EFiled: Jan 13 2015 02:05PM EST
Filing ID 56596106
Case Number 601,2014

IN THE SUPREME COURT OF THE STATE OF DELAWARE

DIANE L. STAYTON,	:	
	:	
Plaintiff Below, Appellant,	:	
	:	**No. 601, 2014**
v.	:	
	:	**Court Below: Superior Court of the State of Delaware, in and for Kent County, C.A.No. K12C-04-026 RBY**
DELAWARE HEALTH CORPORATION, a Delaware Corporation; HARBOR HEALTHCARE CENTER COMPANY, L.L.C. a Limited Liability Company; MARY FRANCIS DRANDORFF, RN, Individually; RUTHANNE ROBERTS JACOBS, RN, Individually; and RENEE L. WOZNICKI EDGE, RN, Individually,	:	
	:	
Defendants Below, Appellees.	:	

APPELLEES' (CORRECTED) ANSWERING BRIEF

MARKS, O'NEILL, O'BRIEN,
DOHERTY & KELLY, P.C.
DAWN C. DOHERTY, ESQUIRE (3164)
NORMAN H. BROOKS, JR., ESQUIRE (2568)
BRETT T. NORTON, ESQUIRE (5559)
300 Delaware Avenue, #900
Wilmington, DE 19801
(302) 658-6538
Attorneys for Defendants Below, Appellees

Dated: January 13, 2015

{DE310781.1}

TABLE OF CONTENTS

TABLE OF CITATIONS ii

NATURE OF PROCEEDINGS 1

SUMMARY OF ARGUMENT 3

STATEMENT OF FACTS 4

ARGUMENT

I. THE SUPERIOR COURT PROPERLY RULED THAT PLAINTIFF'S RIGHT TO RECOVER THE REASONABLE VALUE OF HER MEDICAL TREATMENT DOES NOT INCLUDE AMOUNTS THAT HER HEALTH CARE PROVIDERS PURPORTED TO OVERCHARGE THE MEDICARE TRUST FUND 6

A. QUESTION PRESENTED 6

B. SCOPE OF REVIEW 6

C. MERITS OF ARGUMENT 6

1. The Collateral Source Rule cannot apply because plaintiff did not contract with a health care provider to accept reduced benefits from Medicare 6

2. The Collateral Source Rule cannot apply because Medicare is distinctively different from private collateral sources 10

3. The Collateral Source Rule cannot apply in this matter because double recovery by plaintiff, with Medicare as a collateral source, runs counter to the public purpose of reducing medical expenses and medical liability insurance coverage for health care providers 33

CONCLUSION 35

TABLE OF CITATIONS

CASES:

Baio v. Commercial Union Ins. Co., 410 A.2d 502 (Del. 1979)....................21

Brown v. Am. Home Care Prods., 2001 U.S. Dist. LEXIS 2959
(E.D. Pa. Mar. 21, 2001). 24-26

Bynum v. Mango, 101 P.3d 1149 (Haw. 2004)....................27-30, 32

Daughters of Charity Health Servs. of Waco v. Linnstaedter,
266 S.W.3d 409 (Tex. 2007) 15

Fiduciary Trust Co. v. Fiduciary Trust Co., 445 A.2d 927 (Del. 1982)... 6

Gordon v. Forsyth County Hospital Auth., Inc.,
409 F.Supp. 708 (1976) 28

Harris v. New Castle Cnty., 513 A.2d 1307 (Del. 1986)....................21-22

Haselden v. Davis, 579 S.E.2d 293 (S.C. 2003)....................11, 28

Haygood v. Escabedo, 356 S.W.3d 390 (Tex. 2010)....................13-15

Health Ins. Ass'n of Am. v. Shalala, 23 F.3d 412 (D. D.C. 1994)....................24-25

Holbrook v. Anderson Corp., 996 F.2d 1339 (3d Cir. 1993)....................24

Mackrides v. Marshalls, U.S. Dist. LEXIS 58462 (E.D. Pa. 2013)....................23-26

Mitchell v. Haldar, 883 A.2d 32 (Del. 2005)....................9-10

Moorehead v. Crozer Chester Med. Ctr., 765 A.2d 786 (Pa. 2001)....................34

Onusku v. Kerr, 880 A.2d 1022 (Del. 2005)....................7

Palmer v. Sterling Drugs, Inc. 343 F.Supp. 692 (E.D. Pa. 1972)....................20

Rice v. The Chimes, Inc., et al.,
2005 Del. Super. LEXIS 476 (Del. Super. Mar. 10, 2005)....................3

Sanner v. GEICO, 363 A.2d 397 (N.J. Super. 1976)....................19

Sebelius v. Auburn Regional Medical Center, et al.,
133 S.Ct. 817 (Jan. 22, 2013)....................3

State Farm v. Nalbone, 569 A.2d 71 (Del. 1989)....................7-9

Sweiger v. Del. Park, et al.,
2013 Del. Super. LEXIS 562 (Del. Super. Dec. 13, 2013)....................11

White v. Jubitz Corp., 219 P.3d 566 (Or. 2009)....................26-27

Wills v. Foster, 892 N.E.2d 1018 (Ill. 2008)....................17-19

Yarrington v. Thornberg, 205 A.2d 1 (Del. 1964)....................7

STATUTES:

42 C.F.R. § 405....................14

18 Del.C. § 6862....................10

PUBLICATIONS

George A. Nation, III, *Determining the Fair & Reasonable Value of Medical Services: The Affordable Care Act, Government Insurers, Private Insurers & Uninsured Patients*, 65 BAYLOR LAW REV. 425(Spring 2013)..15-16, 23

Stephen L. Olson, Pat Wassin, *Is the Collatral Source Rule Applicable to Medicaid and Medicare Writeoffs?*, 71 DEF. Couns. J. 172 (1998)....................12

Mark A. Hall & Carl E. Schneider, *Patients as Consumers: Courts, Contracts & the New Medical Marketplace* (2008), 106 MICH L. REV. 643
(Dec. 20, 2007)....................16

Uwe E. Reinhardt, *The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy*, 25 HEALTH AFF. 57 (2006)....................14, 16-17

Keith T. Peters, *What Have We Here? The Need for Transparent Pricing & Quality Information in Healthcare: Creation of an SEC for Healthcare*, 10 J. HEALTHCARE L. & POL'Y 363 (2007)..14

OTHER

Restatement (Second) of Torts § 920 ....17-18, 23

NATURE OF PROCEEDINGS

Plaintiff filed the subject medical negligence complaint on April 23, 2012. In it, she claims personal injury and money damages arising out of an incident that occurred on May 29, 2010 wherein she set her clothing ablaze while lighting a cigarette at the Harbor Healthcare and Rehabilitation Center, a skilled nursing facility located in Lewes, Delaware, where she was a resident. She seeks general compensatory damages for burn and other injuries that were treated at the Crozer-Chester burn hospital as well as special damages, including past medical expenses. She does not pursue a claim for future medical expenses.

The complaint can be fairly summarized as alleging 3 medical negligence actions against 3 individual nurse-defendants and corresponding *respondeat superior* liability claims against the "Legal Entity Defendants."

In Count IV, plaintiff alleged a separate "Private Attorney General" action pursuant to the Medicare as Secondary Payer Act ("MSP"). In Paragraphs 31 and 36, the complaint avers that the Medicare Trust Fund ("Medicare"), has already paid for medical expenses in the amount of $262,550.17.

On June 17, 2014, defendants moved to dismiss Count IV pursuant to Superior Court Civil Rule 12(b)(6). The parties then entered a stipulated Order dismissing Count IV, which was entered by the Court on July 16, 2014.

On June 17, 2014, Defendants likewise filed the Motion for Judgment on the

Pleadings concerning Counts I, II and III seeking judgment as a matter of law that the reasonable value of plaintiff's medical treatment expenses was $262,550.17, *viz.*, the amount paid by the Centers for Medicare and Medicaid Services (CMS), in full satisfaction of the services performed and the charges submitted.

Whereas plaintiff attached 2 exhibits to the Complaint, the trial court was able to dispose of the motion without going outside of the pleadings. By Order dated September 24, 2014, (Ex. A to Opening Brief), the trial court granted defendants' Motion for Judgment on the Pleadings. Plaintiff timely appealed and by Order dated October 29, 2014, this Court accepted plaintiff's interlocutory appeal. Plaintiff/Appellant's Opening Brief was filed on December 1, 2014. This is Defendants' Answering Brief in opposition

SUMMARY OF ARGUMENT

1. DENIED. The Superior Court properly ruled that plaintiff's right to recover the reasonable value of her medical treatment does not include amounts that her heath care providers purported to overcharge the Medicare Trust Fund. Plaintiff's recovery should be limited to the amount actually paid by Medicare, exclusive of the illusory overcharges, because the providers were required by law to accept the amount determined by Regulation and paid by Medicare, as the reasonable value of the treatment. Plaintiff did not contract with her providers to accept discounted benefits from Medicare; nor did she contract for medical benefits through a Medicare Advantage Plan or any other means. As a result, the Collateral Source Rule is not applicable. Whereas Medicare is distinctively different from private collateral sources and its overcharges are illusory, and based upon factors other than the reasonable value of medical services provided, the Collateral Source Rule cannot operate to permit recovery of those illusory charges. Furthermore, because federal law establishes the reasonable value of such services, it would be inequitable to provide a grossly inflated windfall to the Plaintiff. Finally, The Collateral Source Rule cannot apply because a double recovery, with Medicare as a collateral source, runs counter to the public purpose of reducing medical expenses and medical liability insurance coverage for healthcare providers.

STATEMENT OF FACTS

Whereas the Order giving rise to this interlocutory appeal arose out of the trial court's disposition of defendants' Motion for Judgment on the Pleadings, the trial court was able to decide the motion by reviewing the contents of the pleadings. Plaintiff seeks general compensatory damages for burn and other injuries that were treated at the Crozer-Chester burn hospital as well as special damages, including past medical expenses. She does not claim future medical expenses.

In addition to general compensatory damages, Plaintiff seeks to recover the reasonable value of the medical treatment that has been paid by the Medicare Trust Fund alleged to be valued in the amount of $3,683,797.11 (Complaint, Count I, Par.16; Count II, Par. 22; Count III, Par. 28) This amount equals the Sum of Total Charges stated on Page 15 of the Payment Summary Form attached to the Complaint as Ex. A. (Appendix; A-54) Plaintiff further alleges that the Centers for Medicare & Medicaid Services ("CMS") has conditionally paid her expenses such that her recovery is subject to a CMS lien in the amount of $262,550.17. (Complaint, Pars. 31, 36) These payments are set out on Ex. B to the complaint. (*Id.*, Par. 34) Indeed, this is the same amount identified as the "Total Conditional Charges" identified on Page 15 of Ex. B to the complaint. (Appendix; A-67) Upon information and belief, Ex. B is an exact copy of Ex. A. For purposes of their Motion for Judgment on the Pleadings, defendants assumed the accuracy of these amounts, and that the CMS lien

is $262,550.17 as alleged. The complaint *does not* allege that Crozer or any provider has actually billed plaintiff in any amount; that she has been 'balance-billed' for the difference between these 2 amounts; or that the discounted amount was a gift. Moreover, plaintiff *does not* allege that she ever did owe, currently owes, or ever will owe any portion of the medical charges to any medical or service provider.

In sum, plaintiff seeks $262,550.17, *viz.*, the amount of the CMS Total Conditional Charges, as her past medical expenses, and $3,421,246.94, *viz.*, the difference between the Sum of Total Charges ($3,683,797.11), and the Total Conditional Charges ($262,550.17), as the additional reasonable value of those medical treatments. It is this difference that gives rise to defendants' Motion for Judgment on the Pleadings as well as this appeal.

ARGUMENT

I. THE SUPERIOR COURT PROPERLY RULED THAT PLAINTIFF'S RIGHT TO RECOVER THE REASONABLE VALUE OF HER MEDICAL TREATMENT DOES NOT INCLUDE AMOUNTS THAT HER HEALTH CARE PROVIDERS PURPORTED TO OVERCHARGE THE MEDICARE TRUST FUND.

A. *QUESTION PRESENTED*

Whether the reasonable value of plaintiff's medical treatment is the amount to which the CMS and plaintiff's health care providers agreed to accept when that agreement was reached prior to the performance of the medical treatment such that the providers did not gratuitously accept the regulated amounts?

B. *SCOPE OF REVIEW*

This Court's review of the trial court's grant of a Motion for Judgment on the Pleadings presents a question of law, which this Court will review *de novo*. *Id.*, cit. *Fiduciary Trust Co. v. Fiduciary Trust Co.*, Del. Supr., 445 A.2d 927, 930 (1982). This issue was raised by defendants in their Motion for Judgment on the Pleadings, filed June 17, 2014. (Appendix to Opening Brief; A-68 - A-262)

C. *MERITS OF ARGUMENT*

1. The Collateral Source Rule cannot apply to this matter because plaintiff did not contract with her health provider to accept reduced benefits from Medicare.

The parties agree that a tortfeasor is responsible for compensating a plaintiff for the reasonable value of the harm that he or she causes. *Mitchell v. Haldar*, 883 A.2d 32 (Del. 2005). They also agree that a double recovery by plaintiff is acceptable as long as the source of payment for the medical expense is not connected to the same tortfeasor. *Onusko v. Kerr,* 880 A.2d 1022, 1024 (Del. 2005).

The trial court cites *Mitchell v. Haldar* for the proposition that although the collateral source rule was firmly embedded in Delaware law, the *Mitchell* decision was influenced by its previous qualification of the rule in *State Farm v. Nalbone,* which required the plaintiff to have paid *some* consideration. *Id.,* 569 A.2d 71, 75 (Del. 1989)

As a practical matter, the collateral source rule was "firmly embedded" in Delaware law well before *Mitchell* or *Nalbone* as it's been "firmly embedded" in Delaware law for over 50 years. *Yarrington v. Thornberg* , 205 A.2d 1; 1964 Del. LEXIS 174 (Del. 1964) The issue was actually presented to the *Yarrington* Court in the context of a defendant who received a $5,000 credit for payment of medical expenses made available to plaintiff because she was a passenger in his insured vehicle at the time of the accident. In permitting the credit, this Court noted that the Collateral Source Doctrine is predicated upon the theory that a tortfeasor has no interest in, and therefore no right to, benefit from monies received by the injured person from sources unconnected with the defendant. *Id. at 1.* Whereas the

defendant's purchase of auto insurance and the payment of premiums resulted in the availability of the $5,000 payment toward plaintiff's medical expenses, this Court, applying the Collateral Source Doctrine, held that the trial court properly reduced the judgment by that amount.

Twenty-five years later, this Court qualified the Collateral Source Rule holding, "There is no reason that a risk-adverse insured may not contract for a double recovery." *State Farm v. Nalbone,* 569 A.2d 71, 75 (Del. 1989) There, the Supreme Court considered whether an injured plaintiff was entitled to be compensated for net wages lost while she was unable to be actively employed, even though she had received reimbursement for those losses pursuant to a wage continuation or disability plan. *Id.,* at 71. The Court reasoned that if a person paid for both, auto and health insurance coverage, and if an injury occurred, he should be permitted, as a matter of contract law, to receive a double recovery since that is what he paid for. *Id.,* at 75. That being so, the Court concluded that "the conditions under which a double recovery should be allowed may best be determined by examining the consideration that has been paid. *Id.* Whereas Ms. Nalbone had paid no consideration for the wage continuation plan benefit, this Court concluded that recovery was not authorized because her receipt of those benefits created no detriment or loss of entitlement to reimbursement of future losses. *Id. at 72.* In light of *Nalbone*, the *Haldar* court permitted evidence of the full value of plaintiff's

medical treatment rather than limiting it to the amount actually paid by the insurer because plaintiff contracted with the private health insurer for that coverage. 883 A.2d 32 (Del. 2005) Here, Ms. Stayton did not contract with any health care provider to accept any payments from Medicare.

The contract-law inspired principle articulated in *State Farm*, and followed by *Mitchell*, operates as a limitation on the Collateral Source Rule in that "the extent to which the Collateral Source Rule should be applied to permit double recovery should depend upon the contractual expectations that underlie the collateral source payment." *Nalbone*, 569 A.2d 71, 75.

According to *Nalbone*, if a plaintiff has paid consideration "for recovery from a collateral source, then double recovery is permissible." *Id.* The reason barring double recovery is that "the insured has lost nothing, neither wages nor consideration paid to a collateral source for wage compensation". *Id.*

Although many Medicare-eligible individuals receive Medicare benefits directly from the Government, individuals can also elect to receive their benefits through private insurance companies that contract with the Government to provide "Medicare Advantage" plans. 41 U.S.C. § 1395w-21(a)(1). Plaintiff, neither in the briefing below, nor in her Opening Brief, has asserted that she contracted for medical coverage benefits through a Medicare Advantage Plan or any other means. Whereas she did not contract for medical coverage benefits in any respect, the case is

distinguishable from *Mitchell.* The trial court properly limited plaintiff's elements of damages as a matter of law within the reasoning and holding of *Mitchell.*

2. The Collateral Source Rule cannot apply because Medicare is distinctively different from private collateral sources.

As a threshold issue, the trial court noted that the parties agree that the instant motion does not implicate 18 Del.C. § 6862, titled *Collateral Source.* (Order, Ex. A. to Opening Brief, pp. 6-7) This Statute, which was enacted in response to the tremendously increasing number of claims arising from patient care, and the "tremendous increase" in the cost of insurance coverage for health care providers, which endangered citizens' ability to receive quality health care as well as adequate and just compensation for injuries. (Senate Bill 578) Although commentators may debate about whether the common law collateral source rule, relevant to this appeal is a rule of evidence, one of substantive law, or both, Defendants' motion did not require the trial court to resolve that issue. The issue presented was plaintiff's measure of damages at the pleading stage, necessarily drawing all inferences in favor of plaintiff, so as to circumscribe the measure of damages as a matter of law and enter judgment for defendants on the amounts that plaintiff's providers over-charged the CMS, which amounts were extinguished by operation of law. That this issue does not necessarily implicate 18 Del. C. §6862 is demonstrated by the fact that the trial court has addressed it on 2 prior occasions reaching opposite results, discussed

infra, neither of which entailed a claim of medical negligence.

In their Motion for Judgment on the Pleadings, defendants urged the trial court to reject the approach employed by the Superior Court in *Sweiger v. Delaware Park, et al.,* 2013 Del. Super. LEXIS 562 (Dec. 13, 2013), where the plaintiff purportedly received "$134,815.71 worth of medical services" but charges in excess of $59,882.03 were "disallowed" by CMS, and the balance was according to the court "written-off" pursuant to 42 U.S.C. §1395. *Id., at *2* Resolving the motion, the *Sweiger* Court did not discuss how it determined the worth of the services or how a plaintiff incurs damages when Medicare disallows payments in excess of prescribed maximums. The trial court here observed that the *Sweiger* decision was based on the premise that there is no apparent difference between private health care and Medicare (except that Medicare is administered by the federal government.) *Stayton*, Ex. A, p. 9 and then identified fundamental differences between Medicare and private collateral sources. It also referenced that at least one State Supreme Court has held that "it is unconscionable to allow taxpayers to bear the expense of providing free medical care to a person, and then allow that person to take the windfall of expenses from a tortfeasor. *Id.at p.10*, cit. *Haselden v. Davis,* 579 S.E. 2d 293, 296 (S.C. 2003).

The *Stayton* Court's points of distinction between Medicare and private insurance are well taken: Medicare is a Government-sponsored health insurance

program for people 65 years or older who are eligible for social security benefits. 42 U.S.C. §1395(c). *Id.,* at p. 9 It is funded in large part through taxes paid by employers and employees under FICA. 16 U.S.C. §310(b). *Id.* Unlike private insurance, there is no right of subrogation or refund of benefits on a tort recovery for the amount written off under Medicare. *Id.,* cit. Stephen L. Olsen, Pat Wasson, *Is the Collateral Source Rule Applicable to Medicaid and Medicare Writeoffs?* 71 Def. Couns. J. 172, 175 (2004) Unlike private insurance, participation in Medicare is involuntary. *Id.* One does not freely contract for Medicare benefits the way one obtains private insurance. *Id.* Finally, eligibility for Medicare does not in any way suggest that a plaintiff bargained with the federal Government to receive compensation for fees that were never incurred. *Id.*

However, on appeal, plaintiff cites decisional law from other jurisdictions, not submitted in the trial court, which specifically address the issue in the context of Medicare payments, and which require actual consideration of CMS's processes for rate setting, providers' remedies, and the providers' incentives for, and general practice of, overcharging the CMS.

Regarding a provider's remedy, the Medicare statute provides that Government contractors, called Fiscal Intermediaries, receive annual cost reports from care providers, and notify them of the reimbursement amount for which they qualify. A provider dissatisfied with the Fiscal Intermediaries' determination may

appeal to an administrative body, the Provider Reimbursement Review Board (PRRB). 42 U.S.C.§1395oo(a)(3)

The Medicare program covers certain in-patient services that hospitals provide to Medicare beneficiaries. *See Sebelius v. Auburn Regional Medical Center, et al.*, 133 S.Ct. 817; 2013 U.S. LEXIS 915 (January 22, 2013). Providers are reimbursed at a fixed amount per patient, regardless of the actual operating costs they incur in rendering these services. But the total reimbursement amount is adjusted upward for hospitals that serve a disproportionate share of low-income patients. This adjustment is made because hospitals with an unusually high percentage of low-income patients generally have higher per-patient costs; such hospitals, Congress determined, should receive higher reimbursement rates. *Sebelius*, *supra.*, at ***-9, cit. H. R. Rep. No. 99-241, Pt. 1, P.16 (1985).

If the rates are pre-set, reviewed annually, and subject to an administrative appeal process, what would be the providers' incentive to send a charge to CMS in excess of the pre-set amount? According to *Haygood v. Escabedo* (Tx.Supr. 2010), 356 S.W.3d 390; 2011 Tex. LEXIS 514, it has become increasingly difficult to determine what expenses are reasonable because on one hand, health care providers set charges they maintain are reasonable and yet on the other, agree to reimbursement at much lower rates determined by insurers and the Government to be reasonable, resulting in great disparities between amounts billed and payments

accepted. *Haygood, supra.*, at 391.

Medicare Part B generally "pays no more for . . . medical and other health services than the "reasonable charge" for such services." 42 C.F.R. §405.501(a). Criteria for determining reasonable charges include customary charges for similar services and prevailing charges in the same locality for similar services. 42 CFR §405.502(a). Federal law prohibits healthcare providers who agree to treat Medicare patients from charging more than Medicare has determined to be reasonable. *Haygood, supra.*, at 392, cit. 42 USC §1395cc(a)(1)-(2).

Charges for healthcare, once based on a provider's costs and product margin, have more recently been driven by Government regulation and negotiations with private insurers. *Haygood, supra.*, at 393, cit. Keith T. Peters, *What Have We Here? The Need for Transparent Pricing & Quality Information in Healthcare: Creation of an SEC for Healthcare*, 10 J. Healthcare L.&Pol'y 363, 366 (2007) Hospital prices are supposed to be determined by the cost of providing care. However, the reimbursement rates for federal programs such as Medicare and Medicaid drive the list price of healthcare." *Id.* (fns. omit.) That being so, a two-tiered structure has evolved: "list" or "full" rates sometimes charged to uninsured patients but frequently uncollected, and reimbursement rates for patients covered by Government and private insurance. *Haygood, supra.*, cit. *inter alia* Uwe E. Reinhardt, *The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy*, 25 Health Aff.

57, 62 (2006). Few patients today ever pay a hospital's full charges, due to the prevalence of Medicare, Medicaid, HMOs and private insurers who pay discounted rates. *Daughters of Charity Health Servs of Waco v. Linnstaedter,* 266 S.W. 3d 409, 410 (Tex. 2007) cit. *supra.*, at 104 ("[A] hospital's 'regular rates,' 'full charges,' or 'list prices' . . . are generally at least double and may be up to eight times what the hospital would accept as payment in full for the same services from Medicare, Medicaid, HMOs or private insurers. The labels for these charges, 'regular', 'full' or 'list' are misleading because in fact they are actually paid by less than 5% of patients nationally.") Hospitals, like healthcare providers in general, "feel financial pressure to set their 'full charges' . . . as high as possible, because the higher the 'full charge' the greater the reimbursement amount the hospital receives since reimbursement rates are often set as a percentage of the hospital's 'full charge'. *Haygood, supra.*, at 393, cit. *George Nation, supra.*, at 119.

The rise in managed care organizations, which typically restrict payments for services to their members, has reportedly led to an increase in the prices charged to uninsured patients, who do not benefit from providers' contracts with the plans. As one article explains: "Before managed care, hospitals billed insured and uninsured patients similarly. In 1960, 'there were no discounts; everyone paid the same rates' -- usually costs plus 10%. But as some insurers demanded deep discounting, hospitals vigorously shifted costs to patients with less clout." *Howell, supra.*, cit.

Hall & Schneider, *Patients as Consumers: Courts, Contracts & the New Medical Marketplace* (2008), 106 Mich.L.Rev. 643, 663, (fns. omit.) As a consequence, "only uninsured, self-paying U.S. patients have been billed the full charges listed in hospitals' inflated charge masters . . . ," so that a family might find itself "paying off over many years a hospital bill of approximately $30,000 for a procedure that Medicaid would have reimbursed at only $6,000, and commercial insurers somewhere in between" *Howell, supra.*, cit. Reinhardt, *The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy* (2006) 25 Health Affairs 57, 62.

A hospital charge description master, or chargemaster is a uniform schedule of charges represented by the hospital to be its gross billed charge for a given service or item, regardless of the type of payer. A chargemaster is an extensive price list created and maintained by hospitals and other providers, which lists a price for each good and service provided by the hospital. George A. Nation, III, *Determining the Fair & Reasonable Value of Medical Services: The Affordable Care Act, Government Insurers, Private Insurers & Uninsured Patients*, 65 Baylor Law. Rev. 425, 427. During the period 1984-2004, charge master prices increased 10.7% <u>per year</u>, which was much faster than Medicare allowable costs (6.3%) or hospital net revenues (6.6%). *Id.*, at 428 (cit. omit.) Therefore, while increases in the list prices do not add dollar-for-dollar to the net revenues a hospital receives, higher charge master prices do, for a variety of reasons, result in an increase in net revenues. *Id.*

(cit. omit.) In addition, there are other reasons for a hospital to continually set higher list prices and no reason for them not to constantly increase list prices. *Id.*, (cit. omit.) It should be noted then that even in the case of Medicare reimbursement, higher chargemaster rates result indirectly in higher net revenues for hospitals. *Id.*, at 429 (cit. omit.)

Another important characteristics of health care is that chargemaster or list prices are not fair and reasonable. *Id.* (cit. omit.) They are grossly inflated because they are set to be discounted rather than paid. *Id.*, cit. Reinhardt, *The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy, supra.*, at 57.

Plaintiff relies upon the Supreme Court of Illinois' 2008 opinion in *Wills v. Foster* for the proposition that she should be entitled to recover the "billed" amount of her medical expenses. At issue in *Wills* was whether the trial court erred in reducing the jury's award of medical expenses to the actual amounts paid pursuant to Medicaid and Medicare, in full settlement of the bills. *Wills v. Foster*, 892 N.E.2d 1018; 2008 Ill. LEXIS 629. Disposing of the issue, the Illinois court determined the plaintiff could recover the amount of the medical expenses billed to Government, without regard to the language of the federal Statute or Regulation setting forth the method by which the reasonableness of the Government's payment was established and without regard to the Government's right of subrogation. In so doing, the Illinois court referred to Comment C to §920A of the Restatement, which provides the

following example concerning gratuities:

"Gratuities. This applies to cash gratuities and to the rendering of services. Thus, the fact that the doctor did not charge for his services or the plaintiff was treated in a veterans hospital does not prevent his recovery for the reasonable value of the services." *Wills, supra*, at **1024 cit. Restatement (Second) of Torts §920A, Comment C(3) at 515 (1979)

Reliance upon such over-simplistic examples from the Restatement, although apparently persuasive to the Illinois court, without regard for federal law invites inconsistency and establishes bad precedent. Those courts that have cited Comment C(3) of §920A as a basis for their rationale, such as *Wills, supra.*, have ignored operation of the Medical Care Recovery Act (MCRA), 42 U.S.C. §§2651-2653, which provides:

"(a) In any case in which the United States is authorized or required by law to furnish or pay for hospital, medical, surgical or dental care and treatment * * * to a person who is injured * * * under circumstances creating a tort liability upon some third person * * * to pay damages therefore, the United States shall have a right to recover (independent of the rights of the injured * * * person) from said third person, or that person's insurer, the **reasonable value of the care and treatment so furnished**, to be furnished, paid for, or to be paid for and shall, as to this right be subrogated to any right or claim that the injured * * * person * * * has against such

third person **to the extent of the reasonable value** of the care and treatment so furnished, to be furnished, paid for, or to be paid for." 42 U.S.C. 2651(a). (emph. supp)

If the Illinois Court's ruling in *Wills*, *supra.,* is accepted, an injured person could introduce at trial, and recover from the tortfeasor, amounts that the providers billed the CMS in excess of the prescribed maximums (in the present case totaling $3,683,797.11) without regard to what the federal government has determined to be the 'reasonable value' of her care and treatment (in this case $262,550.17).

In order to enforce its rights under the MCRA, the Government may intervene or join in any action brought by the injured person against the party liable for the injury or institute and prosecute in its own name, legal proceedings against the party who is liable for the injury. 42 U.S.C. 2651(d) Under §2651, the Government is permitted to intervene or join in any action by an injured party against the Tortfeasor, and may even bring an action in its own name or that of the injured party against the wrongdoer if the injured party neglects to do so. *Sanner v. GEICO,* 363 A.2d 397 (1976, Law Div.), vacated on other grounds (1977, App. Div.) 376 A.2d 180, cert. granted (1977), 384 A.2d 501 and aff'd (1978) 383 A.2d 429. This Statute affords the Government 3 ways for recovering the reasonable value of the medical and hospital care: 1) by subrogation; 2) by intervening or joining in any action brought by the injured person; and 3) by instituting such action itself or in conjunction with

the injured person; none of these procedures is mandatory and the choice of method is left to the head of the department or agency furnishing the care. *Palmer v. Sterling Drugs, Inc.* (1972, E.D. Pa.) 343 F.Supp. 692. Finally, the President is authorized to prescribe Regulations to enforce the Governments' right of recovery, including Regulations with respect to the determination and establishment of the reasonable value of the hospital and medical care and treatment furnished by law. 42 U.S.C. §2652.

The folly of relying upon examples from obsolete comments in the Restatement is demonstrated when one examines the Government's exercise of its right to receive reimbursement following such payments. The head of the federal department or agency furnishing such care or treatment "may also require the injured * * * person * * * to **assign** his claim or cause of action against the third person to the extent of that right or claim" to the Government 42 U.S.C. §2651. Therefore, by operation of this Statute, the Government *could* require the beneficiary to assign his or her right to recover for the reasonable value of the medical care and treatment furnished by it, which may be prior to or subsequent to, an agreed-upon resolution of the case or a tribunal's determination of liability. In the case *sub judice*, plaintiff essentially argues that the reasonable value of the medical care and treatment furnished by the U.S. Government for purposes of her claim against the tortfeasor is an amount approximately $3,683,797.11 and that the same value for purposes of the

Government's statutory right of subrogation against her recovery is less than one-tenth of that amount, *viz.*, $262,550.17. This result is inequitable.

Delaware law recognizes rights of subrogation arising out of equity, contract and statute. This Court has explained that the doctrine of subrogation owes its origin and nature to equity, and the principals of that *juris prudence* govern its application. See: *Baio v. Commercial Union Insurance Company* (Del. Supr. 1979), 410 A.2d 502, 506; 1979 Del. LEXIS 462 (cits. omit.) Despite its origin and nature in equity, this Court will apply principles of the subrogation, as an equitable remedy, to a statutory right of subrogation because "the objective of subrogation is to reimburse the person who met the obligation of another or paid the money or the compensation owed by another." *Baio, supra.*, at *506 (cit. omit.) In the case at bar, that is the U.S. Government, not Ms. Stayton. The relevant principle is that one who asserts the equitable remedy of subrogation must, in turn, do equity itself. *Baio, supra.*, at *507. Whereas the U.S. has done nothing to suggest that it has acted inequitably, the Court should give effect to the subrogation provision of the MCRA and the Medicare Act. The nature of statutory subrogation was further explained in *Harris v. New Castle County* wherein this Court considered the subrogation rights of plaintiff's employer, New Castle County. *Id.*, 513 A.2d 1307 (Del. 1986) There, the trial court granted the employer's motion for summary judgment holding that the applicable Delaware statute conferred upon the employer-payer a right of

subrogation against the plaintiff's recovery pursuant to a policy of uninsured motorist coverage. In affirming, this Court noted prior decisional law, which concluded that the "obvious purpose" of its predecessor statute was that the recipient of the statutory benefits "shall not collect both the statutory compensation and also the full damages for the injury. *Harris, supra.*, at 1308 (cit. omit.) On appeal, plaintiff argued that since the recovery arising out the uninsured motorist coverage benefits represented a contractual obligation of the employer, the recovery did not constitute a "tort recovery" within the meaning of the statute. Rejecting the argument, this Court found decisive the statutory language explaining the breadth of the employer's right of subrogation. Reaching that result, this Court relied on the "plain purpose of the introductory language" of the statute, which compelled the conclusion that by enacting the subject statute, the legislature placed "no limitation upon an employer's subrogation right of reimbursement for an injured claimant's recovery at law. *Harris, supra.*, at 1309 (cit. omit.) Finally, the court observed that adopting plaintiff's construction of the statute "would also require imputing to the legislature an intent that the right of subrogation and the bar to double recovery hinged on an analysis of the form of action asserted -- contract or tort", which the Court refused to adopt. *Harris, supra.*, at *1309.

The Medicare statute likewise provides for a right of subrogation for the Government. Applying equitable principles to the Government's statutory right of

subrogation, this Court should not permit a plaintiff to engage in a 'bait & switch' approach to the reasonable value of the medical care and treatment that the Government furnished for her, arguing one amount for purposes of her recovery and a lesser amount for purposes of the Government's recovery. Whereas the MCRA provides that the federal Government can specifically require a plaintiff to assign to the Government his or her right to recover the reasonable value of the medical care and treatment furnished by the Government, the Illinois Supreme Court, by relying on an obsolete comment to §920A of the Restatement, and disregarding the statutory language and well-accepted rules of statutory construction, has only put off until another day any meaningful treatment of the these issues.

This issue was considered by the court in *Mackrides v. Marshalls*, U.S.Dist. LEXIS 58462, (E.D. Pa. 2013), where the Court considered the meaning of the parties' settlement agreement. There, the Court concluded that the proposed settlement terms were patently unclear as the Court could not discern whether the agreed-upon settlement amount included the funds necessary to reimburse CMS for the monies expended to furnish plaintiff's medical treatment. The agreement likewise did not indicate whether CMS in fact paid for plaintiff's medical treatment, or whether CMS had elected to waive its reimbursement rights. Therefore, the issue of whether the claim for medical specials, including the obligation to pay the reasonable value of the medical treatment, belonged to plaintiff or defendant was

considered in somewhat of a vacuum as a pure issue of law, similar to that on a motion for judgment on the pleadings. Despite the fact that defendants settled the *Mackrides* claim with the plaintiff, the Court noted that "the Government's independent right of recovery against the tortfeasor [was] not extinguished by the injured parties' settlement and release with the tortfeasor." *Mackrides, Id.,* cit. *Holbrook v. Anderson Corp.*, 996 F.2d 1339, 1341 (3rd Cir. 1993); *Brown v. American Home Care Products*, No. 99-25093, MDL Dkt. No. 1203, 2001 U.S. Dist. LEXIS 2959 at *32 (Ed.Pa. March 21, 2001) Thus, like the MCRA, the MSP creates a direct cause of action in favor of the Government, which is enforceable through judicial action. *Mackrides, supra.,* at *9, cit. *Health Ins. Ass'n v. Shalala*, 306 U.S. App. D.C. 104, 23 F.3d 412, 425 (1994).

Parenthetically, although not argued below, plaintiff now suggests that the position advocated by defendants operates to unfairly discriminate against certain portions of the population, *viz.*, the elderly and the disabled. This argument overlooks the fact that pursuant to the Medical Care Recovery Act ("MCRA"), all recipients of healthcare made available by the federal government are treated the same way. According to the *Mackrides* Court, the MSP Act and the MCRA must be read *in pari materia.* Reading both statutes *in pari materia* leads to the conclusion that once a plaintiff settles a claim against a tortfeasor or primary payer within the meaning of the MSP Act, the Government remains free to pursue its reimbursement

right against a primary payer, such as the liability insurer for defendants herein, regardless of whether the payer has settled a liability claim and paid monies in settlement to a Medicare recipient. *Mackrides v. Marshall's*, U.S.D.C. Ed.Pa., 2013, 2013 U.S. Dist. LEXIS 58462, at *12. Under both statutes, the Government is authorized to bring a direct claim against primary and/or private insurance providers "as well as any entity, including a beneficiary, provider, supplier, physician, attorney, State agency or private insurer that has received a third-party payment". *Mackrides, supra.*, at *10, cit. *U.S. v. Weinberg*, No. 01-0679, 2002 U.S. Dist. LEXIS 12289 at *7-*8 (E.D.Pa. 2002) (cit. *Manning v. United States Mutual Insurance Co.*, 254 F.3d 387, 397 (2d Cir. 2001) and 42 C.F.R. §411.24(g)). See also, *U.S. v. Theriaque*, 674 F.Supp. 395, 400 (D.Mass. 1987) ("[I]t may not be doubted that the MCRA created in the Government a federal substantive right to recover medical expenditures where a tortfeasor is found to have caused the injuries requiring the treatment".); *Brown v. American Homecare Products Corp.*, No. 99-25093, M.D.L. Dkt. No. 11203, 2001 U.S.Dist. LEXIS 2959 at *32 (E.D.Pa. 2001) ("The MSP grants the Government a cause of action against the primary payer or any person who has received payment therefrom for reimbursement of those payments for double damages.") Thus, like the MCRA, the MSP creates a direct cause of action in favor of the Government that is enforceable through judicial action. Brown, supra, cit. *Health Ins. Ass'n v. Shalala*, 306 U.S. App. D.C. 104, 23

F.3d 412, 424 (1994); 42 USC §1395y(b)(2)(B)(ii). Consequently, the Government's independent right of recovery against the tortfeasor is not even extinguished by the plaintiff's settlement and execution of a release in favor of the tortfeasor. *Mackrides, supra.,* at *11, cit. *Holbrook v. Anderson Corp.*, 996 F.2d 1339, 1341 (3d Cir. 1993); *Brown, supra.*, at *26.

Plaintiff relies upon the Supreme Court of Oregon's opinion in *White v. Jubitz* for the proposition that some Medicare coverages require the payment of monthly premiums and yearly deductibles. (Opening Brief, pg. 11) In the same discussion to the effect that many eligible Medicare patients have paid payroll taxes for Medicare during their work lives. However, plaintiff does not suggest, and did not suggest below, that that was a consideration. Moreover, plaintiff does not argue that she paid any consideration, whether in terms of monthly premiums or yearly deductibles for her Medicare benefits but instead, argues that the Medicare benefits were simply a cost-free plan to its participants, much like the gratuitous payments at issue in *Onosku v. Carr*. (Opening Brief, pg. 11) Plaintiff also cites *White* for the proposition that a health care provider, by accepting Medicare payments, "must 'write-off' the remainder of their unpaid charges". (Opening Brief, pgs. 7-8) The artificiality and incentive for a medical provider to send a self-serving "Payment Summary Form", similar to that attached to the Complaint as Ex. A (Appendix; A-43 - A-54) has also been amply discussed in George A. Nation, III's article,

"Determining the Fair& Reasonable Value of Medical Services: The Affordable Care Act, Government Insurers, Private Insurers & Uninsured Patients". (65 Baylor L.Review, 425, Spring, 2013)

In *White,* the defendant stipulated that the plaintiff's medical providers' billed amounts of $39,977 "were both reasonable and necessary". *Id.*, at 569. Considering the issues raised on appeal, the Oregon Supreme Court noted, as a threshold issue prior to its analysis, that the defendant did not contend that the amounts billed to Medicare were excessive, inflated or unreasonable. However, the instant defendants, being the movants at the motion for judgment on the pleadings stage, do assert that in any case where a medical provider bills a Medicare eligible patient, knowing that by operation of law, the invoice, bill or services statement submitted to the Medicare recipient is a nullity, is unreasonable, and likely, unconscionable as a matter of law. In this discussion also, the Oregon court noted that at trial, defendant stipulated "as a factual matter, the providers' charges were both reasonable and necessary". *Id.*, at 569-570.

Similarly, plaintiff relies upon the Supreme Court of Hawaii's decision in *Bynum v. Mango* as support for her position. *Id.,* 101 P.3d 1149, 1151. In *Bynum*, the defendant likewise stipulated "that the medical bills 'reflected medical treatment for [plaintiff] that was necessary for medical conditions that existed during the time of treatment' and were for amounts 'similar to charges made by similar or

comparable health providers for life services in the same geographical area'." *Id.* Although Ms. Stayton contends that the Hawaii court made an extensive analysis of the issue (Opening Brief, pg. 13), a review of the opinion compels the conclusion that the *Bynum* court likewise did not consider the actual language of the MSP.

In sum, the dissent in *Bynum* agreed that the amount paid by Medicaid was a collateral source to benefit a plaintiff who has a right to recover that amount. However, because a plaintiff has never paid, nor ever will be liable for the written-off difference between the billed and paid amount, the minority concluded that it was "unconscionable to permit the taxpayers to bear the expense of providing free medical care to a person and then allow that person to recover damages in medical services from a tortfeasor and pocket the windfall." *Haselden*, at 296 cit. *Bates*, 921 Pa.2d at 253 (quoting *Gordon v. Forsyth County Hospital Authority, Inc.*, 409 F.Supp. 708, 719 (M.D.N.C. 1976)

The *Bynum* decision, on which plaintiff also relies, was likewise decided by a court divided 3 vs. 2, with two of the majority being circuit judges sitting by appointment. The two- justice dissent, authored by Chief Justice Moon, disagreed with the majority's conclusion because it "improperly, unnecessarily, and lightly disregard[ed] this jurisdiction's long-standing formulation and treatment of special damages". *Id.*, at 1163. The chief justice noted that under Hawaii tort law, three categories of damages are recoverable: 1) compensatory damages (including general

and special damages); 2) punitive damages; and 3) nominal damages. *Id.*, at 1163 (cits. omit.) Well-established Hawaii law demonstrated that compensatory damages seek to "compensate the injured party for the injuries sustained, and nothing more", and to restore the plaintiff to the position he would be in if the wrong had not been committed. *Id.* (cits. omit.) Like Delaware law, special damages under Hawaii law "compensate claimants for specific out-of-pocket financial expenses and losses". *Id.*, at 1164 (cit. omit.) They are considered to be synonymous with a pecuniary loss. *Id.* Under well-established Hawaii case law, a plaintiff's award of medical expenses is limited to the pecuniary loss that he or she incurred. *Id.*, at 1164 (cit. omit.) The chief justice also agreed that "it is a fundamental principle of the law of damages that a person who suffers personal injuries because of the negligence of another is entitled to recover the reasonable value of medical care and expenses incurred for the treatment of the injuries. *Id.*, at 1164 (cits. omit.) Therefore, plaintiff's recovery of medical expenses must be limited, according to the minority court, to the amount he or she has paid or became legally obligated to pay. *Id.*, cit. Blacks Law Dictionary 771 (7th Ed. 1999) (defining "incur" as "to suffer or bring on one's self (a liability or expense). The minority noted that in the case *sub judice*, plaintiff's health care providers, pursuant to federal law, were required to accept the amount paid by Medicare and Medicaid as payment in full. Bynum's providers agreed, prior to defendant's tortious conduct, to perform certain services and

treatments in accordance with Medicare's prescribed rates. The minority considered the dispositive question to be whether Bynum was legally obligated to pay the write-off. *Id.*, at 1164. The minority recognized that Medicare law prohibits participating health care providers from seeking reimbursement of the amount written off from anyone, including the plaintiff. *Id.* In other words, a beneficiary, whose medical expenses are paid by Medicare, does not incur the amount written-off by the healthcare provider. *Id.*, at 1164 (cit. omit.) "Consequently, the beneficiary never becomes legally obligated to pay the amount written-off. *Id.* Whereas plaintiff did not incur the amount written off by his health care providers, he was not legally obligated to pay. Therefore, if he recovered the amount paid on his behalf by Medicare, which he is legally obligated to reimburse Medicare under federal law, he will be fully compensated with regard to his past medical expenses. *Id.*

The minority criticized the three-justice majority's conclusion because it contravened Hawaii's law on special damages "by restoring [plaintiff] to a position better than he would have been had the wrong not been committed". *Id.*, at 1165. The minority court considered the majority ruling to permit the recovery of unincurred medical expenses which Hawaii precedent "clearly prohibits". *Id.* The minority considered the majority's holding to be a disregard of precedent, noting that the Supreme Court should not depart from the doctrine of *stare decisis* without some compelling justification, and should not overrule an earlier decision unless the

motions cogent reasons and inescapable logic require it. *Id.*, at 1165 (cits. omit.) In essence, the minority concluded, "by disregarding this jurisdiction's precedent, the majority effectively created a new category of damages as an award for the written-off amount does fall within the permissible categories of compensatory, punitive or nominal damages. *Id.*, at 1165-1166. The minority also rebutted the contention that permitting recovery of the written-off amount ensures that low-income, elderly and disabled individuals are treated equitably *viz. a viz.* privately-insured individuals, by compensating for aspects of the Medicare/Medicaid programs that would substantially limit the plaintiff's recovery of special damages. The majority essentially reasoned that "a Medicare and/or Medicaid beneficiary should recover the same amount of medical expenses as any other individual, irrespective of whether the other individual receives public medical insurance, pays for private medical insurance or is uninsured". *Id.*, at 1166. The minority considered this assertion "plainly wrong" because in an earlier ruling, the Hawaii Supreme Court held that "special damages do not arise solely from the wrongful act itself, but rather depend on the circumstances peculiar to the infliction of each particular injury". *Id.*, at 1166 (cits. omit.) Therefore, the amount of medical expenses recoverable "is not determined by the medical expenses that the healthcare providers may charge and recover from someone else (for example, a privately insured or uninsured individual), but the "out-of-pocket" expenses incurred for the reasonably necessary

medical treatment rendered to Mr. Bynum. *Id.* Otherwise, if awards for medical expenses are increased or decreased based upon what another individual may or may not have incurred, overcompensation or under-compensation may result. *Id.*, at 1166. Finally, the dissent noted that permitting the plaintiff to recover only the Medicare medical expenses will not result in a windfall to the tortfeasor. To the contrary, "limiting the award to the amount incurred ensures that neither party will receive a windfall because tortfeasors will be held fully liable for their actions, and the plaintiff will be made whole. *Id.*, at 1167. However, if, as the majority held, a Medicare beneficiary is allowed to recover medical expenses that no one incurred, the beneficiary would recover a windfall at the expense of taxpayers. *Id.*, cit. *Bozeman v. State*, 879 So.2d 692 705, Reh'g den. (La. 2004) ("it would be unconscionable to permit the taxpayers to bear the expense of providing free medical care to a person and then allow that person to recover damages for [un-incurred] medical expenses from a tortfeasor and pocket the windfall []" *Id.*, at 1167 (cits. omit.)

In sum, when a healthcare provider writes off a portion of a Medicare beneficiary's medical expenses, the beneficiary does not incur any liability for such amount. Therefore, the beneficiary's recovery of the reasonable value of medical expenses should not include the written-off amount as compensatory special damages.

3. The Collateral Source Rule cannot apply in this matter because double recovery by plaintiff, with Medicare as a collateral source, runs counter to the public purpose of reducing medical expenses and medical liability insurance coverage for healthcare providers.

It is axiomatic that the Collateral Source Rule is designed to strike a balance between two competing principles of tort law, sanctioning one windfall and denying the other, and the law properly favors the victim rather than the wrongdoer. The trial Court's opinion accomplished those purposes by adopting the rationale of the Court in *Rice v. The Chimes, Inc., et al.*, 2005 Del. Super. LEXIS 476 (March 10, 2005). There, plaintiff sustained burn injuries that were likewise treated at Crozer. Although the hospital charges totaled $883,000, Medicare paid only $59,000 and "[T]he remaining $824,000 was written off by the hospital pursuant to 42 U.S.C.A. §1395cc-2(a)(8)(A)". *Id.,* at *2. Considering the issue, the trial Court relied upon this federal statute, which requires that an entity receiving payment under the Medicare program "shall agree to accept such payment as payment in full ... in lieu of any payments to which the ... entity would otherwise be entitled" under the law. *Id.* (cit. omit.) Defendants, relying upon the PA Supreme Court's decision in *Moorhead v. Crozer Chester Med. Ctr.,* 564 Pa. 156, 765 A.2d 786 (Pa. 2001), argued that the collateral source rule did not apply to the write-off because it "does not apply to write-offs of expenses that are never paid". *Id.*, at *4 (cit. omit.) Relying

on *Moorhead*, the *Chimes* Court accurately characterized the write-off as an 'illusory charge' because it was simply extinguished by operation of law as the healthcare provider elected to accept the conditional payment directly from Medicare. *Id.*, at *5. (cit. omit.) "Because a write-off is never paid, it cannot possibly constitute payment of any benefit from a collateral source". *Id.* Whereas plaintiff never actually incurred any expense related to write-off, the *Chimes* Court denied plaintiff's motion *in limine,* and permitted him to recover only the amounts actually paid and subject to the lien, holding that by doing so, plaintiff would be "made 'whole' in accordance with the goal of compensatory damages". *Id.*

Moorhead is particularly persuasive as it also arose out of a medical negligence claim. Following trial, the trial Court ruled that plaintiff was entitled to recover only the amount of the lien. *Id.*, at **788. On appeal, a divided appellate court affirmed on separate grounds; two judges concluding that the reasonable value of the services was the amount billed, but that the defendant-hospital was entitled to a set-off in the amount of the write-off because it, as the tortfeasor, forgave that amount, thereby contributing that amount towards its liability. The Supreme Court of Pennsylvania affirmed, albeit on its own rationale, which is compelling at the motion for judgment on the pleadings stage of the proceeding.

CONCLUSION

Defendants ask this Court to recognize the fundamental folly in permitting plaintiff to pursue a recovery purporting to represent the reasonable value of her past medical treatment based upon the illusory charges that her providers submitted to Medicare, when those same providers previously agreed to perform, and did perform, those same treatments for the amounts regulated by law and regulation. Because plaintiff has offered no basis for this Court to supplant operation of the Medicare Acts determination of the value of the medical treatment, Plaintiff's recovery of past medical expenses should be limited to the amount of the Medicare lien: $262,550.17.

Defendants respectfully pray this Court affirm the trial court's opinion in all respects.

Respectfully Submitted,
MARKS, O'NEILL, O'BRIEN,
DOHERTY & KELLY, P.C.

Norman H. Brooks, Jr.
DAWN C. DOHERTY, ESQUIRE (3164)
NORMAN H. BROOKS, JR., ESQUIRE (2568)
BRETT T. NORTON, ESQUIRE (5559)
300 Delaware Avenue, #900
Wilmington, DE 19801
(302) 658-6538
Attorneys for Defendants Below Appellees

CERTIFICATE OF SERVICE

I hereby certify that I have caused copies of the following:

APPELLEES' (CORRECTED) ANSWERING BRIEF

To be served upon:

William D. Fletcher, Jr., Esquire (362)
Schmittinger & Rodriguez, P.A.
414 South State Street
P.O. Box 497
Dover, DE 19903

By electronic service on January 13, 2015.

MARKS, O'NEILL, O'BRIEN, DOHERTY & KELLY, P.C.

BY: */s/ Norman H. Brooks, Jr.*
Dawn C. Doherty, Esquire (3164)
Norman H. Brooks, Jr., Esquire (2568)
Brett T. Norton, Esquire (5559)
300 Delaware Avenue, #900
Wilmington, DE 19801
(302) 658-6538
Attorneys for Defendants Below, Appellees