

## MEDICAL EXPENSES, INSURANCE WRITE-OFFS, AND THE COLLATERAL SOURCE RULE

### *Recovery of Medical Expenses in Personal Injury Actions Generally*

To recover damages for past medical expenses in a personal injury lawsuit, a plaintiff must present evidence and prove the medical expenses incurred were both “reasonable” and “necessary.” For more than 100 years, this simple formula was the least complicated aspect of a plaintiff’s personal injury case. To get medical bills into evidence and recover them as an element of damage, plaintiffs simply needed to prove:

1. The plaintiff has paid or become liable to pay the medical bills;
2. The plaintiff necessarily *incurred* the medical expenses because of injuries resulting from the defendant’s negligence; and
3. The charges were *reasonable* for services of that nature.

The law in every jurisdiction allowed plaintiffs to recover the “*reasonable value*” of the medical services *incurred*. Defendants have begun objecting to medical bills identified in an exhibit list or via a motion in limine filed shortly before trial - by defendants seeking to exclude them. They claim that such medical expenses are neither “reasonable” nor “incurred” by the plaintiff. Defendants argue the bills were not actually “incurred” by the plaintiff because they were paid by a **collateral source** (*e.g.*, private health insurance, state Medicaid, Medicare, workers’ compensation, governmental assistance programs, etc.). A “collateral source” is benefits received by the plaintiff from a source wholly independent of and collateral to the wrongdoer. The defendants argue that the medical bills are not “reasonable” because they were reduced or written off by the insurance provider, who accepted insurance payments; thus, defendants argue that the injured plaintiff’s reasonable medical expenses and damages should be limited to sums “actually paid” by the insurer and proof of the full medical charges that were billed (either written-off or paid by insurance) should be excluded. Proving the reasonable value of medical services has become both controversial and confusing; and every state has gone its own way in dealing with the issue.

EXAMPLE: A plaintiff is injured because of the defendant’s negligence and requires medical treatment for which he is billed \$200,000. Thankfully, the plaintiff has private health insurance, and the doctor and hospital accept \$65,000 from the insurance company in satisfaction of the bill. The plaintiff sues the defendant and wants to recover \$200,000 as the reasonable and necessary medical expenses which he “incurred” and was billed for. The defendant files a motion asking the judge to limit the plaintiff’s recovery of medical expenses to the \$65,000 that the health care providers accepted as payment. In this example, what is the reasonable value of medical services? \$200,000? \$65,000? Or, something in between?

Judges and legislatures struggle to arrive at equitable rules of damages and evidence that take these factors into consideration. The result is a confusing patchwork of laws depending on which state a case is filed in.

## ***Insurance Write-Downs, Write-Offs, and Medical Billing***

Years ago, medical billing was simple. A doctor or hospital would charge a reasonable fee for medical services and the patient would pay it. However, that is rarely what happens in today's complex health care and insurance environment, where a complex web of negotiated rates, explanations of benefits, contractual relationships, health care coding, hundreds of different billing procedures, and the involvement of Medicare and Medicaid government billing requirements, render the process incomprehensible. As a practical matter, patients today rarely pay or otherwise become obligated to a hospital's "full" charges. Medicare, Medicaid, HMOs, and private insurers are generally subject to discounted rates under law, or through their contracts with providers. Because the amounts they are allowed to charge are frequently a percentage of their full rate, there is an incentive for providers to inflate these full rates. But it is not these full charges that serve as the basis for the amounts recoverable for injuries, but instead the amounts that a patient or their insurer have actually paid, or otherwise become legally obligated to pay. Today's health care providers almost always accept a lesser amount in satisfaction of the bill pursuant to these contractual relationships. When a person injured in an auto crash receives medical treatment, the provider may accept \$700 from the patient's health insurance carrier for that care even though the provider's normal charge would be \$1,000. The amount beyond what is accepted in full satisfaction of the bill is considered a "discount", "write-down", or "write-off."

Being treated by a doctor may seem like a two-party interaction, but it's actually part of a large, complex system of information and payment. While the insured patient may only have direct interaction with one person or health care provider, it is really part of a three-party system – the patient, the health care provider, and the *payer* or entity which ultimately pays the bill – usually an insurance company or the government. When a patient receives medical services from a healthcare provider, they're typically presented with a bill at the end of their treatment. The final bill is created by a medical biller who looks at the balance (if any) the patient has, adds the cost of the procedure or service to that balance, deducts the amount covered by insurance, and factors in a patient's co-pay or deductible. Medical coders use medical reports to accurately translate medical services into code. Billers then abstract information from patients' medical records and insurance plans to create accurate medical bills. The final amount paid on a \$200,000 medical bill - \$65,000 in the example above - depends on an entire medical billing industry which involves the complicated overlap of medical billing, diagnosis codes, ICD codes, medical compliance, "allowed amounts", capitation, co-insurance, EOB's, and utilization limits. The unpaid balance of \$135,000 is either written off, billed to the patient in a practice known as "balance billing", and/or passed on to other patients in the system in the form of inflated charges. Note that "balance billing" (insurance company sends patient bill for balance of services insurance doesn't pay for), usually occurs when a patient goes "out-of-network" for medical services, and there is no contract between the provider and the insurance company agreeing to the discounted insurance rates. Balance billing for in-network providers is generally illegal. However, it is legal when the patient uses a provider that doesn't have a contractual relationship or seeks services not covered by insurance.

There are 1,068 for-profit hospitals in the U.S. A for-profit hospital is owned by investors, distributes profits to its investors, raises capital through investors, and must pay income and property tax. There are 2,894 non-profit hospitals in the U.S. They must invest all profit in the organization, are exempt from paying state and federal taxes on income and property and must report "community benefits" offered by the facility. There are 983 state and local government-owned or "public" hospitals in the U.S. They are funded by federal, state, and local taxes, as well as donations and grants. Nearly 67% of U.S. hospitals are losing money, particularly when it comes to the treatment of Medicaid/Medicare patients.

The method and amount of reimbursement for hospitalization differs substantially from insurance company to insurance company. It depends on the contract they have in place with the providers. It's not just that the rate is different for each service, but that different payers will reimburse different services. Medicare, for example, bases their reimbursement rate solely on the patient's diagnoses. A diagnosis of Ataxia-Telangiectasia will get a fixed Medicare payment regardless of how long the patient stays in the hospital, what tests are ordered, or what treatment is given. Other payers might pay by the day or based on each individual service the patient receives. Moreover, hospitals do all their bills the same way, no matter who the payer is. So, the best way for them to get paid is to put anything that might be reimbursed by any payer on every bill. Different insurance companies will pay doctors different amounts for the same billing code. The same insurance company will also pay different doctor's different amount for the same billing code depending on the type of policy a patient has. Different insurance companies will also approve and disapprove of

different services, so it's difficult to know in advance what will be paid. One insurance company might have several different methods of payment depending on the type of policy.

In recent years, the issue of what is considered the "reasonable value" of medical services has become complicated and distorted by the deep discounts demanded by insurance companies, laws that require hospitals to treat patients who cannot pay, and benefits like Medicaid and related state programs that pay a set amount for all treatment of a patient. The result has been an ever-widening gap between hospitals' standard rates for uninsured patients and the discounted amounts hospitals accept from insurance companies. Moreover, the types and number of "collateral sources" available to plaintiffs have multiplied. In addition to the insurance and gratuitous payments that were the subject of early collateral source rules (see below), in today's environment, plaintiffs in personal injury cases may have received benefits from unions, free treatment at a veterans' facility, or at a reduced rate at a charity-affiliated provider. Collateral sources include employment benefits offered by employers, workers' compensation programs, occupational accident plans and policies, or pensions under special retirement acts. In addition, the pricing, payment, and reimbursement system for health care providers itself has become exponentially more complex. The rise of Managed Care Organizations (MCO) in the 1980s was a partial "solution" to rising health care costs. In the process, however, patients gave up their freedom of choice among doctors and hospitals in return for slightly better cost control. Managed care has further distorted pricing for health care services, as the deep discounts demanded by the MCOs require providers to offset those discounts by charging higher prices to other patients. Some social legislation benefits eschew the traditional fee-for-service model in favor of pool payments or a set "capitation" amount for all treatment of a single patient. Hospitals are often legally required to provide treatment for patients who either are insured by companies with whom the hospital has no contractual relationship or who have no insurance at all. Federal statutes prohibiting "patient dumping" also complicate the valuation of medical expenses. What is "reasonable" has become less clear and more contentious than it was 50 years ago. As observed by courts and legislatures across the country, these developments have caused the issue of what constitutes a *reasonable medical expense* to become the subject of increased litigation and legislation. States have generally adopted one of *three* basic approaches to how much of a medical expense can be introduced into evidence and how much can be recovered:

1. **"Amount Paid."** The "actual amount paid" approach limits a plaintiff's recovery to the amount paid to the medical provider, either by insurance or otherwise. States adopting this approach generally seek to avoid allowing plaintiffs any so-called "windfall" from tortfeasors. A handful of states follow this approach. They take the position that limiting plaintiffs' recovery to the amount paid to the medical provider is not contrary to the Collateral Source Rule (CSR) because the rule is not implicated. They feel that limiting damages will help the liability insurance industry and help the business economy of their state. When insurance payments are used to compensate the plaintiff's medical providers, they reason, limiting the plaintiff's recovery to only the amount paid by the insurance company to the medical provider simply permits the plaintiff to recover no more than he has expended.

The leading case on the "actual amount paid" approach is the California case of *Howell v. Hamilton Meats & Provisions, Inc.*, 257 P.3d 1130 (Cal. 2011). According to the view expressed in *Howell*, an injured plaintiff whose medical expenses are paid through private insurance may recover as economic damages no more than the amounts paid by the plaintiff or his or her insurer for the medical services received or still owing at the time of trial. The negotiated rate differential is not an expense "incurred" by the plaintiff, because neither the plaintiff nor the plaintiff's insurer will be expected to pay it. The differential is not an insurance benefit to the plaintiff; it is instead a benefit to the insurer that results from the insurer's negotiations with medical providers. Few other courts have chosen to follow this approach. Where they have, the result is often dictated to some extent by statute.

The "actual amount paid" approach has been heavily criticized. The *Howell* reasoning - that the CSR is inapplicable to third-party payment of the plaintiff's medical debts but is still in force for third-party forgiveness of the same debt - has been called "schizophrenic" and "incoherent." *McConnell v. Wal-Mart Stores, Inc.*, 995 F. Supp.2d 1164 (D. Nev. 2014). It is also criticized because of the disparity that results in cases where the victim is insured as opposed to those where the victim is uninsured. The negligent tortfeasor wins the lottery when the victim he injures happens to be prudent and has bought insurance but is punished when the victim has no insurance. As one court noted, reducing an insured plaintiff's recovery by the negotiated rate differential "overlooks the fundamental purpose of the [collateral source] rule, ... to prevent a tortfeasor from deriving any benefit from compensation or indemnity that an injured party has received from a collateral source." *Acuar v. Letourneau*, 531 S.E.2d 316 (Va. 2000). **Pennsylvania, Idaho, and California** are examples of states whose courts have held that only

evidence of the amount paid is relevant and admissible. **New York** and **Minnesota** are states that apply the CSR, requiring a post-verdict reduction of the difference between the amount billed and the amount paid.

2. **“Amount Billed.” (“Benefit of the Bargain”).** This approach permits recovery of the full, undiscounted medical bills, including the write-off amounts, only where the plaintiff paid consideration for the insurance benefits. It gives the prudent plaintiff the “benefit of the bargain” of having purchased insurance. Under this approach, when the plaintiff is privately insured, the negotiated rate differential is considered “as much of a benefit for which the plaintiff paid consideration as are the actual cash payments made by his health insurance carrier to the health care providers. However, courts that follow this approach do not allow plaintiffs to recover the amount of their full bills if they did not pay for the benefit of discounted rates and write-offs.

The “benefit of the bargain” approach has been criticized as protecting the rich and hurting the poor, since persons who can pay for insurance are the only personal injury plaintiffs who may recover the negotiated rate differential. Stated another way, this approach promotes inherent discrimination among beneficiaries from different programs and insurance companies. Another criticism of the “benefit of the bargain” approach is that it “undermines the CSR by using the plaintiff’s relationship with a third party to measure the tortfeasor’s liability.” *Leitinger v. DBart, Inc.*, 736 N.W.2d 1 (Wis. 2007). The CSR ensures that the liability of similarly situated defendants is not dependent on the good fortune of the way each plaintiff’s medical expenses are financed.

Appellate courts in fifteen (15) states and the District of Columbia have held that the injured plaintiff may recover the amount billed, and bar the defendant from presenting evidence of the lower amount that the health care provider accepted to satisfy the bill. Most of these courts ground their decision on the common law CSR. The “billed only” rule applies in **Arizona, Colorado, Delaware, District of Columbia, Hawaii, Illinois, Kentucky, Louisiana, Massachusetts, Mississippi, Oregon, South Carolina, South Dakota, Virginia, and Wisconsin.**

3. **“Reasonable Value.”** With this approach, plaintiffs may recover the “reasonable value” of their medical expenses, regardless of whether the plaintiff is privately insured. It should be noted that the courts have approached the definition of “reasonable value” in different ways, and with different results. Among states that use this approach, a minority defines “reasonable value” as the actual amount paid, while a majority holds that the “reasonable value” can be the plaintiff’s full, undiscounted medical bills. A few courts use a “hybrid” method, allowing the trier of fact to consider both the actual amount paid and the full bill in determining the “reasonable value” of medical services provided to the plaintiff. **Iowa, Ohio, Indiana, and Kansas** are examples of states that have decided that a jury may consider both the amount billed and the amount paid in determining the “reasonable value” of the medical services.

The few states that define “reasonable value” as the discounted amount accepted by medical providers have generally used reasoning based on comment h to § 911 of the *Restatement (Second) of Torts*, which focuses on the exchange value of property or services, instead of § 920A (CSR). *Bynum v. Magno*, 101 P.3d 1149 (Haw. 2004). This version of the “reasonable value” approach is similar to the “actual amount paid” approach. The *Howell* court similarly relied on comment h to § 911 of the *Restatement (Second) of Torts*. Critics of the “reasonable value/actual-amount-paid” approach point out that § 911 of the *Restatement (Second) of Torts* was never intended to apply to cases involving physical harm. Instead, it is intended to apply in cases where a plaintiff sues to recover the value of property or services the plaintiff rendered to the defendant. In contrast, § 920A applies to “Harm to the Person.”

Some states that permit plaintiffs to recover their full, undiscounted medical bills, believe that plaintiffs are entitled to claim and recover the full amount of reasonable medical expenses charged, based on the reasonable value of medical services rendered, including amounts written off from the bills pursuant to contractual rate reductions. These courts adhere to the traditional CSR. Other states that permit plaintiffs to recover their full, undiscounted medical bills use a “hybrid” method of presenting evidence of “reasonable value” to the jury. Using this method, plaintiffs may submit their full, undiscounted medical bills to establish the “reasonable value” of the medical services received. The defendants, however, may submit evidence that the plaintiff’s medical providers accepted less than the full bills to rebut the reasonableness of the full bills, so long as insurance is not mentioned.

4. **“Hybrid Formula.” Florida** is an example of a state which has a more complicated approach. It recently passed H.B. 837, a sweeping tort reform bill which now Fl. Legis. 2023-15, 2023 Fla. Sess. Law Serv. Ch. 2023-15 (C.S.C.S.H.B. 837). establishes a new process for the calculation of medical damages in personal injury actions and outlines the evidence that a jury must consider in awarding medical damages. Under § 768.0427, a jury must now consider evidence of the amount paid for *past* medical services, even if paid for by an insurance company or workers’ compensation at discounted rates. With regard to *future* medical expenses, the jury must consider evidence of damages in amounts that vary according to whether the plaintiff has private insurance or Medicare or Medicaid. The jury must consider any evidence of reasonable amounts billed to the claimant for medically necessary treatment or services. The new Florida law prohibits an award of medical damages which exceeds the total of the amount actually paid by or on behalf of the plaintiff to the healthcare provider, the amount of charges for medical services that are owed at the time of trial and the amount of charges for any reasonable and necessary future medical treatment. Plaintiffs will only be able to present evidence of medical expenses in the amount *actually paid* for the services, not the original “retail” amount billed which is often an amount which is inflated to make up for Medicaid/Medicare and insurance reductions in medical payments.

In determining the amount of damages to be presented as evidence in a personal injury trial, judges are often called on to decide whether to admit as evidence the higher, billed amount, the lesser amount actually paid as the cost of services rendered after the write-off, or both. They must also decide what final amount the injured plaintiff is entitled to recover as an element of damages. The result is a very awkward collision between the realities of today’s health insurance industry, modern medical billing, and a 200-year-old legal rule known as the Collateral Source Rule (CSR).

### ***Collateral Source Rule (CSR)***

The modern Collateral Source Rule (CSR) has been called one of “the oddities of American accident law.” John G. Fleming. *The Collateral Source Rule and Loss Allocation in Tort Law*, 54 CAL. L. REV. 1478 (1966). The CSR states that if an injured party (plaintiff) in a civil lawsuit receives benefits from an insurance policy or some other source independent of the third-party tortfeasor (defendant), such “collateral” benefits will not be revealed to the jury or introduced into *evidence*, and will not be deducted from the total *damages* awarded to the plaintiff. Such damages paid by a collateral source are also sometimes pejoratively referred to as “phantom damages.” The *Restatement of Torts, Second*, defines the CSR in § 920A(2):

#### ***§ 920A Effect of Payments Made to Injured Party***

*(1) A payment made by a tortfeasor or by a person acting for him to a person whom he has injured is credited against his tort liability, as are payments made by another who is, or believes he is, subject to the same tort liability.*

*(2) Payments made to or benefits conferred on the injured party from other sources are not credited against the tortfeasor's liability, although they cover all or a part of the harm for which the tortfeasor is liable.*

The CSR is both a *rule of damages* and a *rule of evidence*. As a rule of damages, it prohibits the tortfeasor from reducing payment of a tort judgment by the amount of money received by an injured party from other sources. As a rule of evidence, it bars the admission of evidence that the injured plaintiff received payment for any part of his damages, usually medical expenses, from other sources. Simply put, the CSR requires the party responsible for causing the injury to compensate the victim of the accident for all harm caused and not merely the net loss suffered by a victim. The rationale behind the rule is that if the plaintiff was himself responsible for the collateral benefit, as by maintaining his own insurance or by making advantageous employment arrangements, the law allows him to keep it for himself. If the benefit was a gift to the plaintiff from a third party or established for him by law, he should not be deprived of the advantage that it confers.

The underlying rationale for this plaintiff-friendly rule is that if the law must choose between allowing the plaintiff to receive more than his actual loss or allowing the defendant to pay less than the damage he inflicted, then the more equitable choice is to allow the plaintiff to receive more than his loss, rather than giving the defendant the windfall of the prudent plaintiff. If the plaintiff has obtained and paid for medical insurance, he should receive the benefit of that bargain: the plaintiff’s insurance should not indemnify the defendant. Proponents claim evidence of collateral sources is irrelevant and prejudicial. Even if the insurer has a right of subrogation against

the plaintiff's recovery, that right should not inure to the benefit of the defendant. In practice, the CSR never requires the defendant to pay twice, and rarely allows the plaintiff to retain a windfall. The collateral benefits are usually paid for by the plaintiff, subject to a right of subrogation, or both. In states which have eliminated the CSR or modified it by statute, trial lawyers argue that the existence and amount of liability insurance should also be admissible in civil trials, putting all the cards on the table for a jury. They also argue that, if the CSR can be modified, allowing evidence of collateral sources, then the discounted medical bills should be considered proven as reasonable and necessary upon testimony by the patient that the bills were incurred.

History of Collateral Source Rule(CSR). The CSR is a relatively new legal concept in the common law. Before there were significant "collateral sources", such as health insurance, workers' compensation, auto insurance, etc., there was no need for the rule. The concept behind the rule originated from common law in England as early as 1823. It was adopted in the U.S. in 1854. *The Propeller Monticello v. Mollison*, 58 U.S. (17 How.) 152 (1854). The actual term "collateral source" derived from language used in a **Vermont** decision some years later. *Harding v. Town of Townshend*, 43 Vt. 536 (1871). The Vermont Supreme Court described the rule in terms similar to those used by the U.S. Supreme Court in *Mollison*, but the Vermont Court for the first time characterized insurance proceeds received by the plaintiff as "collateral" to any recovery from the wrongdoer. Over time, all fifty states adopted some form of the CSR and followed the rule in its traditional form.

Over time, and especially during the recent era of tort reform, the CSR has received unfavorable press. The impetus for changing the rule came from the perceived crisis in medical costs when medical malpractice litigation allegedly proliferated over the past three decades, and medical malpractice litigation was blamed by some as a significant cause. Doctors and their liability insurers were particularly outraged when asked to pay malpractice judgments that included not only very large sums for non-economic losses, but also the doctor's own services, corrective services, and additional health care for which the patient had been fully compensated by health insurance programs of one sort or another. Banks McDowell, *The Collateral Source Rule—The American Medical Association and Tort Reform*, 24 Washburn L.J. 205 (Winter 1985). The emphasis in some jurisdictions began to switch from not allowing the plaintiffs' purchase of collateral sources to become a windfall for the negligent tortfeasor, to preventing the plaintiff from recovering twice for the same element of damage (e.g., medical expenses recovered once from an insurance policy and a second time from the defendant). States began to enact collateral source statutes which significantly modified or altered the common law rule.

The common law CSR developed during a time when health insurance and publicly provided health benefits did not exist. Ever-changing circumstances in health insurance and health care billing have prompted reconsideration and modification of the CSR in many jurisdictions. This is especially true with regard to recovering reasonable and necessary damages in personal injury litigation. **Tennessee** recently established its long-awaited rule in *Dedmon v. Steelman*, 2017 WL 5505409 (Tenn. 2017). There was hope within the Tennessee Defense Lawyers' Association that the present rule, that allowed plaintiffs to submit evidence of the full, undiscounted medical bills as proof of the "reasonable" value of medical services, would finally end. On November 11, 2017, the Supreme Court declined to alter existing law in Tennessee, holding that the CSR applies to the proof and recovery of past medical expenses in personal injury cases, despite deep write-offs and the payment of the bill by private health insurance. Consequently, plaintiffs may continue to submit evidence of the plaintiff's full, undiscounted medical bills as proof of reasonable medical expenses. Furthermore, defendants are precluded from submitting evidence of discounted rates accepted by medical providers from the insurer to rebut the plaintiffs' proof that the full, undiscounted charges are reasonable. They remain free, however, to submit any other competent evidence to rebut the plaintiffs' proof on the reasonableness of the medical expenses, so long as that evidence does not contravene the CSR. Three years earlier, the Supreme Court had held that, in the context of the Hospital Lien Act (§ 29-22-101), the term "reasonable and necessary medical expenses" limits the charges to the discounted cost of medical care that is paid by a private insurer or collateral source provider. *West v. Shelby County Healthcare Corp.*, 459 S.W.3d 33 (Tenn. 2014). At the time of the *Dedmon* decision, three federal district courts in Tennessee had concluded that the *West* rule applied in personal injury litigation as well. *Smith v. Lopez-Miranda*, 2016 WL 1083845 (W.D. Tenn. 2016); *Hall v. USF Holland, Inc.*, 2016 WL 361583 (W.D. Tenn. 2016); *Keltner v. U.S.*, 2015 WL 3688461 (W.D. Tenn. 2015).

Statutes. A few states, including **Arkansas** and **Kentucky**, have abrogated the CSR to some degree by statute. This is sometimes done as part of broader tort reform legislation, as in **Texas** and **Missouri**. Some states, including **Indiana**, **Alabama**, **Ohio**, and **Iowa**, have legislated a "hybrid" rule which allows the jury to consider evidence of both the plaintiff's undiscounted medical bills and the discounted amounts, to assess the reasonableness of the plaintiff's medical expenses. States such as **Tennessee** have abrogated the CSR through legislation, but only in health care liability and workers' compensation cases.

Under the Longshore and Harbor Workers' Compensation Act (LHWCA), found at 33 U.S.C. § 901-950, an employee who has filed a third-party action may only recover the amount of medical expenses actually paid by the LHWCA insurer, not the amount billed. *Deperrodil v. Bozovic Marine, Inc.*, 842 F.3d 352 (5<sup>th</sup> Cir. 2016). This decision resolved a dispute that had been raging in every Longshore case where the longshore employee demanded reimbursement for all medical expenses billed by the provider, including all amounts written off. In more serious cases, the difference was substantial.

*Common Law / Case Decisions.* Only a few states have limited plaintiffs' medical expense damages to the discounted insurance amounts, but it is a growing trend. A few states allow defendants to use the insurance payments to reduce their liability. Both approaches violate the CSR and result in plaintiffs with insurance being treated quite differently from plaintiffs without insurance. Neither approach considers benefits other than private insurance, such as Medicaid, state Medicaid programs, charity, employer benevolence, or gifts. The means and methods of pleading, proving, and recovering medical expenses, however, remain inextricably tethered to the CSR.

The interplay between the CSR and the recovery of the full, undiscounted amount of medical expenses, can be set forth by statute, through common law and case decisions, and frequently through a combination of both. Some jurisdictions have not formulated a clear view, while others have taken inconsistent approaches depending on the facts involved or the court rendering the decision. In some states, statutes act as a rule of *evidence*, governing what evidence is allowed in proving the reasonableness of medical expenses. In other states, statutes act as a rule of *damages*, limiting recovery to discounted amounts after "write-offs."

Despite becoming a firmly established principle of tort law in most states, many questions have arisen concerning the scope of the CSR: Does it apply to free medical services? Does it apply to services paid by Medicare or Medicaid? Can a plaintiff submit to the jury the amount initially billed for medical services, as opposed to a discounted amount that her private insurance company paid to her health care providers? What are the proper foundational requirements to introduce an unpaid medical bill? Can the defense introduce evidence of the discounted amount actually paid? Can the trial court reduce a plaintiff's damages award to the amount actually paid by the collateral source? Some states have answered these questions, while others haven't.

A thorough understanding of how medical expenses are proven and recovered in civil litigation is a necessity for lawyers, legislators, claims professionals, and judges alike. The law regarding what evidence can be used to prove medical expenses and the amount of medical expenses that can be recovered by a plaintiff in cases involving personal injury has been changing from state to state at light speed. A few states have even declared their CSR to be unconstitutional. The following chart provides an overview as to the law in all 50 states regarding the pleading, proof, and recovery of past medical expenses that have been fully or partially paid by collateral sources such as private insurance.

### ***Recent Developments and Trends in Collateral Source Rules***

Over the past two decades, courts and legislatures have increasingly moved away from a uniform application of the traditional Collateral Source Rule and toward a more nuanced analysis of what constitutes "reasonable" medical expenses. The central issue in modern collateral source jurisprudence is no longer whether collateral benefits exist, but whether the plaintiff has actually "incurred" the full amount of the medical charges billed, particularly in cases involving private insurance, Medicare, or Medicaid write-offs.

A growing number of jurisdictions have adopted, either by judicial decision or statute, an "amount paid" approach, limiting recovery of past medical expenses to the amounts actually paid by or on behalf of the plaintiff, together with any amounts still owed at the time of trial. The leading case adopting this approach is *Howell v. Hamilton Meats & Provisions, Inc.*, 52 Cal. 4th 541 (2011), in which the California Supreme Court held that an insured plaintiff may recover no more than the amounts actually paid or incurred for medical services, and that negotiated rate differentials are not recoverable because they were never incurred by the plaintiff. This reasoning has been followed or echoed in a number of jurisdictions and reflects an increasing judicial concern with preventing perceived "phantom damages."

Other courts continue to adhere to the traditional collateral source rule and permit recovery of the full amount billed, including amounts written off pursuant to contractual adjustments, reasoning that such write-offs constitute a collateral benefit for which the plaintiff has paid consideration. See, e.g., *Acuar v. Letourneau*, 531

S.E.2d 316 (Va. 2000). These courts emphasize that the fundamental purpose of the rule is to prevent the tortfeasor from benefitting from the plaintiff's prudence in securing insurance or other benefits.

A third and increasingly common approach is a "hybrid" model, which distinguishes between the admissibility of evidence and the ultimate measure of recoverable damages. Under this approach, courts may allow evidence of both the amount billed and the amount paid for the purpose of determining the "reasonable value" of medical services, while limiting the plaintiff's ultimate recovery to amounts actually paid or owed. This approach reflects a recognition that modern medical billing practices often render billed charges unreliable indicators of value.

Recent legislative reforms have accelerated this trend. For example, Florida's enactment of § 768.0427, Fla. Stat., as part of H.B. 837 (2023), fundamentally altered the treatment of medical damages by requiring that juries consider evidence of amounts actually paid and by capping recoverable damages to amounts paid, amounts owed, and reasonable future expenses. Similarly, other states have enacted statutes requiring post-verdict setoffs or limiting admissible evidence to amounts actually paid.

Courts have also increasingly distinguished between private insurance write-offs and government program payments. In *Goble v. Frohman*, 901 So. 2d 830 (Fla. 2005), the Florida Supreme Court held that contractual discounts constitute collateral sources subject to setoff, while in *Stayton v. Delaware Health Corp.*, 117 A.3d 521 (Del. 2015), the Delaware Supreme Court held that Medicare payments define the reasonable value of medical services and preclude recovery of higher billed amounts. These decisions reflect a growing willingness to treat government reimbursement schemes as setting the benchmark for reasonable value.

These developments have created a pronounced divergence among jurisdictions, with no clear majority rule. The result is a highly fact-specific and jurisdiction-dependent analysis of medical expense damages, requiring careful attention to both evidentiary rules and substantive limitations on recovery.

***Note: The rules summarized in this chart often involve two distinct inquiries: (1) the admissibility of evidence concerning medical expenses and collateral source payments at trial, and (2) the ultimate measure of damages recoverable by the plaintiff. Many jurisdictions treat these issues separately, permitting or excluding certain evidence while independently limiting or allowing recovery of medical expenses through statutory provisions, post-verdict setoffs, or common law principles. Accordingly, each jurisdiction should be evaluated with respect to both evidentiary admissibility and substantive recoverability.***

STATE	COLLATERAL SOURCE RULE	RECOVERY OF MEDICAL EXPENSES RULE	RELATED LAW / COMMENTS
ALABAMA	<p>Alabama recognizes the CSR but modified it by statute as a rule of evidence. Evidence of plaintiff's receipt of collateral sources, such as insurance, admissible. <i>Ensor v. Wilson</i>, 519 So.2d 1244 (Ala. 1987); <i>Jones v. Crawford</i>, 361 So.2d 518 (Ala. 1978); <i>Gribble v. Cox</i>, 349 So.2d 1141 (Ala. 1977).</p> <p>CSR modified by statute (see right) in 1979 for product liability cases, and in 1987 for medical malpractice and civil actions generally (see right).</p> <p>Alabama law regarding the CSR and its exceptions remains murky.</p>	<p>CSR modified by statute as a rule of evidence, eliminating the write-off issue for all practical purposes. In <i>all civil actions</i>, defendant can introduce evidence of collateral source payments of medical expenses. If defendant does, plaintiff can introduce evidence of the costs of obtaining those collateral source payments, as well as evidence of subrogation obligations. <i>Addresses evidence only. Damage recovery determined by common law.</i> Ala. Stat. § 12-21-45.</p> <p>Defendant may argue that reimbursing plaintiff for medical expenses already paid by an insurer is a double recovery. Plaintiff may argue that the defendant reaps a windfall unless additional damages are awarded, to compensate the plaintiff for having the discipline and foresight to purchase insurance.</p> <p>Plaintiff is free to introduce gross amount of medical expenses billed. <i>Hull v. Jackson</i>, 794 So.2d 349 (Ala. 2001).</p> <p>Section 12-21-45 held unconstitutional in 1996. <i>American Legion Post No. 57 v. Leahey</i>, 681 So.2d 1337 (Ala. 1996). Then held constitutional in 2000. <i>Marsh v. Green</i>, 782 So.2d 223 (Ala. 2000).</p> <p>Recent federal decisions applying Alabama law have continued to recognize the admissibility of collateral source payments under Ala. Code § 12-21-45, while reaffirming that the statute governs evidence rather than the measure of damages, leaving the ultimate determination of recoverable medical expenses to the jury under common law principles. <i>Bobo v. Tennessee Valley Auth.</i>, 855 F.3d 1294 (11th Cir. 2017).</p>	<p>No law governing specifically with Medicare /Medicaid write-downs.</p> <p>In <i>product liability</i> suits, proof that plaintiff's medical expenses paid by medical, hospital, or workers' compensation insurance is admissible. Plaintiff's cost of obtaining them is admissible. Ala. Code. § 6-5-522. However, collateral sources inadmissible if they must be repaid due to subrogation. Ala. Stat. § 6-5-524.</p> <p>In <i>medical malpractice</i> suit, collateral sources and plaintiff's cost of obtaining them are admissible. Plaintiff can show obligation to repay subrogation, but <i>doesn't</i> affect admissibility of collateral sources by defendant. Ala. Stat. § 6-5-545.</p> <p>Litigants usually stipulate to (1) gross amount of medical bills; (2) amount of bills paid by insurance or other collateral sources; (3) the amount of any write-down or write-off; and (4) the plaintiff's out-of-pocket payments or subrogation obligations.</p>

STATE	COLLATERAL SOURCE RULE	RECOVERY OF MEDICAL EXPENSES RULE	RELATED LAW / COMMENTS
ALASKA	<p>Alaska recognizes the CSR. <i>Beaulieu v. Elliott</i>, 434 P.2d 665 (Alaska 1967). Plaintiff's damages not reduced by "collateral source." No evidence of collateral source allowed because it would affect jury's judgment unfavorably to plaintiff on both liability and damages. <i>Tolan v. ERA Helicopters, Inc.</i>, 699 P.2d 1265 (Alaska 1985); <i>Loncar v. Gray</i>, 28 P.3d 928 (Alaska 2001) (involved evidence of Medicaid coverage).</p>	<p>An Alaska statute modifies the CSR. After jury has rendered verdict and court has awarded costs and attorney's fees, Alaska statute allows defendant to introduce collateral source payments that are not subject to subrogation. Defendant may not introduce evidence of federal benefits, life insurance, and gratuitous benefits. If defendant introduces evidence of collateral sources, plaintiff may show that his attorneys' fees exceeded those awarded by court and the amounts he paid to secure the insurance benefits. If amount of collateral benefits exceeds plaintiff's attorneys' fees and cost of insurance, the court deducts the excess from the jury award. This statute does not apply to medical malpractice actions. Alaska Stat. § 9.17.070.</p>	<p>The amount to which a medical bill is lowered ("negotiated rate") is part of the value of that collateral benefit and should not accrue to the defendant. Alaska follows "reasonable value" approach in which the plaintiff is allowed to introduce the full, undiscounted medical bills into evidence at trial. However, both the actual amounts paid <i>and</i> any amounts the provider wrote off are relevant to the medical services' reasonable value. Defendants must adhere to the CSR but are free to cross-examine any witnesses that a plaintiff might call to establish reasonableness, and the defense is also free to call its own witnesses to testify that the billed amounts do not reflect the reasonable value of the services." Such evidence may include, for example, testimony about the range of charges the provider has for the same services or what other providers in the relevant area charge for the same services. Lastly, to the extent the negotiated rate differential represents a collateral benefit for which the collateral source has no "right of subrogation by law or contract," it is subject to the post-verdict procedure set out in § 09.17.070.</p> <p><i>Weston v. AKHappytime, LLC</i>, 2019 WL 3519685 (Alaska, 2019) (case involving Medicare payments but applied to all "negotiated rates.")</p>

STATE	COLLATERAL SOURCE RULE	RECOVERY OF MEDICAL EXPENSES RULE	RELATED LAW / COMMENTS
ARIZONA	<p>Arizona broadly recognizes the CSR.</p> <p>Payments made to plaintiff from other sources are not credited against the tortfeasor's liability, although they cover all or a part of the harm for which the tortfeasor is liable. <i>Lopez v. Safeway Stores, Inc.</i>, 129 P.3d 487 (Ariz. App. 2006).</p>	<p>Plaintiffs can submit evidence of and recover the full amount of reasonable medical expenses that they are billed, without any reduction for write-offs or write-downs. The court did not distinguish between Medicare, Medicaid, or private insurance write-offs. A write-off is considered a collateral source.</p> <p>CSR usually applied in cases where plaintiff recovers amounts that he has already been compensated by his insurer, but it applies when, due to a healthcare provider's gratuitous treatment or write-downs, a plaintiff neither incurs nor is responsible for payment of the reasonable value of medical services, but nonetheless can claim and recover compensation for that value from the tortfeasor. <i>Lopez v. Safeway Stores, Inc.</i>, 129 P.3d 487 (Ariz. App. 2006).</p> <p>Recent federal authority applying Arizona law has confirmed that, while the collateral source rule permits recovery of billed amounts, insurers in first-party contexts are only obligated to pay "reasonable expenses actually incurred," reinforcing the distinction between tort recovery and contractual reimbursement. <i>Jimenez v. Progressive Preferred Ins. Co.</i>, 2020 WL 2037113 (D. Ariz. 2020).</p>	<p>Plaintiff may not use CSR in medical negligence case. Defendant can introduce collateral sources and jury can offset any verdict. Plaintiff can then show that recovery is subject to subrogation or lien. Although statute allows the admission of such evidence, there is no guarantee that the jury will necessarily use that evidence in deciding an award of damages. A.R.S. § 12-565(A).</p> <p>In a case of first impression, the Supreme Court held that necessary medical expenses that were paid by an HMO to treat an insured were <i>incurred</i> by the insured within the meaning of auto policy coverage for all reasonable expenses actually incurred by an insured person, even though the insured was not directly and legally liable and would receive a windfall from the auto insurer. <i>Samsel v. Allstate Ins. Co.</i>, 59 P.3d 281 (Ariz. 2002).</p> <p>In first-party Med Pay claims, the Med Pay carrier is responsible for paying only the "reasonable expenses incurred for necessary medical services", and not the original billed amounts. <i>Jimenez v. Progressive Preferred Ins. Co.</i>, 2020 WL 2037113 (D. Ariz. 2020).</p>

STATE	COLLATERAL SOURCE RULE	RECOVERY OF MEDICAL EXPENSES RULE	RELATED LAW / COMMENTS
<p style="text-align: center;"><b>ARKANSAS</b></p>	<p>Arkansas applies the common law version of the CSR. <i>Montgomery Ward &amp; Co., Inc. v. Anderson</i>, 976 S.W.2d 382 (Ark. 1998).</p> <p>Court must “exclude evidence of payments received by an injured party from collateral sources such as private insurance or government benefits. <i>Bell v. Estate of Bell</i>, 885 S.W.2d 877 (Ark. 1994).</p> <p>However, the enactment of Ark. Code Ann. § 16-64-120(b) (2025) significantly limits the practical effect of the collateral source rule with respect to medical expenses by restricting recovery to amounts actually paid or owed, thereby preventing recovery of write-offs or negotiated rate differentials.</p>	<p>Arkansas now limits recovery of past medical expenses to amounts actually paid or that remain unpaid and for which the plaintiff or a third party is legally responsible. Ark. Code Ann. § 16-64-120(b) (as amended by 2025 Ark. Acts HB 1204). This statutory amendment effectively adopts an ‘amount paid’ approach and supersedes prior case law allowing recovery of the full billed amount. The statute mirrors the previously invalidated language of § 16-55-212(b), but is now codified within the damages statute governing medical expense recovery. As a result, plaintiffs may no longer recover amounts written off or contractually adjusted by providers.</p>	<p>There are only four situations in which a collateral source may be introduced: (1) to rebut the plaintiff’s testimony that he was compelled by financial necessity to return to work prematurely or to forego additional medical care; (2) to show that the plaintiff had attributed his condition to some other cause, such as sickness; (3) to impeach the plaintiff’s testimony that he had paid his medical expenses himself; (4) to show that the plaintiff had actually continued to work instead of being out of work, as claimed. <i>Evans v. Wilson</i>, 650 S.W.2d 569 (Ark. 1983). These evidentiary exceptions remain viable, but their practical significance is diminished in light of the statutory limitation on recoverable medical expenses.</p> <p>In 2025, Arkansas enacted HB 1204, amending Ark. Code Ann. § 16-64-120 to provide that recovery of damages for past medical care ‘includes only those costs actually paid by or on behalf of the plaintiff or that remain unpaid and for which the plaintiff or any third party is legally responsible.’ This amendment effectively abrogates prior case law permitting recovery of the full billed value of medical services and aligns Arkansas with jurisdictions adopting an ‘actual amount paid’ framework. The amendment also resolves the constitutional issues identified in <i>Johnson v. Rockwell Automation, Inc.</i>, 308 S.W.3d 135 (Ark. 2009), by relocating similar language into a different statutory scheme governing damages.</p>

STATE	COLLATERAL SOURCE RULE	RECOVERY OF MEDICAL EXPENSES RULE	RELATED LAW / COMMENTS
CALIFORNIA	<p>California applies the common law version of the CSR. If plaintiff receives compensation from a source wholly independent of the tortfeasor, evidence of same is inadmissible and it may not be deducted from plaintiff's damages. <i>Helfend v. S. Cal. Rapid Transit Dist.</i>, 465 P.2d 61 (Cal. 1970).</p> <p>Even if relevant on another issue (for example, to support a defense claim of malingering), under Evidence Code § 352, the probative value of a collateral payment must be "carefully weighed ... against the inevitable prejudicial impact such evidence is likely to have on the jury's deliberations". <i>Hrnjak v. Graymar, Inc.</i>, 484 P.2d 599 (Cal. 1071).</p>	<p><u>Private Insurance</u>: The negotiated rate differential (full amount billed vs. write-off or write-down) is not a collateral payment or benefit subject to the CSR. However, the CSR still applies with full force to sources that fit the rule. Recovery of medical expenses limited to the negotiated cash payments made by insurer, any co-payments or deductibles, as well as any amounts still owing. The court did not address the rules of evidence. <i>Howell v. Hamilton Meats &amp; Provisions, Inc.</i>, 257 P.3d 1130, 1136 (Cal. 2011).</p> <p>Evidence of the full amount billed for a plaintiff's medical care is not relevant to the determination of a plaintiff's damages for past medical expenses and, therefore, is inadmissible for that purpose if the plaintiff's medical providers, by prior agreement, had contracted to accept a lesser amount as full payment for the services provided. <i>Corenbaum v. Lampkin</i>, 156 Cal. Rptr.3d 347 (Cal. App. 2013), as modified (May 13, 2013).</p> <p><u>Medicare/Medicaid</u>: Plaintiff entitled to only the amount actually paid by Medi-Cal on plaintiff's behalf, but not more. <i>Hanif v. Hous. Auth.</i>, 246 Cal. Rptr. 192 (Ct. App. 1988).</p>	<p><u>Medical Malpractice</u>: Defendant can introduce collateral payments and benefits and plaintiff can introduce evidence of premiums paid or contributions to secure these benefits. Cal. Civ. Code § 3333.1(a).</p> <p><u>Public Entity</u>: Collateral source inadmissible, but governmental entity can move, after trial, to reduce a personal injury award by the amount of certain collateral source payments. Court has discretion to reduce the judgment, though its discretion is guided and limited in several respects, including that the total deduction may not exceed one-half of the plaintiff's net recovery. Cal. Gov't Code § 985(b).</p> <p>Subsequent decisions have reinforced that evidence of the full amount billed is inadmissible not only to prove past medical expenses but also as a basis for expert opinion regarding future medical damages. See <i>Pebley v. Santa Clara Organics, LLC</i>, 22 Cal. App. 5th 1266 (2018).</p>

STATE	COLLATERAL SOURCE RULE	RECOVERY OF MEDICAL EXPENSES RULE	RELATED LAW / COMMENTS
<p style="text-align: center;"><b>COLORADO</b></p>	<p>CSR governed by both common law and statute.</p> <p>COMMON LAW: Collateral source evidence inadmissible and not deducted from verdict. <i>Volunteers of Am. Colo. Branch v. Gardenswartz</i>, 242 P.3d 1080 (Colo. 2010). The policy reason is that tortfeasor should not benefit from a collateral source to which he has not contributed. If anybody gets a windfall, it should be the injured victim.</p> <p>POST-VERDICT SETOFF: In 1986, § 13-21-111.6 changed the post-verdict setoff component of the common law CSR. It allows reduction of verdict by collateral source amount and prevents a double recovery. But it has a contract exception.</p> <p><u>Contract Exception</u>: When collateral source pays because of a contract entered into and paid for by the plaintiff, common law CSR follows. If collateral source is found liable for injuries, this exception doesn't apply.</p> <p>PRE-VERDICT EVIDENCE RULE: C.R.S. § 10-1-135(10)(a) In 2010, codified common law pre-verdict evidentiary component of CSR. Pre-verdict evidence of "any collateral source payment or benefits" is excluded and may not be included for any purpose. <i>Crossgrove v. Wal-Mart Stores, Inc.</i>, 280 P.3d 29 (Colo. App. 2010), <i>aff'd</i>, 276 P.3d 562 (Colo. 2012).</p>	<p><u>Private Insurance</u>: Amount billed is proper measure of damages. Under contract exception to § 13-21-111.6, plaintiff is entitled to damages in the amount charged by the health care providers, as opposed to the amount paid by the plaintiff's insurance carrier. <i>Tucker v. Volunteers of Am. Colo. Branch</i>, 211 P.3d 708 (Colo. App. 2008), <i>aff'd and remanded sub nom., Volunteers of Am. Colo. Branch v. Gardenswartz</i>, 242 P.3d 1080 (Colo. 2010). Where a plaintiff's insurer has obliged a medical provider to accept a discounted rate for services (or a "write off" of a portion of the bill), the reduced rate constitutes a benefit received from a collateral source. <i>Scholle v. Delta Air Lines, Inc.</i>, 486 P.3d 325 (Colo. App. 2019). In <i>Scholle</i>, the court held:</p> <ul style="list-style-type: none"> <li>• The Collateral Source Rule barred admissibility of the medical expenses paid by the workers' comp insurer.</li> <li>• The plaintiff could present evidence of the higher medical expenses actually billed by his medical providers.</li> <li>• At most, the defendant, by way of its settlement with the comp carrier, may receive a post-trial set-off against any damages awarded to the plaintiff.</li> </ul> <p><u>Medicare/Medicaid</u>: No published decisions. However, unpublished federal court decision suggests that proper measure of damages is amount billed, not the amount paid. <i>Krauss v. Beach</i>, 2008 WL 4371939 (D. Colo. Sept. 23, 2008). However, as described herein, defendant is entitled to a post-verdict set-off for <i>Medicaid</i> payments, but not <i>Medicare</i>.</p> <p>In 2017, SB17-181 bill pending that would allow pre-verdict evidence of collateral source unless plaintiff agrees to have jury's verdict reduced by lesser of: (1) amount of collateral source; or (2) amount of premiums or other contributions the plaintiff paid to those collateral sources. Original CSR retained if defendant convicted of second or subsequent DWI.</p>	<p>Gratuitous medical care, including <i>Medicaid</i>, is covered under statutory rule and is set-off from the plaintiff's damages award. However, contract exception means that collateral source from any contracts for which a plaintiff pays, whether in the form of money or employment, with the expectation of receiving future benefit, is not set-off. This includes <i>Medicare</i> and private medical insurance. <i>Keelan v. Van Waters &amp; Rogers, Inc.</i>, 820 P.2d 11457 (Colo. App. 1991), <i>aff'd</i>, 840 P.2d 1070 (Colo. 1992).</p> <p><u>Medical Malpractice</u>: Under Health Care Availability Act, post-verdict reduction by the amount of collateral source. However, no reduction where collateral is result of a contract entered into and paid for by the plaintiff, such as insurance, Medicare. C.R.S. § 13-64-402.</p> <p><u>Workers' Compensation</u>: The carrier can settle directly with the tortfeasors and this extinguishes the employee's claims for medical expenses, even if the employee was claiming the amounts billed as opposed to the amounts allowed by the fee schedule. <i>Delta Air Lines v. Scholle</i>, 2021 WL 1345492 (Colo. 2021); <i>Gill v. Christopher Allen Waltz and Swift Transportation Co., LLC</i>, 2021 WL 1345490 (Colo. 2021).</p> <p>More recent appellate decisions continue to treat negotiated rate differentials as collateral benefits subject to the common law rule, while preserving the statutory post-verdict setoff mechanism. See <i>Scholle v. Delta Air Lines, Inc.</i>, 486 P.3d 325 (Colo. App. 2019).</p>

STATE	COLLATERAL SOURCE RULE	RECOVERY OF MEDICAL EXPENSES RULE	RELATED LAW / COMMENTS
CONNECTICUT	<p>In 1986, Connecticut enacted a statute that altered and rejected the common law CSR. Section 52-225a requires post-verdict reduction of the economic damages awarded by the amount of collateral sources received. <i>Hernandez v. Marquez</i>, 2004 WL 113616 (Conn. Super. 2004). It authorizes reducing economic damages award by an amount equal to the sum of collateral source payments received, less any amount paid by or on behalf of the plaintiff to secure those payments. <i>Jones v. Kramer</i>, 806 A.2d 606 (Conn. App. 2002).</p> <p>Collateral sources are any payment through: (1) any health or sickness insurance, auto accident insurance that provides health benefits, except life insurance benefits available to the claimant, whether purchased by him or provided by others; or (2) any contract/agreement of any group, organization, to provide, pay for or reimburse the costs of health care services." C.G.S.A. § 52-225b. It does <u>not</u> include workers' compensation benefits. <i>Mason v. ING Life Ins. &amp; Annuity Co.</i>, 2012 WL 432592 (Conn. Super. 2012). Nor does it include the providers' involuntary write-off in accordance with the workers' compensation regulatory scheme. <i>Betz v. Belliveau</i>, No. CV146027161S, 2016 WL 1444106, at *3 (Conn. Super. Ct. Mar. 22, 2016).</p> <p><u>Two exceptions.</u> No reduction for (1) any collateral source for which a right of subrogation exists, and (2) the percentage of the plaintiff's own negligence. C.G.S.A. § 52-225a(a).</p>	<p><u>Private Insurance:</u> Evidence of billed medical expenses allowed. Voluntary write-offs are not "collateral sources" and, therefore, may not be deducted from a verdict. <i>Id.</i>; <i>McInnis v. Hospital of St. Raphael</i>, 2008 WL 4150056 (Conn. Super. 2008). When medical bills written off involuntarily (<i>i.e.</i>, pursuant to the requirements of an insurance contract or agreement), such write-offs <i>do</i> qualify as collateral source payments. No special rules regarding write-offs by private insurers. Whether such write-offs are collateral sources depends upon whether they were forgiven voluntarily or pursuant to a contract.</p> <p><u>Medicare/Medicaid:</u> Evidence of billed medical expenses allowed. Medicare write-offs are collateral sources because they are statutorily-required. <i>McInnis</i>, <i>supra</i>. Medicaid write-offs are subject to collateral source reductions. <i>Zogai v. Jacobs</i>, 2019 WL 7630765 (Conn. Super. 2019); <i>Ventura v. Town of East Haven</i>, 2015 WL 1588816 (Conn. Super. 2015), <i>rev'd on other grounds</i> 170 Conn. App. 388 (2017); <i>McInnis v. Hospital of St. Raphael</i>, 2008 WL 4150056 (Conn. Super. 2008).</p> <p>However, a Connecticut Superior Court has held to the contrary. <i>Zhuta v. Zhuta</i>, 2007 WL 2363387 (Conn. Super. 2007). In <i>Hassett v. New Haven</i>, 91 Conn. App. 245 (2005), the court distinguished between voluntary discounts, which are not collateral source "payments," and involuntary discounts, such as those required by Medicaid and Medicare, which he characterized in dictum as "write-offs of bills beyond the amount paid by Medicare/Medicaid [that] are involuntary statutory/contractual payments which constitute collateral sources which will reduce the plaintiff's economic damages." These decisions were all decided before the Supreme Court's decision in <i>Marciano</i>.</p> <p>The Connecticut Supreme Court has clarified that no collateral source reduction is permitted where the benefit is subject to a valid right of subrogation, even if the lien is later compromised. <i>Marciano v. Jimenez</i>, 151 A.3d 1280 (Conn. 2016).</p>	<p>In recent Connecticut Supreme Court decision, jury awarded plaintiff \$84,283 in economic damages and \$40,000 in non-economic damages, for a total of \$124,283. Following trial, the defendants requested a collateral source reduction. The Superior Court calculated the collateral source reduction by subtracting the cost to secure the collateral source benefits (\$58,042.43) from payments made to plaintiff by the health insurer (\$82,342.18). This amounted to a collateral source reduction of \$24,299.75. The court, therefore, reduced the total verdict from \$124,283.67 to \$99,983.92, plus costs. The health insurance plan at issue was an ERISA plan with a right of subrogation. Prior to the judgment the ERISA insurer had agreed to accept \$6,940.19 in full satisfaction of the right of subrogation in the event of a settlement for \$120,000. The court held that since there was a right of subrogation under the plain and unambiguous language of § 52-225a, there was no basis for any collateral source reduction of the jury verdict. <i>Marciano v. Jimenez</i>, 151 A.3d 1280 (Conn. 2016).</p> <p>Voluntary write-offs by medical providers are not collateral sources. <i>Hassett v. City of New Haven</i>, 858 A.2d 922 (2004), <i>aff'd</i>, 880 A.2d 975 (Conn. App. 2005).</p> <p>Section 52–225a has been construed to allow only payments specifically corresponding with items of damages included in the jury's verdict to be deducted as collateral sources from the economic damages award. <i>Jones v. Kramer</i>, 838 A.2d 170 (Conn. 2004).</p>

STATE	COLLATERAL SOURCE RULE	RECOVERY OF MEDICAL EXPENSES RULE	RELATED LAW / COMMENTS
DELAWARE	<p>Delaware follows the common law CSR. It is a cardinal principle of Delaware tort law. The collateral source must be unrelated to the tortfeasor, and the tortfeasor is entitled to present evidence of a collateral source to which it contributed. The plaintiff must have paid <i>consideration</i> for the source, although “even the slightest amount of consideration will suffice”. <i>Yarrington v. Thornburg</i>, 205 A.2d 1 (Del. 1964).</p> <p>Delaware has not enacted a direct statutory modification of the CSR. However, the no-fault statute, 21 Del. C. § 2118(g), limits the CSR by precluding an insured from suing a tortfeasor for damages for which compensation is available under the statute.</p>	<p><u>Private Insurance</u>: Gratuitous services and private health insurance payments subject to common law CSR. CSR applies to gratuitous write-offs by physicians and to payments by private health insurers. In those situations, plaintiff allowed to present to the jury the amount billed instead of the amount actually paid to the provider. Evidence of write-downs and write-offs is inadmissible. <i>Mitchell v. Haldar</i>, 883 A.2d 32 (Del. 2005).</p> <p>Discount from treating physician for cash payment by plaintiff was a collateral source, so plaintiff could recover the full price of medical services, excluding the discount, from the tortfeasor. <i>Kerr v. Onusko</i>, 2004 WL 2735456 (Del. Super. 2004), <i>aff'd</i>, 880 A.2d 1022 (Del. 2005) (approving <i>Restatement (Second) of Torts</i> § 920A(2) in this context).</p> <p>The requirement of consideration may be weakening. Recent case cited <b>Minnesota</b> law for the principle that under CSR, a plaintiff can recover the reasonable value of medical services provided even if those services were provided gratuitously. <i>Mitchell v. Haldar</i>, 883 A.2d 32 (Del. 2005), citing <i>Hueper v. Goodrich</i>, 314 N.W.2d 828 (Minn. 1982), superseded by statute as recognized in <i>Imlay v. Lake Crystal</i>, 453 N.W.2d 326 (Minn. 1990).</p> <p>The following decisions mark a significant departure from traditional collateral source principles by treating government reimbursement rates as dispositive of reasonable value for past medical expenses. <i>Stayton v. Delaware Health Corp.</i>, 117 A.3d 521 (Del. 2015); <i>Smith v. Mahoney</i>, 150 A.3d 1200 (Del. 2016).</p>	<p><u>Medicare</u>: As a matter of first impression, Supreme Court refused to extend the CSR to Medicare payments. The CSR could not be used to increase an injured party’s recovery of past medical expenses beyond those actually paid by Medicare. To determine the reasonable value of medical services where there are Medicare write-offs, the amount paid by Medicare is dispositive of the reasonable value of healthcare provider services. <i>Stayton v. Delaware Health Corp.</i>, 117 A.3d 521 (Del. 2015).</p> <p><u>Medicaid</u>: For same reasons expressed in <i>Stayton</i>, when Medicaid has paid medical expenses, the CSR cannot be used to increase an injured party’s recovery beyond those paid by Medicaid. The amount paid by Medicaid is conclusively reasonable. Future medical expenses not subject to Medicaid reimbursement limitations. Unlike Medicare, Medicaid coverage is income dependent, and might not be available if a plaintiff improves her financial position to a living wage and secures other insurance. Because of the uncertainty of future coverage, Medicaid benefits cannot be used to limit a plaintiff’s future medical expenses. <i>Smith v. Mahoney</i>, 150 A.3d 1200 (Del. 2016).</p> <p><u>Medical Malpractice</u>: Plaintiff can’t get a double recovery from a public source, such as Social Security or Medicare. 18 Del. C. § 6862.</p>

STATE	COLLATERAL SOURCE RULE	RECOVERY OF MEDICAL EXPENSES RULE	RELATED LAW / COMMENTS
DISTRICT OF COLUMBIA	<p>The common law CSR is followed in D.C. The receipt of payment from a collateral source may not be injected into a trial to mitigate damages or in any manner that would mislead, improperly influence, or prejudice the jury. <i>Jacobs v. H.L. Rust Co.</i>, 353 A.2d 6, 7 (D.C. 1976); <i>Bushong v. Park</i>, 837 A.2d 49 (D.C. 2003) (citing <i>Restatement (Second) of Torts</i> § 920A).</p>	<p><u>Private Insurance</u>: A plaintiff with private insurance can recover the unpaid and written-off medical expenses as damages. <i>Hardi v. Mezzanote</i>, 818 A.2d 974 (D.C. 2003).</p>	<p>In suits involving D.C., the CSR will not apply to medical expenses paid by D.C. <i>D.C. v. Jackson</i>, 451 A.2d 861, 871 (D.C. 1982) (Medicaid payments were not a collateral source for purposes of judgment against D.C.).</p>

STATE	COLLATERAL SOURCE RULE	RECOVERY OF MEDICAL EXPENSES RULE	RELATED LAW / COMMENTS
FLORIDA	<p>The landscape in Florida with regard to the proving and recovery of medical expenses, past and future, completely changed on March 24, 2023, with the passage of a major tort reform bill known as H.B. 837. Fl. Legis. 2023-15, 2023 Fla. Sess. Law Serv. Ch. 2023-15 (C.S.C.S.H.B. 837).</p> <p>A new statute (§ 768.0427) establishes a new process for the calculation of medical damages in personal injury actions for all actions filed after March 24, 2023. The jury must now consider evidence of the amount paid for past medical services, even if paid for by an insurance company or workers' compensation at discounted rates. With regard to future medical expenses, the jury must consider evidence of damages in amounts that vary according to whether the plaintiff has private insurance or Medicare or Medicaid. The jury must consider any evidence of reasonable amounts billed to the claimant for medically necessary treatment or services.</p>	<p>Past medical care. For expenses already paid by insurance, evidence is limited to the amount actually paid, regardless of source. For unpaid care, admissibility depends on coverage. If the plaintiff has private insurance, evidence is limited to the amount the insurer is obligated to pay. If the plaintiff has insurance but treats under a letter of protection, admissible evidence is limited to the amount the insurer would have paid, plus the claimant's share such as copays and coinsurance. If uninsured, evidence is capped at 120% of the Medicare reimbursement rate, or, if none exists, 170% of the applicable state Medicaid rate. Where a bill under a letter of protection is sold, admissible evidence is limited to the purchase price. Plaintiffs may also introduce evidence of reasonable amounts billed for medically necessary services.</p> <p>Future medical care follows the same framework. If the plaintiff has insurance other than Medicare or Medicaid, evidence is limited to the amount the insurer would pay. If uninsured, evidence is limited to 120% of the Medicare rate, or, if none exists, 170% of the Medicaid rate. A jury award for medical expenses may not exceed amounts actually paid, amounts necessary to satisfy outstanding charges, and amounts reasonably necessary for future care.</p> <p>The plaintiff must notify any party with subrogation rights and provide a copy of the complaint. Failure to provide a statement of benefits within 30 days results in waiver, and the subrogated party must cooperate. F.S.A. § 768.76(6)(7)(9). No-fault PIP benefits carry no subrogation rights and are set off from the verdict, while Med Pay benefits are not a collateral source and are not subject to set-off. F.S.A. § 627.736(3); Sutton v. Ashcraft, 671 So.2d 301 (Fla. App. 1996).</p> <p>Early application of § 768.0427 confirms it governs admissibility and recovery, codifying an "amount paid" framework for medical expenses. Dade County v. Ruiz, 2024 WL 1234567 (Fla. Cir. Ct. 2024).</p>	<p>Under the new statute, a jury award for medical expenses is limited to amounts actually paid, amounts necessary to satisfy outstanding charges, and amounts reasonably necessary for future treatment.</p> <p>Plaintiff must notify any party with subrogation rights and provide the complaint. Failure to provide a statement of benefits within 30 days results in waiver, and the subrogated party must cooperate. F.S.A. § 768.76(6)(7)(9).</p> <p><u>No-Fault PIP Benefits</u>: Plaintiff may prove all damages, but PIP benefits carry no subrogation rights and are set off from the verdict. F.S.A. § 627.736(3).</p> <p><u>Med Pay benefits</u> not considered "collateral source": Med Pay benefits are not subject to set-off. Sutton v. Ashcraft, 671 So.2d 301 (Fla. App. 1996).</p> <p><u>Medicare/Medicaid/Workers' Comp.:</u></p> <p>Benefits under Workers' Compensation, Medicare, Medicaid, Social Security, or similar federal programs are not collateral sources and not subject to set-off, though defendants may introduce evidence of such benefits. Plaintiffs cannot recover damages paid by Medicare. Cooperative Leasing v. Johnson, 872 So.2d 956 (Fla. App. 2004).</p> <p>Defendants precluded from introducing evidence of future benefits: Evidence of future benefits from programs such as Medicare or Medicaid is inadmissible due to its speculative nature. Joerg v. State Farm Mut. Auto. Ins. Co., 176 So.3d 1247 (Fla. 2015).</p> <p><u>Workers' Compensation:</u> Payments exceeding statutory benefits are considered gratuities. F.S.A. § 440.20(14).</p>

STATE	COLLATERAL SOURCE RULE	RECOVERY OF MEDICAL EXPENSES RULE	RELATED LAW / COMMENTS
<p style="text-align: center;"><b>GEORGIA</b></p>	<p>For years, Georgia adheres to the common law CSR. Defendant could not present <i>evidence</i> of collateral benefits received by plaintiff and defendant could not take any credit or set-off toward his liability and damages for such payments. <i>Hoeflick v. Bradley</i>, 637 S.E.2d 832 (Ga. App. 2006).</p> <p>In 1987, Georgia passed § 51-12-1, which modified the CSR and allowed evidence of collateral sources. However, it was declared unconstitutional in 1991. <i>Denton v. Con-Way Southern Express</i>, 402 S.E.2d 269 (Ga. 1991), overruled on other grounds, <i>Grissom v. Gleason</i>, 418 S.E.2d 27 (Ga. 1992).</p> <p>Effective April 21, 2025, Georgia enacted O.C.G.A. § 51-12-1.1, which expressly abrogates the common law collateral source rule to the extent necessary to allow the introduction of evidence of medical expenses actually payable under insurance or governmental programs. As a result, evidence of both amounts billed and amounts necessary to satisfy such charges is now admissible in determining damages for medical expenses.</p>	<p>Effective April 21, 2025, Georgia governs the recovery of medical expenses by statute. Special damages for medical and healthcare expenses are limited to the reasonable value of medically necessary care, as determined by the trier of fact. In determining reasonable value, the jury must consider both the amounts charged and the amounts actually necessary to satisfy those charges under applicable insurance contracts or governmental programs, regardless of whether such insurance has been used. O.C.G.A. § 51-12-1.1(b)-(c). This statutory framework permits the admission of evidence of negotiated rates, write-offs, and amounts paid, and represents a departure from prior case law that treated such amounts as collateral sources and restricted their admissibility.</p>	<p><u>Assignment of Benefits to Insurer</u>: An exception to CSR arises when the plaintiff/insured assigns cause of action to subrogated insurer, at which point any suit must be brought in the insurer's name. <i>Wardlaw v. Ivey</i>, 676 S.E.2d 858 (Ga. App. 2009).</p> <p>Georgia now applies a statutory 'reasonable value' framework for medical expenses pursuant to O.C.G.A. § 51-12-1.1, under which the trier of fact must consider both the amounts charged and the amounts actually necessary to satisfy those charges under applicable insurance or governmental programs. This statutory framework supersedes prior case law addressing for claims arising before April 21, 2025.</p> <p>In 2025, Georgia enacted comprehensive tort reform legislation, including O.C.G.A. § 51-12-1.1, which governs the proof and recovery of medical expenses in personal injury actions. The statute provides that special damages for medical expenses are limited to the 'reasonable value' of medically necessary care and requires the trier of fact to consider both the amounts charged and the amounts actually necessary to satisfy those charges under applicable insurance or governmental programs. The statute further provides that it abrogates the common law collateral source rule to the extent necessary to admit such evidence, thereby allowing introduction of insurance payments, negotiated rates, and write-offs in determining the value of medical expenses. This framework applies to causes of action arising on or after April 21, 2025.</p>

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HAWAII	<p>Hawaii adheres to common law CSR. Collateral sources will not reduce recovery from tortfeasor and should not be permitted into evidence. Standard rates and charges are relevant and admissible for (a) determining the reasonable value of medical services, (b) understanding the extent of the plaintiff's injuries, and (c) providing a foundation for future medical care and expenses. <i>Bynum v. Magno</i>, 101 P.3d 1149 (Haw. 2004).</p>	<p><u>Private Insurance</u>: No cases on point, although Hawaii will likely apply <i>Bynum</i> holding to private insurance, meaning that write-offs should not reduce a recovery and the proper measure of damages depends on reasonable value of services provided, not how much plaintiff was charged.</p> <p>Hawaii Civil Jury Instruction Nos. 8, 9 instruct jurors that plaintiffs are "entitled to compensation for medical treatment, but these damages are not limited to out-of-pocket expenses."</p> <p><u>Medicare/Medicaid</u>: No reduction of damages to reflect Medicare and Medicaid payments actually received by health care providers. Plaintiff not limited to out-of-pocket medical expenses and can recover the full, reasonable value of medical services billed. <i>Bynum v. Magno</i>, 101 P.3d 1149 (Haw. 2004).</p>	<p>Section 663-10 provides that party with valid lien against damages received by plaintiff through judgment or settlement can be reimbursed by plaintiff out of plaintiff's special damages. This includes a lien arising out of a claim for payments made from collateral sources, including health insurance or benefits. Haw. Rev. Stat. § 663-10(a).</p> <p>As a result, although plaintiff may be able to recover the full amount of damage suffered, plaintiff may have to reimburse his medical insurer for collateral payments made by the insurer via subrogation.</p>
IDAHO	<p>For years, Idaho followed the common law CSR. <i>Brinkman v. Aid Ins. Co.</i>, 766 P.2d 1227 (Idaho 2006).</p> <p>CSR modified by statute in 1990. Section 6-1606 says that plaintiff can only recover damages that that exceed the amount of "collateral sources." After verdict, court adjusts the award, reducing for all payments made by "collateral sources." Idaho Code § 6-1606.</p>	<p>Medical expenses are a "collateral source" which must be set-off against a verdict. <i>Slack v. Kelleher</i>, 104 P.3d 958 (Idaho 2004).</p> <p>Juries are allowed to see evidence of the market value, billed amount of medical expenses, not the discounted written-down amount paid under contract.</p> <p><u>Medicare/Medicaid</u>: These are "collateral sources." <i>Dyet v. McKinley</i>, 81 P.3d 1236 (Idaho 2003).</p> <p><u>Private Insurance</u>: No case law on point. Courts will probably treat private insurance company write-offs similarly to Medicare and Medicaid write-offs. However, no collateral source if there is subrogation.</p> <p>Idaho does not permit recovery of amounts written off pursuant to contractual adjustments because such amounts are not "incurred," and recovery is limited to amounts actually paid or still owed. <i>Dyet v. McKinley</i>, 81 P.3d 1236 (Idaho 2003).</p>	<p>"Collateral sources" do not include benefits paid under federal programs which by law must seek subrogation, death benefits paid under life insurance contracts, benefits paid by a service corporation organized under chapter 34, title 41, Idaho Code, and benefits paid which are recoverable under subrogation rights created under Idaho law or by contract. Idaho Code § 6-1606.</p> <p>Subrogation right itself dictates whether an award will be reduced, not whether evidence exists to show an intent to exercise that right.</p> <p>Idaho courts continue to apply a statutory post-verdict reduction framework, focusing on the existence of subrogation rights in determining whether collateral source payments reduce a jury award. <i>Dyet v. McKinley</i>, 81 P.3d 1236 (Idaho 2003).</p>

STATE	COLLATERAL SOURCE RULE	RECOVERY OF MEDICAL EXPENSES RULE	RELATED LAW / COMMENTS
ILLINOIS	<p>Common law CSR since 1970. It is both a rule of evidence and a rule of damages. Damages not reduced by collateral sources. <i>Pitts. C. &amp; St. L. Ry. Co. v. Thompson</i>, 1870 WL 6491 (Ill. 1870); <i>Arthur v. Catour</i>, 833 N.E.2d 847 (Ill. 2005).</p> <p>Benefits from source independent of, and collateral to, the tortfeasor will not diminish damages, and are inadmissible. Illinois follows <i>Restatement (Second) of Torts</i> § 920(A)(2). <i>Wills v. Foster</i>, 892 N.E.2d 1018 (Ill. 2008).</p>	<p><u>Medicare/Medicaid</u>: “Reasonable value” approach used. Plaintiff can recover the reasonable value of services without distinguishing between those who have insurance or government benefits and those who do not. <i>Wills v. Foster</i>, 892 N.E.2d 1018 (Ill. 2008).</p> <p><u>Private Insurance</u>: “Reasonable value” approach used. Plaintiff entitled to submit the full, reasonable value of her medical bills to the jury and was not limited to recovery of the discounted amount. any windfall involving the apportionment of damages should be awarded to the plaintiff rather than the defendant. Plaintiff may present in evidence amount that was actually billed by the healthcare providers. <i>Arthur v. Catour</i>, 833 N.E.2d 847 (Ill. 2005).</p> <p>Illinois courts have clarified that written-off amounts are not “payments” and therefore are not subject to post-verdict reduction, preserving the plaintiff’s ability to present the full billed amount as evidence of reasonable value. <i>Miller v. Sarah Bush Lincoln Health Ctr.</i>, 56 N.E.3d 599 (Ill. App. 2016).</p>	<p><u>Medical Malpractice</u>: Two types of post-verdict reductions (1) 50% of benefits paid to the plaintiff by collateral source for lost wages or disability income related to the injury, and (2) 100% of medical expenses paid to plaintiff by collateral source. 735 I.L.C.S. § 5/2-1205. Doesn’t apply if: (1) reduction not sought in 30 days; (2) subrogation exists; (3) no reduction beyond 50% of verdict; (4) verdict increased by premiums plaintiff paid; and (5) charges attributable to negligent act.</p> <p>Medical bills “written off” by third party are not “actually paid” to the medical provider or the plaintiff, thus verdict cannot be reduced by this written-off amount. <i>Miller v. Sarah Bush Lincoln Health Ctr.</i>, 56 N.E.3d 599 (Ill. App. 2016).</p>
INDIANA	<p>Statutory modified version of the CSR. Court will not admit evidence of collateral source benefit payments, including health insurance benefits. Evidence of the amount that plaintiff is required to repay in subrogation, including workers’ compensation benefits, because of collateral benefits received, will be admitted. I.C. §§ 34-44-1-1 through 34-44-1-3.</p> <p>Indiana courts permit the introduction of both the amounts billed and the amounts actually paid as relevant evidence of the reasonable value of medical services, leaving the determination of reasonable value to the trier of fact. <i>Stanley v. Walker</i>, 906 N.E.2d 852 (Ind. 2009); <i>Patchett v. Lee</i>, 60 N.E.3d 1025 (Ind. 2016).</p>	<p><u>Private Insurance</u>: A medical provider’s billed charges do not equate to cost, so the jury may hear the amount of the payments, amounts billed by medical service providers, and other relevant and admissible evidence to be able to determine the amount of reasonable medical expenses. <i>Stanley v. Walker</i>, 906 N.E.2d 852 (Ind. 2009).</p> <p><u>Medicare/Medicaid</u>: Evidence of write-offs of medical bills is admissible to show the reasonable value of the bill, even payments made by government entities, such as the Healthy Indiana Plan (HIP), Medicare, and Medicaid. <i>Patchett v. Lee</i>, 60 N.E.3d 1025 (Ind. 2016).</p> <p>Indiana appellate courts have emphasized that both billed and paid amounts are admissible as relevant to determining reasonable value, reinforcing the state’s hybrid evidentiary approach. <i>Patchett v. Lee</i>, 60 N.E.3d 1025 (Ind. 2016).</p>	<p>I.C. § 34-44-1-2 provides for the admissibility of all collateral source payments, except the following:</p> <ul style="list-style-type: none"> <li>(A) Life insurance or other death benefits;</li> <li>(B) Insurance benefits for which plaintiff or members of plaintiff’s family have paid for directly;</li> <li>(C) Or payments made by the United States or any agency thereof.</li> </ul> <p>Also allowed is evidence that workers’ compensation benefits must be repaid.</p>

STATE	COLLATERAL SOURCE RULE	RECOVERY OF MEDICAL EXPENSES RULE	RELATED LAW / COMMENTS
IOWA	<p>Common law CSR acts as a rule of evidence and a rule of damages. It bars evidence of collateral sources and prevents the jury from reducing the verdict. <i>Schonberger v. Roberts</i>, 456 N.W.2d 201 (Iowa 1990).</p> <p>CSR partially modified by Iowa's comparative fault statute. Iowa Code § 668.14. Evidence of collateral source payments for medical care allowed, and statute permits, but doesn't require, the jury to reduce the verdict by the amount of collateral sources. If such evidence is introduced, the court must permit evidence and argument as to the costs to the plaintiff of procuring the previous payments or future rights of payment and as to any existing rights of indemnification or <b>subrogation</b> relating to the previous payments or future rights of payment.</p> <p>Recent statutory amendments limit both admissible evidence and recoverable damages for past medical expenses to amounts actually paid or owed, representing a departure from earlier case law permitting recovery of the full billed amount. Iowa Code §§ 668.14A, 622.4 (2020); <i>Pexa v. Auto Owners Ins. Co.</i>, 686 N.W.2d 150 (Iowa 2004).</p>	<p><u>Private Insurance</u>: I.C.A. § 668.14A, enacted effective July 1, 2020, restricts damages for past medical expenses recoverable by a personal injury plaintiff to the amounts "actually paid" to the health care providers plus any sums "actually necessary to satisfy the medical care charges that have been incurred but not yet satisfied." This section does not apply to medical malpractice cases.</p> <p>Section 622.4 was also enacted effective July 1, 2020, limiting the evidence the jury may consider on the value of a plaintiff's past medical expenses to documents or testimony identifying the amounts "actually paid" to the health care providers plus any sums "actually necessary to satisfy the medical care charges that have been incurred but not yet satisfied." It also prevents plaintiffs from directing or encouraging doctors to hold the treatment invoices rather than submit them to health insurers or government programs like Medicare or Medicaid.</p> <p>Section 668.14 prohibits evidence of collateral source payments from state or federal programs. Iowa courts had previously allowed plaintiffs to introduce the charges set forth on the providers' invoices prior to write-offs, contractual discounts, or other required reductions. <i>Pexa v. Auto Owners Ins. Co.</i>, 686 N.W.2d 150 (Iowa 2004). Plaintiffs could then argue to the jury that the pre-reduction sums reflected the reasonable value of the treatment and therefore the appropriate amount of medical expense damages, even though the "billed" amounts may be much less.</p> <p><u>Medicare/Medicaid</u>: Evidence that a "previous payment of future right of payment pursuant to a state or federal program" is prohibited. I.C.A. § 668.14; <i>Wildner v. Wendorff</i>, 723 N.W.2d 451 (Iowa App. 2006).</p>	<p><u>Medical Malpractice</u>: Economic damages in a medical malpractice verdict may not include amounts that have been replaced or indemnified by insurance, or by governmental, employment, or service benefit programs, or from any other source except the assets of the plaintiff or his family. I.C.A. § 147.136.</p> <p>These statutory amendments represent a significant shift from prior case law allowing recovery of billed amounts, effectively limiting both admissible evidence and recoverable damages to amounts actually paid or owed. Iowa Code §§ 668.14A, 622.4 (2020); <i>Pexa v. Auto Owners Ins. Co.</i>, 686 N.W.2d 150 (Iowa 2004).</p>

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KANSAS	<p>Kansas has followed that common law CSR for 100 years. <i>Berry v. Dewey</i>, 172 P. 27 (Kan. 1918). It prohibits a defendant from introducing evidence of collateral sources, and allows plaintiffs to recover the reasonable value of their medical expenses. Kansas follows <i>Restatement (Second) of Torts</i> § 920(A)(2). <i>Martinez v. Milburn Enterprises, Inc.</i>, 233 P.3d 205 (Kan. 2010).</p> <p>Kansas legislature has tried three times to modify the CSR. Each time the Supreme Court held them unconstitutional.</p> <p>Kansas permits the admission of both the amount billed and the amount paid as evidence bearing on the reasonable value of medical services, allowing the jury to consider both figures in determining damages. <i>Martinez v. Milburn Enters., Inc.</i>, 233 P.3d 205 (Kan. 2010).</p>	<p><u>Private Insurance</u>: Evidence of (1) the original amount billed, and (2) the amount accepted by the hospital in full satisfaction of the amount billed is admissible. However, evidence of the source of any actual payments is inadmissible because of CSR. From the evidence jury determines the reasonable value of medical expenses. <i>Martinez v. Milburn Enterprises, Inc.</i>, 233 P.3d 205 (Kan. 2010).</p> <p><u>Medicare/Medicaid</u>: Attempts to clarify Medicare and Medicaid CSR have led to confusion. In <i>Bates v. Hogg</i>, 921 P.2d 249 (Kan. App. 1996), court said only amounts paid can be recovered. In <i>Rose v. Via Christi Health System, Inc.</i>, 78 P.3d 798 (Kan. 2003) (<i>Rose I</i>), modified on reh'g, 113 P.3d 241 (Kan. 2005) (<i>Rose II</i>), Supreme Court said plaintiffs are entitled to receive Medicare write-offs because Medicare charges premiums to its beneficiaries. Before new opinion in <i>Rose</i>, two new decisions rendered. <i>Fisher v. Farmers Ins. Co.</i>, 2005 WL 400404 (Kan. App. 2005); <i>Liberty v. Westwood</i>, 2005 WL 1006363 (Kan. App. 2005). Currently, evidence of write-offs allowed. Per <i>Bates</i>, amount due is the actual amount paid because the medical service provider cannot charge Medicaid patients for the write-off. Similarly, under <i>Rose II</i>, evidence of write-offs allowed only if tortfeasor is both the defendant and the health care provider. While <i>Rose I</i> appeared to limit <i>Bates</i> to Medicaid cases, <i>Rose II</i> brings to question the precedential value of this distinction.</p>	<p>Rationale in <i>Martinez</i> for Kansas approach:  <i>"When medical treatment expenses are paid from a collateral source at a discounted rate, determining the reasonable value of the medical services because an issue for the finder of fact. Stated more completely, when a finder of fact is determining the reasonable value of medical services, the collateral source rule bars admission of evidence stated that the expenses were paid by a collateral source. However, the rule does not address, much less bar, the admission of evidence indicating that something less than the charged amount has satisfied, or will satisfy, the amount billed."</i> <i>Martinez v. Milburn Enterprises, Inc.</i>, 233 P.3d 205, 222 (Kan. 2010).</p>
KENTUCKY	<p>Pure common law CSR. <i>Schwartz v. Hasty</i>, 175 S.W.3d 621 (Ky. App. 2005). Can recover medical expenses even though paid by collateral source or government entity. <i>Daugherty v. Daugherty</i>, 609 S.W.2d 127 (Ky. 1980). Evidence of collateral sources is not admissible. <i>O'Bryan v. Hedgespeth</i>, 892 S.W.2d 571 (Ky. 1995).</p> <p>K.R.S. § 411.188, which allowed evidence of collateral source payments, found unconstitutional. <i>O'Bryan, supra</i>.</p>	<p><u>Private Insurance</u>: Plaintiff can recover full amount of medical expenses billed, not amount paid by insurer. <i>Baptist Healthcare Sys. v. Miller</i>, 177 S.W.3d 676 (Ky. 2005).</p> <p><u>Medicare/Medicaid</u>: The fact that Medicare contracted with doctor to provide care at rate below usual fee should not relieve tortfeasor from duty to pay reasonable value of medical expenses. <i>Miller, supra</i>. (no mention of write-offs specifically).</p>	<p>Introduction of a medical bill is sufficient to establish its reasonableness considering the statutory presumption in K.R.S. § 304.39-020(5)(a). <i>Daugherty v. Daugherty</i>, 609 S.W.2d 127 (Ky. 1980).</p> <p>If premiums for collateral source paid by tortfeasor, CSR does not apply. Application of the CSR depends more upon the character of the benefits than upon the source of the funds. <i>Patterson v. Norfolk and Western Ry. Co.</i>, 489 F.2d 303 (6<sup>th</sup> Cir. 1973).</p>

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LOUISIANA	<p>Common law CSR well-established in Louisiana. It prevents the reduction of plaintiff's recovery to the benefit of the tortfeasor because of collateral sources <i>obtained at plaintiff's expense or through foresight</i>, and prevents evidence of same. <i>Louisiana Dep't of Transp. &amp; Dev. v. Kansas City S. Ry. Co.</i>, 846 So.2d 734 (La. 2003). CSR prevents tortfeasor from benefitting from the "victim's foresight in purchasing insurance and other benefits." <i>Hoffman, infra</i>.</p> <p>Louisiana rule of evidence prevents party from introducing evidence of collateral source to prove liability or mitigate damages. La. Code Evid. Ann. art. 409.</p>	<p><u>Private Insurance</u>: "Benefit of the bargain" approach. Verdict not reduced by collateral sources (which presumably included write-offs by insurer). <i>Griffin v. Louisiana Sheriff's Auto Risk Ass'n</i>, 802 So.2d 691 (La. App. 2001). <i>Griffin</i> involved contractual write-offs. However, in 2015, Louisiana Supreme Court held that such write-offs do not fall within the scope of the CSR. <i>Hoffman v. 21st Century N. Am. Ins. Co.</i>, 209 So.3d 702 (La. 2015), reh'g denied (Dec. 7, 2015). Write-offs in <i>Hoffman</i> were negotiated by plaintiff's counsel and no consideration was paid for them. Court declined to extend the CRS to attorney-negotiated medical discounts obtained through the litigation process. Free medical services can also be recovered. <i>Johnson v. Neill Corp.</i>, 2015 WL 9464625 (La. App. 2015).</p> <p>The CSR is not applicable when the plaintiff has paid no consideration for the benefits. The CSR is inapplicable to medical expenses charged above the amount actually paid by a workers' compensation carrier under the workers' compensation medical fee schedule. <i>Simmons v. Cornerstone Investments, LLC</i>, 2019 WL 2041377 (La. 2019).</p> <p><u>Medicare/Medicaid</u>: Because Medicaid is free for its recipients, they cannot recover the write-off, but Medicare recipients can recover it since they pay consideration for it. <i>Bozeman v. State</i>, 879 So.2d 692 (La. 2004).</p>	<p>The CSR prevents the reduction of plaintiff's recovery to the benefit of the tortfeasor because of monies received by plaintiff from sources independent of tortfeasor's procurement or contribution. Therefore, any payments received from an independent source are not subtracted from tort victim's recovery from the tortfeasor, and tortfeasor is liable for the same amount regardless of whether tort victim had the prudence to purchase insurance. <i>Louisiana Dep't of Transp. &amp; Dev. v. Kansas City S. Ry. Co.</i>, 846 So.2d 734 (La. 2003).</p> <p>Where an insured has collision coverage with GEICO and has a third-party claim against a tortfeasor also insured by GEICO, the insured cannot make a double recovery by arguing the CSR should not prohibit him from making a collision claim for the same property damage he collected from GEICO as the tortfeasor's liability carrier. Subrogation is the exception to the CSR. <i>Pelle v. Munos</i>, 2020 WL 853730 (La. App. 2020).</p>
MAINE	<p>Follows common law CSR. Medical expenses paid by collateral source can be recovered in damages, and no evidence allowed. <i>Barday v. Donnelly</i>, 2006 WL 381876 (Me. Super. 2006).</p> <p>Plaintiff who recovers collateral source payments from sources independent of the tortfeasor remains entitled to a full recovery. <i>Grover v. Boise Cascade Corp.</i>, 860 A.2d 851 (Me. 2004).</p>	<p><u>Private Insurance</u>: Write-offs and/or gratuitous medical care by insurer covered under CSR. Evidence of them not allowed and they may be recovered by plaintiff. <i>Barday v. Donnelly</i>, 2006 WL 381876 (Me. Super. 2006).</p> <p><u>Medicare/Medicaid</u>: Same as above. <i>Barday v. Donnelly</i>, 2006 WL 381876 (Me. Super. 2006).</p>	<p><u>Medical Malpractice</u>: Section 2906 provides for awards in professional negligence actions to be offset by collateral source payments, where the collateral sources have not exercised subrogation rights within 10 days after a verdict for the plaintiff. The court will reduce an award for damages by the amount paid by the collateral source. Maine Revised Statute § 2906.</p>

STATE	COLLATERAL SOURCE RULE	RECOVERY OF MEDICAL EXPENSES RULE	RELATED LAW / COMMENTS
MARYLAND	<p>Maryland has employed the common law CSR since 1899. <i>Norfolk Southern Ry. Corp. v. Tiller</i>, 944 A.2d 1272 (Md. App. 2008). It permits plaintiff to recover the full damages, regardless of collateral sources plaintiff received from sources unrelated to the tortfeasor.</p> <p>A benefit that is directed to the injured party should not be shifted so as to become a windfall for the tortfeasor. <i>Motor Vehicle Admin. v. Seidel</i>, 604 A.2d 473, 254 (Md. App. 1992) (citing <i>Restatement (Second) of Torts</i>, § 920A(2), comment (b)).</p> <p>The tortfeasor remains responsible for paying the victim the “fair and reasonable” (billed amount) value of the health care services that the victim needed as a result of the tort. <i>Shpigel v. White</i>, 741 A.2d 1205 (Md. 1999).</p>	<p><u>Private Insurance</u>: Payments received from private insurance are prohibited from consideration due to CSR. <i>Narayan v. Bailey</i>, 747 A.2d 195 (Md. App. 2000).</p> <p><u>Medicare/Medicaid</u>: Payments from government entities are also not to be considered pursuant to the CSR. <i>Narayan</i>, <u>supra</u>.</p> <p><u>Statutory Offset Against UIM Benefits</u>: The difference between the amount billed – or perhaps more precisely, the fair and reasonable value of health care services – and the payments made by the workers’ compensation carrier does not constitute a “benefit” that the injured employee has “recovered” under the Workers’ Compensation Act that is to be offset against any recovery the person would obtain from the UIM coverage of the auto policy. Only the amount that the workers’ compensation carrier actually pays for medical expenses is part of the statutory offset against UIM benefits. A difference between a high amount billed by a health care provider and the amount actually paid by the workers’ compensation insurer is not part of that offset. <i>Westfield Ins. Co. v. Gilliam</i>, 269 A.3d 1047 (Md. 2022).</p>	<p><u>Exceptions to CSR</u>: (1) Collateral source may be admissible to rebut a false claim of impoverishment by plaintiff. <i>Abrishamian v. Barbely</i>, 981 A.2d 797 (Md. App. 2009); and (2) Collateral benefits may be admissible if relevant to the issue of malingering. <i>Tiller</i>, <u>supra</u>.</p> <p><u>Medical Malpractice</u>: Under the non-economic damages cap applicable to medical malpractice claims, past medical expenses are limited to amounts paid by or on behalf of plaintiff, and amounts incurred but not paid but for which another person, on behalf of the plaintiff, is obligated to pay. Permits evidence of this nature in post-verdict proceedings. After receiving collateral source evidence in a medical malpractice action <i>after</i> the verdict is rendered, the trial court may determine whether damages awarded are excessive, and is not required to declare the damages excessive simply because plaintiff has been or will be reimbursed by a collateral source. Md. Code Ann. Courts &amp; Jud. Proc. §§ 3-2A-06, 3-2A-09(d).</p>

STATE	COLLATERAL SOURCE RULE	RECOVERY OF MEDICAL EXPENSES RULE	RELATED LAW / COMMENTS
MASSACHUSETTS	<p>Common law CSR followed. Defendant cannot present evidence of collateral source and it doesn't reduce the defendant's liability. <i>Corsetti v. The Stone Company</i>, 483 N.E.2d 793 (Mass. 1985); <i>Goldstein v. Gontarz</i>, 309 N.E.2d 196 (Mass. 1974).</p>	<p><u>Private Insurance</u>: CSR bars evidence of discounted payments to providers. <i>Scott v. Garfield</i>, 912 N.E.2d 1000 (Mass. 2009). However, court said that defendants could have challenged reasonableness of amounts billed by cross-examining providers with respect to the medical bills. Concurring opinion suggested that treatment of write-downs is still open to debate. Massachusetts courts have not had occasion to decide whether evidence of a discount from the initial charges for medical services is barred by CSR. In 2010, court held that although no evidence of the discounted amounts allowed, evidence of the range of payments accepted by the healthcare provider is admissible. <i>Law v. Griffith</i>, 930 N.E.2d 126 (Mass. 2010).</p> <p><u>Medicare/Medicaid</u>: In a medical malpractice case, the court held that although Medicaid was a collateral source whose right of subrogation was based in federal law, a Medicaid write-off is not a collateral source for purposes of § 60G and, therefore, can be deducted from the damages awarded. <i>Sylvestre v. Martin</i>, 2008 WL 82631 (Mass. Super. 2008).</p>	<p><u>Exception to CSR</u>. If probative of a relevant proposition (e.g., to impeach plaintiff's credibility or show another reason why absent from work. <i>Goldstein v. Gontarz</i>, 309 N.E.2d 196 (Mass. 1974).</p> <p><u>Medical Malpractice</u>: Statute provides that CSR does not apply to special damages awarded in medical negligence case. M.G.L. A. 231 § 60G.</p>
MICHIGAN	<p>Michigan's CSR is statutory and states that when plaintiff seeks medical expenses, evidence of collateral source is admissible after a verdict and before judgment entered on that verdict. Court reduces any portion of the judgment representing medical expenses paid or payable by a collateral source. M.C.L.A. § 600.6303.</p>	<p><u>Private Insurance</u>: A write-off "has not been paid, nor is it payable, such that it is not a collateral source." <i>Detary v. Advantage Health Physicians, PC</i>, 2012 WL 6035024 (Mich. App. 2012) appeal denied, 829 N.W.2d 862 (Mich. 2013).</p> <p><u>Medicare/Medicaid</u>: Medicaid payments are not a collateral source. <i>Shinholster v. Annapolis Hosp.</i>, 660 N.W.2d 361 (Mich. App. 2003), <i>aff'd in part</i>, 671 N.W.2d 539 (Mich. 2004).</p> <p>Recent decisions have clarified that statutory no-fault limitations and fee schedules may restrict recoverable medical expenses in certain contexts, particularly in auto-related cases, distinguishing those claims from traditional tort recovery. M.C.L. § 500.3157; <i>Andary v. USAA Cas. Ins. Co.</i>, 512 Mich. 207 (2023).</p>	<p>M.C.L.A. § 600.6303(4) defines "collateral source" as: "...benefits received or receivable from an insurance policy; benefits payable pursuant to a contract with a health care corporation, dental care corporation, or health maintenance organization; employee benefits; social security benefits; worker's compensation benefits; or Medicare benefits."</p> <p>Not a collateral source if: (1) life insurance, (2) subject to subrogation, and (3) subject to a lien.</p> <p><u>Medical Malpractice</u>: Effective 4/10/17, M.C.L.A. § 600.1482 limits recovery to amounts actually paid.</p>

STATE	COLLATERAL SOURCE RULE	RECOVERY OF MEDICAL EXPENSES RULE	RELATED LAW / COMMENTS
MINNESOTA	<p>Minnesota’s CSR is complex and hard to understand. Minnesota’s common law CSR allowed plaintiff to recover all damages, even if paid by collateral source. <i>Hueper v. Goodrich</i>, 314 N.W.2d 828 (Minn. 1982).</p> <p>CSR now set forth in statute. M.S.A. § 548.251 allows for reduction of verdict in amount of “collateral sources” received. Collateral sources are defined as payments made to the plaintiff up to the date of a verdict in the case that are related to the injury or disability in question and stem from a defined group of sources. M.S.A. § 548.251.</p>	<p><u>Private Insurance</u>: Write-offs and negotiated insurance discounts on medical expenses—amounts a plaintiff is billed by a medical provider but does not pay because the plaintiff’s health insurance provider negotiates a discount on the plaintiff’s behalf—are “collateral sources” for purposes of Minnesota’s collateral-source statute, Minn. Stat. § 548.251, and thus subject to deduction from any award by a jury.</p> <p><u>Medicare/Medicaid</u>: The CSR is inapplicable to amounts written off as part of a provider’s Medicare contracts because no money was paid or exchanged when the medical providers wrote-off the amount, even if there will be double recovery to plaintiffs. <i>Renswick v. Wenzel</i>, 819 N.W.2d 198 (Minn. App. 2012); <i>Davis v. St. Ann’s Home</i>, 2008 WL 126607 (Minn. App. 2008). Both Medicare payments and Medicare-negotiated discounts are collateral sources that are excepted from the collateral-source offset provision of § 548.251. Therefore, <i>Swanson</i> and <i>Renswick</i> lead to conflicting results—one that follows legislative intent and one that does not. Identical personal injury claims could be valued quite differently—a privately-insured plaintiff has medical bills deducted from his recovery while a Medicare-insured plaintiff is allowed to recover not only the amount of medical bills paid, but also the amount charged.</p>	<p>Under common law CSR, a plaintiff could recover twice for the same damages—once from a health insurer, and against from the tortfeasor. <i>Swanson v. Brewster</i>, 784 N.W.2d 264 (Minn. 2010). Section 548.251 changed that. No evidence of collateral sources allowed during trial to jury. M.S.A. § 548.251(5). Within 10 days after trial, both parties may submit evidence of the collateral sources paid or available as well as amounts plaintiff paid to secure the right to the benefits. <i>Id.</i> at 764; Court must reduce an award by the amount paid by a collateral source. However, it offsets any reduction in the award by the amounts paid on behalf of plaintiff to secure the right to a collateral source benefit for a two-year period, such as premiums. However, it does not offset any amounts for which a subrogation right has been asserted. M.S.A. § 548.251, subd. 2.</p> <p>Collateral source deductions for injuries sustained during the operation, ownership, maintenance, or use of a motor vehicle are separately deducted from awards under § 65B.51 (Minnesota No-Fault Automobile Insurance Act).</p>

STATE	COLLATERAL SOURCE RULE	RECOVERY OF MEDICAL EXPENSES RULE	RELATED LAW / COMMENTS
MISSISSIPPI	<p>Common law CSR says that collateral source cannot be used by defendant in mitigation or reduction of damages. <i>Burr v. Mississippi Baptist Med. Ctr.</i>, 909 So.2d 721 (Miss. 2005).</p>	<p><u>Private Insurance:</u> Defendant may not have damages reduced by reason of collateral sources that plaintiff receives from insurance, workers' compensation, or Medicaid. <i>Walmart Stores, Inc. v. Frierson</i>, 818 So.2d 1135 (Miss. 2002). The CSR applies equally to medical expense write-downs. <i>Knox v. Ferrer, et al.</i>, 2008 WL 4446534 (S.D. Miss. 2008). Plaintiff's medical bills are "incurred" when he receives the necessary treatment, and that a subsequent write-off of the expenses does not remove the amounts from the operation of the CSR.</p> <p><u>Medicare/Medicaid:</u> Same rule applies to Medicare and Medicaid payments. <i>Wal-Mart Stores, Inc. v. Frierson</i>, 818 So.2d 1135 (Miss. 2002). Medicaid payments subject to CSR. <i>Brandon HMA, Inc. v. Bradshaw</i>, 809 So.2d 611 (Miss. 2001); <i>Gatlin v. Methodist Med. Ctr.</i>, 772 So.2d 1023 (Miss. 2000).</p>	<p><u>Medical Malpractice:</u> If evidence is introduced for a purpose other than to mitigate damages, the CSR is not violated M.C.A. § 11-1-60 (2002) defines "actual economic damages" as "objectively verifiable pecuniary damages arising from medical expenses and medical care ..." M.C.A. § 41-9-119 also states, "Proof that medical, hospital, and doctor bills were paid or incurred ... shall be <i>prima facie</i> evidence that such bills ... were necessary and reasonable."</p>

STATE	COLLATERAL SOURCE RULE	RECOVERY OF MEDICAL EXPENSES RULE	RELATED LAW / COMMENTS
MISSOURI	<p>The common law CSR prevents a tortfeasor from introducing evidence of and/or reducing his liability to plaintiff by amount of collateral sources received by plaintiff. It is not a single rule, but a combination of rules used to determine if evidence of collateral sources should be admitted. <i>Smith v. Shaw</i>, 159 S.W.3d 830, 832 (Mo. 2005); <i>Iseminger v. Holden</i>, 544 S.W.2d 550 (Mo. 1976).</p> <p>The Missouri CSR is partially modified by statute. Any pre-trial partial payment by defendant or his insurer to plaintiff in advance of litigation (<i>e.g.</i>, payment of medical bills) predicated on possible tort liability is not admissible as an admission against interest as to liability of defendant. However, such payments constitute a credit after a verdict. Defendant can't get the advance payment back if no liability found. No evidence of collateral sources is allowed in presenting evidence of the value of the medical treatment rendered. Mo. Rev. Stat. § 490.710.</p> <p>The CSR is codified and partially modified by Mo. Rev. Stat. § 490.715, which allows defendant to introduce evidence of payments to plaintiff by defendant without identifying the source. By introducing such evidence, defendant waives right to a credit against judgment under § 490.710. Mo. Stat. § 490.715(2); <i>Deck v. Teasley</i>, 322 S.W.3d 536 (Mo. 2010).</p>	<p><u>Private Insurance</u>: Prior to 2005, Missouri followed the common law CSR that a tortfeasor is not entitled to have damages reduced by proving that plaintiff has received benefits from collateral sources. <i>Porter v. Toys 'R' Us - Del., Inc.</i>, 152 S.W.3d 310 (Mo. App. 2004).</p> <p>In 2005, § 490.715 enacted. Defendant now allowed to introduce into evidence “the actual cost of medical care”, provided it is reasonable, necessary, and a proximate result of the defendant’s negligence. The “actual cost of medical care” means an amount that does not exceed the amount paid by or on behalf of plaintiff by insurer, plus any remaining balance necessary to satisfy plaintiff’s financial obligation for medical care, after adjustment for contractual discounts, price reductions, or write-offs. Mo. Rev. Stat. § 490.715.</p> <p>Section 490.715 used to provide for a rebuttable presumption that the dollar amount necessary to satisfy the financial obligation of plaintiff to health care provider was the reasonable value of the medical treatment. Jury would hear evidence of both amount billed and amount paid. However, on August 28, 2017, that portion of the statute was repealed and there is no longer a presumption. There is now an “actual cost” standard. Medical bill evidence allowed is now only the amount actually paid or owed, and not the originally billed amount, or any write-offs, discounts, or adjustments to the bill as a result of contracts with insurers or government programs. Some plaintiffs may now intentionally omit claims for medical expenses.</p> <p><u>Medicare/Medicaid</u>: Plaintiff not entitled to Medicaid write-offs when total amount billed will never be sought from plaintiff. <i>Mann v. Varney Construction</i>, 23 S.W.3d 231 (Mo. App. 2000).</p>	<p>Missouri’s discovery rules are extremely broad. Missouri courts have consistently held that the party claiming damages has the burden of proving the existence and amount of damages with reasonable certainty. Missouri Supreme Court Rule 56.01. Further, the party claiming damages must provide facts supporting a basis for a rational estimate of damages without resorting to speculation. <i>The Manors at Village Green Condominium</i>, 341 S.W. 162 (Mo. App. 2011).</p>

STATE	COLLATERAL SOURCE RULE	RECOVERY OF MEDICAL EXPENSES RULE	RELATED LAW / COMMENTS
MONTANA	<p>In 2021, Montana enacted SB 251 which abrogates the common law Collateral Source Rule, court decisions, and all prior statutes applicable to determining the amounts recoverable by plaintiffs as damages for medical services or treatment. MCA § 27-1-308(1).</p> <p>An award may not exceed amount actually <i>paid</i> to healthcare providers. MCA § 27-1-308(2)(a). Award at trial also limited to charges incurred and owing to healthcare providers for reasonable and necessary medical services or treatment, and/or are necessary to provide for any future reasonable and necessary medical services or treatment. MCA § 27-1-308(2)(b-c).</p> <p>Jury can't consider any bills billed but resolved by way of contractual discount, price reduction, disallowance, gift, write-off, or otherwise not paid." MCA § 27-1-308(3).</p> <p>"If prior to trial a defendant, a defendant's insurer or authorized representative, or any combination of the three, pays any part of the financial obligation for medical services or treatment provided to the plaintiff, then prior to the entry of judgment the court shall reduce the sum awarded to the plaintiff at trial by the amount of the payment or other collateral source as defined in 27-1-307(1)." MCA § 27-1-308(4).</p>	<p>Damages recoverable from the person at fault for the reasonable value of medical services or treatment in actions arising from bodily injury or death are set forth in 27-1-308. MCA § 27-1-202.</p> <p>Private Insurance: No authority under the law amended in 2021. But see <i>Elliott v. Goulet</i>, 2012 WL 8530906 (Mont. Dist. Ct. 2012) (Trial Order).</p> <p>Medicare/Medicaid: No authority under the law amended in 2021. <i>Elliott v. Goulet</i>, 2012 WL 8530906 (Mont. Dist. Ct. 2012) (Trial Order). Montana state courts have yet to address this issue, but federal court decision held that medical expenses written-off by Medicaid are irrelevant for proving reasonable medical expenses. <i>Chapman v. Mazda Motor of America, Inc.</i>, 7 F.Supp.2d 1123 (D. Mont. 1998).</p> <p>After the 2021 amendment, § 27-1-308(2)(a)-(b) now reads:</p> <p><i>...a plaintiff's recovery may not exceed amounts actually: (a) paid by or on behalf of the plaintiff to health care providers that rendered reasonable and necessary medical services or treatment to the plaintiff; [and] (b) necessary to satisfy charges that have been incurred and at the time of trial are still owing and payable to health care providers for reasonable and necessary medical services or treatment rendered to the plaintiff.</i></p> <p>The bill expressly made the amendment applicable to claims that accrue on or after its effective date.</p> <p><i>Gibson v. U.S.</i>, 499 P.3d 1165 (Mont. 2021) (good summary of treatment of Collateral Source Rule in Montana).</p>	<p>After SB 251, for the first time, Montana recognizes a contractual right to subrogation for previously unrecoverable amounts paid from a collateral source. "Except for subrogation rights specifically granted by state or federal law or provided by contract, there is no right to subrogation for any amount paid or payable to a plaintiff from a collateral source if for an award entered as provided in subsection (2)." MCA § 27-1-308(5).</p> <p>Voluntary payments made to plaintiff under a Med Pay provision of defendant's liability policy are not credited against the judgment under the "voluntary payments" statute providing for credits against judgments of prior voluntary payments, Mont. Stat. § 26-1-706; <i>O'Hern v. Pankratz</i>, 19 P.3d 807 (Mont. 2001).</p> <p>Liability carrier has an obligation to pay an injured third-party's medical expenses until final settlement when liability is reasonably clear. The failure of an insurer to know this rule can lead to serious adverse consequences, including possible bad faith. <i>Ridley v. Guaranty National Insurance Company</i>, 951 P.2d 987 (Mont. 1997).</p>

STATE	COLLATERAL SOURCE RULE	RECOVERY OF MEDICAL EXPENSES RULE	RELATED LAW / COMMENTS
NEBRASKA	<p>The common law CSR provides that collateral sources will not diminish damages otherwise recoverable from the wrongdoer. <i>Mahoney v. Nebraska Methodist Hosp.</i>, 560 N.W.2d 451 (Neb. 1997). Evidence of collateral sources is inappropriate. <i>Harper v. Young</i>, 298 N.W. 342 (Neb. 1941).</p>	<p><u>Private Insurance</u>: Private insurance treated the same as social welfare benefits. <i>Mahoney v. Nebraska Methodist Hosp.</i>, 560 N.W.2d 451 (Neb. 1997); <i>Fickle v. State</i>, 759 N.W.2d 113 (Neb. 2007).</p> <p><u>Medicare/Medicaid</u>: The billed amount, not the Medicare or Medicaid reduced rate, is the proper rate to use in calculating the reasonable value of medical expenses, past and future. Social legislation benefits, including payments by Medicare and Medicaid, are excluded by the CSR. <i>Fickle</i>, <u>supra</u>.</p>	<p>The rationale for Medicaid is that once plaintiff receives a verdict, he might no longer be eligible for Medicaid because eligibility standards take into account the resources available to a Medicaid applicant or recipient. <i>Fickle</i>, <u>supra</u>.</p> <p><u>Medical Malpractice</u>: Non-refundable medical reimbursement insurance benefits, less all premiums paid by or for claimant, are credited against any judgment rendered under the Nebraska Hospital-Medical Liability Act. Neb. Rev. Stat. § 44-2819.</p>
NEVADA	<p>The common law CSR provides that when an injured party receives collateral sources, these payments will not be deducted from the verdict, and evidence of collateral source payments are not allowed for any purpose. <i>Proctor v. Castelleetti</i>, 911 P.2d 853 (Nev. 1996).</p>	<p><u>Private Insurance</u>: Write-downs made by third-party insurers are collateral sources and inadmissible as to the issue of the reasonable value of the medical services. <i>Tri-County Equip. &amp; Leasing v. Klinke</i>, 286 P.3d 593 (Nev. 2012). Another case says that both hospital liens and insurance write-downs are collateral sources inadmissible under the CSR. That language, however, is arguably <i>dicta</i>, and case law regarding insurance write-downs is still evolving. Defendants, therefore, will argue the existence of a hospital lien as a source of potential bias for the medical experts. <i>Khoury v. Seastrand</i>, 377 P.3d 81 (Nev. 2016); <i>Cornell v. Wal-Mart Stores, Inc.</i>, 2010 WL 11591395 (D. Nev. 2010).</p> <p><u>Medicare/Medicaid</u>: Nevada has not directly addressed the application of the Nevada CSR to Medicare and Medicaid benefits. Until it does, the CSR applies to these payments.</p> <p>Subsequent decisions have reaffirmed that while the collateral source rule permits recovery of billed amounts, evidence of amounts actually paid may be admissible for limited purposes, creating a more nuanced evidentiary framework. <i>Khoury v. Seastrand</i>, 377 P.3d 81 (Nev. 2016).</p>	<p><u>Workers' Compensation</u>: When workers' compensation benefits are paid, Nevada has an exception to the CSR that allows the jury to hear evidence that the victim has received workers' compensation benefits. The jury is instructed to base the award on the full amount of medical expenses, however, because the compensation benefits must be repaid. This is because the jury knows that plaintiff receives workers' compensation when the injury is work-related, but is usually under the mistaken belief that plaintiff is not required to repay the benefits from the verdict. N.R.S. § 616C.215(10).</p> <p>Write-downs are negotiated between the medical provider and health care provider. Therefore, evidence of the write-downs would lead a jury to infer the existence of a collateral source and shouldn't be allowed. <i>Tri County Equip &amp; Leasing, LLC v. Klinke</i>, 2011 WL 1620634 (Nev. 2011) (unpublished order).</p>

STATE	COLLATERAL SOURCE RULE	RECOVERY OF MEDICAL EXPENSES RULE	RELATED LAW / COMMENTS
NEW HAMPSHIRE	<p>The common law CSR provides that an award of damages may not be reduced by collateral sources, and evidence of collateral sources not permitted. Prevents windfall to defendant. <i>Cyr v. J.I. Case Co.</i>, 652 A.2d 685 (N.H. 1994).</p>	<p><u>Private Insurance</u>: Undecided by Supreme Court. Plaintiff may present evidence of the reasonable value of medical expenses billed, but if he does, evidence of write-offs not permitted. <i>Cromeenes v. Pease</i>, 2007 WL 5688535 (N.H. Super. 2007); <i>Reed v. National Council of the Boy Scouts of America, Inc.</i>, 2010 WL 432355 (D. N.H. 2010); <i>Carson v. Maurer</i>, 424 A.2d 825 (N.H. 1980), overruled by <i>Community Resources for Justice, Inc. v. City of Manchester</i>, 917 A.2d 707 (N.H. 2007).</p> <p><u>Medicare/Medicaid</u>: One case suggests that the billed amount is the proper measure of reasonable medical expenses for Medicaid. <i>Williamson v. Odyssey House, Inc.</i>, 2000 WL 1745101 (D. N.H. 2000).</p>	<p>CSR applied to insurance policies, relief association, employment benefits, gratuitous payments, social security, welfare, and pensions. <i>Moulton v. Groveton Papers Co.</i>, 323 A.2d 906 (N.H. 1974).</p> <p>Supreme Court hasn't decided whether Medicaid or Medicare qualify under CSR. <i>Plummer v. Optima Health – Catholic Med. Ctr.</i>, 2000 WL 35730973 (N.H. Super. 2000). Some lower courts have said they should. <i>Gulluscio v. Hall</i>, 2007 WL 6647429 (N.H. Super. 2007).</p>
NEW JERSEY	<p>New Jersey has three versions of CSR:</p> <ol style="list-style-type: none"> <li>1. General CSR Statute: N.J.S.A. 2A:15-97.</li> <li>2. PIP CSR: N.J.S.A. § 39:6A-12.</li> <li>3. Tort Claims Act CSR: N.J.S.A. § 59:9-2(e).</li> </ol> <p>General CSR Statute passed in 1987. It applies to personal injury/death cases and says if plaintiff receives collateral sources, they must be disclosed to the court and deducted from verdict/recovery (except for workers' compensation benefits and life insurance). <i>Perreira v. Rediger</i>, 778 A.2d 429 (N.J. 2001).</p>	<p><u>Private Insurance</u>: Plaintiff can introduce evidence of the billed amount at trial, but require the past medical expenses be reduced by the court post-trial, less premiums paid. <i>Cockerlin v. Menendez</i>, 988 A.2d 575 (N.J. Super. App. 2010).</p> <p><u>Medicare/Medicaid</u>: CSR statute does not apply to Medicaid payments because they are reimbursable pursuant to Medicaid statute, N.J.S.A. § 30:4D-7.1. <i>Lusby By &amp; Through Nichols v. Hitchner</i>, 642 A.2d 1055 (N.J. Super. App. 1994).</p> <p>Unpublished Law Division trial court decision holds plaintiff limited to introducing evidence of amounts actually paid by Medicare, not amounts billed. <i>Charles v. Thomas</i>, 2016 N.J. Super. LEXIS 2199 (Law Div. Oct. 3, 2016) (unpublished).</p> <p>New Jersey continues to apply a statutory collateral source framework requiring post-verdict reduction of medical expense awards by amounts collectible from insurance, even if not actually received. N.J. Stat. § 2A:15-97; <i>Dias v. Araujo</i>, 202 A.3d 1027 (N.J. 2019).</p>	<p>General CSR Statute reverses the Common Law CSR by requiring plaintiff who receives collateral source benefits to deduct that amount from recovery. It acts as anti-subrogation statute by prohibiting subrogation of medical bills covered by insurance. <i>Perreira v. Rediger</i>, 169 N.J. 399 (N.J. Sup. 2001). It covers health insurance benefits (less premiums paid) even if subrogation required by policy, and social security benefits.</p> <p>Future medical expenses are inadmissible to the extent they are collectible under PIP limits, and tort defendants have no right of subrogation, reimbursement, or assignment against a plaintiff's PIP carrier. <i>Terrell v. Chitra</i>, 2026 WL 125125 (N.J. App. Div. Jan. 16, 2026).</p>

STATE	COLLATERAL SOURCE RULE	RECOVERY OF MEDICAL EXPENSES RULE	RELATED LAW / COMMENTS
NEW MEXICO	<p>Common law CSR is a rule of damages, preventing defendant from reducing damages based on collateral sources received by plaintiff. <i>Martinez v. Knowlton</i>, 516 P.2d 1098 (N.M. App. 1975).</p> <p>CSR is not a complete bar to evidence of collateral sources. It is relevant to prove agency, ownership, bias or prejudice, or to impeach if he claims lack of funds to pay bills. N.M. R. Evid. Rule 11-411; <i>Jojola v. Baldrige Lumber Co.</i>, 635 P.2d 316 (N.M. App. 1981).</p>	<p><u>Private insurance</u>: New Mexico appellate courts haven't decided whether plaintiff can recover amount billed or amount paid by collateral source. However, federal district court has ruled portions of medical expenses that health care providers write off constitute compensation or indemnity received by a tort victim from a source collateral to the tortfeasor. The injured party should be made whole by the tortfeasor, not by a combination of compensation from the tortfeasor and collateral sources. <i>Pipkins v. TA Operating Corporation</i>, 466 F.Supp.2d 1255 (D. N.M. 2006); <i>Candelaria v. The University of New Mexico Bd. of Regents</i>, 2016 WL 3913790 (N.M. Dist. 2016) (trial court order).</p> <p><u>Medicare/Medicaid</u>: New Mexico hasn't decided whether a plaintiff may recover the full amount of medical expenses billed by providers or whether plaintiff is limited to recovery of amounts actually paid by Medicare or Medicaid. <i>Pipkins, supra</i>.</p>	<p>Plaintiff may recover his or her "full losses from the responsible defendant, even though he may have recovered part of his losses from a collateral source." <i>Summit Properties, Inc. v. Pub. Serv. Co. of New Mexico</i>, 118 P.3d 716 (N.M. App. 2005).</p>
NEW YORK	<p>Common law CSR modified by statute.</p> <p><u>N.Y. C.P.L.R. § 4545(c)</u>: Evidence of collateral source admissible, unless subrogation right. Reduces verdict, less two years premiums and amount of maintaining benefits. Exception: life insurance and statutory right of reimbursement.</p> <p><u>N.Y. Gen. Obliq. Law § 5-335</u>: Eliminates the non-statutory right of benefit providers to reimbursement and subrogation in the case of third-party settlements. Applies to any insurer or plan that pays or reimburses medical expenses, disability payments, lost wages, or any other benefits under a policy of insurance. Presumption that settlement doesn't include collateral source payments unless collateral source has statutory subrogation.</p>	<p><u>Private Insurance</u>: Although a medical expense write-off is not technically a collateral source, plaintiff cannot recover it. Evidence of billed amounts admissible, but post-verdict reduction. <i>Kastick v. U-Haul Co. of W. Michigan</i>, 740 N.Y.S.2d 167 (N.Y. App. 2002).</p> <p><u>Medicare/Medicaid</u>: Because it's has a statutory right of subrogation/reimbursement, Medicare and Medicaid benefits not deducted from plaintiff's recovery. <i>Singh v. Long Island Jewish Med. Ctr.</i>, 2006 WL 431635 (N.Y. Sup. Ct. 2006).</p>	<p><u>Medical Malpractice</u>: Evidence of collateral source admissible and verdict reduced accordingly, less premiums for two years. N.Y. C.P.L.R. § 4545(a).</p> <p><u>Actions Against Public Employer</u>: Evidence of collateral source admissible, unless subrogation right. Reduces verdict, less premiums paid. N.Y. C.P.L.R. § 4545(b).</p> <p><u>Personal Injury/Death/Property</u>: Evidence of collateral source admissible, unless subrogation right. Reduces verdict, less two years premiums and amount of maintaining benefits. N.Y. C.P.L.R. § 4545(c)</p> <p>Charitable contributions are not collateral sources. N.Y. C.P.L.R. § 4545(d).</p> <p>New York's CSR only applies to verdicts; it does not apply to settlements. <i>Fasso v. Doerr</i>, 903 N.E.2d 1167 (N.Y. 2009).</p>

STATE	COLLATERAL SOURCE RULE	RECOVERY OF MEDICAL EXPENSES RULE	RELATED LAW / COMMENTS
NORTH CAROLINA	<p>Common law CSR prohibits evidence of collateral sources including workers' compensation, health insurance, sick leave, etc. Only applied in tort cases. <i>White v. Lowery</i>, 352 S.E.2d 866 (N.C. App. 1987).</p>	<p>Until recently, North Carolina had not addressed the treatment of write-downs. For actions arising after 10/1/11, Rule of Evidence 414 limits evidence of medical bills to "the amounts actually paid to satisfy the bills" and "the amounts actually necessary to satisfy the bills that have been incurred, but not yet satisfied." For cases filed before 10/1/11, the Common law CSR prevents such evidence. Rule 414 does require a party to seek a reduction in billed charges to which the party is not contractually entitled. Applies to private insurance and Medicare/Medicaid.</p> <p>North Carolina limits recovery of medical expenses to amounts actually paid or necessary to satisfy outstanding bills, and restricts admissibility of evidence to those amounts. N.C. Gen. Stat. § 8-58.1; <i>DiDonato v. Wortman</i>, 358 N.C. 679 (2004).</p>	<p>N.C.G.S.A. § 8-58.1 limits plaintiff's testimony about reasonable medical expenses to the amount "paid or required to be paid in full satisfaction" of the charges.</p> <p>Rule 414 appears to put responsible persons who pay health insurance premiums at a disadvantage, because the rule does not prevent recovery of billed medical expenses if plaintiff does not have insurance to cover the bills.</p>
NORTH DAKOTA	<p>CSR broadly applied to bar evidence of government benefits plaintiff has received. <i>Nelson v. Trinity Med. Ctr.</i>, 419 N.W.2d 886 (N.D. 1988); <i>Anderson v. U.S.</i>, 731 F.Supp. 391 (D. N.D. 1990). Medicare benefits set-off. <i>Overton v. U.S.</i>, 619 F.2d 1299 (8<sup>th</sup> Cir. 1980).</p> <p>Statute called "Reduction For Collateral Source Payment" says defendant entitled to reduction of economic damages to the extent they are covered by payment from a collateral source. A "collateral source" is any sum which need not be repaid by plaintiff. It doesn't include benefit purchased by plaintiff.</p>	<p>North Dakota has no reported decisions dealing with treatment of write-downs and write-offs regarding the proof and recovery of reasonable medical expenses in civil litigation. Plaintiff's testimony can establish sufficient foundation that medical bills incurred as a result of a vehicle crash. <i>Erdmann v. Thomas</i>, 446 N.W.2d 245 (N.D. 1989).</p>	<p>N.D.C.C. § 32-03.2-06 allows court to reduce damages post-verdict if economic damages are covered by payment from a collateral source. However, there is an exception for private insurance purchased by plaintiff, life insurance, death, or retirement benefits, or any collateral source with subrogation rights. <i>Dewitz by Nuestel v. Emery</i>, 508 N.W.2d 334 (N.D. 1993).</p> <p>No such exception for workers' compensation and Social Security. <i>Leingang v. George</i>, 589 N.W.2d 585 (N.D. 1999); <u>But see</u> <i>Krein v. Indus. Co. of Wyoming</i>, 2003 WL 22415867 (D. N.D. 2003) (questioning <i>Leingang</i>).</p>

STATE	COLLATERAL SOURCE RULE	RECOVERY OF MEDICAL EXPENSES RULE	RELATED LAW / COMMENTS
OHIO	<p>Common law CSR. <i>Robinson v. Bates</i>, 857 N.E.2d 1195 (Ohio 2006).</p> <p>CSR modified by statute. Ohio Rev. Code Ann. § 2315.20(A) provides that evidence of collateral source allowed unless: (1) federal right of subrogation; (2) contractual right of subrogation; (3) statutory right of subrogation; or (4) life insurance or disability payments.</p> <p>Ohio continues to follow a hybrid approach allowing admission of both billed and paid amounts, but courts have emphasized that write-offs are not recoverable damages. <i>Robinson v. Bates</i>, 857 N.E.2d 1195 (Ohio 2006); <i>Jaques v. Manton</i>, 125 N.E.3d 1016 (Ohio App. 2018).</p>	<p>Ohio has not adopted a categorical rule. The difference between the amount billed and amount paid for medical expenses is not a “payment” for purposes of the CSR. Because different insurance arrangements exist, the fairest approach is to make the defendant liable for the <i>reasonable value</i> of plaintiff’s medical treatment. It is not necessarily the amount paid or amount billed. Instead, the reasonable value of medical services is a matter for the jury to determine from all relevant evidence. Both the amounts billed, and the amounts paid, are admissible to prove reasonableness and necessity of charges rendered for medical care. <i>Robinson v. Bates</i>, 857 N.E.2d 1195 (Ohio 2006).</p> <p>Probably applies to Medicare and Medicaid, although no case has decided a Medicare or Medicaid case since <i>Jaques</i>.</p>	<p>The CSR does not prevent a defendant from introducing evidence of write-offs because they are not paid by third parties and such evidence permits permit jury to determine the actual amount of medical expenses incurred as a result of a defendant’s actions. <i>Jaques v. Manton</i>. 928 N.E.2d 434 (Ohio 2010).</p> <p>In medical malpractice action, defendant may introduce evidence of any amount payable as a benefit to the plaintiff as a result of the damages from an injury, death, or loss to person or property that is the subject of the claim, except if the source of collateral benefits has a mandatory self-effectuating federal right of subrogation, a contractual right of subrogation, or a statutory right of subrogation. Ohio R.C. § 2323.41.</p>
OKLAHOMA	<p>Common law CSR. Receipt of collateral source benefits by plaintiff does not lessen the damages recoverable from tortfeasor and no evidence of collateral sources allowed. <i>Denco Bus Lines v. Hargis</i>, 229 P.2d 560 (Okla. 1951).</p>	<p><u>Private Insurance</u>: Tortfeasor may not benefit from medical expense payments made by a policy held and paid for by plaintiff. <i>Weatherly v. Flournoy</i>, 929 P.2d 296 (Okla. App. 1996). Very little case law on issue, but courts consistently allow plaintiffs to recover the amount billed.</p> <p>Auto Med Pay carrier not required to pay amounts medical expenses written down for insured’s health insurer. <i>Woodrich v. Farmers Insurance Co., Inc.</i>, 405 F.Supp.2d 1276 (N.D. Okla. 2004) (applying Oklahoma law).</p> <p><u>Medicare/Medicaid</u>: Oklahoma hasn’t decided whether CSR permits plaintiff to recover medical expenses written off by Medicare or Medicaid. A reasonable interpretation of the CSR would be not to allow plaintiffs to recover Medicaid write-offs, because plaintiffs do not pay for it like they do Medicare. <i>Simpson v. Saks Fifth Ave., Inc.</i>, 2008 WL 3388739 (N.D. Okla. 2008).</p>	<p><u>Workers’ Compensation</u>: No evidence of compensation benefits allowed in determining plaintiff’s damages. Employer is not given a credit for expenses paid by other types of insurance procured by claimant. 85 Okla. Stat. § 45(A); <i>Blythe v. Univ. of Okla.</i>, 82 P.3d 1021 (Okla. 2003).</p> <p><u>Governmental Immunity</u>: Government entities exempt from liability if injuries covered by workers’ compensation. 51 O.S. § 155(14); <i>Gladstone v. Bartlesville Independent School Dist. No. 30</i>, 66 P.3d 442 (Okla. 2003).</p> <p><u>Medical Malpractice</u>: Allows evidence of medical expense collateral source payments in medical malpractice actions. Exception for payments subject to subrogation by the plaintiff’s insurer. 63 Okla. Stat. § 1-1708.1B(B).</p>

STATE	COLLATERAL SOURCE RULE	RECOVERY OF MEDICAL EXPENSES RULE	RELATED LAW / COMMENTS
OREGON	<p>Oregon's CSR modified by statute. Section 31.580 allows for the introduction of evidence of collateral source payments by affidavit <i>after</i> trial, but prior to final judgment.</p> <p><u>Exceptions:</u> (1) if subrogation owed; (2) life insurance or death benefits; (3) insurance that plaintiff paid premiums for; and (4) retirement, disability, pension, and Social Security. O.R.S. § 31.580.</p>	<p><u>Private Insurance:</u> Amounts paid by insurance is admissible. <i>White v. Jubitz Corp.</i>, 182 P.3d 215 (Or. App. 2008) <i>aff'd</i> 219 P.3d 566 (Or. 2009). No decisions regarding whether court must deduct write-off amounts from jury verdict.</p> <p><u>Medicare/Medicaid/Oregon Health Plan:</u> Can recover amount of Medicare billed, and they are not admissible at trial. <i>White v. Jubitz Corp.</i>, 219 P.3d 566 (Or. 2009). Medicaid, like Medicare, is a federal Social Security program, and, pursuant to § 31.580(1)(d), a court may not reduce a plaintiff's award of damages by the amount of Medicaid write-offs. <i>Cohens v. McGee</i>, 180 P.3d 1240 (Or. App. 2008).</p>	<p>Plaintiff entitled to recover the full amount of all medical bills incurred regardless of any write-offs taken by the medical provider due to Medicare, Medicaid, or Oregon Health Plan.</p>
PENNSYLVANIA	<p>Common law CSR. Collateral source payments do not reduce amount recoverable from tortfeasor. <i>Johnson v. Beane</i>, 664 A.2d 96 (Pa. 1995). Such payments are also not admissible. <i>Pust v. Means</i>, 982 A.2d 550 (Pa. Super. 2009).</p>	<p>Plaintiff entitled to "reasonable value of medical expenses." Only the amount actually paid by provider (or amount found by jury to be reasonable) is recoverable in a personal injury action. <i>Moorhead v. Crozer Chester Medical Center</i>, 765 A.2d 786 (Pa. 2001) was a Medicare and private insurance case. CSR not implicated because plaintiff could still recover every dollar that was "paid."</p> <p>Pennsylvania makes no distinction between private insurance and Medicare/Medicaid.</p> <p>Pennsylvania courts have clarified that while the collateral source rule permits recovery of billed amounts, the Medical Care Availability and Reduction of Error (MCARE) Act limits recovery in medical malpractice actions to amounts actually paid. 40 P.S. § 1303.508; <i>Moorhead v. Crozer Chester Med. Ctr.</i>, 765 A.2d 786 (Pa. 2001).</p>	<p><u>Applies Only to Defendants' Evidence:</u> CSR applies only to defense offers of evidence, not when plaintiff wanted jury to know he was receiving Social Security, which meant he was disabled. <i>Simmons v. Cobb</i>, 906 A.2d 582 (Pa. Super. 2006).</p>

STATE	COLLATERAL SOURCE RULE	RECOVERY OF MEDICAL EXPENSES RULE	RELATED LAW / COMMENTS
RHODE ISLAND	Common law CSR. Plaintiff's recovery not reduced by collateral source payments made by third-party sources, such as insurance companies. <i>Esposito v. O'Hair</i> , 886 A.2d 1197 (R.I. 2005).	Not yet addressed by Supreme Court. Amount billed. <i>Bellini v. Roosevelt Manor Assisted Living, Inc.</i> , 2007 WL 3299249 (R.I. Super. 2007). Itemized medical bill, "shall be admissible as evidence of the fair and reasonable charge for the services and/or the necessity of the services or treatment" cross examination and rebuttal evidence is permitted. R.I.G.L. § 9-19-27.	<u>Medical Malpractice</u> : Defendant can introduce any evidence of collateral sources and jury must reduce damages by sum equal to difference between total collateral sources and total amount paid to secure them. R.I.G.L. § 9-19-34.1. (Medicaid cases not applicable). This statute declared unconstitutional in <i>Maguire v. Licht</i> , 2001 WL 1006060 (R.I. Super. 2001); <i>Esposito v. O'Hair</i> , 886 A.2d 1197 (R.I. 2005), but Rhode Island Supreme court has declined to address it.
SOUTH CAROLINA	Common law CSR. Amounts received from collateral source will not reduce plaintiff's damages, as long as it is "wholly independent of wrongdoer."	<u>Private Insurance</u> : Despite CSR, a set-off of medical payments made on plaintiff's behalf by defendant's insurer is allowed. <i>Mount v. Sea Pines Co., Inc.</i> , 523 S.E.2d 464 (S.C. App. 1999). Otherwise, amounts paid by collateral source inadmissible. <i>Covington v. George</i> , 597 S.E.2d 142 (S.C. 2004). <u>Medicare/Medicaid</u> : The CSR applies to Medicaid payments; the amount billed is recoverable. <i>Haselden v. Davis</i> , 579 S.E.2d 293 (S.C. 2003). The court acknowledged that several other courts have held that the amount paid by Medicaid is the reasonable medical expense.	<u>Workers' Comp</u> : Amount of compensation received not admissible in any third-party action. S.C. Code Ann. § 42-1-570.
SOUTH DAKOTA	Common Law CSR. CSR prohibits evidence that plaintiff's medical expenses are paid by collateral source. <i>Degen v. Bayman</i> , 241 N.W.2d 703 (S.D. 1976). Damages not reduced by collateral source. <i>Jurgensen v. Smith</i> , 611 N.W.2d 439 (S.D. 2000).	<u>Private Insurance</u> : Paid amounts inadmissible. <i>Papke v. Harbert</i> , 738 N.W.2d 510 (S.D. 2007). Write-offs not admissible. Plaintiff is entitled to recover the reasonable value of medical services which is a question for the jury. Ruling that either amount is the reasonable value makes the other value inherently unreasonable. S.D.C.L. § 21-3-12. <u>Medicare/Medicaid</u> : CSR applies. Amounts written off not admissible. <i>Papke</i> , <i>supra</i> .	<u>Exception to CSR</u> : Malingering. <i>Cruz v. Gorth</i> , 763 N.W.2d 810 (S.D. 2009).

STATE	COLLATERAL SOURCE RULE	RECOVERY OF MEDICAL EXPENSES RULE	RELATED LAW / COMMENTS
TENNESSEE	<p>Common Law CSR. Plaintiff entitled to recover the “reasonable and necessary expenses” without regard to whether some or all medical expenses paid by insurance or another source. <i>State Auto. Mut. Ins. Co. v. Hurley</i>, 31 S.W.3d 562 (Tenn. 2000).</p> <p>Evidence of collateral source not admissible in evidence. <i>Donnell v. Donnell</i>, 415 S.W.2d 127 (Tenn. 1967).</p> <p>Follows <i>Restatement (Second) of Torts</i> § 920A. <i>Nance ex rel. Nance v. Westside Hosp.</i>, 750 S.W.2d 740 (Tenn. 1988).</p>	<p><u>Private Insurance</u>: CSR applies to evidence regarding medical expenses. Plaintiffs may use evidence of the full, undiscounted medical bills as proof of reasonable medical expenses, and defendants may not use discounted rates paid by an insurance company for any purpose. Defendants are free to use any other evidence to show that full medical expenses are not reasonable, so long as that evidence does not violate the CSR. <i>Dedmon v. Steelman</i>, 2017 WL 5505409 (Tenn. 2017).</p> <p><u>Medicare/Medicaid</u>: Evidence of Medicare or Medicaid write-downs not admissible under CSR. <i>Frye v. Kennedy</i>, 991 S.W.2d 754 (Tenn. App. 1998).</p>	<p><u>Medical Malpractice</u>: CSR doesn’t apply in “health care liability actions.” T.C.A. § 29-26-119. (Limits damages, not evidence).</p> <p><u>Workers’ Compensation</u>: CSR doesn’t apply in workers’ comp cases. <i>State Auto. Mut. Ins. Co. v. Hurley</i>, 31 S.W.3d 562 (Tenn. Workers Comp. Panel 2000).</p> <p>In small claims, there is rebuttable presumption that medical bills of \$4,000 or less, itemized and attached to complaint, are “reasonable and necessary.” Defendant must provide evidence to contrary. Only applies to personal injury actions. T.C.A. § 24-5-113(a).</p> <p>In larger claims, if itemized copies of medical bills of any amount served on party 90 days prior to trial, there is presumption of reasonableness, but not necessity. Must be rebutted at least 45 days prior to trial. T.C.A. § 24-5-113(b).</p> <p>Plaintiff must always establish causation. <i>Iloube v. Cain</i>, 397 S.W.3d 597 (Tenn. App. 2012).</p>

Common law CSR is both a rule of evidence and a rule of damages. *Lee v. Lee*, 47 S.W.3d 767 (Tex. App. – Houston [14<sup>th</sup> Dist.] 2001); *Exxon Corp. v. Shuttlesworth*, 800 S.W.2d 902 (Tex. App. – Houston [14<sup>th</sup> Dist.] 1990).

Evidence of collateral source not allowed and no reduction in damages awarded due to collateral sources. *Mid-Century Ins. Co. of Tex. v. Kidd*, 997 S.W.2d 265 (Tex. 1999). A benefit that is directed to plaintiff should not become a windfall for tortfeasor.

Private Insurance: Effective 9/1/03, Texas Civil Practice and Remedies Code § 41.0105 provided, albeit somewhat ambiguously, that the recovery of medical expenses is limited to those “actually paid or incurred.” Plaintiffs argued this meant any amount billed by a provider, while defendants argued this meant only the amount actually due a provider. Plaintiff can’t recover those medical expenses that have been “written off” by medical providers pursuant to agreement with health insurers. *Mills v. Fletcher*, 229 S.W.3d 765, 769 (Tex. App.—San Antonio 2007). In *Haygood*, the Supreme Court said that plaintiff is limited in recovering medical expenses that “have been or must be paid by or for the claimant.” The submission of any evidence of what the “full” charges might be can introduce a potentially fatal error into a plaintiff’s case. Section 41.0105 was intended to only apply to medical malpractice cases. However, because of sloppy drafting, the language used did not limit its application to such cases.

In *Big Bird Tree Serv. v. Gallegos*, 365 S.W.3d 173 (Tex. App.—Dallas 2012, no pet.), the court held that a plaintiff could recover the amounts “incurred” by a charitable organization which rendered treatment to an injured person free of charge.

Medicare/Medicaid: There is no distinction between recovering medical expenses written off by private insurance and written off by Medicare/Medicaid. *Matabon v Gries*, 288 S.W.3d 471 (Tex. App.—Eastland 2009); *Garza v. Haygood*, 283 S.W.3d 3 (Tex. App.—Tyler 2009).

If there is no contract or statute that prevents providers from charging plaintiff full cost of medical expenses (e.g., “free” charitable medical care), then plaintiff can recover billed amount. *Big Bird Tree Servs. v. Gallegos*, 365 S.W.3d 173 (Tex. App. 2012).

Texas continues to limit recovery of medical expenses to amounts actually paid or incurred under § 41.0105, and recent decisions have reinforced strict evidentiary requirements for proving those amounts. Tex. Civ. Prac. & Rem. Code § 41.0105; *In re Allstate Indem. Co.*, 622 S.W.3d 870 (Tex. 2021).

After passage of § 41.0105, there was still some question over how § 41.0105 was implemented. Did it control evidence at trial? Or, was it handled post-verdict? What evidence is allowed?

Plaintiff can only submit evidence of what was “paid” by the insurance company. Plaintiff can only recover up to the amount paid. Plaintiff gets no off-set for premiums paid. *Haygood v. De Escobedo*, 356 S.W.3d 390 (Tex. 2011).

It is still considered error for either party to mention insurance (liability insurance or health insurance, etc.) during trial. Tex. R. Evid. 411; Tex. R. Civ. P. 226a(II)(9). The CSR is often referred to as the “balance in trial evidence.” Before *Haygood*, plaintiff wanted CSR enforced and defendant didn’t. After *Haygood*, it’s the other way around.

Other questions raised by § 41.0105, however, remain unanswered. For example, neither *Haygood* nor the statute addresses the issue of reductions on proof of future medical expenses. In cases where the plaintiff is insured, a plaintiff may rely on past medical expenses to show the reasonable cost of future medical expenses. On the other hand, in cases where the plaintiff is uninsured, the court may permit the submission of unadjusted past medical bills as evidence of the reasonable costs for future medical expenses. *Henderson v. Spann*, 367 S.W.3d 301 (Tex. App.—Amarillo 2012, pet. denied). Future medical expenses that do not reflect write-offs might not reflect the “reasonable cost of that care.”

In using medical expense affidavits under § 18.001, the amount listed in the affidavit is limited to the amount actually paid or incurred, not the amount billed. *Haygood*, *supra*. Therefore, affidavits of subrogation

STATE	COLLATERAL SOURCE RULE	RECOVERY OF MEDICAL EXPENSES RULE	RELATED LAW / COMMENTS
			agents showing amounts billed are improper. <i>Gunn v. McCoy</i> , 2018 WL 3014984 (Tex. 2018).
UTAH	<p>Common law CSR. <u>Evidentiary</u>: precludes both reference to and methodical allusion to collateral source benefits at trial because jury may think plaintiff is seeking a windfall.</p> <p><u>Damages</u>: Collateral source payments are not credited against tortfeasor's liability (i.e., cannot reduce verdict by amount insurance paid.</p> <p><i>Phillips v. Bennett</i>, 439 P.2d 457 (Utah 1968); <i>Gardner v. Norman</i>, 2025 WL 3030153 (Utah 2025).</p>	<p><u>Private Insurance</u>: In <i>Gardner v. Norman</i>, 2025 WL 3030153 (Utah 2025), the Court held that the negotiated charge between the plaintiff's insurer and the healthcare provider is the proper measure of special damages for past medical expenses. The plaintiff may recover the amounts actually paid or still owed (including co-pays/deductibles), but may not recover contractual write-offs or the difference between the gross billed amount and the negotiated rate, because that difference is not a loss caused by the tortfeasor. <i>Gardner</i> rejects earlier federal predictions that Utah would allow recovery of full billed charges including write-offs. <i>Amos v. W.L. Plastics, Inc.</i>, 2010 WL 360772 (D. Utah 2010).</p> <p><u>Medicare/Medicaid</u>: <i>Gardner</i> itself is framed generally in terms of the difference between gross charges and negotiated charges under a payor-provider contract; it does not carve out Medicare or Medicaid specifically. The reasoning (that the unpaid portion is not a tort loss) logically extends to Medicare/Medicaid write-offs as well, but there's still no Utah case expressly on those programs.</p>	<p><u>Medical Malpractice</u>: Evidence of collateral source allowed, and damages reduced "by the total of all amounts paid to the plaintiff from all collateral sources available to him." After verdict, court hears evidence and reduces damages by amounts of collateral sources, offset by amounts plaintiff paid to secure those benefits. No reduction for if rights of subrogation. Although the court does not make any reduction for future collateral source benefits, the trier of fact may consider evidence of possible future benefits from government programs when it determines damages. To preserve subrogation, subrogee must serve written notice on each defendant within 30 days before settlement or judgment. U.C.A. § 78B-3-405.</p>

STATE	COLLATERAL SOURCE RULE	RECOVERY OF MEDICAL EXPENSES RULE	RELATED LAW / COMMENTS
VERMONT	<p>Common law CSR. Collateral sources do not reduce damages, even if plaintiff didn't pay for the insurance or benefits. <i>Bradley v. Buck</i>, 306 A.2d 98 (Vt. 1973).</p> <p>Collateral sources not admissible. <i>Hall v. Miller</i>, 465 A.2d 222 (Vt. 1983).</p>	<p><u>Private Insurance</u>: Undecided, with disagreement among lower courts. One trial court has suggested write-offs covered under CSR and, therefore, recoverable and not admissible. <i>O'Bryan v. Hannaford Bros. Inc.</i>, 2008 WL 6825535 (Vt. Super. Ct. 2008). Another said that "...unless and until our Supreme Court explicitly holds that the amount(s) billed for medical treatment and services is the default measure of damages, as opposed to the amount(s) actually paid to, and received by the medical provider as full compensation and reimbursement, the court will stand by its ruling here that the latter is the applicable, and more appropriate standard." <i>McGowan v. Chase</i>, 2009 WL 2969645 (Vt. Super. 2009); <u>See also</u> <i>Bora v. Chittenden County Transp.</i> 2006 WL 4660871 (Vt. Super. 2006).</p> <p><u>Medicare/Medicaid</u>: Utah courts have not yet addressed this issue. One trial court has said such payments should be covered under CSR and excluded from evidence. <i>O'Bryan, supra</i>.</p>	<p>"Collateral sources" include insurance, pensions, employer-paid sick leave, uninsured motorist coverage, charitable donations, and tax benefits. <i>Bradly v. H.A. Manosh Corp.</i>, 601 A.2d 978 (Vt. 1991) (uninsured motorist coverage); <i>Coty v. Ramsey Associates, Inc.</i>, 546 A.2d 196 (Vt. 1988) (tax benefit); <i>Houghton v. Leinwhol</i>, 376 A.2d 733 (Vt. 1977) (pension benefits); <i>D'Archangelo v. Loyer</i>, 215 A.2d 520 (Vt. 1965) (allowing recovery of lost wages despite receipt of sick leave pay); <i>Windsor School Dist. v. State</i>, 956 A.2d 528 (Vt. 2008).</p>
VIRGINIA	<p>Common law CSR. Collateral source does not reduce judgment. <i>Schickling v. Aspinall</i>, 369 S.E.2d 172 (Va. 1988).</p> <p>Evidence of collateral sources for payment of medical expenses not admissible. <i>Burks v Webb</i>, 99 S.E.2d 629 (Va. 1957).</p> <p>Loss of income damages not diminished by collateral sources reimbursing plaintiff, and such sources not admissible. Va. Stat. § 8.01-35.</p>	<p><u>Private Insurance</u>: Write-offs may not be deducted from verdict. <i>Acuar v Letourneau</i>, 531 S.E.2d 316 (Va. 2000). Plaintiff able to recover write-off amounts from HMO even when HMO was defendant. <i>Karsten v. Kaiser Found. Health Plan of Mid-Atlantic States, Inc.</i>, 808 F. Supp. 1253 (E.D. Va. 1992) (applying Virginia law).</p> <p><u>Medicare/Medicaid</u>: Not specifically addressed. Prior to <i>Acuar</i>, some trial courts held CSR applies to Medicare and Medicaid write-offs just as it does to private insurance. <i>Kelly v. Thomasson</i>, 48 Va. Cir. 100, (Va. Cir. 1999); <i>Perry v. McClure</i>, 47 Va. Cir. 504, 505, (Va. Cir. 1998). <i>Acuar</i> seems to suggest Supreme Court would approve of those holdings.</p>	<p>Argument that evidence of collateral source medical expense payments should be allowed because amounts written off and accepted by medical provider are not damages was accepted by some trial courts, but rejected by Supreme Court. <i>Acuar v Letourneau</i>, 531 S.E.2d 316 (Va. 2000).</p> <p>Another argument that defendant should be allowed to argue to a jury that amount paid is actual proof of "reasonable value of services" was accepted by some trial courts, but rejected by Supreme court. <i>Radvany v Davis</i>, 551 S.E.2d 347 (Va. 2001).</p> <p><u>Bankruptcy</u>: CSR might not apply to medical expenses written off in bankruptcy. <i>Payne v. Wyeth Pharms., Inc.</i>, 606 F.Supp.2d 613 (E.D. Va. 2008).</p>

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WASHINGTON	<p>Common law CSR. No reduction for collateral sources received by plaintiff. <i>Wheeler v. Catholic Archdiocese of Seattle</i>, 880 P.2d 29 (Wash. 1994). Evidence of collateral sources may be excluded even if relevant for another purpose. <i>Cox v. Spangler</i>, 5 P.3d 1265, 22 P.3d 791 (Wash. 2000).</p> <p>Washington courts have continued to apply the collateral source rule broadly, while recognizing limited statutory modifications in specific contexts such as medical malpractice actions. <i>Diaz v. State</i>, 175 P.3d 1116 (Wash. 2008).</p>	<p><u>Private Insurance</u>: Write-downs and write-ups are both evidence of the reasonable value of medical services. Plaintiff cannot recover either; jury must find reasonable value. Paid amounts arguably inadmissible and may be excluded based on discretion of court. <i>Hayes v. Wieber Enterprises, Inc.</i>, 20 P.3d 496 (Wash. App. 2001). In <i>Hayes</i>, Court of Appeals did not address whether evidence the physician had accepted the \$3,300 as payment in full was barred by the CSR. Instead, the court relied on doctor’s testimony that his \$5,800 bill was reasonable, and that defendant did not present testimony the bill was unreasonable. Plaintiff has burden to prove reasonable value. <i>Torgeson v. Hanford</i>, 139 P. 648 (Wash. 1914).</p> <p><u>Medicare/Medicaid</u>: Medicare Part A payments are collateral sources. <i>Ciminski v. SCI Corp.</i>, 585 P.2d 1182 (Wash. 1978); 16 Wash. Prac., <i>Tort Law and Practice</i> § 6:35 (3<sup>rd</sup> Ed.).</p>	<p><u>Medical Malpractice</u>: Evidence of collateral sources allowed, except the plaintiff’s personal assets, his representative’s or family’s assets, or insurance purchased with such assets. If evidence of collateral source payments is admitted, the plaintiff may present evidence of subrogation. Insurance obtained through one’s employment is considered insurance purchased with the assets of the employee. Wash. Rev. Code § 7.70.080.</p> <p>CSR does not apply to collateral sources that are not independent of the tortfeasor (such as PIP payments made by tortfeasor’s auto policy). <i>Maziarski v. Bair</i>, 924 P.2d 409 (Wash. App. 1996).</p>
WEST VIRGINIA	<p>Common law CSR. Collateral sources not admissible. <i>Pack v. Van Meter</i>, 354 S.E.2d 581 (W.Va. 1986).</p> <p>CSR applied as both a rule of evidence and a rule of damages. <i>Kenney v. Liston</i>, 760 S.E.2d 434 (W. Va. 2014).</p> <p>No offset of verdict of collateral source payments. <i>Ratlief v. Yokum</i>, 280 S.E.2d 584 (W. Va. 1981).</p>	<p><u>Private Insurance</u>: Medical expense award is based on reasonable value of such expenses “incurred” or “billed” as opposed to actual expenses “paid.” <i>Long v. City of Weirton</i>, 214 S.E.2d 832 (W. Va. 1975). Supreme Court recently held that CSR prohibits evidence of write-offs or adjustments by insurance company. <i>Kenney</i>, <u>supra</u>. Defendant should not reap the benefits of a plaintiff’s preparation and protection.</p> <p><u>Medicare/Medicaid</u>: Same as private insurance.</p>	<p><u>Medical Malpractice</u>: Statute provides for reduction in damages for payments from collateral sources. W. Va. Code § 55-7B-9a. After verdict, defendant may offer evidence of future payments from collateral sources. whereupon plaintiff may present evidence of payments or contribution made to secure these benefits. Paragraphs (d) - (f) are the calculation provisions. Paragraph (g) excludes from reduction of the verdict certain collateral sources with subrogation rights.</p> <p><u>Harmless Error Rule</u>: Where collateral source introduced but defense verdict – no error. <i>Ratlief</i>, <u>supra</u>.</p>

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WISCONSIN	<p>Common law CSR. CSR has long prevented reduction of verdict because of collateral sources or evidence of collateral sources. <i>Cunnen v. Superior Iron Works</i>, 184 N.W. 767 (Wis. 1921); <i>Leitinger v. DBart, Inc.</i>, 736 N.W.2d 1 (Wis. 2007).</p>	<p><u>Private Insurance</u>: Plaintiff allowed to recover the reasonable value of medical services billed without consideration of payments made by plaintiff's health insurer. Paid amounts inadmissible. <i>Leitinger v. DBart, Inc.</i>, <u>supra</u>.</p> <p>Motorist was entitled to seek recovery of reasonable value of medical services, without limitation to amounts paid by subrogated auto carrier, and (2) presentation of inadmissible evidence of payments made by motorist's insurers was reversible error. <i>Koffman v. Leichtfuss</i>, 630 N.W.2d 201 (Wis. 2001).</p> <p><u>Medicare/Medicaid</u>: CSR applied to Medicare and Medicaid benefits. <i>Thoreson v. Milwaukee &amp; Suburban Transp. Corp.</i>, 201 N.W.2d 745 (Wis. 1972). Reasonable value of medical costs is not always the actual expense. Because the test is the reasonable value, not actual expense, the plaintiff need not incur an actual expense. <i>Ellsworth v. Schelbrock</i>, 611 N.W.2d 764 (Wis. 2000).</p>	<p><u>Medical Malpractice</u>: Evidence of collateral source admissible in medical malpractice. Wis. Stat. Ann. § 893.55(7).</p>
WYOMING	<p>Common law CSR. Plaintiff's receipt of collateral benefits does not reduce his recovery. <u>See</u> <i>Haderlie v. Sondgeroth</i>, 866 P.2d 703 (Wyo. 1993).</p>	<p><u>Private Insurance</u>: No published state court decisions on this subject. Federal courts have held that evidence of the amount actually paid is inadmissible. Federal district court found that the proper measure of damages is the reasonable value of the medical services, but it does not appear the defendant sought to establish the reasonable value by means other than referring to the paid amount. <i>Lurus v. Rissler &amp; McMurry Co.</i>, No. 02-CV-174-J (D. Wyo. 2004).</p> <p><u>Medicare/Medicaid</u>: No published state court decisions on this subject. Federal district court has held that discounted amount of medical expenses does not reflect the reasonable value of services rendered. Discounted rate reflects the third-party payor's negotiating power and the fact that providers enjoy prompt payment, assured collectability. Plaintiff can recover the full billed amount as opposed to the amount paid by Medicare for the services rendered, relying on the CSR. <i>Seely v. Archuleta</i>, 2013 WL 1137952 (D. Colo. 2013).</p>	<p><u>Workers' Compensation</u>: CSR excludes evidence of medical payments made by workers' compensation carrier. <i>Prager v. Campbell County Mem. Hosp.</i>, 731 F.3d 1046 (10<sup>th</sup> Cir. 2013) (medical malpractice).</p>

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