

**Unmasking Phantom Damages in Hawai'i: Limiting Recoverable
Medical Expenses to the Amount Paid by Medicaid.
An Examination of *Bynum v. Magno***

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I. INTRODUCTION

National healthcare and medical liability are currently in a state of crisis¹ due in large part to increases in the number of medical malpractice lawsuits and the amount of damage awards.² In fact, estimates show that the average amount of damages awarded in medical liability cases has skyrocketed to \$3.5 million.³ Lawmakers have attributed the rise in malpractice insurance premiums to “frivolous” malpractice lawsuits and awards.⁴ As a result of the crisis, some medical insurers are leaving the market; those insurers who remain greatly increase their rates due to the lack of competition.⁵

Patients are also directly affected, as physicians retire earlier, move their practices, or refuse to perform high-risk procedures due to high premiums.⁶ The rise in litigation and insurance premiums has also

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¹ Donald J. Palmisano, *Health Care in Crisis: The Need for Medical Liability Reform*, 5 YALE J. HEALTH POL'Y, L. & ETHICS 371, 371 (2005). See also Stephen L. Olson & Pat Wasson, *Is the Collateral Source Rule Applicable to Medicare and Medicaid Write-Offs?*, 71 DEF. COUNS. J. 172, 172 (2004).

² Palmisano, *supra* note 1, at 373.

³ Olson & Wasson, *supra* note 1, at 172 (citation omitted). Additionally, more than half of all medical liability cases result in jury awards in excess of \$1 million. *Id.*

⁴ Kathryn Zeiler, *Turning from Damage Caps to Information Disclosure: An Alternative to Tort Reform*, 5 YALE J. HEALTH POL'Y, L. & ETHICS 385, 385 (2005) (citation omitted).

⁵ HEALTH POLICY STUDIES DIVISION, NGA CENTER FOR BEST PRACTICES, ADDRESSING THE MEDICAL MALPRACTICE INSURANCE CRISIS 1 (2002).

⁶ Richard E. Anderson, *Effective Legal Reform and the Malpractice Insurance Crisis*, 5 YALE J. HEALTH POL'Y, L. & ETHICS 341, 343 (2005).



prompted some physicians to practice “defensive medicine,” ordering additional testing and procedures in an attempt to evade liability.⁷

This problem has affected our island state as well. Over the past several years, Hawai‘i has lost many qualified physicians and specialists who leave the islands due to continued monetary losses and the rising costs of treating patients.⁸ For some of these physicians, the steady increases in medical malpractice insurance have made medicine a difficult business.⁹ As a result, many doctors have reduced the number of patients they see; some have stopped taking new patients altogether.¹⁰

Physicians are not the only healthcare providers affected by the healthcare crisis; Hawaii's hospitals and nursing homes are also experiencing large losses which are expected to grow in the future.¹¹ As a

⁷ Bryan A. Liang & LiLan Ren, *Medical Liability Insurance and Damage Caps: Getting Beyond Band Aids to Substantive Systems Treatment to Improve Quality and Safety in Healthcare*, 30 AM. J.L. & MED. 501, 502 (2004).

⁸ Helen Altonn, *Medicare Cut to Hurt Seniors: Congress Must Act to Avoid a Crisis*, *Health Officials Say*, Honolulu Star Bulletin, October 16, 2004, at: <http://starbulletin.com/2002/10/16/news/story1.html> (last visited February 22, 2005). Dr. Philip Hellreich, legislative chairman of the Hawaii Medical Association, stated that some of the islands’ best physicians are leaving the state; notably, shortages have occurred in specialty areas, like rheumatology. *Id.*

⁹ For example, Dr. Antonio Cavazos Jr. of San Antonio, Texas, was forced to move offices twice in five years in an attempt to cut costs. He attributed rising costs to a 300 percent increase in malpractice insurance and Medicare payment cuts and discounts. Star Bulletin Staff and Wire, *Doctors Say Costs Eating Up Incomes: Reduced Payments, Expensive Insurance Combine to Make it Tough Going, They Say*, Honolulu Star Bulletin, March 8, 2003, at: <http://starbulletin.com/2003/03/08/business/story1.html> (last visited February 23, 2005) [hereinafter “*Costs Eating Incomes*”]. Hawai‘i dermatologist, Dr. Philip Hellreich, experienced a 25 percent increase in malpractice insurance and expected a 50 percent increase in the coming year. *Id.*

¹⁰ *Id.* See also Helen Altonn, *Isle Doctors Wearing Thin Over Seniors’ Bills: Some Worry that High Costs Will Force Them to Leave the State*, Honolulu Star Bulletin, March 17, 2002, at: <http://starbulletin.com/2002/03/17/news/story3.html> (last visited February 22, 2005) [hereinafter “*Wearing Thin*”] (stating that According to reports by the New York Times, “significant numbers of doctors for the first time are refusing to take Medicare patients, saying the government pays too little to cover costs of care for the elderly”). *Id.*

¹¹ Lyn Danninger, *Hawaii Hospitals Continue to Lose Money: Unfunded Care will Cost Isle Hospitals \$169 Million this Year*, Honolulu Star Bulletin,

result, some island hospitals have been forced to lay off employees and close community programs and services.¹² Several important programs, including substance abuse treatment programs, nutrition programs, elderly services, school health and counseling, and outpatient clinics for the needy, have already been forced to close.¹³ Executives have speculated that in the future, hospitals may have to effect significant layoffs or even go out of business to cope with rising costs.¹⁴

This trend suggests the increasing difficulty that healthcare providers have in providing adequate care to the community, based on the rising costs of doing business. In the end it is not only healthcare providers, but also the community, and in fact, those individuals in greatest need, who are negatively impacted by these rising costs, as physicians and much needed programs and services are forced to relocate, downsize, or even close.¹⁵ Despite this stark reality, the Supreme Court of Hawai`i held in *Bynum v. Magno*¹⁶ that the collateral source rule prohibits a reduction in a patient's special damages award to reflect the actual, discounted payments made by Medicare and Medicaid,¹⁷ thus providing for plaintiff overcompensation. Such a ruling could fuel the medical liability crisis by increasing overall costs to the system, and possibly further limiting the care, services, and programs available to island residents.

November 3, 2002, at: <http://starbulletin.com/2002/11/03/business/story2.html> (last visited February 22, 2005).

¹² In 2000, St. Francis Healthcare System eliminated 150 jobs. Finances later forced the hospital to eliminate 40 more jobs and close some community services. Lyn Danninger, *Hawaii's Hospitals See Continuing Losses as Reimbursements Tumble: Costs for Education and Charity Care also are Mounting at Cash-Strapped Facilities*, Honolulu Star Bulletin, December 21, 2003, at: <http://starbulletin.com/2003/12/21/business/story2.html> (last visited February 22, 2005).

¹³ *Id.*

¹⁴ Larry O'Brien, Chief Executive Officer of Kapiolani Medical Center stated that hospitals may have to enact these severe measures as a result of rising costs. He also opined that the rising cost situation would worsen in the future, with baby boomers turning 65, thus qualifying them for Medicare coverage. *Id.*

¹⁵ *See supra* notes 6-13 & accompanying text.

¹⁶ 106 Hawai`i 81, 101 P.3d 1149 (Haw. 2004).

¹⁷ *Id.* at 81, 101 P.3d at 1150.

This note argues that the Supreme Court of Hawai'i incorrectly decided *Bynum* and proposes that allowing patients to recover damages in excess of the amount actually paid provides a windfall to patients, in contravention of standing Hawai'i damages law.¹⁸ Such a ruling over-compensates plaintiffs, with taxpayers, insurance companies, and the medical industry bearing the extra costs. This note also argues that according to Hawai'i case law, plaintiffs in medical negligence suits should be limited to recovering medical expenses in the actual amount paid by Medicaid for their treatment and care.¹⁹

This paper also suggests that the proposed approach would provide a more equitable result in light of policy concerns; plaintiffs will still be eligible to receive general and specific damages outside of their medical expenses, thus compensating them for their injuries and the incidental effects of their injuries.²⁰ Additionally, defendants will still be liable for their negligent conduct, fulfilling the deterrence rationale behind tort law damages. Adopting such an approach will ultimately fulfill the policies and rationales behind tort law damages, while ensuring that the medical industry, and in turn, the community, are not forced to bear the extra costs and burdens of excess damages awards.

After the Introduction, Part II of this paper provides background information on the Medicaid and Medicare systems. This section also provides background on the concepts and policies behind tort law damages and the collateral source rule. In addition, it also introduces *Bynum* and describes how the Court's decision fits within the framework of the mentioned policies behind tort law compensation.

Part III examines several key aspects regarding compensation of Medicaid and Medicare patients in medical negligence suits. First, it discusses the varying approaches which have been taken in response to the issue of Medicaid payments and the collateral source rule. Specifically, this part will discuss, in depth, the majority and dissenting opinions in *Bynum*, and the reasoning behind their respective conclusions. Next, this section discusses the national split of authority on the topic, analyzing selected cases that have and have not limited recovery to actual, billed Medicaid amounts. Finally, it suggests that *Bynum* was incorrectly decided in light of Hawai'i precedent, policy concerns, and the rationale

¹⁸ See *infra*, Part III.C.2.

¹⁹ See *infra*, Part III.C.2.

²⁰ See *infra*, Part III.C.1.c.

behind tort law damages, and argues that limiting recovery to the “amount paid” would be the most just result.

The comment concludes by suggesting that ultimately, tort reform in this area is necessary, but that the recommended approach would, in the end, most benefit all involved parties, as well as the community at large, producing the most equitable result.

II. BACKGROUND

A. THE MEDICAID AND MEDICARE SYSTEMS

In 1965, the Social Security Act established the Medicare and Medicaid programs.²¹ Currently, Medicare provides medical coverage to roughly 40 million Americans who are either over 65, or who are under 65 with certain disabilities;²² the program is primarily financed by mandatory payroll taxes administered by the Federal government.²³ The program is additionally funded by premiums paid by enrollees.²⁴ Because enrollees pay premiums, authorities liken the program to private insurance.²⁵

In contrast, the Medicaid program, which is jointly funded by federal and state government, pays for medical assistance for qualifying low-income individuals and families.²⁶ Medicaid is currently the largest provider of medical assistance to families with limited income and

²¹ *Medicare Information Resource*, Centers for Medicare and Medicaid Services, available at: <http://www.cms.hhs.gov/medicare/> (last visited February 24, 2005).

²² *Id.*

²³ *Bozeman v. Louisiana*, 879 So.2d 692, 705 (La. 2004).

²⁴ *Rose v. Via Christi Health System, Inc.*, 276 Kan. 539, 545-46, 78 P.3d 798, 803 (Kan. 2003).

²⁵ *See, e.g., Hodge v. Middletown Hosp. Assn.*, 62 Ohio St.3d 236, 241, 581 N.E.2d 529, 533 (Ohio 1991) (concluding that because Medicare is funded by beneficiary premiums, it acts as a form of insurance).

²⁶ *Welcome to Medicaid*, Centers for Medicare and Medicaid Services, available at: <http://www.cms.hhs.gov/medicaid/> (last visited February 24, 2005). Medicaid recipients must meet certain financial requirements in order to receive coverage. Under Quest, Hawaii's Medicaid program, recipients' income cannot exceed 100% of the federal poverty level. In addition, recipients' assets cannot exceed \$2,000 per individual, or \$3,000 per couple. *What is Hawaii Quest*, Hawaii Quest, available at: <http://www.state.hi.us/dhs/Q-Book.html> (last visited February 25, 2005).

resources.²⁷ Health care providers charge Medicaid discounted fees for their services; these discounted rates are charged in exchange for the providers' participation in the program.²⁸ Under this program, Medicaid beneficiaries do not pay any premiums to receive health care benefits.²⁹

Although Medicaid and Medicare provide much-needed assistance to qualifying individuals, several factors have made it difficult for health care providers to treat these types of patients.³⁰ Indeed, as the numbers of malpractice suits and Medicare and Medicaid patients continue to rise, the issue of damages compensation for services rendered through these programs "will become an ever-increasing cause of concern[.]"³¹ The *Bynum* holding, which allows plaintiff recovery in excess of the amounts actually paid by Medicare and Medicaid, will additionally become an increasing area of concern in Hawai'i damages law.

B. TORT LAW DAMAGES

In general, the law of torts seeks "to put an injured person in a position as nearly as possible equivalent to his position prior to the tort."³² This purpose is accomplished by awarding an injured plaintiff damages for his or her injury.³³

²⁷ *Welcome to Medicaid*, *supra* note 26.

²⁸ Olson & Wasson, *supra* note 1, at 172. See also William R. Jones, Jr., *Managed Care and the Tort System: Are We Paying Billions in Phantom Healthcare Charges?*, 32 AZ ATTORNEY 28, 29 (1996) (stating that both parties benefit from this arrangement. The healthcare provider benefits by securing a large number of patients through its lowered rates. In return, the plan receives treatment for subscribers at discounted rates). *Id.*

²⁹ Bozeman, 879 So.2d at 705.

³⁰ "Doctors in Hawaii and across the mainland are reaching a point where they can't afford to care for elderly patients under Medicare and Medicaid rates . . ." *Wearing Thin*, *supra* note 10.

³¹ Olson & Wasson, *supra* note 1, at 178 (2004).

³² RESTATEMENT (SECOND) OF TORTS § 901 cmt. a (1979).

³³ *Id.* The nature of the individual harm will determine the form of damages imposed on the tortfeasor. In cases where a plaintiff has been physically injured, monetary damages are given to compensate the plaintiff for "the pain or distress or for the deterioration of the bodily structure." *Id.* In cases where the injury suffered is wrongful seizure of land or chattels, however, the plaintiff may be recompensed by money or "specific restoration of what was taken from him[.]" *Id.*

The concept of tort law damages is defined as “the compensation which the law will award for an injury done, a compensation, restitution, recompense, or satisfaction in money for a loss or injury sustained or suffered, or compensation for actual injury.”³⁴ The term, damages, expresses “in dollars and cents” the extent of the plaintiff’s sustained injuries.³⁵ Because it is often impossible to fully compensate injured plaintiffs for the entire scope of their injuries, however, tort damages seek to assess the value of “past, present and future loss of pleasure and happiness.”³⁶

There are several purposes behind the maintenance of tort actions and determining the measure of tort damages, including: compensation for the plaintiff’s injuries, a determination of rights, the punishment of tortfeasors and the deterrence of negligent conduct, and the vindication and injured parties.³⁷

There are several categories of recoverable damages, each of which are designed to fulfill the aforementioned purposes behind tort damages. These categories of tort damages can generally be envisioned as a two-tiered structure. Three types of recoverable damages make up the first-tier: (1) compensatory damages, (2) punitive damages, and (3) nominal damages.³⁸ Compensatory damages function to “compensate the injured party for the injury sustained, and nothing more,”³⁹ and to “restore the plaintiff to the position he or she would be in if the wrong had not been committed.”⁴⁰ Punitive damages are imposed against a tortfeasor, in conjunction with compensatory damages, for the specific purpose of punishing the tortfeasor for his conduct and deterring him from similar future acts.⁴¹ In contrast, “[n]ominal damages are a trivial sum of money

³⁴ 25 C.J.S. *Damages* § 1 (2004) (citations omitted).

³⁵ *Id.*

³⁶ MARSHALL S. SHAPO, BASIC PRINCIPLES OF TORT LAW 341 (West Group 1999) (citation omitted).

³⁷ RESTATEMENT § 901, *supra* note 32.

³⁸ Bynum, 106 Hawai`i at 95, 101 P.3d at 1163 (Moon, J., dissenting).

³⁹ *Id.* (citing *Kuhnert v. Allison*, 76 Hawai`i 39, 44, 868 P.2d 457, 462 (1994)).

⁴⁰ *Id.* (citing *Gump v. Wal-Mart Stores, Inc.*, 93 Hawai`i 417, 423, 5 P.3d 407, 413 (2000)).

awarded to a litigant who has established a cause of action but has not established that he is entitled to compensatory damages.”⁴² In Hawaii, nominal damages are limited to “one dollar plus costs.”⁴³

The second tier of the damages structure consists of the two main forms of compensatory damages: general damages and specific damages. These individual forms of compensatory damages serve differing purposes, and will be examined separately.

1. General Damages

General damages seek to compensate injured plaintiffs for “harm so frequently resulting from the tort that is the basis of the action[,] that the existence of damages is normally to be anticipated[.]”⁴⁴ In other words, general damages include those damages naturally and necessarily resulting from the harm done.⁴⁵ Such damages usually “need not be alleged in order to be proved[.]”⁴⁶ as the “mere allegation of the wrong gives sufficient notice . . . of the kind of damages that will be claimed at trial.”⁴⁷

General damages normally provide recovery for incidental effects of the injury, which are presumed in conjunction with the injury.⁴⁸ Thus, general damages encompass recovery for things like pain and suffering, loss of enjoyment, and inconvenience.⁴⁹ According to Hawai`i First

⁴¹ *Id.* at 95-96, 101 P.3d at 1163-64 (quoting *Masaki v. Gen. Motors Corp.*, 71 Haw. 1, 6, 780 P.2d 566, 570, *reconsideration denied*, 71 Haw. 664, 833 P.2d 899 (1989)).

⁴² RESTATEMENT (SECOND) OF TORTS § 907 (1979). Thus, nominal damages are awarded “when a cause of action for a tort exists but no harm has been caused by the tort or the amount of harm is not significant or is not so established that compensatory damages can be given[.]” *Id.* at cmt. a.

⁴³ EDMUND BURKE, ET AL., DAMAGES FOR PLAINTIFF AND DEFENSE ATTORNEYS IN HAWAII 2 (National Business Institute, Inc. 1990)(citations omitted).

⁴⁴ RESTATEMENT (SECOND) OF TORTS § 904 (1979).

⁴⁵ *Ellis v. Crockett*, 51 Haw. 45, 50, 451 P.2d 814, 819 (Haw. 1969).

⁴⁶ RESTATEMENT § 904, *supra* note 44.

⁴⁷ *Ellis*, 51 Haw. at 51, 451 P.2d at 819.

⁴⁸ RESTATEMENT § 904, *supra* note 44, at cmt. a.

⁴⁹ *Dunbar v. Thompson*, 79 Hawai`i 306, 315, 901 P.2d 1285, 1294 (App. 1995). *See also* SHAPO, *supra* note 36, at 349-57 (describing items such as pain,

Circuit Court Jury Instructions, general damages “are those damages which fairly and adequately compensate the plaintiff for any past, present, and reasonably probably future disability, pain, emotional suffering and mental anguish caused by the injuries/damages sustained.”⁵⁰

Because of the highly individual and subjective nature of items claimed under general damages, such items are not easily quantified or “measured definitively in monetary terms.”⁵¹

2. *Special Damages*

Whereas general damages are not easily measured in money terms,⁵² special damages include items whose monetary value can be accurately calculated.⁵³ Indeed, the pecuniary nature of special damages distinguishes them from general damages.⁵⁴ Thus, the issue of special damages is generally less complicated and is based on the premise of reimbursing the plaintiff for their “expenditures for hospital bills, the costs of medical care, surgery and drugs, and other aids to recovery or rehabilitation.”⁵⁵ These damages serve to compensate plaintiffs “for specific out of pocket financial expenses and losses[.]”⁵⁶ and nothing more, and to restore the plaintiff, as closely as possible, to their pre-injury position.⁵⁷ In addition to medical treatment and rehabilitation costs,

suffering, fear, capacity to enjoy life, consortium, bereavement, and intangible death damages as categories of non-economic damages falling under “general damages.”).

⁵⁰ BURKE, *supra* note 43, at 5 (National Business Institute, Inc. 1990) (citation omitted).

⁵¹ Sprague v. California Pacific Bankers & Ins. Ltd., 102 Hawai`i 189, 199-200, 74 P.3d 12, 22-23 (Haw. 2003) (citations omitted).

⁵² *See Id.* & accompanying text.

⁵³ Zanakis-Pico v. Cutter Dodge, Inc., 98 Hawai`i 309, 327, 47 P.3d 1222, 1240 n.2 (Haw. 2002).

⁵⁴ Ellis, 51 Haw. at 52-53, 451 P.2d at 820. Pecuniary damages can be calculated in monetary terms, and include items such as loss of wages and cost of medical expenses. *Id.*

⁵⁵ SHAPO, *supra* note 36, at 339.

⁵⁶ Norris v. Hawaiian Airlines, Inc., 74 Haw. 235, 264, 842 P.2d 634, 647 (Haw. 1992).

⁵⁷ Bynum, 106 Hawai`i at 96, 101 P.3d at 1164 (Moon, J., dissenting).

special damages in personal injury torts also include items such as “loss of earnings, and diminished capacity to work.”⁵⁸

Special damages are further distinguished from general damages because they are the “natural but not the necessary result of an alleged wrong and are such that they do not follow by implication of law merely upon proof of a wrong.”⁵⁹ In other words, the existence of special damages is not readily presumed as resulting from the tortious act.

Because the amount of special damages depends on the individual circumstances of the particular injury,⁶⁰ the injured plaintiff is required to plead and prove every item of loss claimed in order to recover.⁶¹ Claiming and pleading the true amount of loss claimed often becomes problematic when collateral sources provide payment for items and services recoverable as special damages.

C. THE COLLATERAL SOURCE RULE

The collateral source rule is both a rule of evidence and a rule of damages.⁶² As a damages doctrine, the rule states that payments received by the plaintiff, from third parties sources, will not decrease said plaintiff’s recovery against a defendant.⁶³ Thus, from a damages viewpoint, the rule prohibits a defendant from subtracting from the damages award against him any amount that a plaintiff may have received from an independent source.⁶⁴

From an evidentiary prospective, the rule bars admission of any evidence indicating that the plaintiff “received payment for any part of his damages, including medical expenses, from other sources.”⁶⁵ In both capacities, the rule seeks to ensure that plaintiffs are compensated for all harms incurred, and not just their net loss incurred.⁶⁶

⁵⁸ Dunbar, 79 Hawai`i at 315, 901 P.2d at 1294.

⁵⁹ Ellis, 51 Haw. at 50, 451 P.2d at 819.

⁶⁰ *Id.*

⁶¹ Zanakis-Pico, 98 Hawai`i at 327, 47 P.3d at 1240 n.2.

⁶² Michael F. Flynn, *Private Medical Insurance and the Collateral Source Rule: A Good Bet?*, 22 U. TOL. L. REV. 39, 42 (1990) (citation omitted).

⁶³ RESTATEMENT (SECOND) OF TORTS § 920A cmt. b. (1979).

⁶⁴ SHAPO, *supra* note 36, at 339.

⁶⁵ Flynn, *supra* note 62, at 42 (1990) (citation omitted).

⁶⁶ *Id.* (citation omitted).

Although practical application of the collateral source rule “continues to spawn litigation[,]”⁶⁷ the rule has persisted since its early inception in American jurisprudence.

1. Case Law History on the Collateral Source Rule

Many consider the United State Supreme Court’s 1854 decision in *The Propeller Monticello v. Mollison*⁶⁸ to be the case establishing the collateral source rule in American jurisprudence.⁶⁹ In this case, a propeller, the Monticello, collided with a schooner, the Northwestern, on Lake Huron.⁷⁰ As a result of the collision, the Northwestern sank and lost all of its cargo.⁷¹ Mollison, the owner of the Northwestern, brought suit to recover damages for his losses.⁷²

At trial, the district judge awarded Mollison \$6,150, the value of the schooner and the salt it carried.⁷³ On appeal the circuit court affirmed.⁷⁴ The master of the Monticello then appealed to the United States Supreme Court, claiming as error the court’s award of damages which, he claimed, had already been compensated by Mollison’s insurance policy.⁷⁵

The Supreme Court held that Mollison’s receipt of insurance payments could not be used to offset the amount of damages owed by the master of the Monticello for the harms done.⁷⁶ In reaching this conclusion, the Court reasoned that the existence of outside insurance was of no “concern” to the master of the Monticello; as such, the master was

⁶⁷ Note, *Unreason in the Law of Damages: The Collateral Source Rule*, 77 HARV. L. REV. 741, 741 (1964).

⁶⁸ 58 U.S. 152 (1854).

⁶⁹ See e.g. Christian D. Saine, *Preserving the Collateral Source Rule: Modern Theories of Tort Law and Proposal for Practical Application*, 47 CASE W. RES. L. REV. 1075, 1077 (1997); Olson & Wasson, *supra* note 1, at 173.

⁷⁰ *Monticello*, 58 U.S. at 152.

⁷¹ *Id.*

⁷² *Id.*

⁷³ *Id.* at 152-53.

⁷⁴ *Id.* at 153.

⁷⁵ *Id.* at 153-155.

⁷⁶ *Id.* at 155.

“bound to make satisfaction for the injury he ha[d] done.”⁷⁷ In effect, the Court’s holding created the framework for the current rule, which basically provides “that in an action for compensatory damages, the defendant will not be permitted to establish that the plaintiff did not actually sustain the amount of injury alleged, if diminution resulted from the conduct of a third person.”⁷⁸

Although this rule has persisted for well over a century, there are many competing views which advocate or criticize its retention in the American common law. This split of authority has affected Hawai`i jurisprudence as well; competing interpretations of the collateral source rule were some of the factors that fueled the difference in opinion between the dissent and majority in *Bynum*.⁷⁹

2. *Competing Views of the Rule*

Proponents of the rule state that defendants should not profit from the plaintiff’s receipt of benefits from a third party.⁸⁰ Thus, the rule seeks to prevent tortfeasors from receiving a *windfall* due to independent benefits received by the plaintiff.⁸¹ Additionally, the rule has a punitive purpose; proponents argue that the rule ensures that guilty parties will not escape liability for the harms they have caused.⁸²

In contrast, opponents of the rule argue that the rule serves to overcompensate plaintiffs, by allowing them double-recoveries for their injuries.⁸³ Because juries do not consider payments that plaintiffs have received from outside sources, opponents argue that withholding evidence of collateral compensation results in inflated verdicts for plaintiffs.⁸⁴ These opponents also argue that the possibility of double-recovery may provide incentive to potential plaintiffs to become tort victims.⁸⁵

⁷⁷ *Id.* at 156.

⁷⁸ *Unreason in the Law of Damages: The Collateral Source Rule*, *supra* note 67, at 741.

⁷⁹ *See infra* Parts III.A.2, III.A.3.

⁸⁰ Saine, *supra* note 69, at 1077 (citation omitted).

⁸¹ RESTATEMENT § 920A, *supra* note 63, at cmt. b.

⁸² Flynn, *supra* note 62, at 46 (citation omitted).

⁸³ Saine, *supra* note 69, at 1079 (citation omitted).

⁸⁴ Flynn, *supra* note 62, at 46 (citation omitted).

⁸⁵ Saine, *supra* note 69, at 1079.

Additionally, opponents argue that the punitive rationale behind the rule is “primitive and archaic.”⁸⁶ These opponents argue that the collateral source rule is not the proper device for punishing defendants; rather, awarding punitive damages should be used to deter and punish tortfeasors for their conduct.⁸⁷

These competing values behind the collateral source rule played a critical role in the *Bynum* disposition, especially because application of the rule to medical payments by Medicare and Medicaid had previously never been litigated in Hawai‘i.⁸⁸

3. Collateral Source Rule & Medical Expenses

The Supreme Court of Hawai‘i understandably grappled with application of the collateral source rule to medical expenses, considering the potentially far-reaching effects of their ruling on such an important issue. The collateral source rule is especially critical in the area of medical expenses, because plaintiffs often receive substantial amounts of compensation from a myriad of collateral sources, such as insurance policies and pensions; these collateral sources often cover costly items such as doctors’ and hospital costs.⁸⁹ In fact, insurance industry analysts argue that double-recovery by plaintiffs contributed to the “insurance availability and affordability crises in this country.”⁹⁰

Due to the potential compensation dilemmas posed by the rule, several states have statutorily modified, or even nullified the rule altogether.⁹¹ In fact, some states have nullified the rule as applied specifically to medical malpractice litigation, thus allowing defendants to reduce their damages owed by payments and reimbursements received by plaintiffs.⁹²

⁸⁶ Flynn, *supra* note 62, at 46 (citation omitted).

⁸⁷ *Id.* at 47.

⁸⁸ *See infra* note 92 & accompanying text.

⁸⁹ SHAPO, *supra* note 36, at 339.

⁹⁰ Saine, *supra* note 69, at 1080.

⁹¹ SHAPO, *supra* note 36, at 339.

⁹² *Id.*

D. *INROADS: BYNUM V. MAGNO*

In November 2004, as a matter of first impression, the Supreme Court of Hawai'i held in *Bynum v. Magno*⁹³ that the collateral source rule prohibited reducing a patient's damages award to reflect the discounted Medicaid rates actually paid to health care providers. In practical effect, this holding will provide a windfall to injured plaintiffs, by awarding them damages amounts in excess of the total amount actually paid for their medical treatment. This is especially so for Medicaid patients, who pay no premiums in exchange for their health care coverage. In fact, in some cases, plaintiffs are awarded amounts hundreds of thousands of dollars in excess of the amount billed to Medicaid.⁹⁴

Given the current crisis in the national and local healthcare and medical liability systems and the increasing number of medical malpractice suits,⁹⁵ the Court's decision in *Bynum* may place further strain on Hawaii's already tenuous health care situation.⁹⁶

III. ANALYSIS

A. *THE SUPREME COURT OF HAWAII'S DECISION: BYNUM*

1. *Context & Procedural History*

In July 1998, while vacationing on the Big Island of Hawai'i, Joseph Bynum experienced severe chest pain.⁹⁷ After initial examination at the North Hawai'i Community Hospital, Bynum was transferred to Queen's Medical Center in Honolulu for further evaluation and treatment.⁹⁸ Defendant cardiologist, Dr. Joana Magno, became Joseph's attending physician.⁹⁹ After consulting with a Dr. Michael Dang, a cardiovascular surgeon and Dr. John Callan, a pulmonologist, Dr. Magno

⁹³ 106 Hawai'i 81, 101 P.3d 1149 (2004).

⁹⁴ See, e.g., *Bozeman*, 879 So.2d at 695 (jury awarded plaintiff \$613,626.64 in medical expenses when Medicaid actually paid \$291,863.56 for said medical services).

⁹⁵ See *supra* notes 1-2 & accompanying text.

⁹⁶ See *supra* notes 8-14 & accompanying text.

⁹⁷ *Bynum*, 106 Hawai'i at 83, 101 P.3d at 1151.

⁹⁸ *Id.*

⁹⁹ *Id.*

advised Joseph Bynum that bypass surgery was needed on an urgent basis.¹⁰⁰ Magno made this recommendation despite knowing of Bynum's previous medical history, which made bypass surgery an undesirable option.¹⁰¹ Magno, however, presented surgery as the only option and did not advise the Bynum family of any alternative options or forms of treatment.¹⁰²

Bynum suffered respiratory distress during the bypass procedure.¹⁰³ As a result of the complications, Bynum became dependent on mechanical ventilation.¹⁰⁴ After a 3 month stay in Queen's Hospital, Bynum spent the remainder of his life in California intensive care facilities.¹⁰⁵ Medicare initially paid for all of Bynum's medical bills.¹⁰⁶ However, in order to qualify Joseph for Medicaid, and to protect the family's life savings, the Bynums legally divorced on February 11, 2004.¹⁰⁷ Thereafter, Joseph received coverage under Medi-Cal, California's Medicaid program.¹⁰⁸ Bynum passed away on February 21, 2002.¹⁰⁹

Prior to Bynum's death, the family filed a lawsuit against Defendants Magno, Dang, Callan, and Queen's Hospital.¹¹⁰ During trial, the Bynums produced medical bills reflecting standard or customary rates charged for the services provided by the medical facilities where Joseph had lived.¹¹¹ In response, defendants filed a motion in limine to limit

¹⁰⁰ *Id.*

¹⁰¹ Bynum had previously experienced respiratory failure and had a history of lung disease; such a history created a "red flag" to bypass surgery. *Id.*

¹⁰² *Id.*

¹⁰³ *Id.*

¹⁰⁴ *Id.*

¹⁰⁵ *Id.*

¹⁰⁶ *Id.*

¹⁰⁷ *Id.*

¹⁰⁸ *Id.*

¹⁰⁹ *Id.*

¹¹⁰ *Id.* Eventually, "the district court dismissed with prejudice all claims against Callan, Dang, and Queen's, pursuant to a stipulation for partial dismissal." *Id.* at 84, 101 P.3d at 1152.

¹¹¹ *Id.* at 83, 101 P.3d at 1151.

Bynum's recovery of medical expenses to "only those fees *actually paid* to his healthcare providers as full and final payment for the services."¹¹² Defendants argued that a patient cannot recover medical expenses in excess of those actually paid by Medicare or Medicaid to a healthcare provider.¹¹³ The court denied the motion and presented the jury with bills reflecting the amounts normally charged by comparable health care providers for similar services.¹¹⁴ After deliberation, the jury returned a verdict against Magno, awarding Joseph Bynum \$2,063,750 in damages.¹¹⁵

Magno appealed this judgment to the United States Ninth Circuit Court of Appeals, claiming as error the district court's submission of standard rates to the jury.¹¹⁶ In an unpublished memorandum decision, the Ninth Circuit reversed and remanded to the district court, posing "the novel question under Hawaii law whether the discounted amount paid to a healthcare provider by Medicaid and Medi-Cal reflects the amount that should be awarded to a plaintiff in a negligence action."¹¹⁷ Upon remand, the district court certified the question to the Supreme Court of Hawai'i.¹¹⁸

2. *The Opinion*

In a 3-2 split,¹¹⁹ the Court held, as a matter of first impression, that the collateral source rule prohibited a reduction in a patient's damages award to reflect the actual, discounted payments made by Medicare and Medicaid to healthcare providers.¹²⁰ Accordingly, the Court also held that

¹¹² *Id.* (emphasis added).

¹¹³ *Id.*

¹¹⁴ *Id.* at 83-84, 101 P.3d at 1151-1152.

¹¹⁵ *Id.* at 84, 101 P.3d at 1152. Joseph Bynum was awarded \$1,462,500 in special damages and \$601,250 in general damages. His wife, Lila Bynum, was awarded \$107,250 in general damages.

¹¹⁶ *Id.* See also *Bynum v. Magno*, 55 Fed.Appx. 811 (9th Cir. 2003).

¹¹⁷ *Id.* (citing *Bynum v. Magno*, 55 Fed.Appx. 811, 816-17 (9th Cir. 2003)).

¹¹⁸ *Id.*

¹¹⁹ Justice Acoba wrote for the majority, joined by Circuit Court Judge Pollack (in place of Justice Nakayama, recused) and Circuit Court Judge Del Rosario (by reason of vacancy). Chief Justice Moon dissented, joined by Justice Levinson. *Id.* at 82, 101 P.3d at 1150.

¹²⁰ *Id.*

evidence of customary or standard rates for services received was relevant, and thus admissible into evidence.¹²¹

In her appeal, defendant Magno questioned the applicability of the collateral source rule to gratuities such as Medicaid benefits. In holding that the collateral source rule applied to Medicaid benefits, the Court relied heavily on the Restatement (Second) of Torts, and stated that although these benefits may be considered “gratuities,” the collateral source rule equally applies to services provided free of charge.¹²² As a rationale behind its holding, the Court stated that:

[B]ecause a plaintiff would be able to recover the ‘reasonable value’ of medical services if such services were rendered gratuitously, it would appear to follow that a plaintiff should be allowed to recover the ‘reasonable value’ of such services, even if Medicare/Medicaid had already paid a . . . discounted amount[] of the ‘reasonable value’ of such services.¹²³

Thus, the court reasoned that because plaintiffs who received free medical care would be able to recover the full, “reasonable value” of said care, Medicaid patients should likewise recover the “reasonable value,” rather than the amount paid, for their treatment. Additionally, the Court stated that the collateral source rule applies to social legislation benefits, including Medicare and Medicaid.¹²⁴

As a matter of policy, the Court stated that allowing plaintiffs to recover the customary or standard amounts charged would lead to a more equitable and just result.¹²⁵ Indeed, the Court stated that a contrary result would “penalize the recipient of Medicare/Medicaid payments.”¹²⁶

¹²¹ *Id.*

¹²² *Id.* at 87, 101 P.3d at 1155 (citation omitted).

¹²³ *Id.* at 88, 101 P.3d at 1156.

¹²⁴ *Id.* The Court classified sources such as social security and welfare payments as forms of social legislation. *Id.* Accordingly, the Court concluded that Medicare and Medicaid, which are government medical insurance programs for the elderly/disabled and low-income individuals, respectively, classify as social legislation benefits subject to the collateral source rule. *Id.* (citations omitted).

¹²⁵ *Id.* at 93, 101 P.3d at 1161.

¹²⁶ *Id.* In reaching this conclusion, the Court stated that a contrary holding would, in practical effect, mean that injured plaintiffs who received gratuitous medical treatment would not be entitled to recovery monetary damages from a tortfeasor. *Id.* at 1162.

3. Dissent's View

In its opinion, the dissent stated that the majority's holding "restor[ed] [the plaintiff] to a position *better* than he would have been had the wrong not been committed."¹²⁷ Thus, the dissent stated that the majority's holding contravened Hawai'i precedent and unnecessarily "disregarded this jurisdiction's long standing formulation and treatment of special damages."¹²⁸ According to the dissent, the real question essentially posed by the district court was "whether the *amount written-off* (*i.e.*, the amount charged less the amount paid) can be awarded as medical expenses to a plaintiff in a negligence action."¹²⁹

In support of its conclusion that the "written-off" amount *cannot* be awarded as damages in a negligence action, the dissent stated that the purpose of special damages is to "compensate claimants for specific *out of pocket financial expenses and losses*["]"¹³⁰ As such, Bynum's recovery of medical expenses should have been limited to the amount which he was "legally obligated to pay",¹³¹ or his out-of-pocket expenditures. The dissent also argued that by allowing Bynum to collect unincurred medical costs, thus restoring him to a position better than he would have been but for the wrong committed, the majority had created a new category of damages.¹³²

The dissent additionally concluded that because Bynum was not legally obligated to pay the written-off amount,¹³³ he would be fully compensated upon recovery of the amount "paid on his behalf by

¹²⁷ *Id.* at 97, 101 P.3d at 1165 (Moon, J., dissenting).

¹²⁸ *Id.* at 95, 101 P.3d at 1163 (Moon, J., dissenting).

¹²⁹ *Id.* (Moon, J., dissenting).

¹³⁰ *Id.* at 96, 101 P.3d at 1164 (Moon, J., dissenting) (citing *Dunbar v. Thompson*, 79 Hawai'i 306, 315, 901 P.2d 1285, 1294 (App. 1995).

¹³¹ *Id.* (Moon, J., dissenting).

¹³² *Id.* at 97-98, 101 P.3d at 1165-1166 (Moon, J., dissenting).

¹³³ "Medicare and Medicaid law prohibits participating health care providers from seeking reimbursement of the amount written-off from anyone, including the beneficiary, Medicare and/or Medicaid . . . [A] beneficiary, whose medical expenses are paid by Medicare and/or Medicaid, does not incur the amount written-off by the health care provider. Consequently, the beneficiary never becomes legally obligated to pay the amount written off." *Id.* at 96-96, 101 P.3d at 1164-65 (citations omitted).

Medicare and Medicaid.”¹³⁴ Such a holding would ensure that the plaintiff was fully compensated, and that neither part received a windfall.¹³⁵

Although the majority and dissenting opinions differed on both substantive and policy grounds, both sides drew their conclusions based partly on the rationales from seminal cases from other jurisdictions.

B. LIGHTNING SPLITS THE TRUNK: COMPETING VIEWS

Nationally, states’ decisions greatly vary on the application of the collateral source rule to payment of medical expenses. This is an understandable variation, given the complexity of the issue; this complexity is further reflected in the great split of authority on application of the collateral source rule to Medicaid and Medicare write-offs.

1. Cases Applying the Collateral Source Rule

In 2001, the Mississippi Supreme Court decided *Brandon HMA, Inc. v. Bradshaw*,¹³⁶ an important case exploring application of the collateral source rule to Medicaid write-offs. In that case, plaintiff Dawn Bradshaw brought suit against Brandon HMA, Inc., alleging negligent medical treatment by the hospital’s nursing staff.¹³⁷ While being treated at the hospital for bacterial pneumonia, doctors inserted a tube into plaintiff’s chest to drain accumulated fluid.¹³⁸ Due to discomfort caused by the chest tube, a doctor prescribed plaintiff Lorcet Plus, a narcotic pain reliever that carries risks and requires precaution when administered.¹³⁹ Nurses at the hospital failed, however, to properly monitor Bradshaw’s vital signs following ingestion of the drug. Due to the nurses’ failure to monitor her condition, plaintiff progressed to a state where she stopped breathing and had to be resuscitated; she remained comatose for two weeks.¹⁴⁰ As a result of the lack of oxygen, plaintiff suffered permanent brain damage.¹⁴¹

¹³⁴ *Id.* (Moon, J., dissenting).

¹³⁵ *Id.* at 99, 101 P.3d at 1167 (Moon, J., dissenting).

¹³⁶ *Brandon HMA, Inc. v. Bradshaw*, 809 So.2d 611 (Miss. 2001).

¹³⁷ *Id.* at 613.

¹³⁸ *Id.* at 614.

¹³⁹ *Id.*

¹⁴⁰ *Id.* at 614-15.

¹⁴¹ *Id.* at 615.

At trial, the jury awarded Bradshaw a total of \$9,000,000 in damages.¹⁴² On appeal, defendant argued that the trial court erred “in admitting evidence of the total amount of Bradshaw’s past medical bills, as opposed to the amount of medical costs paid by Medicaid.”¹⁴³ According to the defendant, the plaintiff should not be eligible for any recovery in excess of the amount paid by Medicaid, because no one was responsible for those excess amounts.¹⁴⁴ Defendant additionally argued that rewarding the written-off amount would be “against the spirit of compensatory damages[,]” allowing the plaintiffs to profit from their injuries.¹⁴⁵

The Supreme Court of Mississippi held that the collateral source rule applies to Medicaid payments.¹⁴⁶ In support of its holding, the court stated that “[t]here is no reason why Medicaid benefits should be treated any differently than insurance payments.”¹⁴⁷ In reaching this conclusion, the court was influenced by the policy rationale that persons should not be penalized because they accept medical assistance.¹⁴⁸

Similarly, in 2003, the Supreme Court of South Carolina held in *Haselden v. Davis*¹⁴⁹ that the plaintiff could introduce as medical expenses the full amount billed by healthcare providers.¹⁵⁰ In *Haselden*, the estate of Carolyn Hill brought wrongful death and survival actions against defendant physician after Hill died of breast cancer.¹⁵¹ Decedent’s estate alleged that defendant “failed to timely read a suspicious mammogram” performed on Hill in November 1991.¹⁵² Due to the defendant’s

¹⁴² *Id.* at 613.

¹⁴³ *Id.*

¹⁴⁴ *Id.* at 618.

¹⁴⁵ *Id.* at 618-19.

¹⁴⁶ *Id.* at 619.

¹⁴⁷ *Id.* at 618. *But see infra* notes 191-198 (distinguishing Medicaid from premium-for-service healthcare providers, such as Medicare).

¹⁴⁸ *Id.* at 619.

¹⁴⁹ *Haselden v. Davis*, 353 S.C. 481, 579 S.E.2d 293 (S.C. 2003).

¹⁵⁰ *Id.* at 485, 579 S.E.2d at 295.

¹⁵¹ *Id.* at 482, 579 S.E.2d at 294.

¹⁵² *Id.*

negligence, decedent's breast cancer had spread into her lymph nodes by the time the breast cancer was diagnosed in June 1993.¹⁵³

During trial, the court allowed plaintiffs to introduce medical expenses billed to Hill in the amount of \$77,905.21.¹⁵⁴ Defendant argued that the amount of medical expenses should be limited to the amount actually paid by Medicaid, or a total of \$24,109.04.¹⁵⁵ Ultimately, the jury awarded \$1,000,000.00 to Hill's estate and \$1,082,103.71 to her statutory beneficiaries.¹⁵⁶ The South Carolina Court of Appeals affirmed the trial court's ruling regarding medical expenses.¹⁵⁷

In holding that a plaintiff is not limited to the amount paid by Medicaid, the Supreme Court of South Carolina stated that a plaintiff is entitled to recover the reasonable value of received medical treatment, and "not necessarily the amount paid."¹⁵⁸ According to the court, one of the purposes behind the collateral source rule is to prevent defendants from receiving a windfall.¹⁵⁹ In support of its holding, the court stated that:

[A] defendant physician who agrees to become a Medicaid provider, thereby agreeing to accept as compensation for medical services those amounts set forth in the Medicaid agreement, who thereafter bills a Medicaid patient for the full value of his services, may not claim that the true, reasonable value of those services is the lesser amount paid by Medicaid.¹⁶⁰

Thus, the court concluded that the amount billed by the healthcare provider was admissible to determine the reasonable value of medical services provided.¹⁶¹

Although the Hawai'i Supreme Court utilized similar substantive and policy rationales in reaching its *Bynum* holding, other jurisdictions have persuasively held that plaintiff recovery should be limited to the amount paid. These jurisdictions reason that placing such limitations on

¹⁵³ *Id.*

¹⁵⁴ *Id.*

¹⁵⁵ *Id.*

¹⁵⁶ *Id.*

¹⁵⁷ *Id.*

¹⁵⁸ *Id.* at 484, 579 S.E.2d at 295.

¹⁵⁹ *Id.* at 485, 579 S.E.2d at 295.

¹⁶⁰ *Id.*

¹⁶¹ *Id.*

recovery comports with the purposes behind tort damages and produces a more equitable result for both parties.¹⁶²

2. Cases Limiting Recovery to “Amount Paid”

Among the several jurisdictions that limit recovery to the “amount paid,” the prevailing rationale is that the actual amount paid by Medicaid “is dispositive of the reasonable value of medical services.”¹⁶³ In *Bozeman v. Louisiana*,¹⁶⁴ a motorist’s widow sued the state of Louisiana, alleging dangerous highway conditions, after her husband was severely injured in an auto accident. On May 12, 1993, while driving down a stretch of Louisiana highway, Tommy Bozeman’s right tires “dropped off the paved portion of the highway onto the shoulder just as [he] came upon a curve.”¹⁶⁵ As a result of the accident, Bozeman suffered several fractures, bruises, abrasions, and brain damage.¹⁶⁶ On November 2, 1993, Bozeman applied for and was granted Medicaid coverage.¹⁶⁷

Ten days after receiving coverage approval, Tommy’s wife, Linda Bozeman, filed a petition for personal injuries against the State’s Department of Transportation and Development.¹⁶⁸ At trial, the jury awarded plaintiffs damages plus an additional \$613,626.64 in medical expenses.¹⁶⁹ The State appealed the award, arguing that the trial court should have limited medical expenses based on the amounts paid for these expenses by Medicaid.¹⁷⁰ The Court of Appeals remanded to the trial court for a re-determination of special damages based on medical expenses.¹⁷¹ On remand, the trial court adjusted the special damages award from \$613,626.64 to \$344,999.59, holding that “medical expenses

¹⁶² See *infra* Part III.B.2.

¹⁶³ Haselden at 485, 579 S.E.2d at 295.

¹⁶⁴ Bozeman, 879 So.2d at 692.

¹⁶⁵ *Id.* at 694.

¹⁶⁶ *Id.*

¹⁶⁷ *Id.*

¹⁶⁸ *Id.*

¹⁶⁹ *Id.*

¹⁷⁰ *Id.* at 694-95.

¹⁷¹ *Id.* at 695.

‘written-off’ pursuant to the Medicaid program requirements are not recoverable by [the] plaintiff.”¹⁷²

Plaintiffs appealed the adjustment of special damages, but the Louisiana Court of Appeal affirmed the trial court’s determination.¹⁷³ On writ of certiorari, the Supreme Court of Louisiana held that Medicaid recipients cannot collect the written-off amounts, or unincurred costs of healthcare treatment as special damages for medical expenses.¹⁷⁴ The court reasoned that because recipients pay no premiums for Medicaid coverage, their “patrimony is not diminished” in receiving this collateral benefit.¹⁷⁵ Thus, it would be unconscionable to require those funding the Medicaid program, the taxpayers, to bear the expenses of providing gratuitous healthcare to tort plaintiffs and then to permit said plaintiffs to collect excessive medical expenses and incur a windfall.¹⁷⁶

The court, however, strictly limited its holding “to the amounts written off by the health care providers in accordance with the Medicaid program.”¹⁷⁷ As such, the court did not exclude all gratuitous collateral sources in its holding.¹⁷⁸ Rather, the court’s holding was “limited to the amounts written off by the health care provider, where no consideration was provided for that benefit, as contrasted with Medicare and private insurance, where consideration is provided for the benefit.”¹⁷⁹

In *Dyet v. McKinley*,¹⁸⁰ the Idaho Supreme Court took a much more expansive view of write-offs. Whereas the *Bozeman* court limited its holding to Medicaid benefits, the *Dyet* court held that plaintiff was prohibited from recovering the amount actually paid by *Medicare* to

¹⁷² *Id.*

¹⁷³ *Id.*

¹⁷⁴ *Id.* at 693-94.

¹⁷⁵ *Id.* at 705.

¹⁷⁶ *Id.*

¹⁷⁷ *Id.* at 706 (Knoll, J., concurring).

¹⁷⁸ According to the court’s holding, the collateral source rule is still applicable to plaintiffs who receive gratuitous compensation from private benefactors; such plaintiffs are still entitled to full recovery of medical expenses against the tortfeasor. *Id.* at 706 (Knoll, J., concurring).

¹⁷⁹ *Id.* at 706 (Knoll, J., concurring).

¹⁸⁰ 139 Idaho 526, 81 P.3d 1236 (Id. 2003).

healthcare providers.¹⁸¹ In *Dyet*, plaintiff Mari Ann Dyet was injured after being struck by defendant William McKinley's car.¹⁸² As a result of the accident, Dyet, a Medicare recipient, suffered a fractured hip and femur, requiring multiple surgeries and insertion of an artificial hip.¹⁸³ Dyet's medical providers would customarily charge \$89,367.71 for their services; however, because Dyet was a Medicare recipient, the charges were reduced to \$21,712.49.¹⁸⁴

At trial, the jury returned a special damages verdict for medical expenses in the amount of \$89,367.71, the amount customarily charged by the healthcare providers for Dyet's received services.¹⁸⁵ The district court reduced the medical expenses verdict by \$67,665.22, awarding Dyet \$21,712.49, the amount actually paid by Medicare.¹⁸⁶

On appeal, the Supreme Court of Idaho held that plaintiff could *not* recover the write-off amount.¹⁸⁷ The court reasoned that, "[a]lthough the write-off technically is not a payment from a collateral source within the meaning of the collateral source statute, it is not an item of damages for which plaintiff may recover because plaintiff has incurred no liability thereof."¹⁸⁸ In its decision, the court affirmed the district court's finding, that "although Medicare write-offs are technically not payments from a collateral source, plaintiffs may not recover the amount of the write-off from a tortfeasor because it was not an item of damages for which the plaintiff ever became obligated."¹⁸⁹

¹⁸¹ *Id.* at 529, 81 P.3d at 1239. In contrast, the *Bozeman* court stated that because individuals pay into the Medicare system by means of compulsory payroll taxes, that Medicare benefits were more akin to private insurance benefits; as such, the court noted that the collateral source rule should apply to Medicare benefits. *Bozeman*, 879 So.2d. at 705-06.

¹⁸² *Dyet*, 139 Idaho at 527, 81 P.3d at 1237.

¹⁸³ *Id.*

¹⁸⁴ *Id.*

¹⁸⁵ *Id.* at 528, 81 P.3d at 1238.

¹⁸⁶ *Id.*

¹⁸⁷ *Id.* at 529, 81 P.3d at 1239.

¹⁸⁸ *Id.* at 529, 81 P.3d at 1239 (citation omitted).

¹⁸⁹ *Id.* (citation omitted).

Dyett and *Bozeman* are but two examples of the many jurisdictions limiting recovery to the “amount paid.”¹⁹⁰ Like these “amount paid” jurisdictions, the *Bynum* dissent similarly opined that awarding injured plaintiffs written-off amounts exceeds the scope of compensatory damages, by placing said plaintiffs in a better position than they would have been, but for the injury.¹⁹¹ Any contrary interpretation of the rule, as applied to Medicaid write-offs, ignores the purpose and scope of tort law compensatory damages and the compelling policy concerns regarding the tenuous state of healthcare and the medical liability system.

C. RATIONALE AND POLICIES TURN THE TIDE: BYNUM WRONGLY DECIDED

The Supreme Court of Hawai‘i incorrectly decided *Bynum* in contravention of standing Hawai‘i damages precedent and the rationales behind tort law compensation. From a policy perspective, limiting damages to the amount paid is also the most compelling and necessary approach, given the current medical liability crisis affecting our state and nation.

1. Overcompensating Plaintiffs: “Phantom” Damages¹⁹²

a. General Goals & Principles of Damages

The goal of special damages is to compensate plaintiffs for their out of pocket expenses and losses suffered.¹⁹³ Because the law attempts to put a plaintiff in the exact position he would be in, but for the tortious act,

¹⁹⁰ See, e.g., *McAmis v. Wallace*, 980 F.Supp. 181 (W.D. Va. 1997). In that case, the United States District Court for the Western District of Virginia held that “[p]laintiff cannot recover as compensatory damages any medical expenses which were not incurred either personally or by Medicaid.” *Id.* at 183. See also *Hanif v. Housing Authority*, 200 Cal.App.3d 635 (Cal. Ct. App. 1988). In that case, the Court of Appeal of the Third District of California held that “[f]undamental principles underlying recovery of compensatory damages in tort actions” mandated that injured plaintiffs recover no more than the amount paid for their medical treatment. *Id.* at 640.

¹⁹¹ See *supra* note 127 & accompanying text.

¹⁹² See, e.g., *Jones*, *supra* note 28, at 29 (stating that amounts written off by managed health care plans are akin to “phantom” damages which have never been incurred by the plaintiff).

¹⁹³ See *supra* note 56-57 & accompanying text.

damages are permitted *only* to compensate plaintiffs for costs “precisely commensurate” with the harm incurred.¹⁹⁴

Medicaid recipients do not directly incur any out of pocket financial liability for the costs associated with their treatment. Because Medicaid recipients do not incur liability for the actual billed costs of their treatment, it logically follows that they do not incur any pecuniary responsibility for the amounts written off by their healthcare providers.¹⁹⁵ In fact, healthcare providers are prohibited by federal law from charging patients or outside sources for the written-off medical expenses.¹⁹⁶ Allowing Medicaid patients to recover the write-off amounts compensates them for charges they were never liable to pay. Rather, plaintiffs should be compensated for the “reasonable” amount of medical expenses; the “reasonable” amount of compensatory recovery for injured Medicaid patients is the amount actually paid by Medicaid.

b. Practical Application: “Reasonable” Damages

In determining recoverable damages, “[t]he amount of the medical expense must be reasonable. The amount that the plaintiff actually paid or the liability he incurred is evidence bearing on the proper measure of damages.”¹⁹⁷ Because the Medicaid plaintiff does not incur liability for medical bills, based on this proposition, the most reasonable amount of recovery would be that amount which is due Medicaid upon tort recovery, or the amount actually paid. If plaintiffs are allowed to recover not only the amount billed, but also the written-off expenses, they will be placed in a better situation than they would have been but for the injury. After Medicaid collects its amount due, plaintiffs may still stand to profit very considerable sums of money from these special damages.¹⁹⁸

Proponents of write-off recovery argue that plaintiffs will not be overcompensated in recovering written-off expenses because of

¹⁹⁴ Olson & Wasson, *supra* note 1, at 176.

¹⁹⁵ *Id.*

¹⁹⁶ *Id.*

¹⁹⁷ JACOB A. STEIN, DAMAGES AND RECOVERY: PERSONAL INJURY AND DEATH ACTIONS 140 (The Lawyers Co-operative Publishing Company 1972).

¹⁹⁸ *See, e.g.*, Terrel v. Nanda, 759 So.2d 1026 (La. App. 2000). In this case, Medicaid recipient’s healthcare bills totaled \$1,110,922.82; the hospital was reimbursed \$164,084.92 by Medicaid, resulting in a \$946,838 write off amount. *Id.* at 1028.

subrogation of claims by the insurer.¹⁹⁹ Although Medicaid claims subrogation upon tort recovery is statutorily mandated,²⁰⁰ this argument is unfounded. Indeed, the legislative history behind Hawaii's subrogation statute suggests the Legislature's intent to limit the State's recovery "to rights or claims for special damages[.]" as "it would be inequitable to allow [the State] to be subrogated to the extent of claims for general damages."²⁰¹ As such, Medicaid will only recover the amounts of money it has expended for plaintiff's medical treatment, and nothing more.²⁰²

c. Bynum Majority Utilized the Wrong Rationale

In its opinion, the majority states that "limiting expenses to the pecuniary loss suffered by a plaintiff would mean . . . that injured plaintiffs who received gratuitous medical services . . . would *not* be entitled to recover any monetary amount from the tortfeasor."²⁰³ This assertion would be correct if plaintiffs were limited *only* to recovery of special damages resulting from pecuniary loss. This, however, is not the case.

Rather, in medical negligence suits, plaintiffs are still eligible to receive other special damages outside of medical expenses, including "loss of earnings and diminished capacity to work[.]"²⁰⁴ Additionally, injured plaintiffs are still able to receive general damages which compensate for

¹⁹⁹ Douglas Rallo, *Insurance Write-Offs and the Collateral Source Rule*, 38-SEP Trial 42, 44 (2002).

²⁰⁰ See HAW. REV. STAT. § 346-37(c) (Supp. 1997) (stating that the Department of Human Services, which institutes Hawaii's Medicaid program, "shall have the right to recover . . . medical assistance . . . furnished by the department"). See also *State Medicaid Manual, Part 03-Eligibility*, Centers for Medicare and Medicaid Services, at: http://www.cms.hhs.gov/manuals/45_smm/sm_03_im_3900_to_im_3900.asp (last visited 3/1/05) (stating that pursuant federal statutes, state Medicaid programs are rightfully allowed to recover their costs from "any liable third party"). *Id.*

²⁰¹ *Nacino v. Koller*, 101 Hawai'i 466, 471, 71 P.3d 417, 422 (Haw. 2003) (citing SEN. STAND. COMM. REP. NO. 894-80, *reprinted in* 1980 SENATE JOURNAL, at 1449).

²⁰² HAW. REV. STAT. § 346-37(c) (Supp. 1997) (stating that the amount recoverable by the State shall not "exceed the full amount of the costs of medical assistance . . . furnished by the department").

²⁰³ Bynum, 106 Hawai'i at 94, 101 P.3d at 1162.

²⁰⁴ *Id.* at 99, 101 P.3d at 1167 n.1 (Moon, J., dissenting)

items such as pain and suffering, fear, inconvenience, and loss of enjoyment.²⁰⁵ Where the facts of the case dictate, plaintiffs also may be eligible to receive punitive damages.²⁰⁶ These other forms of recoverable damages will also ensure that the tortfeasor does not go unpunished; the goal of deterrence will still be accomplished.

The *Bynum* majority also incorrectly interpreted the meaning of “reasonable” value of services, as applied to Medicaid benefits. In calculating reasonable value, the majority stated that “an injured person is entitled to damages for all expenses and the *value* of *services* reasonably made necessary by the harm.”²⁰⁷ Based on this proposition, the majority held that the “reasonable” value of services was the amount customarily charged for the medical treatment, and not the discounted rate actually billed Medicaid.²⁰⁸ In support of this approach, the majority cited the Restatement (Second) of Torts, stating that “the value of medical services made necessary by the tort can ordinarily be recovered although they have created no liability or expense to the injured person, as when a physician donates his services.”²⁰⁹ In essence, the majority reasoned that because plaintiffs who receive gratuitous medical care are allowed to recover the full value of said care as compensatory damages, the Medicaid patient, by analogy, should also receive the full value of medical treatment as compensatory damages, and *not* the discounted Medicaid amount.

Although the collateral source rule provision of the Restatement does suggest that plaintiffs may recover the “value” of medical services intended to be gratuitous, like pro-bono treatment donated by a physician, the Restatement does explicitly limit recovery for *paid* treatment in determining “value of services rendered.”²¹⁰

When the plaintiff seeks to recover for expenditures made or liability incurred to third persons for services rendered, normally the amount recovered is the reasonable value of the services rather than the amount paid or charged. *If, however, the injured person paid less than the*

²⁰⁵ See *supra* note 44 & accompanying text. See also *Bynum*, 101 Hawai‘i at 99, 101 P.3d at 1167 n.1 (Moon, J., dissenting).

²⁰⁶ See *supra* note 37 & accompanying text.

²⁰⁷ *Bynum*, 106 Hawai‘i at 91-92, 101 P.3d at 1159-60 (citation omitted).

²⁰⁸ *Id.* at 89, 101 P.3d at 1157.

²⁰⁹ *Id.* at 92, 101 P.3d at 1160 (citation omitted).

²¹⁰ See RESTATEMENT (SECOND) OF TORTS § 911 com.h.

*exchange rate, he can recover no more than the amount paid, except when the low rate was intended as a gift to him.*²¹¹

Because the collateral source rule provision of the Restatement is silent as to proper calculation of the “reasonable” value of recoverable damages for Medicaid-paid services, it seems logical to infer that the preceding damages valuation provision should be read concurrently with that provision. As such, because the discounted Medicaid rate was not intended as a gift to *Bynum*, but rather was a condition of participation in the Medicaid program,²¹² and because the Restatement states that plaintiffs may not recover more than the “amount paid” for paid services, plaintiff should be limited to recovery of the amount paid.

Additionally, although the *Bynum* majority does not make any distinction between Medicaid and Medicare recipients,²¹³ measuring the amount of costs incurred, and thus the amount of damages due, should differ depending on the healthcare program involved. In its decision, the *Bynum* majority misleadingly classified healthcare services received under *both* programs as the “benefits” of social legislation.²¹⁴ In actuality, Medicare recipients pay premiums for their medical coverage.²¹⁵ In this regard, Medicare “is akin to private insurance and can be distinguished

²¹¹ See Hanif, 200 Cal.App.3d at 643 (quoting the RESTATEMENT (SECOND) OF TORTS § 911 com. h.).

²¹² See Appellant’s Opening Brief at 55-56, 55 Fed.Appx. 811 (9th Cir. 2003) (No. 01-16541) (stating that Medicare and Medicaid approved providers agree “in advance to accept the reduced fees as full and final payment for their services and are statutorily prohibited from ‘balance billing’ Bynum or any other source for the difference between the approved amount and their customary charges.”) *Id.*

²¹³ Instead, the majority states that *both* Medicare and Medicaid are funded *solely* by government sources. *Bynum*, 106 Hawai’i at 84, 101 P.3d at 1152 n.9 & 10. *But see infra* notes 198-99. Additionally, the majority applies its holding to both Medicaid and Medicare medical expense payments. *Id.* at 81, 101 P.3d at 1149.

²¹⁴ *Id.*

²¹⁵ Rose, 276 Kan. at 546, 78 P.3d at 803. See also Mary Vorsino, *Medicare Premium Hike Could Hurt Isle Poor*, Honolulu Star Bulletin, October 16, 2003, at: <http://starbulletin.com/2003/10/16/news/story3.html> (last visited February 22, 2005) (stating that in 2003, island seniors paid \$58.70 per month in Medicaid premiums, and that the premiums would rise in 2004).

from Medicaid in that regard.”²¹⁶ As such, Medicare recipients should not be strictly limited to the “amount paid” in receiving damages awards, as they have paid into the system, essentially purchasing their own medical insurance. Because Medicare recipients have paid premiums for their healthcare coverage, the prospect of overcompensation upon write-off recovery is diminished.²¹⁷

Unlike Medicare recipients, Medicaid beneficiaries do not pay into the program in order to receive healthcare benefits.²¹⁸ Rather, Medicaid benefits are gratuitously provided to qualifying, low-income individuals; tax-payer dollars fund the program.²¹⁹ Eligibility is determined based on the recipient’s financial status; no prior payment into the Social Security program is required as a prerequisite to coverage.²²⁰ Indeed, according to the *Bynum* majority, Medicaid is funded ““by taxes collected from society in general.””²²¹

2. *Hawai`i Case Law Does Not Support the Majority’s Ruling*

In reaching its holding, the *Bynum* majority strayed from standing Hawai`i case law regarding the categories of recoverable damages.²²² The Court’s holding essentially allows plaintiffs to recover expenses no one has ever paid, and for which the plaintiff has incurred no financial liability. Because special damages are limited to those necessary to make

²¹⁶ *Id.*

²¹⁷ Although this note proposes that compensation of written-off amounts should differ depending on the receipt of Medicare or Medicaid benefits, determining the amount of special damages due under Medicare is beyond the scope of this inquiry.

²¹⁸ *See supra* note 29 & accompanying text. *See also* Bozeman, 879 So.2d. at 705 (stating that Medicare recipients pay consideration, in the form of compulsory taxes and premiums, in exchange for their receipt of healthcare coverage; in this regard, the court opined that Medicare, as opposed to Medicaid, recipients, would be able to recover written-off amounts).

²¹⁹ *See supra* note 26 & accompanying text.

²²⁰ Anthony Viorst, *Recovery of Medical Expenses by Insured Medical Malpractice Victims*, 33-JUL COLO. LAW. 113, 115 (2004) (citation omitted).

²²¹ *Bynum*, 106 Hawai`i at 88, 101 P.3d at 1156.

²²² *Id.* at 95, 101 P.3d at 1163 (Moon, J., dissenting). *See also supra* notes 38-43 & accompanying text.

a plaintiff whole,²²³ allowing Medicaid recipients to collect unpaid amounts “creates a new category of special damages.”²²⁴ In practical effect, the majority’s holding creates a class of special damages which will not only recompense, but which will advance a plaintiff’s pecuniary interest.

Although the majority’s holding does not comport with standing precedent, the dissent concedes that precedent may be disregarded when “compelling justification” calls for such a result.²²⁵ In the present case, there is no compelling justification which calls for the award of Medicaid write-offs as damages. In support of its holding, the majority states that Medicaid write-offs are “benefits conferred on the injured party” which may “not [be] credited against the tortfeasor’s liability.”²²⁶ The majority cites the Restatement (Second) of Torts, which states that any double compensation which results from collateral benefits should be conferred on the plaintiff rather than the tortfeasor.²²⁷ Therefore, based on this proposition, any windfall should be enjoyed by the injured plaintiff, rather than the negligent tortfeasor.

Given the long-standing tort policy of restoring a plaintiff to his pre-injury state and nothing more,²²⁸ double compensation in favor of a plaintiff is not “compelling justification.” In fact, allowing recovery of unpaid expenses may actually be a slippery slope, which “form[s] a basis [for the plaintiff] to demand and receive additional compensation for more intangible injuries such as pain and suffering.”²²⁹

In light of tort policy and the current state of healthcare, the more compelling goal is working towards ending the medical liability crisis which is affecting not only our island state, but the nation as a whole.

3. Policy Concerns: Healthcare in Crisis

Throughout the nation, roughly six hundred medical malpractice claims will be filed today alone.²³⁰ Current statistics show that more than

²²³ *Id.* (Moon, J., dissenting).

²²⁴ *Id.* at 97-98, 101 P.3d at 1165-66 (Moon, J., dissenting).

²²⁵ *Id.* at 97, 101 P.3d at 1165 (Moon, J., dissenting) (citations omitted).

²²⁶ *Id.* at 86, 101 P.3d at 1154 (citation omitted).

²²⁷ *Id.* (citation omitted).

²²⁸ *See supra* notes 56-57 & accompanying text.

²²⁹ Olson & Wasson, *supra* note 1, at 178 (citation omitted).

²³⁰ Anderson, *supra* note 6, at 346 (citation omitted).

125,000 malpractice claims are still pending.²³¹ Defending against these claims is very costly; insurers incur an average of \$85,000 in litigating a claim through a jury trial.²³² More startling is the fact that insurance losses on medical malpractice claims are on the rise.²³³ It is these losses that have been credited as the greatest factor driving the increase in insurance premium rates.²³⁴ In turn, the effects of these increased rates are filtered down to the average citizen, as the threat of looming medical liability and high insurance premiums forces physicians and healthcare providers to limit or discontinue the services they provide.²³⁵

The majority's decision in *Bynum* may place further strain on the already tenuous state of Hawai'i healthcare, as it will contribute to the continued cycle of insurance losses on unnecessary damages. In practical effect, the majority's holding mandates that insurance carriers pay out "phantom" damages that have been written off pursuant to Medicaid agreements. In the end, it will be the malpractice insurance providers who are forced to absorb these unpaid costs. Doctors, and in turn needy patients, will suffer the after effects of such a holding.²³⁶

Limiting damages can have a direct effect on the rise, or decrease, in insurance rates. In fact, studies show that in states that have instituted some form of damage caps, malpractice insurance premiums have

²³¹ *Id.* (citation omitted).

²³² *Id.* at 345-46 (citation omitted).

²³³ RICHARD J. HILLMAN & KATHRYN G. ALLEN, UNITED STATES GENERAL ACCOUNTING OFFICE, MEDICAL MALPRACTICE INSURANCE: MULTIPLE FACTORS HAVE CONTRIBUTED TO PREMIUM RATE INCREASES 1 (2003).

²³⁴ *Id.*

²³⁵ *See supra* notes 6-14 & accompanying text.

²³⁶ *See supra* notes 6-14 & accompanying text. *See also* Helen Altonn, *Trauma Specialist Shortages Pose Crisis for State: A House Bill Would Pay for Specialists in Queen's Understaffed Emergency Room*, Honolulu Star Bulletin, February 11, 2005, at: <http://starbulletin.com/2005/02/11/news/story9.html> (last visited March 1, 2005) (stating that the Queen's Hospital trauma center, the only one in the state, is greatly understaffed. The lack of critical specialist help is due, partly, to physician unwillingness to take on emergency cases in light of medical liability insurance coverage concerns).

declined quite significantly without cognizable effects on the quality of healthcare.²³⁷

These statistics provide some hope for states, like Hawai'i, who have been affected by the liability crisis. Written-off medical expenses in a *single* case sometimes total hundreds of thousands of dollars. Multiplying this amount by the many medical liability cases filed each may result in more, staggering losses for the medical liability insurance and healthcare industries. Capping damages to the amount paid may alleviate some of the high financial burdens on these insurers and healthcare providers, while still ensuring that plaintiffs are compensated for their injuries. Successful limitation of phantom damages may also help to keep rising medical liability premiums at bay. In the end, everyone, from insurers to treating physicians to the ordinary patient in need of medical attention, may benefit.

IV. CONCLUSION

In medical liability suits, Medicaid recipients should be limited to recovery of the medical expenses actually paid for their treatment. Such an approach is consistent with Hawai'i damages precedent and fulfills the rationales behind tort recovery. From a policy perspective, this approach is also the most judicious, given the current tenuous state of healthcare in Hawai'i.

Limiting recovery to the amount paid may help to alleviate the current state of medical liability crisis, however, the award of unpaid damages amounts is just *one* of the many factors contributing to the crisis. In the end, some form of tort reform, whether judicial or legislative, is necessary to ensure efficient operation of the medical liability insurance and healthcare systems. The proposed judicial approach is a positive step in that direction.

²³⁷ Palmisano, *supra* note 1, at 376 (citations omitted). According to one report, caps on liability awards resulted in an average 34% reduction in liability insurance premiums. *Id.*