IN THE UTAH SUPREME COURT

TROY GARDNER, Plaintiff/Appellee, vs. TYLER NORMAN, Defendant/Appellant.	Appeal No. 2024-03440SC

BRIEF OF *AMICI CURIAE* NATIONAL FEDERATION OF INDEPENDENT BUSINESS SMALL BUSINESS LEGAL CENTER, INC., NATIONAL ASSOCIATION OF MANUFACTURERS, AMERICAN TORT REFORM ASSOCIATION, COALITION FOR LITIGATION JUSTICE, INC., AMERICAN PROPERTY CASUALTY INSURANCE ASSOCIATION, NATIONAL ASSOCIATION OF MUTUAL INSURANCE COMPANIES, AMERICAN TRUCKING ASSOCIATIONS, INC., AND UTAH TRUCKING ASSOCIATION IN SUPPORT OF DEFENDANT/APPELLANT AND REVERSAL

On Appeal from the Third Judicial District Court
In and For Salt Lake County, State of Utah
Honorable Keith Kelly, Trial Court Civil No. 220906066

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IDENTITY AND INTEREST OF *AMICI CURIAE*

Amici are organizations whose missions support advancing a balanced civil justice system. Their members include businesses of all sizes, manufacturers, trucking companies, and insurers. *Amici* have a substantial interest in ensuring that awards for medical care reflect the reasonable value of such services. *Amici*'s members are adversely impacted by the district court's approach to valuing special damages, which presents a factfinder with list prices for medical services that a plaintiff's healthcare provider did not receive, while excluding amounts actually accepted by the healthcare provider as full payment for its services. This approach results in inflated medical damage awards that reflect medical billing and negotiation practices rather than their reasonable market rates.

Amici submitting this brief are:

- The National Federation of Independent Business Small Business Legal Center, Inc., a nonprofit, public interest law firm established to provide legal resources and be the voice for small businesses in the nation's courts;
- The National Association of Manufacturers, the largest manufacturing association in the United States;
- The American Tort Reform Association, a nationwide civil justice reform coalition;

- The Coalition for Litigation Justice, a nonprofit association formed by insurers to address the litigation environment for toxic-tort claims;[1]

- The American Property Casualty Insurance Association, the leading national trade association for home, auto, and business insurers, with a legacy dating back 150 years. APCIA members represent all sizes, structures, and regions—protecting families, communities, and businesses in the U.S. and across the globe;

- The National Association of Mutual Insurance Companies, which serves the interests of local and regional mutual insurance companies on main streets across America as well as many of the country's largest national insurers;

- The American Trucking Associations, Inc., the national association of the trucking industry, which, in conjunction with 50 state affiliated trucking organizations, represents over 30,000 motor carriers of every size, type, and class of operation; and

- The Utah Trucking Association, Inc., the state trucking association in Utah dedicated to ensuring that laws, rules, and regulations are written and enforced in a manner that will enhance safety, improve efficiency for Utah truck drivers and Utah trucking companies and minimize negative impacts to business and to the people of Utah that are served by the trucking industry.

NOTICE, CONSENT, AUTHORSHIP, AND FUNDING

Amici provided timely notice to counsel of record for all parties to the appeal of their intent to file this brief.[2] All parties consented to its filing.

[1] The Coalition includes Century Indemnity Company; Allianz Reinsurance America, Inc.; Great American Insurance Company; Nationwide Indemnity Company; Resolute Management, Inc., a third-party administrator for numerous insurers; and TIG Insurance Company.

[2] Counsel for *amici* provided timely notice of their intent to file of an *amicus* brief in support of Defendant, although the signatories to the brief have changed to include the above organizations.

No party or party's counsel authored this brief in whole or in part or contributed money to fund preparing or submitting the brief. No person or entity—other than *amici curiae*, their members, or their counsel—contributed money to fund preparing or submitting this brief.

INTRODUCTION AND SUMMARY OF ARGUMENT

This case presents a straightforward question: Can a plaintiff recover damages for medical expenses based on list prices not actually paid to a plaintiff's healthcare providers, or should a plaintiff instead recover damages based on amounts actually paid and accepted for such services?

Here, the Plaintiff, who was involved in a minor automobile accident with a Salt Lake City police officer, sought $7,267.77 for an emergency room visit, CT scan, and eye examination based on "chargemaster" list prices for services, when his healthcare providers accepted $4,487.75 as full payment. The difference between the two amounts, $2,780.02, constitutes "phantom damages." These "damages" do not reflect an injury to the Plaintiff caused by the Defendant. They were never incurred and simply do not exist.

Plaintiffs may recover the reasonable value of medical care necessary to treat an injury caused by a tortfeasor. Chargemaster rates and other list prices, however, generally do not reflect the reasonable market value of medical services. These rates are often merely the starting point for negotiation between healthcare providers and payors. Providers rarely receive

these full "sticker prices." Rather, list prices for healthcare services often far exceed amounts providers routinely accept as full payment.

The collateral source rule does not require courts to treat these list prices as conclusively establishing the reasonable value of medical services. That rule exists so that a tortfeasor's liability is not reduced when the injured person's costs will be covered by third parties. The rule allows "double recovery" in the limited sense that a plaintiff can recover from both the tortfeasor and an insurer for the same injury. It does not offer "double recovery" in the sense that a plaintiff is entitled to an award based on a list price for treatment that is double (or more) its actual value. That is just an inflated award that miscalculates the amount of damages caused by a defendant and experienced by a plaintiff.

The difference between list prices and amounts paid is not a benefit that a plaintiff secures through obtaining insurance. It reflects the complexities of the modern medical-pricing and billing system. The reasonable value of medical care, as with other products and services, is established through the market. That value—the amount that a willing buyer and seller agree to in a voluntary exchange—is the amount paid and accepted for the medical care, regardless of who pays for it.

This Court should not endorse a misinterpretation of the collateral source rule that (1) requires admitting evidence of list prices that mislead and

confuse the factfinder by presenting an amount that a plaintiff's providers did not receive as the value of care; (2) excludes the best evidence of the reasonable value of medical care, which is the total amount actually paid (from whatever source) and accepted by a plaintiff's providers as full payment; and (3) will lead to vastly inflated awards, both for medical expenses and, indirectly, for general damages. The Court should, instead, follow the growing number of states that ensure that tort law reflects reality and hold that the amount actually paid to a plaintiff's healthcare providers is admissible evidence of the reasonable value of medical care.

ARGUMENT

I. CHARGEMASTER RATES AND OTHER LIST PRICES SET BY HEALTHCARE PROVIDERS, BUT RARELY PAID AND NOT ACTUALLY RECEIVED BY THE PLAINTIFF'S PROVIDERS, DO NOT REFLECT THE REASONABLE VALUE OF MEDICAL CARE

"Chargemaster" rates for medical treatments as well as other list prices that may appear on a healthcare provider's invoice, but are rarely paid and not actually received by a plaintiff's providers, do not reflect the reasonable value of care provided to that plaintiff. The Court should not permit introduction or recovery of list prices that were not paid, because these figures mislead the factfinder and result in inflated damage awards.

As background, it is common practice for healthcare providers to set a fee for each service or treatment, typically represented by a Current

Procedural Terminology (CPT) code.[3] CPT codes are uniform and set by a panel of the American Medical Association, but the amount healthcare providers charge for these services are not. Each healthcare provider is free to set its own fee for each CPT code. Healthcare providers use a similar system to set list prices for various medical products, supplies, and services not included in CPT codes.[4] The healthcare provider records its list prices in its billing system or "chargemaster" and that "standard charge" or "gross rate" is often indicated on the provider's invoice, as it was here.

Chargemaster rates or other list prices for healthcare services often serve as an opening offer or bid, like an MSRP for a new car. Patients and insurers (whether private or governmental) rarely pay these "sticker prices."[5] The market sets the reasonable value of a product or service, not its sticker price or a seller's opening bid. By definition, the fair market value of a service is the amount at which a willing buyer and seller agree, in an arm's length transaction, to pay for and provide that service.[6]

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[3] *See* Am. Med. Ass'n, The CPT® Code Process (2024).

[4] *See* Centers for Medicare & Medicaid Services, HCPCS Level II Coding Procedures (explaining use of the Healthcare Common Procedure Coding System (HCPCS)).

[5] *See Haygood v. De Escabedo*, 356 S.W.3d 390, 393 (Tex. 2011) (observing that healthcare provider "list" rates reflect negotiations with government programs and private insurers and are rarely collected).

[6] *See, e.g.*, Utah Code § 59-2-102(13)(a) (defining "fair market value," for taxation purposes, as "the amount at which property would change hands

Chargemaster or other list prices for medical services do not reflect an agreed amount between a buyer and seller. Indeed, there is often a stark difference between a healthcare provider's list price for a particular service or procedure and the amount it customarily accepts as full payment, whether paid by a private insurer, a government program, or directly by a patient. Chargemaster rates are often many multiples the amount providers routinely accept.[7] Rather, healthcare providers typically receive payment based on negotiated rates with managed care plans or schedules set by Medicare rules.[8] Likewise, uninsured patients rarely pay list prices, as healthcare providers offer programs providing subsidies or discounts to low-income patients and write off an increasing amount of bills that reflect list prices.[9] Hospital

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between a willing buyer and a willing seller, neither being under any compulsion to buy or sell and both having reasonable knowledge of the relevant facts.").

[7] *See, e.g.*, Ge Bai & Gerard F. Anderson, *U.S. Hospitals Are Still Using Chargemaster Markups to Maximize Revenues*, 35(9) Health Affairs 1658, 1662 (2016); George A. Nation III, *Hospital Chargemaster Insanity: Heeling the Healers*, 43 Pepp. L. Rev. 745, 748 (2016).

[8] *See Daughters of Charity Health Servs. of Waco v. Linnstaedter*, 226 S.W.3d 409, 410 (Tex. 2007) ("Few patients today ever pay a hospital's full charges, due to the prevalence of Medicare, Medicaid, HMOs, and private insurers who pay discounted rates."); *see also* Centers for Medicare & Medicaid Services, *Fee Schedule - General Information*.

[9] One study found that patients at California hospitals with private insurance paid 41% of list prices, patients with Medicare and Medicaid paid 35% and 30% of list prices, respectively, and uninsured patients paid 39% of list prices. Glenn A. Melnick & Katya Fonkych, *Hospital Pricing and the Uninsured: Do the Uninsured Pay Higher Prices?*, 27 Health Aff. 116, 118 (2008). The study

representatives caution that "[t]he chargemaster can be confusing because it's highly variable and generally not what a consumer would pay."[10]

The gap between chargemaster rates and amounts typically accepted as payment, the significant variation in pricing among healthcare providers, confusion over hospital bills, and lack of pricing information accessible to consumers were among considerations that led the federal government to adopt price transparency disclosure requirements.[11] These regulations require hospitals to post on their websites their list price ("gross charge") alongside the amounts they have agreed to accept from third-party payors and from uninsured or self-paying patients for each service or procedure.[12] These disclosures confirm that list prices do not necessarily reflect the reasonable value of medical care. Indeed, the evidence in this case indicates that the Plaintiff's healthcare providers did not actually receive the list prices for

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found that, over time, the ratios declined for all payers in part due to the rapid increase in list prices. *See id*.

[10] Sarah Kliff & Dan Keating, *One Hospital Charges $8,000 — Another, $38,000*, Wash. Post, May 8, 2013 (quoting Carol Steinberg, Vice President of the American Hospital Association).

[11] *See generally* Final Rule, Price Transparency Requirements for Hospitals to Make Standard Charges Public,, 84 Fed. Reg. 65,524, 65,525-27, 65,538 (Nov. 27, 2019) (codified at 45 C.F.R. part 180).

[12] *See* 45 C.F.R. § 180.50.

medical treatment that the Plaintiff sought to recover through the civil justice system.[13]

Yet, plaintiffs' attorneys here and in other Utah cases seek to present to judges and juries confusing and misleading chargemaster rates that do not reflect the reasonable value actually received for the medical services provided to plaintiffs. They contend that a tortfeasor should not "benefit" from "negotiated rates" between a healthcare provider and insurer. But it is this very negotiation and the resulting amount paid that establishes the most reliable market-based measure of the reasonable value of medical care. Courts and juries deciding tort claims should not be blindfolded from this reality.

II. AWARDING PHANTOM DAMAGES DOES NOT SERVE THE COMPENSATORY PURPOSE OF TORT LAW OR ADVANCE THE GOALS OF THE COLLATERAL SOURCE RULE

"[T]he basic purpose of tort law is to place an injured person in a position as nearly as possible to the position he would have occupied but for the defendant's tortious behavior."[14] As this case demonstrates, however, some courts permit plaintiffs to receive amounts of medical expenses that exceed actual damages, and are often are multiples of what the plaintiff or the

[13] *See* Appellant's Br. at 23–24.

[14] *Scott v. Universal Sales, Inc.*, 2015 UT 64, ¶ 48, 356 P.3d 1172 (quoting *Kilpatrick v. Wiley, Rein & Fielding*, 2001 UT 107, ¶ 97, 37 P.3d 1130 (internal quotation marks omitted)).

plaintiff's insurer routinely pays for medical care. This overpayment—the difference between the "chargemaster" list price for medical services or the amount initially billed by a healthcare provider, and the amount that the plaintiff's healthcare provider accepted as full payment for those services—is sometimes referred to as "phantom damages." Phantom damages are simply not "damages" at all. Neither the plaintiff nor the tortfeasor's insurer will ever be called upon to pay that amount. Nor will the plaintiff's healthcare provider receive payment at that level.

Injured plaintiffs may recover their medical expenses, provided that they establish that these expenses are both reasonable and necessary to address the harm caused by the tortfeasor.[15] It is the plaintiffs' responsibility to present evidence "to show that the medical expenses accurately reflect the necessary treatment that resulted from the injuries and that the charges are reasonable."[16] The question is whether chargemaster or other list prices set solely by a healthcare provider, primarily as a starting point for negotiation with insurers and other payors, conclusively establish the reasonable value of the plaintiff's medical care, even though the plaintiff's providers accepted less as full payment for that care. As discussed earlier, these prices generally do

[15] *See Gorostieta v. Parkinson*, 2000 UT 99, ¶ 35, 17 P.3d 1110.

[16] *Id.*

not reflect market value, particularly when the plaintiff's healthcare providers accepted a lower amount as full payment. In such instances, the amount actually paid by the plaintiff or third party for the plaintiff's medical care and accepted by the healthcare provider should establish the market-based reasonable value of the service. Chargemaster rates above amounts actually paid to a patient's healthcare providers do not reflect the reasonable value of medical care and are instead merely a starting bid that providers know will be significantly reduced in nearly all instances.

Here, however, Plaintiff argues, and the district court ruled, that the collateral source rule prohibits basic application of market principles in determining the reasonable value of medical care. The collateral source rule does no such thing. It provides that "a wrongdoer is not entitled to have damages, for which he is liable, reduced by proof that the plaintiff has received or will receive compensation or indemnity for the loss from an independent collateral source."[17] "[T]he usual role of the collateral source rule is to prevent insurance payments of damages from reducing the wrongdoer's liability."[18] The usual role of the collateral source rule is not, and should not be, to authorize inflated awards for medical expenses.

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[17] *Gibbs M. Smith, Inc. v. U.S. Fid. & Guar. Co.*, 949 P.2d 337, 345 (Utah 1997) (quoting *DuBois v. Nye*, 584 P.2d 823, 825 (Utah 1978)).

[18] *Id.*

This Court has indicated that "public policy favors giving the plaintiff a double recovery rather than allowing a wrongdoer to enjoy reduced liability simply because the plaintiff received compensation from an independent source."[19] But this public policy basis for the collateral source rule is not advanced by calculating damages for medical expenses based on list prices that a plaintiff's healthcare providers did not receive. Indeed, calculating damages based on the reasonable value of medical expenses has nothing to do with the collateral source rule, which only concerns reimbursement from an independent source. Determining damages based on the actual amount paid and accepted continues to allow for "double recovery" in the limited sense of the common-law rule—the plaintiff can recover those damages even if they were covered and fully paid by an insurer. What a plaintiff cannot do is receive "double recovery" in the sense of inflating the measure of his or her actual damages by double or more based on a list price that far exceeds what the plaintiff's healthcare providers actually received as payment for that care. Certainly, the Court did not mean "double recovery" in the sense of permitting damages that are inflated to be double their actual worth (or more).

Plaintiff argues, and the district court agreed, that lower rates for medical services negotiated between insurers and healthcare providers

[19] *Wilson v. IHC Hosp., Inc.*, 289 P.3d 369, 381 (Utah 2012) (quoting *Green v. Denver & Rio Grande W. R.R. Co.*, 59 F.3d 1029, 1032 (10th Cir. 1995)).

(whether considered "discounts" or "write offs" from list prices) are a benefit that a patient earned through purchasing insurance and paying premiums. Under this theory, a plaintiff is purportedly entitled to collect the list prices of medical treatments under the collateral source rule. The California Supreme Court has persuasively rebutted this incorrect view. As the court explained:

> Plaintiff … receives the benefits of the health insurance for which she paid premiums: her medical expenses have been paid per the policy, and those payments are not deducted from tort recovery.
>
> Plaintiff's insurance premiums contractually guaranteed payment of her medical expenses at rates negotiated by the insurer with the providers; they did not guarantee payment of much higher rates the insurer never agreed to pay. Indeed, had her insurer not negotiated discounts from medical providers, plaintiff's premiums presumably would have been higher, not lower. In that sense, plaintiff clearly did not pay premiums for the negotiated rate differential. Recovery of the amount the medical provider agreed to accept from the insurer in full payment of her care, but not more, thus ensures plaintiff receives the benefits of her thrift and the tortfeasor does not garner the benefits of his victim's providence.[20]

In sum, the "discount" between the list price and the amount paid is not a collateral benefit, it is the difference between fiction and reality.

The evidentiary purpose of the collateral source rule, avoiding any prejudice from informing a jury that a plaintiff's expenses were covered by insurance, remains intact when juries hear the actual amount paid for the plaintiff's medical services, rather than a list price. This purpose is served

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[20] *Howell v. Hamilton Meats & Provisions, Inc.*, 257 P.3d 1130, 1144 (Cal. 2011) (internal quotations omitted).

when a plaintiff bears no need to indicate, in a case tried to a jury, the source of the payment. But the jury must learn the amount actually accepted by a plaintiff's healthcare providers as payment for their services to the plaintiff, regardless of who paid them. That amount is highly relevant; indeed, it is the best evidence of the reasonable value of the medical services provided to the plaintiff, and thus the measure of that plaintiff's damages. The purposes of the collateral source rule are not advanced by blocking a judge or jury from considering this key information when determining the reasonable value of the plaintiff's medical care. When the factfinder is permitted only to consider list prices for medical treatment that were not paid to the plaintiff's healthcare providers, it does, however, violate the fundamental principle of tort law that a plaintiff is entitled to recover only reasonable charges to be made whole.[21]

Plaintiffs' lawyers seek to present chargemaster list prices for medical expenses, rather than the actual amount paid for the plaintiff's treatment, for other reasons—none of which advance the purposes of the collateral source rule. First, though this case involves a patient whose only medical expenses stemmed from examinations following a minor automobile accident, other cases may involve more extensive medical care, lengthy rehabilitation, or even lifelong future treatment. In such cases, the gap between the higher

[21] *See Gorostieta*, 2000 UT 99, ¶ 35.

chargemaster or other list prices and the actual value of the plaintiff's medical care (the amount a plaintiff's healthcare providers accepted as full payment) can add up to hundreds of thousands of dollars.[22]

Second, introduction of chargemaster or other list prices never received by the plaintiff's healthcare providers may mislead a factfinder to inappropriately inflate other aspects of damages. For instance, juries often consider the amount of the plaintiff's medical expenses when making the inherently subjective and difficult determination of an appropriate amount to award for his or her pain and suffering. Some jurors use a multiple of the medical expenses to compute a pain and suffering award.[23] In this case, the district court's award of $8,000 in general damages rounded up and roughly doubled the Plaintiff's already-inflated special damage award, compounding that error. Noneconomic damage awards should reflect actual harm and not be

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[22] *See, e.g., Lee v. Small,* 829 F. Supp. 2d 728, 742 (W.D. Iowa 2011) (plaintiff introduced evidence and sought recovery of roughly $700,000 in medical invoices when healthcare providers accepted about $300,000 as full payment from private health insurance and Medicare); *Goble v. Frohman*, 901 So.2d 830, 832 (Fla. 2005) (in which a jury awarded $574,554.31 for past medical expenses, reflecting the list prices the plaintiff's providers had billed, rather than the $145,970.76 that they accepted as full payment); *Wal-Mart Stores, Inc. v. Crossgrove*, 276 P.3d 562, 568 (Colo. 2012) (Eid, J., dissenting) (plaintiff sought $242,000 billed for medical services, when providers accepted $40,000 as payment in full).

[23] Neil Vidmar, *Empirical Evidence on the Deep Pockets Hypothesis: Jury Awards for Pain and Suffering in Medical Malpractice Cases*, 43 Duke L.J. 217, 253–54 (1993).

influenced by list prices for treatment that merely reflect medical pricing practices.

Finally, the district court's ruling indicates an additional motivation for plaintiffs to introduce chargemaster or other list prices that their healthcare providers did not receive: The court found that a party who "delays payment until after a lawsuit is filed and judgment is entered . . . should not be entitled to the same discounts available to patients or their insurers who voluntarily agree to pay at the time medical services are rendered."[24] In essence, the district court applied the collateral source rule to boost the plaintiff's damages to account for the time value of money and punish a defendant for exercising its right to have its liability decided at trial.[25]

These considerations do not advance the purposes of the collateral source rule and they are inappropriate considerations when calculating damages. Rather, Utah law addresses these interests through the availability of pre-judgment interest in appropriate circumstances. In fact, Utah law specifically provides that if a defendant rejects a reasonable settlement offer, opts to go to

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[24] Order Denying Defendants' Motion in Limine to Exclude All Evidence of Chargemaster Rates for the Medical Services Plaintiff Received at 2 (Nov. 7, 2023).

[25] *See id.* ("Such a later paying party should not have the benefit of discounts that result from pre-service contracts such as PPO agreements or self-pay arrangements negotiated from providers.").

trial, and is found liable, it must pay prejudgment interest on the plaintiff's medical expenses.[26] The interest rate is indexed to market rates and begins to accrue on the first date in which the medical expenses were incurred.[27] In cases involving serious injuries, prejudgment interest can be substantial.[28] This statute assures that the time value of money is accounted for in a judgment in appropriate cases. Defendants receive no benefit from rejecting reasonable settlement offers and taking meritorious cases to trial. Distorting the collateral source rule to fulfill this purpose is both inappropriate and unnecessary.

It is wrong to misapply the collateral source rule in a manner that disregards that list prices generally reflect modern medical billing practices and justifies grossly inflated awards that do not reflect the reasonable market value of medical services.[29] When courts distort the collateral source rule to

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[26] Utah Code § 78B-5-824.

[27] *Id.*

[28] *See, e.g., Marland v. Asplundh Tree Expert Co.*, No. 1:14-CV-40, 2017 WL 2599867 (D. Utah June 15, 2017) (adding $111,199.66 in prejudgment interest to past medical expenses of $193,760); *Sprague v. Avalon Care Center-Bountiful 350 South, LLC*, No. 140908104, 2017 WL 7048283 (Utah D. Ct. Dec. 6, 2017) (adding $190,258.56 in prejudgment interest to $481,000 in past special damages).

[29] *See, e.g.*, J. Zackary Balasko, Comment, *A Return to Reasonability: Modifying the Collateral Source Rule in Light of Artificially Inflated Damage Awards*, 72 Wash. & Lee L. Rev. Online 16 (2015); Todd R. Lyle, Comment, *Phantom Damages and the Collateral Source Rule: How Recent Hyperinflation in Medical Costs Disturbs South Carolina's Application of the Collateral Source Rule*, 65 S.C. L. Rev. 853 (2014); Lauren M. Martin, Comment, *Who's*

allow plaintiffs to recover amounts above that which was actually paid and accepted for a plaintiff's medical care, they are "embracing a fiction that either blindfolds or misleads jurors, when the economic damages are readily capable of precise measurement."[30] The Court should interpret tort law principles, including the collateral source rule, in a manner that reflects reality and makes plaintiffs whole.

III. STATES INCREASINGLY PROVIDE THAT PLAINTIFFS MAY ONLY RECOVER AMOUNTS ACTUALLY PAID AND ACCEPTED FOR THEIR MEDICAL TREATMENT, NOT LIST PRICES

As the gap between list prices and the amount healthcare providers typically accept as full payment for their medical services has grown, states are correcting misuse of the collateral source rule to require inflated awards for medical expenses. This Court should follow this trend, which upholds the purpose of the collateral source rule while ensuring that the tort system values medical damages in a manner that reflects economic reality.

As the Defendant explained, states vary in their approaches to valuing medical damages.[31] About one-third preclude or limit the ability of plaintiffs to

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Swallowing the "Bitter Pill"?: Reforming Write-Offs in the State of Washington, 37 Seattle U. L. Rev. 1371 (2014).

[30] Victor E. Schwartz & Christopher E. Appel, *Perspectives on the Future of Tort Damages: The Law Should Reflect Reality*, 74 S.C. L. Rev. 1, 7 (2022).

[31] *See* Appellant's Br. at 21–23.

recover phantom damages,[32] slightly more allow recovery of list prices, and, in the remainder, like Utah, the issue remains undecided, unclear, or subject to inconsistent rulings.[33]

California law, as discussed earlier, exemplifies the approach this Court should follow. In California, a plaintiff may not recover list prices indicated on a healthcare provider's bill that were never paid "for the simple reason that the injured plaintiff did not suffer any economic loss in that amount."[34] Rather, "a personal injury plaintiff may recover *the lesser* of (a) the amount paid or incurred for medical services, and (b) the reasonable value of the services."[35] Where a healthcare provider has accepted less than a listed or billed amount as full payment for the plaintiff's treatment, the amount paid, not the list price,

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[32] States that limit phantom damages generally fall in three categories: (1) those that admit evidence of the amount paid to the plaintiff's healthcare providers and exclude unpaid list prices (complete bar); (2) those that permit introduction of list prices but require the court to subtract unpaid amounts (set-off approach); and (3) those that allow evidence of both the list prices and amounts paid (all-in approach). *Amici's* position is that the first approach best fulfills the compensatory goal of the tort system while the second and third approaches, which are preferable to requiring factfinders to award list prices, are problematic because they mislead the jury and result in inflated awards.

[33] *See* Victor E. Schwartz & Cary Silverman, Truth in Damages; Florida Juries Should Base Personal Injury Awards on Actual Costs of Treatment, Not Inflated Medical Bills 11–12 (Fla. Justice Reform Inst. 2019 (surveying state law as of 2019, since which time additional states have precluded phantom damages).

[34] *Howell*, 257 P.3d at 1133.

[35] *Id.* at 1138 (emphasis in original).

is admissible to prove the plaintiff's damages, though the source of the payment (the insurer) is not.[36] This approach properly balances the goals of fully and fairly compensating the plaintiff, while maintaining the collateral source rule's evidentiary exclusion of independent sources of payment that the plaintiff secured.

Likewise, the Texas Supreme Court has instructed that, although "it has become increasingly difficult to determine what expenses [for medical care] are reasonable" because of the "great disparities" between healthcare providers' list prices and amounts typically accepted as payment, courts must limit admissible evidence to amounts actually paid or legally obligated to be paid for the plaintiff's treatment.[37] Without such a rule, plaintiffs present testimony that list prices are reasonable, even when they far exceed what healthcare providers collect for each plaintiff's care.[38] Any relevance of list prices to measuring the value of a plaintiff's medical care or noneconomic damages is "substantially outweighed by the confusion it is likely to generate" and therefore inadmissible.[39]

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[36] *See id.* at 1146.

[37] *Haygood*, 356 S.W.3d at 393, 398.

[38] *Id.* at 394.

[39] *Id.* at 398.

Multiple state supreme courts have agreed that, rather than advance the purpose of the collateral source rule, "impos[ing] liability for medical expenses that a health care provider is not entitled to charge does not prevent a windfall to a tortfeasor; it creates one for a claimant."[40]

In recent years, five state legislatures have intervened to prevent or correct the type of misapplication of the collateral source rule sought here. Florida, Iowa, Montana, North Carolina, and Oklahoma have each provided that evidence offered to prove the amount of damages for past medical treatment or services is limited to the amount actually paid, regardless of the source of payment.[41] While the Utah legislature can modify or even eliminate the collateral source rule, as it has in the medical liability context,[42] it is firmly

[40] *Id.* at 395; *see also Goble*, 901 So. 2d at 832 ("[F]orcing an insurer to pay for damages that have not been incurred would result in a windfall to the injured party," which would be passed on to the state's residents through higher insurance rates); *Moorhead v. Crozer Chester Med. Ctr.*, 765 A.2d 786, 790 (Pa. 2001), *abrogated on other grounds by Northbrook Life Ins. Co. v. Commonwealth*, 949 A.2d 333 (Pa. 2008) ("Awarding [a plaintiff an amount charged but never incurred] would provide her with a windfall and would violate fundamental tenets of just compensation.").

[41] Fla. Stat. § 768.0427(2) (enacted 2023); Iowa Code §§ 622.4, 668.14A (enacted 2020); Mont. Code Ann § 27-1-308 (enacted 2021); N.C. Gen. Stat. Ann. ch. 8C, Rule 414 (enacted 2011); Okla. Stat. Ann. tit. 12, § 3009.1 (enacted 2011); *see also* Tex. Civ. Prac. & Rem. Code Ann. § 41.0105 (enacted 2003).

[42] Utah Code Ann. § 78B-3-405.

within this Court's purview to interpret and properly apply this common law doctrine.[43]

Allowing plaintiffs to recover list prices that are often multiples of amounts actually accepted by their healthcare providers as full payment will affect everyone who lives and works in Utah. Should the district court's approach become the law of this state, damage awards and settlement demands will be arbitrarily and unnecessarily higher in virtually every personal-injury case—from common slip-and-fall and auto accident claims to product liability actions. Ultimately, these higher costs, based on fiction rather than reality, will be reflected in insurance rates paid by Utah's drivers, homeowners, and businesses. The collateral source rule does not compel this misguided path.

CONCLUSION

For these reasons, the Court should hold that the district court erred in admitting evidence of list prices for the Plaintiff's medical treatment and excluding evidence of amounts the Plaintiff's healthcare providers actually accepted as full payment for his medical care. The Court should vacate the verdict and remand the matter for a new trial on damages.

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[43] *See DuBois*, 584 P.2d at 825 n.1 (citing Utah case law for the origin of the collateral source rule).

Respectfully submitted,

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Dated: August 23, 2024

CERTIFICATE OF COMPLIANCE

Pursuant to Utah R. App. P. 24(a)(11), I certify that this brief complies with the word count limitations of Utah R. App. P. 24(g) because, excluding parts of the document exempted by Rule 24(g)(2), this document contains 5,470 words.

I further certify that this brief complies with the requirement of Utah R. App. P. 21 governing public and private records.

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CERTIFICATE OF SERVICE

I hereby certify that on this 23rd day of August, 2024, a true and correct copy of the foregoing *Amici Curiae* Brief was electronically filed with the Clerk of the Court, which sent notification of such filing to the following:

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