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Reviews and Cases of Note

Special Editors: Lane Hudgins, Thomas Ireland, and Gerald Martin

This will be the first in a series of features on "Reviews and Cases of Note" in the Journal of Legal Economics that will focus on reviews of legal decisions, case studies and articles of interest to forensic economics that may have appeared in media that forensic economists do not typically read. The papers will not present original research in the sense usually required for double-blind editorial review. It must be written well enough to satisfy members of the editorial board of the journal, but reviews of this kind should not be claimed as "peer reviewed publications." Lane Hudgins, Tom Ireland and Jerry Martin will serve as editors for this section, but other editorial board members may also be asked to comment on submissions. One of the objectives of this section is to assist writers in getting their reviews into publishable condition. Reviews should be short, but we will try to work with persons submitting reviews to get their reviews into publishable form to a degree that would not be appropriate with double blind editorial review. If you want to submit reviews for future issues, send drafts or suggestions to Tom Ireland at ireland@umsl.edu. Regular submission fees will not be charged. When legal cases are described, as in this first review, it should be understood that the author or authors are not legal experts and the descriptions provided should not be assumed to be authoritative or "good law" without consultation with a qualified legal expert.

The Concept of *Reasonable Value* in Recovery of Medical Expenses in Personal Injury Torts*

In a recent Arizona case, I was asked by George Crough, an attorney for the State of Arizona, to look into an issue I had not previously confronted, but which I subsequently discovered has been the source of litigation throughout the United States. The issue George Crough wanted me to consider and address was the determination of the reasonable value of past medical expenses of an injured plaintiff. This was a damages element I had always taken for granted. In all of my previous cases, I was told by my retaining attorney what amount of past medical expenses the plaintiff had incurred. Typically, I did not (and still do not) mention this issue in most of my reports of economic damages caused by an injury to a plaintiff. I had always thought that past damages were whatever they were and that an economist, as an economist, added no value by adding up those expenses. In this case, however, the issue was more complicated. I discovered that the issue was so complicated that case law in how to deal with it varies significantly from state to state and that some states have passed legislation dictating how that issue should be handled. I have thus far found and described 20 legal decisions that provide the substance readers may wish to consider if confronted with that issue.

The issue can best be illustrated with an example based on assumed facts. Assume that an automobile accident has caused a personal injury that resulted in a plaintiff spending several months in a hospital. The plaintiff's bills for treatment by medical doctors, tests, surgical interventions and hospitalization totaled $500,000. The plaintiff however had good medical insurance and those bills were paid for by the plaintiff's insurance. Assume that the obligations of the plaintiff have been completely covered so that the insurance company has no right to claim any portion of the plaintiff's award if the plaintiff wins a tort recovery that includes his medical expenses. (This means that there is no right of *subrogation*. See the definitions that follow this introduction to relevant legal decisions.) The plaintiff has had no out-of-pocket expense and will have no future out-of-pocket expense for past medical treatments, regardless of the size of the award the plaintiff wins in tort litigation. However, the actual amount paid for the plaintiff's medical bills by the plaintiff's third party insurer was $100,000. The 5 to 1 ratio between amount billed and the amount paid in this example is not unusual. The amount paid by third party payers is typically only a small fraction of the amount originally billed by medical care provides. Third party payers have contracts with medical care providers that define how much third party payers, including Medicare and Medicaid programs, will pay based on original amounts billed and only a small fraction of persons receiving medical services actually pay original amounts billed for those services.

In the Arizona case in which I was retained, there was no question that collateral source offsets could not be taken. That is not true in all states and in all types of legal actions. California's MICRA legislation for medical malpractice cases allows offsets for collateral source payments to be taken

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from alleged damages amounts. New York allows offsets for a wide variety of collateral offsets in all types of tort litigation. Other states also have exceptions to the general rule that offsets for collateral sources cannot be taken, particularly in medical malpractice cases. The issue I confronted was not about whether offsets for collateral source payments could be taken. Offsets for collateral source payments were not permitted in Arizona. The plaintiff was going to receive an award equal to the "reasonable value" of his past medical expenses if the plaintiff proved liability. The plaintiff would get to keep whatever was awarded for past medical expenses even though the plaintiff had no out-of-pocket costs relating to those expenses. That fact was not being challenged in the case I was involved with. What was being challenged was whether the amount to be recovered as a "windfall gain" by the plaintiff was the amount originally billed by medical care providers, the amount actually paid by the plaintiff's third party payers, or some figure in between those two amounts. (I have put quotations around the term "windfall gain" because it is doubtful that the plaintiff has been "made whole" in the sense that he would have consented in advance to the injury for the amount awarded in the tort action. In that sense, even though the amount awarded for past medical expenses did not replace any out-of-pocket less, it also probably did not make the injured plaintiff better off than if the injury had not occurred.)

In the case descriptions provided at the end of this review, the term for the amount to be awarded when there is a difference between the amount billed by medical service providers and third party payers is "reasonable value." Some states have specifically defined "reasonable value" to be the amount actually paid. Other states have ruled in specific cases that the amount billed in that case is the "reasonable value" for the services in that case. Decisions indicating that the amount billed should be paid typically avoid saying that the "reasonable value" of those services is *always* the amount billed in every case. That appears to be based on the understanding of the courts in those states that medical care providers may sometimes charge fees that are not "reasonable." Among the decisions for which I have provided descriptions, I have found no decisions that relied on a standard other the amount billed by medical care providers or the amount actually paid by third party payers. There is sometimes an implication that some other amount might, under some circumstances, be appropriate, but no indication about how that "other" amount might be determined.

The underlying question is how an economist should determine the value of medical services for which there is no true market value. The role of third party payers in the practice of medicine in the United States is anything but perfectly competitive. As such, there is no simple market

standard that an economist could rely upon in determining the "reasonable value" of medical services. As some of the courts have ruled, the market power of third party providers may be so great that an individual without the market power of a third party provider would actually have to pay the original amounts that medical service providers billed. Generally, legal representation in such circumstances can provide reductions from amounts originally billed toward amounts that third party payers pay, but perhaps not quite as low as the rates third party payers can negotiate.

Another important issue is that many medical services are provided on a "charity" basis for individuals who cannot rely on third party payers. Hospitals, in particular, cannot turn away persons in need of emergency health care simply because the individuals are poor, uninsured and cannot afford to pay for their medical care. As a result the cost of "charity" care by medical care providers is included in the billing rates charged to patients who can afford to pay for medical services, either through sufficient existing wealth or through their relationships with third party payers. Prices in American medicine often have little relationship to any notion of what is reasonable or what might be the prices in a competitive market. Given give the choice between $500,000 billed by medical care providers and the $100,000 paid by third party payers in my example, it is likely that $100,000 is closer to whatever proxy for "reasonable value" or "competitive equivalent" that we might come up with.

It was an interesting challenge to come up with opinions regarding this matter. In this short introduction to the case descriptions, I have not considered all of the directions that might be taken. I have also not considered such gimmicks as "balance billing" in Arizona that allows health care providers to seek the balance of bills from a settlement. Going further into this area will probably occur the next time this issue becomes relevant to the work I am expected to do on a case.

For the present, I wanted to introduce readers to the issue of "reasonable value" as it applies to recovery for past medical expenses. I have also provided several definitions that may be useful. Both the case descriptions and definitions provided below are or will be available at the forensic economics website at the University of Missouri at St. Louis. The website can be found at http://www.umsl.edu/forensiceconomics.

Definitions

Collateral Source. A collateral source is a third party source for payments for costs incurred because of an injury or death that come from a source. "Third party source" means a source of funds other than coming from the

defendant in a legal action. Examples would be private life insurance that provides financial support for families of a decedent, disability insurance that provided regular payments to replace lost earnings, and so forth.

Collateral Source Rule. The collateral source rule is a general legal provision that offsets from damages awarded in tort actions should not be taken because expenses have been paid by a third party who was not responsible for an individual's injury. In a wrongful death action, for example, the amount won in a tort action from the defendant who caused the death will not be reduced by the amount paid out to the surviving spouse by private life insurance. Amounts paid in the form of disability insurance or disability programs through Social Security typically cannot be subtracted from amounts won in tort actions for lost income, and so forth. The term "collateral source rule" should be used carefully. Many states and some federal statutes create exceptions to the general rule that offsets cannot be taken. Thus, what may be called the collateral source rule in a given state or may be the applicable version of the collateral source rule for purposes of litigation under federal statutes may have important exceptions to the general rule described here. Exceptions are particularly important in New York and California.

Subrogation. Various types of third party payers, including Workman's Compensation Programs, disability insurance and third party payer plans sometimes have "subrogation clauses" such that payments made to an injured worker must be repaid if that worker wins damages for the same losses in tort actions. Immediately following an injury, a worker may begin receiving payments from a workman's compensation program or from a disability insurance program, with the understanding and legal obligation that these payments must be repaid if the injured person wins a tort settlement large enough to trigger the subrogation clause.

Cases Involving a Determination of Reasonable Value of Medical Costs

Acuar v. Letourneau, 260 Va. 180; 531 S.E.2d 316 (Va. 2000). This decision relates to whether Letourneau's medical bills that his health care providers wrote off could be submitted to the jury. The Court interpreted this decision as hinging on the collateral source rule and held that Letourneau was entitled to recover for amounts originally billed, even though a portion of those bills were written off. The court said: "The collateral source rule is designed to strike a balance between two competing

principles of tort law: (1) a plaintiff is entitled to compensation sufficient to make him whole, but no more; and (2) a defendant is liable for all damages that proximately result from his wrong. A plaintiff who receives double recovery for a single tort enjoys a windfall; a defendant who escapes, in whole or in part, liability for his wrong enjoys a windfall. Because the law must sanction one windfall and deny the other, it favors the victim of the wrong rather than the wrongdoer."

Arthur v. Catour, 345 Ill. App. 3d 804; 803 N.E.2d 647 (Ill. App. 2004). An Illinois Court of Appeals determined that an injured plaintiff may recover as damages the entire amount billed for medical services, not to the discounted amount actually paid by her insurance carrier. The Court said: "[S]imply because medical bills are often discounted does not mean that the plaintiff is not obligated to pay the billed amount. Defendants may, if they choose, dispute the billed amounts as unreasonable, but it does not become so merely because plaintiff's insurance company was able to negotiate a lesser charge. For the same reasons, plaintiff receives no 'windfall' when she is compensated for her reasonable medical expenses. To the extent that she receives an amount greater than that paid by her insurer in satisfaction of the bill, that difference is a benefit of her contract with the insurer, not one bestowed on her by defendants."

Arthur v. Catour, 216 Ill. 2d 72; 833 N. E.2d 847 (2005). An Illinois Court of Appeals in *Arthur v. Catour,* 345 Ill. App. 3d 804; 803 N.E.2d 647 (Ill. App. 2004) had determined that an injured plaintiff may recover as damages the entire amount billed for medical services, not to the discounted amount actually paid by her insurance carrier. The Court said: "[S]imply because medical bills are often discounted does not mean that the plaintiff is not obligated to pay the billed amount. Defendants may, if they choose, dispute the billed amounts as unreasonable, but it does not become so merely because plaintiff's insurance company was able to negotiate a lesser charge. For the same reasons, plaintiff receives no 'windfall' when she is compensated for her reasonable medical expenses. To the extent that she receives an amount greater than that paid by her insurer in satisfaction of the bill, that difference is a benefit of her contract with the insurer, not one bestowed on her by defendants." The question of whether a plaintiff can claim loss of amounts initially billed was then certified to the Illinois Supreme court, which said: "We hold that a plaintiff may present to a jury the amount the plaintiff's health-care providers initially billed for the services rendered."

Bynum v. Magno, 101 P. 3d 1149 (Hawaii, 2004.) The U.S. District Court for Hawaii had certified these questions to the Hawaii Supreme Court: "Where a plaintiff's healthcare expenses are paid by Medicare and/or Medi-Cal, does the discounted amount paid to a healthcare provider by [Medicare] and Medi-Cal constitute the amount that should be awarded as medical special damages to a plaintiff in a negligence action? In this circumstance, is evidence of amounts billed in excess of the amount paid irrelevant and inadmissible?" The Hawaii Supreme Court answered "no" to both questions and provided extended discussion of the collateral source rule applications in this case. A plaintiff can sue for damages in Hawaii based on the stated costs of medical treatment even if the medical providers agreed to accept a discount under Medicare and Medicaid rules.

Colomar v. Mercy Hospital, Inc., 461 F. Supp. 1265 (S.D.Fla. 2006). This decision denied Mercy Hospital's motion to dismiss plaintiff's second amended complaint in a breach of contract claim involving allegations of deceptiveness on the part of Mercy Hospital. Plaintiff was billed at rates charged to uninsured patients for medical services. Colomar claimed she was charged nearly $12,863 for medical services that actually cost $2,098; that Catholic Health Care hospitals, including Mercy Hospital, generally charge uninsured patients at 370% of Medicare reimbursement rates; that Mercy Hospital in particular charges uninsured patients rates at 450% of Medicare Reimbursement Rates; that CHE's cost-to-charge ratio is 394%, meaning that on average CHE hospitals charge almost four times their costs to uninsured patients; and that CHE hospitals rank in the top 10% of hospitals nationwide in terms of cost-to-charge ratio. The Court said: "Mercy's premise, that unreasonable pricing claims can only be established by showing that prices grossly exceed the market, is far too restrictive a test of reasonableness." The court also held that the relevant market comprises both uninsured patients and patients covered by insurance policies and federal program and added: "[S]imply looking at the rates charged by other hospitals can give a false sense of value. That is, if other hospitals grossly overcharge for services relative to their costs, then a mere side-by-side comparison of hospitals' unreasonable charges would make them appear reasonable. Such consistency, standing alone, is not synonymous with reasonableness."

Coyne v. Campbell, 11 N.Y.2d 372; 183 N.E.2d 891; 230 N.Y.S.2d 1 (New York 1962). A doctor was injured in an automobile accident. He received medical treatment, physiotherapy and care from his professional colleagues and his nurse and incurred no out-of-pocket expenses. The court held that

"damages must be compensatory only." The court also said: "If this were – and it is not – a case of "payment from a collateral source," *Healy v. Rennert* (9 N Y 2d 202) would be authority for recovery.

Fonseca v. United States, 2007 U.S. Dist. LEXIS 12836 (E.D.Wis. 2007). This is an FTCA action governed by Wisconsin law. The issue related to recovery for medical expenses originally billed at $605,954 for which the State of Wisconsin paid $213,019. The Court cited *Lagerstrom v. Myrtle Werth Hosp. - May Health Sys.*, 2005 WI 124, 285 Wis. 2d 1, 31, 700 N.W.2d 201 (2005), as recognizing the collateral source rule as both a rule of evidence and a rule of damages. However, the Court pointed out that § 893.55(7) modified the collateral source rule "in medical malpractice cases such that evidence of collateral source payments, including payments from state and federal program, is admissible in medical malpractice actions." The court continued: "Further, if such evidence is admitted evidence of a plaintiff's obligation to make subrogation payments is also admissible. . . In addition, in determining the reasonable value of medical services, a factfinder may take collateral source payments into consideration. However, such factfinder may not reduce the reasonable value of medical services based on such payments." The Court therefore rejected the claims of the United States.

Goble v. Frohman, 901 So. 2d 830 (Fla. 2005). This decision upheld both the trial court and the Florida Court of Appeals, which had held that amounts paid by third party providers could be recovered, but not amounts before billing prices were discounted. This is explicit in Section 768.76, which says: "In any action to which this part applies in which liability is admitted or determined by the trier of fact and in which damages are awarded to compensate the claimant for losses sustained, the court shall reduce the amount of such award by the total of all amounts which have been paid for the benefit of the claimant, or which are otherwise available to the claimant, from all collateral sources; however, there shall be no reduction for collateral sources for which a subrogation or reimbursement right exists. . ." In this case, Goble's medical providers billed for $574,554.31. Aetna was able to arrange to discount the bills to $147,970.76, for which Aetna had the right of subrogation. The trial court held that $147,970.76 could be recovered, not $574,554.31.

Grell v. Bank of America, 2007 U.S. Dist. LEXIS 33280. (M.D.Fla 2007). This is an order making a small reduction in the award for past medical expenses, but holding that expenses for which Grell was liable both for the

past and in the future should not be discounted. The decision made it clear that the standard under Florida law that a plaintiff can only recover for amounts actually paid or for which the plaintiff is liable, including amounts subject to subrogation. The Court cited *Goble v. Frohman*, 901 So. 2d 830 (Fla. 2005) as holding that contractual discounts, should be set off against amounts recoverable by plaintiffs, as acknowledged by *Grell*. However, amounts still owed were not subject to such reductions.

Hanif v. Housing Authority of Yolo County, 200 Cal. App. 3d 635; 246 Cal. Rptr. 192 (Cal. App. 1988). This decision held that the right to recover for past medical costs was limited to the actual amounts accepted by medical service providers and not the amounts originally billed by medical providers. The trial court had found that amounts originally billed represented the "reasonable value" of the services provided even though Medi-Cal had paid only about 60% of the amounts charged. There was no evidence that the plaintiff was or would become liable for the difference. The Court of Appeals said: "[A] person injured by another's tortuous conduct is entitled to recover the reasonable value of medical care and services reasonably required and attributable to the tort. . . . The question here involves the application of that measure, i.e., whether the 'reasonable value' measure of recovery means that an injured plaintiff may recover from the tortfeasor more than the actual amount he paid or for which he incurred liability for past medical services. Fundamental principles underlying recovery of compensatory damages in tort actions compel the following answer: no."

Katiuzhinsky v. Perry, 2007 Cal. App. LEXIS 1104 (Cal. App. 2007). The California Court of Appeals reversed the trial court decision based on the trial court's misplaced reliance on several previous California decisions that the reasonable value for which the defendant was liable was the amount a medical care provider was willing to accept for services provided to a plaintiff. The Katiuzhinsky court reviewed decisions in *Hanif v. Housing Authority*, 200 Cal App. 3d 635 (1998), *Nishihama v. City and County of San Francisco*, 93 Cal.App.4th 298 (2001), and *Parnell v. Adventist Health System/West*, 35 Cal.4th 595 (2005), pointing out that in each of those cases, payments by a third party provider extinguished the plaintiff's liability for further payment. In *Katiuzhinsky*, Mercy General Hospital sold its $144,000 medical lien to MedFin for $72,000 and several other doctors sold their liens at a discount to MedFin at lower prices. MedFin is a financial service company that works with plaintiff law firms. It is willing to purchase medical accounts and liens from medical service providers,

usually at 50 cents on the dollar. Prior to treatment, MedFin makes a pre-services determination whether it would be willing to make this purchase. After services are provided, the medical service provider decides whether or not to sell the account and liens. The Court of Appeals pointed out that the plaintiff was still responsible for the full amount of the bill and that the sale of rights did not take place until after medical services were provided. Therefore, since plaintiffs were still liable for the full amount of the bill, the reasonable value was determined to be the amount owed, not the amount received by medical providers from MedFin.

Lagerstrom v. Myrtle Werth Hospital, 2005 WI 124; 700 N.W.2d 201 (WI 2005). This decision defines the meaning of the language about collateral sources in the Wisconsin medical malpractice statute § 893.55(7). The court said: "We conclude that the text of § 893.55(7) explicitly allows evidence of collateral source payments to be introduced in medical malpractice actions but fails to state the purpose for which such evidence is admitted. We further conclude that if evidence of collateral source payments from sources including Medicare, other state or federal government programs, medical insurance or write-offs, and discounted or free services is presented to the fact-finder, then the parties must be allowed to furnish the jury with evidence of any obligations of subrogation or reimbursement. . . We conclude that the circuit court must instruct the fact-finder that it must not reduce the reasonable value of medical services on the basis of the collateral source payments. Although the jury is instructed not to use the evidence of collateral source payments to reduce the award for medical services, evidence of collateral source payments may be used by the jury to determine the reasonable value of medical services."

Leitinger v. Dbart, Inc. 2007 WI 84 (Wisc. 2007). The Wisconsin Supreme Court held that the collateral source rule prohibits parties in a personal injury action from introducing evidence of the amount actually paid by the injured person's health insurance company, a collateral source, for medical treatment rendered to prove the reasonable value of the medical treatment. Defendants had argued that amounts actually paid for the medical services should be admissible to prove the reasonable value of those services and the trial court had ruled on that basis. The Court of Appeals reversed on the ground that amounts actually paid could not be introduced and the Court of Appeals was affirmed by the Wisconsin Supreme Court.

Lopez v. Safeway Stores, Inc., 2006 Ariz. App. LEXIS 23 (Ariz. App. 2006). The decision involved a slip and fall accident in which the medical

bills of Lydia Lopez totaled approximately $59,700, but more than $42,000 of the total was "completely written off as adjustments" and only $16,837 was paid to fully satisfy contractually agreed-upon payments. The Arizona Court of Appeals upheld a trial court decision to allow Lopez recovery of the amount billed instead of the amount that was actually paid.

Moorhead v. Crozer Chester Medical Center, 564 Pa.156; 765 A.2d 786 (Pa. 2001). This decision by Justice Cappy held that the plaintiff was "entitled to recover $12,167.40, the amount which was actually paid on her behalf by Medicare and Blue Cross, collateral sources." The Court went on to say: "The essential point to recognize is that appellee is not seeking to diminish Appellant's recovery by this amount. Rather, the issue is whether Appellant is entitled to collect the additional amount of $96,500.91 as an expense. Appellant did not pay $96,500.91, nor did Medicare or Blue Cross pay that amount on her behalf. The collateral source rule does not apply to the illusory "charge" of $96,500.91 since that amount was not paid by any collateral source. A dissent by Justice Nigro would have supported the Superior Court's decision to allow the plaintiff to recover $108,668.31 ($12,167.40 plus $96,500.91) as the "reasonable value" of the medical services provided.

Papke v. Harbert, 2007 SD 87 (South Dakota 2007). The South Dakota Supreme Court held "that defendants are precluded from entering into evidence the amounts 'written off' by medical care providers because of contractual agreements independent of defendants." This ruling relates primarily to recovery of past medical costs when previously existing contractual relationships between medical care providers and third party payers for medical services provide for routine reductions of costs originally billed to plaintiffs, often by as much as two thirds. With this decision, plaintiffs may recover the "reasonable value" of the services and defendants are precluded from defining "reasonable value" as the amounts actually paid. The Court acknowledged that this will sometimes result in windfall gains to plaintiffs and argues that it is better for plaintiffs to get windfall gains than that defendants get the benefits of such reductions. The Court said: "In South Dakota, it is well settled that plaintiffs are entitled to recover the reasonable value of their medical services, and what constitutes reasonable value is a jury question. We think it unwise for us to make a broad declaration that the reasonable value of medical services equals the amount paid, not the amount billed. (Citation). Such decision would create an inference that the actual amount billed to patients by medical care providers is, as a matter of law, unreasonable. This Court equally cannot

hold that a plaintiff is always entitled to recover the entire amount billed, rather than the amount paid. Such a ruling would declare that the amount billed, as a matter of law, constitutes the reasonable value for provided services. Both results invade the province of the jury in its role of determining reasonable value (italics as in original)." This decision review legal cases in a number of other states that deal with this question and would constitute a primer for forensic economists trying to understand this issue.

Reyher v. State Farm Mutual Automobile Insurance Company, 2007 Colo. App. LEXIS 1846 (Colo. App. 2007). Reyher was injured in an automobile accident and was treated by Dr. Brucker, who sent his bills to State Farm Insurance who sent them to Sloans Lake for "repricing." State Farm paid Dr. Brucker only for those portions of his bills it deemed reasonable. State Farm then contacted the Colorado Department of Insurance (DOI), which held only that the data in the database used by State Farm was "current, accurate and sufficient to make recommendations regarding the reasonableness of charges in compliance with regulation 5-2-8," but made no other recommendations. The Court held that the DOI had not determined whether State Farm had compensated Reyher for all of her "reasonable" medical expenses. It also said: "Moreover, it is not clear that the DOI could have made such determinations in the proceedings before it." See DOI Reg. No. 5-2-8(2) ("This regulation is not intended to define reasonable and necessary expenses as such terminology is used in the Act.")

Robinson v. Bates, 160 Ohio App. 3d 668; 205 Ohio 1879 (Ohio App. 2005). This decision holds that, under the collateral source rule, a plaintiff's recovery of the reasonable value of her medical treatment is not limited to the amount paid by her insurance even if there is no continuing liability to the plaintiff. Thus, Robinson could submit her medical bills as evidence even though the amounts billed for were settled for an amount less than the amounts stated on the bills. The court pointed out that: "Negotiated and contracted discounts on medical bills between healthcare providers and insurers are increasingly prevalent. Under these agreements, an insurer's liability for medical expenses billed to the insured is often satisfied at discounted rates, with the remainder being 'written-off' by the healthcare providers." The court also said: "Numerous courts have determined that a plaintiff is entitled to recover the reasonable value of the medical services regardless of the amount paid by the plaintiff's insurance." The decision then reviews a number of legal decisions both for and against this proposition.

Watson v. Taylor, M.D., 2007 U.S. Dist. LEXIS 16210 (D. KS 2007). The Court rejected the plaintiff's appeal for a new trial. One of the grounds for the appeal was a claim that the Court erred in overruling plaintiff's objections to a line of questioning during the cross examination of economist, Kurt Krueger, Ph.D. The challenged line of questioning involved whether Dr. Krueger was making the assumption that plaintiff was actually paying the drug costs of the medicine she was receiving when he calculated her future costs for prescription medicine. The plaintiff claimed that these questions violated the collateral source rule and were unfairly prejudicial. The Court held that the questions were proper. The extended discussion of the collateral source rule in this decision would be of interest to many forensic economists.

Wills v. Foster, 2007 Ill. App. LEXIS 406 (Ill. App. 2007). This decision held that a jury's personal-injury award for compensatory damages should be reduced from $80,163.47 to $19,005.50, based on payments of that amount for medical services by Medicare and Illinois Medicaid fully disposing of the plaintiff's liability for those services. The decision cited *Peterson v. Lou Bachrodt Chevrolet Co.*, 76 Ill. 2d 353, 392 N.E.2d 1 (Ill. 1979) in doing so, and distinguished this case from *Arthur v. Catour*, 216 Ill 2d 72, 833 N.E.2d 847 (Ill. 2005) in doing so. The court pointed to the fact that the *Arthur* decision involved a private insurance company that had bargained with health care providers on behalf of the plaintiff in that case, where subrogation was possible, but *Arthur* did not apply when the plaintiff had paid no premiums as a result of any contractual arrangement, as in the current case.

— Thomas R. Ireland, Ph.D.