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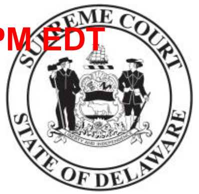

# IN THE SUPREME COURT FOR THE STATE OF DELAWARE

| | | |
|---|---|---|
| JENNIFER SMITH, | ) | |
| | ) | |
| Plaintiff Below, | ) | |
| Appellant/Cross-Appellee, | ) | Case Number 642, 2015 |
| | ) | |
| v. | ) | |
| | ) | |
| DELAINE MAHONEY, | ) | |
| | ) | |
| Defendant Below, | ) | |
| Appellee/Cross-Appellant | ) | |

## APPELLEE/CROSS-APPELLANT DELAINE MAHONY'S ANSWERING BRIEF AND OPENING BRIEF ON CROSS-APPEAL

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## NATURE OF PROCEEDINGS

This appeal concerns a personal injury lawsuit brought by Appellant/Cross Appellee/Plaintiff-Below Jennifer L. Smith ("Smith") that arose from two motor vehicle accidents. *Jennifer Smith v. Delaine Mahoney, et al.*, C.A. No. 12C-10-046 MMJ at 2 (Del. Super. Ct. Nov. 20, 2015). (B-56).[1]

During the litigation below, Appellee/Defendant-Below Nicole Marie Richards ("Richards") filed a motion in limine to limit Plaintiff's past medical expenses and to strike Plaintiff's future medical expenses. (A-8). On May 15, 2015, Appellee/Cross Appellant/Defendant-Below Delaine Mahoney ("Mahoney") filed a Notice of Joinder. (A-11). The Motion requested the trial court apply the recent Superior Court decision of *Stayton v. Del. Health Corp.,* 2014 Del. Super. LEXIS 481 (Del. Super. Ct. Sept. 24, 2014), in which the court held the collateral source rule did not apply to Medicare write-offs. Plaintiff opposed the Motion, and on May 21, 2015, the trial court denied the Motion. (A-12).

The case went to trial on June 1, 2015. The jury reached a verdict on June 3, 2015. (A-12-13). The jury awarded $24,911 for past medical expenses. (B-56). The jury also awarded $10,000 in future medical expenses. *Id.*

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[1] References identified as "B-____" are found in Appellee/Cross-Appellant Delaine Mahoney's Appendix. References identified as 'A-___" are found in Appellant Smith's Appendix.

On June 17, 2015, Mahoney filed a Motion to Alter or Amend a Judgment regarding the awards for past and future medical expenses, (B-7), based on the Supreme Court's decision affirming the Superior Court's decision in *Stayton*. Based on the Court's decision, Mahoney sought to amend the verdict to reflect that the collateral source rule did not extend to Medicaid write-offs. After briefing and oral argument, the trial court granted Mahoney's motion as to past medical expenses but denied the motion with regard to future medical expenses. (B-56). Smith appealed the trial court's decision on past medical expenses, and Mahoney cross-appealed on the issue of future medical expenses.

This is Appellee/Cross-Appellant Mahoney's Answering Brief on Appeal and Opening Brief on Cross-Appeal.

## SUMMARY OF ARGUMENT

1. Denied. Pursuant to the reasoning of this Court's decision in *Stayton v. Delaware Health Corp.,* 117 A.3d 521 (Del. 2015), the collateral source rule does not extend to medical expenses written off by Medicaid.

2. Denied. The exclusion of Medicaid write-offs from the collateral source rule does not violate or affect a litigant's right to a jury trial or due process of law.

3. Denied. A litigant's access to the Courts is not burdened by excluding Medicaid write-offs from the collateral source rule.

## SUMMARY OF ARGUMENT ON CROSS-APPEAL

4. The Collateral Source Rule does not apply to Medicaid when calculating a plaintiff's future medical expenses, because a plaintiff, who is enrolled in Medicaid at the time of trial must prove future medical damages to a reasonable probability. As future medical damages are speculative and conjectural in nature, the proper measure for determining them is through the present value of the plaintiff's medical expenses. The most probable basis for determining the present value of a Medicaid plaintiff's future medical expenses is the amount currently paid by Medicaid.

## STATEMENT OF FACTS

Appellant Jennifer Smith ("Smith") and Appellee/Cross-Appellant Delaine Mahoney ("Mahoney") were involved in a motor vehicle accident on October 5, 2010. (B-56). Smith was then involved in a second accident on January 6, 2011, with Defendant below, Nicole Richards. *Id.* Smith asserted that she was injured as a result of both accidents and sought medical treatment. *Id.*

Smith was enrolled in Medicaid at the time of both motor vehicle accidents. *Id.* She continued to be enrolled in Medicaid during the course of her medical treatment and this litigation. (B-26, 56). At the time of oral argument in the matter below, Smith admitted that she was still enrolled in Medicaid. Although she hoped to eventually leave the program, she was unable to do so at that time. (B-26), (A-56).

Medicaid paid for Smith's treatment with Dr. Grossinger after the accident and asserted a lien of $5,197.71. (B-56). At trial, Smith introduced into evidence a redacted medical bill from Grossinger Neuropain, showing total charges of $22,911.00. *Id.* The jury was not informed that Medicaid had paid $5,187.71 for this treatment and that Dr. Grossinger wrote off the balance. *Id.*

As Smith's medical expert, Dr. Grossinger testified that Smith would require future medical treatment of approximately $3,300 a year. *Id.* He arrived at this amount by opining that Smith would require follow up appointments with a physician

and prescribed medications of approximately $1,800 a year and the possibility of injections, which would cost approximately $1,500 per injection. *Id.* This is the same type of treatment that Smith had received from Dr. Gorssinger in the past and which had been paid by Medicaid. (B-56); (A-39).

The jury returned its verdict on June 3, 2015. (B-56). The jury awarded $15,000 for pain and suffering, $24,911 for past medical expenses, and $10,000 in future medical expenses. *Id.* In its Order of November 20, 2015, the trial court, reduced Smith's past medical expenses to $5,197.71, as the amount actually paid by Medicaid for Smith's treatment. *Id.*

## ARGUMENT

## I. THE SUPERIOR COURT CORRECTLY APPLIED *STAYTON* WHEN IT REDUCED SMITH'S PAST MEDICAL BILLS TO THE AMOUNT PAID BY MEDICAID.

### A. Question Presented

Whether this Court's decision and reasoning in *Stayton* applies to Medicaid, so that the collateral source rule does not extend to Medicaid write-offs? This issue was raised in Appellee/Defendant's Motion below to Alter or Amend the Judgement (A-18); and in oral argument on the Motion. (B-27).

### B. Scope of Review

As this issue raises a legal question, this Court will review the matter *de novo*. *Stayton v. Del. Health Corp.,* 117 A.3d 521, 526 (Del. 2015).

### C. Merits of Argument

#### *1.* Under *Stayton* the Collateral Source Rule does not extend to Medicaid write-offs.

In *Stayton v. Del. Health Corp*, the Court refused to extent the collateral source rule to Medicare write-offs. *Stayton,* 117 A.3d at 530. While the Court recognized the long history of the collateral source rule in Delaware, it noted that *Stayton* was a case of first impression. *Id.* In reaching its decision, the Court did not create an exclusion for Medicare, but simply recognized that the collateral source rule did not

extend to Medicare write-offs. The Court held that Delaware would follow the view that "provider write-offs are not payments made to or benefits conferred on the injured party." *Id*. The Court found that the only entity that received a benefit from the write-offs were federal taxpayers.[2] *Id.* at 531.

Appellant Smith is seeking to avoid the effect of *Stayton* by arguing that differences between Medicare and Medicaid make Medicaid more like private health insurance than the governmental program of Medicare. Smith's arguments, however, intend to reargue the Court's decision in *Stayton* rather then distinguish Medicare from Medicaid.[3] (*See* n. 5 of Appellant Opening Br. at 9).

Smith asserts that the difference between the two programs is that Medicaid providers have a choice as to whether to bill Medicaid. Smith states that this choice creates a benefit conferred by the medical provider upon the patient and, therefore,

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[2] The Court's decision in *Stayton* relied upon many sources that addressed Medicare and Medicaid together, without distinction. The Court noted the prior Superior Court decision of *Rice v. The Chimes, Inc.*, 2005 Del. Super. LEXIS 476 (Del. Super. March 10, 2005), in which that court found that the collateral source rule did not extend to the amounts written off by Medicare **and Medicaid**. At footnote 26, the Court noted that "Medicare **and Medicaid** beneficiaries are subject to a lien covering government payments on any personal injury recovery." *Stayton* at n. 26. The *Stayton* trial court's decision also discussed the similarities between Medicare and Medicaid: "Unlike private insurance, there is no right of subrogation or refund of benefits on a tort recovery for the amount written off under Medicare **or Medicaid**." *Stayton,* 2014 Del. Super. LEXIS 481 at *10 (emphasis added). "The law attempts to put the plaintiff in a position as close as possible to his position before the tort. Hence, Medicare **and Medicaid** operate differently than private collateral sources." *Id.* at *11 (emphasis added).

[3] If Plaintiff disagrees with the *Stayton* Court's decision, her redress is with the Legislature.

the collateral source rule should apply to Medicaid write-offs. In reaching this analysis, Smith misreads *Stayton*. The *Stayton* Court recognized that once a provider submits the bill to Medicare it cannot recover the remainder of its bill, nor can it bill anyone else. *Stayton,* 117 A.3d at 524. Medical providers are free to accept or not accept Medicare and Medicaid patients. The authorities relied upon by Smith have also acknowledged the right of providers to not submit their charges to Medicare. *See, e.g.,* Caroline C. Pace, *Tort Recovery for Medicare Beneficiaries: Procedures, Pitfalls and Potential Values*, 49 APR Hous. Law. 24, 27 (2012).

Medicare and Medicaid payments to medical providers for services that maybe covered by a no-fault or other primary insurance, permit the government to assert a lien against any recovery made against its payments. 42 U.S.C. § 1395y(b)(2)(A)(ii); *Richardson v. State Farm Mut. Auto. Ins. Co.,* 2009 Del. Super. LEXIS 920 (Del. Super. April 14, 2009). Once a medical provider submits medical bills to Medicare/Medicaid, they must accept the Medicare/Medicaid payment in full satisfaction for his service. 42 CFR 447.15; *See also Evanston Hosp. v. Hauck*, 1 F.3d 540, 542 (7th Cir. App. 1993). The provider cannot accept a conditional payment from Medicare/Medicaid and then seek to recover the balance of its bill from the patient or even the patient's tort recovery. 42 CFR 447.15.

Contrary to Smith's argument, patients can "opt out" of the Medicare program

by choosing to not inform their providers that they are enrolled in Medicare and then personally pay the provider's bill. Given the significant benefits available from Medicare, it is unclear who would ever want to opt out of Medicare or that they would ever be able to strike a better bargain on their bills than obtained by Medicare.

Smith then asserts that one purpose of tort law and the recovery of increased damages under the collateral source rule is to act as a deterrent to potential tortfeasors. But as stated in the Chief Justice's concurring opinion, the issue of deterrence was specifically addressed when the Court declined to extent the collateral source rule to Medicare write-offs: "Moreover, requiring the tortfeasor to bear the full cost of the harm imposed on the victim, the victim's insurer, and the victim's healthcare providers, **and no more**, sets the right incentive for deterrence." *Stayton*, 117 A.3d 521, 537 (Del. 2015) (Strine, C.J., concurring) (emphasis added).

**2. Medical providers are not conferring a benefit on their patients by accepting Medicaid payments.**

The choice by medical providers to bill their services to Medicaid and accept the Medicaid payments in full satisfaction for their services does not confer a benefit on the patient. Smith's assertion to the contrary would twist the *Stayton* Court's holding. Regarding the issue of who received the benefits from the Medicare write-offs, the Court found that the amounts written-off were the result of the agreement

between the medical provider and Medicare, and, therefore, any benefit received was to the federal taxpayer that supported Medicare. *Stayton,* 117 A.3d at 531. By the same analysis, any benefit from the write-offs obtained by Medicaid is conferred upon the federal and state taxpayers who support Medicaid. "It would be unconscionable to permit the taxpayers to bear the expense of providing free medical care to a person and then allow that person to recover damages for medical services from a tort-feasor and pocket the windfall." *Martinez v. Milburn Enters.*, 233 P.3d 205, 211 (Kan. 2010) (*quoting Bates v. Hogg*, 921 P.2d 249 (Kan. 1996)). The *Stayton* Court went on to recognize, in *dicta*, that adjustments similar to Medicare write-offs made by private health insurance is also a benefit that an insurer obtains for itself, not for its insured. *Stayton*, 117 A.3d at 531 (*quoting Haygood v. De Escabedo*, 356 S.W.3d 390, 395 (Tex. 2011)). It is widely recognized that these write-offs are not the incentive for individuals to purchase health insurance. *Id.*

Once a provider affirmatively chooses to accept Medicaid, they agree to abide by the rules and regulations of the Medicaid program, including the amount of compensation they receive for services rendered, and that they may not balance bill the unpaid portion of the charges or seek reimbursement for the unpaid balance from other sources. 42 CFR 447.15; *Evanston,* 1 F.3d at 542. Plaintiff relies on the affidavit of her treating physician, Dr. Grossinger, that states, as a non-sequitur, that

medical providers are unlikely to submit their medical bills to Medicaid if the Plaintiff does not obtain the windfall from pleading damages in the amount of the fully invoiced bill. (*See* A-36, ¶¶ 10-11).

This position calls into question the intentions of the treating medical provider. Is the purpose of the treatment to cure the patient, or to help the patient make a larger recovery? Rather, the choice by medical providers to bill Medicaid is a business decision made by the provider. The medical provider may decide to accept Medicaid so that it may receive payment more quickly, or to assure that the medical provider would receive some payment for the services, rather than face the uncertainty of a future payment in full by the patient.

In *Spectrum Health Continuing Care Group v. Anna Marie Bowling Irrevocable Trust*, 401 F.3d 304 (6th Cir. 2005), the Court discussed the various reasons why a provider may decide to accept payment from Medicaid rather than waiting to see if it can recover more from its patient's settlement with the alleged tortfeasor. *Id.* In *Spectrum*, Anna Marie Bowling was injured during a medical procedure. While her medical malpractice claim was pending, she was admitted to a nursing home. *Id.* at 308. The nursing home decided to submit their expenses to Medicaid and received compensation from Medicaid. *Id.* Anna Marie Bowling's medical malpractice claim was later resolved and the nursing home sought the

difference between its usual billed expenses and the amount that it received from Medicaid. *Id.* at 309. The Court found that the nursing home could not obtain more than what it had received from Medicaid, because it chose to accept the Medicaid payment. *Id.* at 313. The Court noted that the reason the nursing home made the choice to accept Medicaid payment was to avoid the risk of no recovery and to avoid the possible delay in recovery. *Id.* at 316. The element of choice that Smith relies so heavily upon is not a choice to give a benefit to the patient, but rather a choice that benefits the medical provider. The medical provider weighed the pros and cons and decided to bill Medicaid for the certain payment that it would receive from Medicaid.

### 3. Letters of Protection represent unconscionable contracts of adhesion.

Letters of protection are often handed to a patient before treatment is given or assured under conditions that often are in *extremis*. The sample letter of protection, that Smith produced in the proceedings below, states that if the medical provider is not allowed to recover for their services in full from a tort settlement, then the medical provider does "not assure" that the medical provider will be available to provide expert testimony for that patient. (B-1). But even with a letter of protection, once a medical provider accepts Medicare or Medicaid payments, that provider may no longer seek to recover the amounts that were written-off. *See* 42 CFR 447.15. Yet

Smith asserts that a personal injury cause of action is an asset to be used to bargain for a letter of protection. Appellant Opening Br. at 13. To view the claim as an asset is incorrect. It is not a tangible asset, it is simply a legal right. Further, the letters of protection do not assist the patient, as the patient is generally required to pay for the treatment in full even if she does not make a recovery, at which point it may be too late to bill Medicaid.

Plaintiff incorrectly asserts that "the provider has the option of seeking payment from the tortfeasor's liability insurer". Appellant Opening Br. at 15. In Delaware, a medical provider may not bring a suit against a tortfeasor's liability insurer. *See Kent General Hospital, Inc. v. Blue Cross & Blue Shield, Inc.,* 442 A.2d 1368, 1369-70 (Del. 1982)(medical provider can either bill the patient's insurer directly or the patient). A medical provider's options in Delaware are either to bill Medicare/Medicaid or a private health insurer and accept the terms of its agreement with the those entities, or to bill the patient. The medical provider cannot seek reimbursement for its services from a third-party except in certain statutory circumstances. *See, e.g.,* 21 *Del. C.* § 2118.

**4. Acceptance of Medicaid payments by the provider does not confer a benefit on patient in the form of service gratuitously rendered.**

As discussed above with regard to Medicare, a Medicaid write-off confers no

benefit on the patient. To extend the collateral source rule to Medicaid write-offs would allow the exception to swallow the general rule that the tortfeasor bear the cost of the harm, and no more.

Smith asserts that the present case is more similar to *Onusko v. Kerr* than it is to *Stayton*. In *Onusko*, a physical therapist reduced the cost of medical treatment for personal injuries to encourage the patient to pay cash. *Onusko*, 880 A.2d 1022, 1024-5 (Del. 2005). This was a private agreement reached between the patient and the provider. *Id.* When the patient later sued the tortfeasor, she was permitted to plead the fully invoiced bill as her damages. *Id.* at 1025. In the present case, the Medicaid write-off accepted by the provider is not pleadable by Smith because there is no loss or harm to Smith for the write-off. The present case did not involve the private transaction discussed in *Onusko*, but rather was based on rules and regulations established by Medicaid and accepted by Smith's medical provider.

Smith argues that Dr. Grossinger conferred a benefit on her by accepting Medicaid payments, foregoing any right to recoup the remainder of his bill, so that Plaintiff could continue receiving medical treatment from him. Rather, Dr. Grossinger's acceptance of the Medicaid payment was not a benefit upon Plaintiff but a business decision by Dr. Grossinger. Dr. Grossinger asserts that his practice would not survive if he billed Medicaid for all of his patients, insinuating that if he refused

to accept Medicaid, many of his patients would go without treatment. (A-36). However, we note that there are at least 37 practicing neurologists in New Castle County and another 30 physicians that specialize in pain management/physical medicine and rehabilitation in New Castle County. (B-66). If Dr. Grossinger refused to treat Plaintiff because he did not want to accept Medicaid, Plaintiff was able to turn to many other providers.

Thus, the collateral source rule does not extend to Medicaid write-offs. *Rice v. Chimes, Inc.,* 2005 Del. Super. LEXIS 476 at *6-7 (Del. Super. March 10, 2005). "In Delaware a plaintiff is entitled to compensation sufficient to make him whole, but no more." *Stayton*, 117 A.3d at 534. Awarding plaintiffs the amounts that were written-off for Medicaid would allow the plaintiff a windfall, violating the "fundamental tenets of just compensation." *Rice,* 2005 Del. Super. LEXIS 476 at *4.

As with the medical bills considered in *Stayton*, a significant portion of the medical bills in the present case were written off. Dr. Grossinger's bill shows that $4,255.31 of Plaintiff's treatment was paid by Medicaid. (A-40-45). There is no practical difference between Medicare and Medicaid that would distinguish *Stayton* from the present case. The collateral source rule does not extend to Medicaid write-offs.

## II. THE EXCLUSION OF MEDICAID WRITE-OFFS FROM THE COLLATERAL SOURCE RULE DOES NOT VIOLATE OR AFFECT THE RIGHT TO A JURY TRIAL OR DUE PROCESS OF THE LAW.

### A. Question Presented

Whether the exclusion of Medicaid write-offs from the collateral source rule violates the right to a jury trial and due process? This issue was raised in Plaintiff Smith's Answering Brief to Defendant Mahoney's Motion to Alter or Amend the Judgment. (A-16).

### B. Scope of Review

Constitutional claims are reviewed *de novo*. *Powell v. State,* 49 A.3d 1090, 1103 (Del. 2012).

### C. Merits of Argument

#### 1. What the common law gives, the common law may take away.

Appellant Smith reviews the long and storied history underpinning the right of all Delawareans to a jury trial, which is now fixed in our State Constitution. Del. Const. Art. I, §4 (1909). Smith also acknowledges the genesis of the collateral source rule in the common law. Smith's historical exegesis fails, however, to acknowledge that what the common law gives, the common law may take away. *Travelers Indem. Co. v. Lake*, 594 A.2d 38 (Del. 1991); *citing Gutierrez v. Collins*, 583 S.W.2d 312,

317 (Tex. 1979) ("the genius of the common law rests in its ability to change, to recognize when a time-worn rule no longer serves the needs of society. . .").

While it is true that the determination of damages is ordinarily reserved to the jury, both statutes and the common law have acted in myriad ways to limit and guide a jury's determination of damages. This is evidenced when statutes or common law provide ranges or restrict consideration on damages. Section 2118 of Title 21 of the Delaware Code provides that amounts paid by no-fault insurance are inadmissible in a lawsuit brought against the tortfeasor. 21 *Del. C.* § 2118(h). The Worker's Compensation Statute provides limits and standards to recovery, based on certain qualifications. 19 *Del. C.* §§2324-2326. Courts have also placed limits or considerations for recovery of punitive damages. *See, e.g., Ripsom v. Beaver Blacktop, Inc.,* 1988 Del. Super. LEXIS 117 at *51 (Del. Super. Apr. 6, 1988) (Delaware courts have formulated prudential limitations in considering an award of punitive damages.) The determination of damages can also be expanded by statute or common law. Under the American Rule, attorney fee shifting is not permitted, but the Uniform Deceptive Trade Practices Act allows for the recovery of attorney's fees to the prevailing party. *See* 6 *Del. C.* § 2533(b); *Stephenson v. Capano Dev., Inc.,* 462 A.2d 1069 (Del. 1983).

Jurisprudence regarding the reach of the collateral source rule itself, is

instructive. "The collateral source rule is an exception to the general principles governing compensatory damages." *Stayton,* 117 A.3d at 534. In a negligence lawsuit, "a plaintiff is entitled to compensation sufficient to make him whole, **but no more**." *Id.* at 534, citing *Mitchell v. Haldar,* 883 A.2d 32, 38 (emphasis added). The collateral source rule was created as an exception to this general rule. With the enactment of the Medicare and Medicaid programs in the 1960s and more recently the Affordable Care Act in 2010, courts and legislatures around the country have been re-examining the applicability of the collateral source rule. *See, e.g., Howell v. Hamilton Meats & Provisions, Inc.,* 257 P.3d 1130 (Cal. 2011); *Stanley v. Walker*, 906 N.E.2d 852 (Ind. 2009); *Moorehead v. Crozer Chester Med. Ctr.,* 765 A.2d 786 (Pa. 2001).

In the present case, Smith was enrolled in Medicaid, (B-56); her medical provider decided to receive payment for his services from Medicaid, *Id.*; the medical provider wrote-off the amount of his charges not paid by Medicaid, (A-45); leaving Smith responsible only for paying back the Medicaid lien. 42 CFR 447.15. Smith did not and will not suffer a harm greater than the amount of the Medicaid lien. She does not require the windfall recovery of the Medicaid write-off to make herself whole.

The damages at issue in the present case are liquidated damages, for invoiced

medical bills in a specific amount, rather than unliquidated damages as for pain and suffering, which require that the jury consider evidence submitted to determine a value for non-monetary damages. When the jury considers liquidated damages, such as past medical expenses or lost wages, the amount before the jury has already been monetized and has a present value.

The *Stayton* Court analyzed several methods for determining the reasonable value of medical services. *See Stayton,* 117 A.3d at 531-534. After considering each method, including whether to allow the jury to consider the reasonable value for the medical services, the Court determined that "[o]n balance, . . . the better course is to treat the amount paid by Medicare as dispositive of the reasonable value of healthcare provider services." *Id.* at 533.[4]

Smith now argues that the *Stayton* ruling violates an injured plaintiff's right to a jury trial and due process. Smith cites to a criminal case, *Craig v. State*, in which Mr. Craig had been convicted of various criminal offenses, including robbery in the first degree. 457 A.2d 755, 760 (Del. 1983). The *Craig* Court addressed whether

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[4] In the present case, Smith has no difficulty claiming an inflated amount charged by the medical provider as the baseline for the value of her medical services. In applying the collateral source rule to the present case, the jury was presented with the inflated charges by her medical providers as the amount that the jury should award for past medical expenses if it found such treatment related to Smith's injuries. It is only when a lesser amount, which was accepted in full satisfaction by that same medical provider, is introduced to the jury that Smith asserts that her rights to a jury trial and due process are violated.

certain legal presumptions shift the burden of persuasion to the defendant, specifically an instruction regarding a rebuttable presumption relating to the possession of recently stolen goods. *Id.* The Court stated that the question was "whether a reasonable juror could have interpreted the instruction as shifting the criminal burden of persuasion on a necessary element of the offense." *Id.* at 762. The Court found no error in providing the rebuttable presumption charge. *Id.* The issue of rebuttable or irrebuttable presumptions has no relevance to the application of the collateral source rule or a plaintiff's access to the courts and due process.

In the present case, Smith has the burden of proving her damages, here in liquidated form. When looking at the specific amounts that were invoiced by the medical provider, paid to the medical provider, and considered satisfaction of Smith's debt to the medical provider, the amount required to make Smith whole was a sum certain and properly considered dispositive by the Court. *Stayton*, 117 A.3d at 533-534. There is no constitutional issue raised in these circumstances. The Court has simply modified the reach of the collateral source rule to recognize the dispositive nature of Medicare payments for the value of the treatment received.

**2. Smith's right to due process is not effected by application of *Stayton*.**

Smith asserts that the adoption of the *Stayton* Court's exclusion of write-offs from the collateral source rule would create a discrepancy between those plaintiffs

who are enrolled in Medicaid and those that have private health insurance. The *Stayton* Court addressed this issue:

> Stayton also contends that a rule limiting her recovery to the amount of Medicare payments would differentiate between similarly situated personal injury claimants because victims covered by Medicare would receive less compensation in a tort suit than parties with private medical insurance coverage.

*Id.* at 526. The Court rejected this position, and held that it would not extend the collateral source rule to Medicare write-offs. *Id.* In his concurring opinion, the Chief Justice noted that the decision illustrated "the wisdom of taking a Hippocratic approach to applying long-standing doctrines that have been extended beyond what was necessary to accomplish their original goal." *Id.* at 534 (Strine, C.J., concurring).

Smith's reliance on *Lecates v. Justice of Peace Court No. 4,* 637 F.2d 898 (3d Cir. 1980), for the proposition that she is being denied equal access to the courts is misplaced. *Lecates* involved a genuine question of the public's access to the court. Mr. Lecates was sued in a debt action in the Justice of the Peace Court, which is not a court of record. *Id.* at 898. Mr. Lecates requested a jury trial during the Justice of the Peace Court proceeding. *Id.* at 901. His request was refused. *Id.* Mr. Lecates also moved to dismiss the claim, which was denied, and judgment was entered against him. *Id.* Delaware law required that a defendant appearing before the Justice of the

Peace post a bond in order to appeal a decision. *Id.* Mr. Lecates requested that the bond be waived due to his indigency so that he could pursue his appeal to the Superior Court. The Justice of the Peace denied that request stating that he did not have the power to waive the required bond. *Id.* Due to his indigency, Mr. Lecates was unable to secure a surety bond and, therefore, was unable to obtain a trial by jury. *Id.* at 902.

The Third Circuit addressed whether the state could place a monetary barrier between a defendant and his access to a jury trial. *Id.* This was a question about a court-mandated administrative fee. The Third Circuit found that "the State must make some accommodation to insure that the indigent have an equal opportunity to receive the same judicial process that is within the reach of more fortunate litigants." *Id*. at 912.

The contention that Smith does not have full access to the courts simply because one portion of her damages claim is limited to the amount actually paid by Medicaid, misapprehends the nature of the issue at stake in the present case. By limiting a common law exception to a common law rule, there is no restriction or effect on Smith's right to due process. Her access to the courts has not been limited. She has recovered the reasonable value of the medical services provided to her, determined by her own medical provider when he accepted the Medicaid payment in

full satisfaction of the services provided. She has received compensation for her pain and suffering, a value that was determined by a jury of her peers. Plaintiff was treated no differently than other personal injury plaintiffs when her jury considered and made an award for each element of her claim, including pain and suffering, past liquidated damages, and future damages.

### 3. Differential treatment and equal-access to Medicaid.

Smith's reliance on the Medicaid Act's requirement for equal access to the same care and services available to the general population in the same geographical area is inapplicable to the present case. When discussing the equal-access requirement, and assuring that the Medicaid write-off does not adversely affect the <u>value</u> of service, the Act's requirement is plainly intended to ensure that the <u>quality</u> of treatment is the same as that received by all other patients. *See* 42 U.S.C. §§ 1396a(a)(30); 1396(10)(b)(i); *Medical Soc. Of New York v. Toia*, 560 F.2d 535 (2d Cir. 1977) (States are required to safeguard against unnecessary utilization of medical care and services and to assure that medical payments are not in excess of reasonable charges consistent with quality of care). For example: if the standard of care requires that a fractured bone be reset in a hard cast, the medical provider is required to give the Medicaid patient the same hard cast as the privately insured patient would receive or that any other patient would receive from the same provider. An ace bandage may

not be substituted for the hard cast, because it is cheaper to provide. The Medicaid Statute is not stating that the invoiced and paid bill must be the same for all patients, but simply that Medicaid has the advantage in bargaining for a lower cost for the same medical services that an individual or a private insurance company may not have. By accepting the Medicaid patient, the provider accepts Medicaid's terms and conditions. 42 CFR 447.15.

## III. INDIGENT PLAINTIFFS' ACCESS TO THE COURTS IS UNAFFECTED BY EXCLUDING MEDICAID WRITE-OFFS FROM THE COLLATERAL SOURCE RULE

### A. Question Presented

Does excluding Medicaid write-offs from the collateral source rule affect indigent plaintiffs' access to the Courts? This issue was raised in Plaintiff Smith's Answer to Defendant Mahoney's Motion below to Amend or Alter the Judgment (A-18).

### B. Scope of Review

Constitutional claims are reviewed *de novo*. *Powell v. State,* 49 A.3d 1090, 1103 (Del. 2012).

### C. Merits of Argument

Appellant Smith argues that without the potential economic windfall from the collateral source rule, personal injury lawsuits will be rendered uneconomical. Appellant Opening Br. at 32. Smith further argues that the amount written-off by Medicaid is necessary for the Medicaid-eligible tort victim and to the taxpayer, who supports Medicaid, to fully recovery the economic loss of medical services paid and the costs associated with recovering Medicaid's lien. *Id.* Appellee Mahoney agrees that Smith has a constitutional right of access to the courts that is supported by a long and distinguished history of jurisprudence and legal commentary. Rather, the issue

presented is whether Smith's access to the courts is dependent on her obtaining ancillary compensation for damages she never sustained and a windfall for a benefit that she never obtained.

While a plaintiff is required to pay a small filing fee with the court when filing a complaint, it is a leap of logic to conclude that denying Smith recovery of a Medicaid write-off is the same as limiting her ability to file the complaint in the first place. Moreover, a truly indigent plaintiff can always file a simple petition for the *in pauperis* waiver for such filing fees and costs. The limit on Medicaid write-offs from the collateral source rule is simply a rule for measuring a liquidated damage. It places no burden on a plaintiff when filing the lawsuit or litigating it.

Smith acknowledges that for common-law negligence, a plaintiff's remedy is found in compensatory damages, "just and full compensation." *Maier v. Santucci*, 697 A.2d 747, 749 (Del. 1997). Just and full compensation for medical expenses is satisfied by an award for the amount that was actually paid by Medicaid. *Stayton,* 117 A.3d at 534 ("a plaintiff is entitled to compensation sufficient to make him whole, but no more"). In the present case, Smith received just and full compensation. Her access to the Court was not limited. She had a jury trial, which determined a value for her pain and suffering and found certain past medical expenses to be related to the accident. Further, Plaintiff acknowledged that it was her own provider that

choose to accept the Medicaid payment. In doing so, Smith has also accepted the Medicaid payment amount as the value for her medical services.

Lawsuits litigated to trial can be costly for both the plaintiff and the defendant. Smith argues that plaintiffs enrolled in Medicaid will automatically have smaller verdicts. Appellant Opening Br. at 32. The argument that without the recovery of Medicaid write-offs to subsidize their litigation, trials will produce smaller recoveries, is an argument about the cost effectiveness of litigation and not an argument about constitutional access. Smith's reliance *Helfend v. S. Cal. Rapid Trans. Dist.,* 465 P.2d 61 (Cal. 1970), regarding the collateral source rule essentially being used to compensate attorneys bringing the lawsuit, would be contrary to the American rule, which provides that each party must pay its own attorney fees. *Johnston v. Arbitrium (Cayman Islands) Handels AG*, 720 A.2d 542, 545 (Del. 1998) ("Under the American Rule, absent express statutory language to the contrary, each party is normally obliged to pay only his or her own attorneys' fees, whatever the outcome of the litigation").

As for litigation costs, the Rules of Civil Procedure and the Courts strongly encourage parties to resolve their cases through means other than a jury trial. Superior Court Civil Rule 16 requires that all parties in good faith submit to a form of alternative dispute resolution ("ADR"). Superior Court Civil Rule 68 provides for

offers of judgment with the goal of encouraging settlement before trial. Settlement demands made pursuant to 6 *Del. C.* § 2301 also serve the purpose of encouraging settlement and reducing costs. Smith's assertion regarding the marginal utility of bringing a lawsuit because success is a "fifty-fifty proposition" is not present in this case. *See* Appellant Opening Br. at 33. When liability is admitted, as it was below, the plaintiff is essentially guaranteed an award of some level of damages.

Although the number of civil cases filed has increased slight year over year, the number reaching trial each year has decreased. In 2002 in New Castle County there were 138 trials. By 2008, there were 84 trials. In 2015, there were 56 trials. *See* Statistics on Civil Filing from the Superior Court Prothonotary. (B-79). The decreased number of trials is largely due to the Court's successful emphasis on ADR and rules that encourage settlement.

The trial court's decision to not extend the collateral source rule to Medicaid write-offs is not an artificial limit on recovery. There is nothing artificial about a liquidated damage that has been fully paid. Smith is able to recover the reasonable value of the medical services she received, subject to Delaware statutes such as 21 *Del. C.* § 2118(h). Smith's medical provider agreed to accept the Medicaid reimbursement in full satisfaction of the medical services he provided. The lien for the Medicaid payment is the only amount that Smith owes and that the tortfeasor is

liable to pay. This is also the amount that the medical provider agreed would be sufficient for his medical services, rather than the typically inflated amount originally billed to Smith. The amount paid by Medicaid is not an artificial limit, it is, rather, an amount agreed upon by all parties involved.

On the other hand, it is the collateral source rule that encourages artificially inflated damages. In times past, this issue was not a problem because the cost of services bore some relationship to the actual value of the services. Over time, medical expenses became increasingly inflated as medical providers began discounting their billing rates for HMOs and government programs. *See Howell v. Hamilton Meats & Provisions, Inc.,* 257 P.3d 1130, 1141 (Cal. 2011) ("The rise of managed care organizations, which typically restrict payments for services to their members, has reportedly led to increases in prices charged to uninsured patients, who do not benefit from providers' contracts with the plans").

If Smith feels that the lower court's decision not to extend the collateral source rule to Medicaid write-offs results in an inequitable result, she is always free to ask the General Assembly for legislation that would add a surcharge for attorney fees or other costs, as has been done in worker's compensation cases. *See* 19 *Del. C.* § 2320(10)(a).

Smith returns to the idea that the collateral source rule is necessary for its

deterrence effect on tortfeasors. If the purpose of the collateral source rule was to act as a deterrence, the rule should be re-examined as there is no evidence of such deterrence, with or without the inclusion of Medicaid write-offs.

The assertion that the taxpayer will be adversely affected is also unsubstantiated. Smith states that Medicaid will not be reimbursed for its lien on the recovery because only in specific cases will it actually seek out reimbursement. Appellant Opening Br. at 34. This is at odds with actual practice, where Medicaid is repaid from the tort settlement. Smith has a duty to repay the lien, and no litigation is required. 31 *Del. C.* § 522(b). Smith may negotiate the lien or request that it be waived, but Smith has a duty to repay that lien as a matter of course.[5]

Limiting the collateral source rule on Medicaid write-offs and returning to the general rule regarding damages does not limit a plaintiff's access to the courts, constitutionally or as a practical matter.

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[5] Liability carriers are also required to report settlements of Medicare claimants, or possibly face penalties. 42 U.S.C. § 1395y(b)(8). For this reason, liability insurers require assurance in settlement agreements and releases that Medicare and Medicaid liens are paid out of the settlement proceeds, to avoid additional claims and penalties.

## ON CROSS-APPEAL BY APPELLEE

### IV. THE SUPERIOR COURT ERRED WHEN IT ENTERED AN ORDER DENYING DEFENDANT/APPELLEE MAHONEY'S REQUEST TO REDUCE FUTURE MEDICAL EXPENSES.

### A. Question Presented

Whether the Collateral Source Rule applies to future Medicaid write-offs for medical expenses that will be potentially incurred by the claimant when the claimant is currently a recipient of Medicaid benefits? If the Collateral Source Rule is not applicable to the write-offs, what is the proper calculus for determining the amount of future medical expenses? This issue was raised in Defendant/Appellee's motion below to Alter or Amend the Judgment (A-18–24), and in oral argument below. (B-27).

### B. Scope of Review

Application of the Collateral Source Rule is a question of law subject to *de novo* review. *Stayton v. Del. Health Corp.*, 117 A.3d 521, 526 (Del. 2015).

### C. Merits of Argument

#### 1. A plaintiff bears the burden of establishing future medical expenses and must do so based on her medical treatment's present value.

In Delaware, "a plaintiff cannot recover speculative or conjectural damages because the law 'refuses to allow a plaintiff damages relating to the future

consequences of a tortious injury unless *the proofs establish with reasonable probability* the nature and extent of those consequences.'" *Stayton v. Del. Health Corp.*, 117 A.3d 521 (quoting *Laskowski v. Wallis*, 205 A.2d 825, 826 (Del. 1964)) (emphasis added). The burden is on the plaintiff to establish the reasonable probability of future damages. *Steppi v. Stormwasser*, 297 A.2d 26, 27–28 (Del. 1972) (citing *Henne v. Balick*, 146 A.2d 394 (Del. 1958); 22 Am.Jur.2d § 298; 25A C.J.S. Damages § 185(6)). In *Steppi v. Stormwasser*, this Court addressed the issue of which party bears the burden of proving the "present value" of an award for future loss of income. *Steppi*, 297 A.2d at 26–27. There, the *Steppi* Court explained:

> In a case like this, the burden is upon the plaintiff to prove the nature and extent of the loss caused by the defendant; that burden, to the extent it concerns future earnings, is not satisfied by proof of the amount that she would have earned had she not been injured; that is not the true measure of her loss. Her proof is not complete without evidence of the present value of that loss. [I]t is our opinion that the burden of proof is logically upon the plaintiff in this respect.

*Id.* at 27 (*Cf. Henne*, 146 A.2d 394; 22 Am.Jur.2d § 298; 25A C.J.S. Damages § 185(6)).

Though *Steppi* definitively held that a plaintiff bears the burden of establishing future damages, it also addressed the proper metrics for determining a future income award. This rationale was expanded to future medical expenses in *Thorpe v. Bailey*.

The plaintiff in *Thorpe* was in an automobile accident, the injuries from which were found to be permanent. *Thorpe v. Bailey*, 386 A.2d 668, 668 (Del. 1978). The jury returned a verdict for $23,000.00 for future medical expenses. *Id.* The *Thorpe* Court determined that any award for future medical expenses had to be discounted to the present value of those services. *Id.* The Court noted "[a]ny attempt to read the future is, of course, subject to the human condition" and that it was "well aware of the fragile basis for any award based on what is expected to occur down the years." *Id.* at 669. Therefore, the *Thorpe* Court determined that "[g]iven all of the uncertainties involved in attempting to fairly match compensation with anticipated medical expenses, . . . a lump sum award for all such damages, projected over the time period in question, *should be reduced to its value as of the date of judgment*." *Id.* (emphasis added).

The *Thorpe* Court listed four policy reasons for this determination, three of which are directly relevant to the case *sub judice*. First, it explained that failing to use a plaintiff's medical expenses' present value would result in a windfall to the plaintiff and an improper penalty to the defendant. The Court stated:

> If the sum is not discounted, then the amount paid to compensate for a future loss will . . . exceed the amount required to make full recompense and thus provide a larger monetary value than the loss when it is actually incurred. Thus, not reducing a jury's verdict for future medical expenses to present value would result in overpayment to a plaintiff at

> the time of future loss and an improper penalty against a defendant. The purpose of reduction to present worth is . . . to strike a fair balance between the parties by eliminating a windfall for a plaintiff and an unnecessary penalty for a defendant.

*Id.*

Second, the *Thorpe* Court specifically acknowledge that "reducing an award for future medical expenses to present worth should help to measure more accurately the 'compensation'" due. *Id.* As the jury's duty is to resolve a *present* monetary dispute between the parties, the *Thorpe* Court found that it is more fair if the verdict reflected the present value of such costs. *Id.* (emphasis added). This approach seeks to remove speculation and conjecture from future damages awards.

Lastly, the *Thorpe* Court noted that requiring a verdict for future medical expenses be based on the present value of such services was in line with its holding in *Steppi*. It stated "[i]t would be logically inconsistent to treat damages for the loss of future earnings differently from damages for future medical expenses. The advantage of the present use of money is the same in either event and . . . the future loss is similarly periodic in nature." *Id.*

Smith argues that applying *Stayton* to future medical expenses of Medicaid enrollees would only enhance speculation in calculating such damages since Medicaid is meant to be a temporary service. However, Smith has the burden of

establishing with reasonable probability the nature and extent of her future damages. In establishing the above rules, this Court attempted to remove some speculation and conjecture in calculating awards based on the future. Applying the rule articulated in *Steppi* and *Thorpe* to the context of the Collateral Source Rule and Medicaid,[6] the proper metric for determining Smith's future medical expenses is what Medicaid actually paid her healthcare providers for the rendition of their services, *i.e.*, their present values. As it is Smith's burden to establish future damages, it would also be her burden to show that the costs of those same health care services will increase because she will not be a Medicaid recipient in the foreseeable future.

Smith has produced no evidence showing that she will not use Medicaid in the foreseeable future. Instead, she has merely stated that she does not wish to be on Medicaid and that Smith's husband is currently searching for a job that provides healthcare benefits. (B-26). Appellee Mahoney acknowledges this desire and sympathizes with Smith's circumstances. However, a desire for a specific event to occur is not evidence that it will likely occur at a certain future date. Smith has the

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[6] Defendant understands that *Steppi* and *Thorpe* are not directly on point with regard to the issue of whether *Stayton* requires that any future medical expenses award for claimants receiving Medicaid benefits be reduced to the rate Medicaid has actually paid for such health services in the past. *Steppi* and *Thorpe* addressed the issue of inflation and its effects on an individual's future income and the future costs of medical treatment/expenses. With that said, their rationale is applicable to the issue *sub judice* in that they specifically discuss which party has the burden of proving future damages and why the present value of the plaintiff's damages must be used to determine an appropriate award for future damages.

burden of establishing to a reasonable probability what her future medical expenses will be. Absent Smith establishing to a reasonable probability a specific change in her medical expenses, the rationales of *Steppi* and *Thorpe* apply, as measured by the *present* values of those health services received and paid, and used to determine what a future expense will be. As "[t]he jury's job is to resolve a present monetary dispute between the parties . . . it is more likely to be done fairly if the verdict reflects present values." *Thorpe*, 386 A.2d at 669.

2. **The speculative nature of a plaintiff's future eligibility for Medicaid benefits should not prevent *Stayton*'s applicability to the calculation of future medical expenses for Medicaid recipients.**

In its decision below, the trial court stated "[f]or the purposes of future medical expenses, the court finds that future Medicaid eligibility is purely speculative and conjectural. Therefore, Plaintiff's . . . award for future medical expenses will not be reduced by estimates of future Medicaid write-offs." (B-56). This reasoning, however, cuts both ways. "There is nothing about the future that is not speculative. Will the Plaintiff ever sustain any future expenses, and, if so, in what amount, is entirely speculative." *Russum v. IPM Dev. P'ship LLC*, 2015 Del. Super. LEXIS 376, *8 (Del. Super. Jul. 15, 2015).

In *Russum*, the Superior Court addressed how *Stayton*'s holding affected future

medical damages. There, the plaintiff argued that a reduction of future medical damages awards for Medicare recipients is speculative. *Id.* at *6–7. The court explained "the Supreme Court requires proof of 'damages relating to future consequences of a tortious injury' be 'established with reasonable probability [as to] the nature and extent of those consequences.'" *Id.* (quoting *Laskowski*, 205 A.2d at 826; and citing to *Stayton*, 117 A.3d at 534). As such, the Superior Court determined that an expert that has been retained to opine on future medical costs must account for any appropriate write-off received through Medicare. *Id.*

Though there are differences between Medicare and Medicaid, one being that Medicaid is meant to be temporary, a future medical expenses award in this case should be determined based on the contemporary payments actually made by Medicaid to Smith's medical providers. At the time of the December 10, 2010 motor vehicle accident Smith was enrolled in the Medicaid program even though she was employed. (B-3). Throughout the entire litigation, through verdict on June 3, 2015, Smith continued to receive Medicaid benefits. (B-26). At the time of oral argument on October 8, 2015 for the motion below, Smith was still enrolled in Medicaid. (A-54). To Defendant/Appellee Mahoney's knowledge, Smith remains a Medicaid recipient. Smith bears the burden of establishing to a reasonable probability what her future medical expenses will be and has failed to provide any evidence indicating that

she will no longer be enrolled in Medicaid in the foreseeable future. Though Smith's affidavit states that she does not wish to remain on Medicaid, that is only an indication of an aspiration. Because Smith was a Medicaid enrollee on the date of the accident, at the time of trial, and apparently continues to be enrolled, it would be equally speculative to assume that she will not be enrolled in Medicaid in the future. The only fact established to a reasonable probability is that Smith has received Medicaid benefits in the past and continues to receive them today. Therefore, the *Stayton* and *Russum* standards should apply in this case when calculating the future medical expenses of Smith, who was a Medicaid enrollee at the time of trial when such damages were determined by the jury.

## CONCLUSION

Plaintiffs in Delaware are "entitled to compensation sufficient to make [them] whole, but no more." *Stayton* 117 A.2d at 534. The Medicaid write-offs are not owed by Smith , and she does not require them to make her whole. Instead, the write-offs are benefits to the taxpayers that support Medicaid, just as the Medicare write-offs are benefits to the taxpayers that support Medicare and not the plaintiff enrolled in Medicare. *Id.* at 531. As such, the collateral source rule, an exception to the general rule of damages, should not be extended to Medicaid write-offs.

The decision to not extend the collateral source rule to Medicaid write-offs does not violate the Plaintiff's constitutional right to a jury trial and due process. Nor does it hinder her access to the courts. Medicaid write-offs, and the taxpayers who support them, should not be used as a subsidy for plaintiffs to pursue personal injury lawsuits.

The Collateral Source Rule does not apply to Medicaid when calculating a plaintiff's future medical expenses. A plaintiff must prove future medical damages to a reasonable probability. As future medical damages are speculative and conjectural in nature, the proper measurement for determining them is through the present value of the plaintiff's medical expenses. As the present value of a Medicaid plaintiff is the amount paid by Medicaid to the plaintiff's healthcare providers, that

amount should be used to determine a Medicaid plaintiff's future medical damages. Although it may be speculative that a Medicaid recipient will continue to receive such benefits in the future, it is equally speculative that such recipient will not receive them in the future. As such, a Medicaid plaintiff must prove to a reasonable probability that she will no longer receive Medicaid benefits in the foreseeable future as well as what the her future medical expenses will be.

For the foregoing reasons, the decision of the trial court regarding past medical expenses should be affirmed and the decision regarding future medical expenses should be reversed.

Respectfully submitted,

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