) 5th, Personal Injury Damages 1. If the amount is not reasonable, plaintiffs cannot recover it. Moreover, the bills alone are not *prima facie* evidence of their own reasonableness. *See Canyon Ambulatory Surgery Ctr. v. SCF Arizona*, 225 Ariz. 414, 422-24, 239 P.3d 733, 740-43 (App. 2010); *Larsen v. Decker*, 196 Ariz. 239, 243-44, 995 P.2d 281, 285-86 (App. 2000). Plaintiffs are usually ill-prepared for attacks on the reasonableness of bills. They are often ready with a doctor to testify that the *services* were medically reasonable and necessary, but not an administrator, billing specialist, or other expert with foundation to address the reasonableness of the costs.

As courts across the country have come to realize, health care providers routinely recover only a fraction of the amount "billed" for care. *See Stanley v. Walker,* 906 N.E.2d 852, 857 (Ind. 2009) (noting that hospitals ordinarily accept approximately 40% of the billed amount in full satisfaction). Also, it is increasingly recognized that the billed amounts for medical care are arbitrary. In the case of hospital charges, the bills are generated from a hospital-specific price list called a "chargemaster." As Steven Brill explained in a recent issue of *Time Magazine* devoted to medical billing, "[n]o hospital's charge-master prices are consistent with those of any other hospital, nor do they seem to be based on anything objective." Steven Brill, *Special Report: Why Medical Bills Are Killing Us*, Time Magazine, Mar. 4, 2013, at 22. These chargemaster rates were established decades ago and have continued to rise essentially automatically, leading to preposterous results, such as a single dose of an over-the-counter painkiller costing nearly as much as a year's supply of the same medication. Hospital officials frequently admit that these rates are wholly unrelated to the actual cost of care and do not represent the amounts the provider actually expects to receive for services rendered. These are merely numbers on a ledger that routinely add up to 3 to 4 times what the health care provider actually receives.

Understanding that almost nobody pays the billed amount, and that it is not based on anything objective, helps rebut a claim that the billed amount is reasonable. *Abbott* helps as well, because it provides that, at least when dealing with AHCCCS, the full billed amount is not just an arbitrary number that providers expect to be ignored, it is a number that they are precluded from collecting. *Abbott* means that no one is actually entitled to the higher amount that was never paid by AHCCCS, which makes the number easier to disregard in a personal injury case. AHCCCS plaintiffs can no longer point to balance-billing liens as justification to claim as damages an amount greater than the providers actually accepted as payment in full.

Reasonableness is the strongest basis upon which to challenge a plaintiff's claimed medical expenses—it highlights that plaintiffs have the burden of proving every aspect of their cases, including damages, and it is consistent with *Lopez*, which expressly does not deal with reasonableness. That said, it is important to note that *Lopez* is also vulnerable to attack because its logical underpinning does not accurately describe the health care marketplace. As explained above, *Lopez* rests on an assumption that an insurer

drives down an insured's bills below the market rate. Therefore, "write-offs" are seen as a collateral source benefit. Moreover, one traditional justification of applying the collateral source doctrine to insurance "write-offs" is to encourage the purchase of insurance. However, especially in light of the Affordable Care Act, this is no longer realistic—if it ever was. The reality is that insurers dominate the medical marketplace, which means the amount paid by insurance is closer to a market rate than the arbitrary "billed" amount that is almost never paid. When all the participants in the market pay the insurance rate, that insurance rate is not a negotiated discount. Also, a judicial rule of damages aimed to encourage people to purchase insurance is no longer needed.

Nationwide, the Law of Medical Damages Is Changing.

With its logical premise increasingly undercut, *Lopez* could be reconsidered and overturned. Indeed, over the last fifteen years, courts and legislatures around the country have begun to reject *Lopez*-style interpretations of the collateral source rule.

Several states now generally endorse the view that medical damages are the amount paid for care as opposed to the amount billed. North Carolina, Oklahoma, and Texas have all adopted this standard. N.C. Gen. Stat. Ann § 8C-1, Rule 414; Ok. Stat. § 3009.2; Tex. Civ. Prac. & Rem. Code § 41.0105. In other states, the appellate courts have endorsed a broad paid-only approach. Perhaps the most thorough and influential ruling on this topic, the California Supreme Court's opinion in *Howell v. Hamilton Meats & Provisions,* 257 P.3d 1130 (Cal. 2011), held that a plaintiff may not recover the undiscounted sum of a medical bill that is never paid by or on behalf of the injured person. Courts in New York and Pennsylvania have reached the same conclusion. *Kastick v. U-Haul Co. of W. Mich.,* 292 A.D.2d 797, 798 (N.Y. App. Ct. 2002); *Moorhead v. Crozer Chester Med. Ctr.,* 765 A.2d 786, 790 (Pa. 2001). Other courts have reached the same conclusion in the limited circumstances of medical expenses covered by Medicare. *See Dyet v. McKinley,* 81 P.3d 1236 (Idaho 2003); *Bozeman v. State,* 879 So.2d 692 (La. 2004).

Other jurisdictions have adopted a hybrid approach. For example, in Missouri, by statute, a rebuttable presumption exists that the amount accepted by a provider for services rendered "represents the value of the medical treatment." Mo. Ann. Stat. § 490.715. In Massachusetts, an appellate court decision sensitive to the danger of the jury finding out that the plaintiff was insured, allows defendants to call medical providers to present testimony about the "range of payments" that the providers accept as full reimbursement for the services rendered. *Law v. Griffith*, 930 N.E.2d 126, 135 (Mass. 2010). And Ohio permits the parties to present evidence of both the full billed amount and the paid amount. *Robinson v. Bates*, 857 N.E.2d 1195 (Ohio 2006). Indiana's and Kansas's high courts have followed this approach, but forbid mentioning the source of any payment on the plaintiff's behalf. *Stanley*, 906 N.E.2d 852; *Martinez v. Milburn Enter. Inc.*, 233 P.3d 205, 220 (Kan. 2010).

Still other states have statutes that partially reverse the common law collateral source rule after verdict. In some states, the court makes a post-verdict adjustment to the judgment to exclude any damages that have or will be compensated by certain collateral sources, though these statutes have significant exceptions. *See, e.g., White v. Jubitz Corp.,* 219 P.3d 566, 572 (Or. 2009) (concluding that statute did not apply to private insurance or Medicare benefits). In some states, amounts that were never paid are considered "collateral sources" that are subtracted from the ultimate judgment. *See, e.g., Goble v. Frohman,* 901 So. 2d 830, 833 (Fla. 2005); *Swanson v. Brewster*, 784 N.W.2d 264 (Minn. 2010).

Conclusion

It is tempting to hope that *Abbott* is a sign of things to come or that it will open the door to a reconsideration of *Lopez*. Though it deals only with AHCCCS, its reasoning underscores the hypocrisy of the plaintiffs' bar's position with respect to damages. When it cuts into the plaintiffs' bottom line, the amount the treating provider accepted as payment is the amount owed, regardless of the supposed reasonableness of the charge. But when it comes to demanding payment from a defendant, the amount paid has nothing to do with the damages. *Abbott*, of course, is not a sea change, does not invalidate *Lopez*, and still faces a hurdle in front of the Arizona Supreme Court, but perhaps its reasoning will start to nudge the law in a more fair direction. But until that day comes, reasonableness is still the key to challenging medical damages.