Collateral Source Rule Approaches and its Implications for Usual, Customary and Reasonable Pricing

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Abstract

The Collateral Source Rule is a legal doctrine that holds if an injured party receives some compensation for his injuries from a source wholly independent of the tortfeasor, such payment should not be deducted from the damages which the plaintiff would otherwise collect from the tortfeasor. This longstanding rule in civil procedure has been recently challenged in courts and state legislatures throughout the United States in the presentation of evidence regarding past and future medical expenses. As healthcare costing has become increasing complex, some courts have allowed evidence to be presented to the jury about reduction in plaintiff's medical expenses based upon amounts paid by third party vendors. As such, life care planners have experienced the impact of the various approaches by state courts when presenting testimony about future medical expenses contained in the life care plan. This article discusses the current approaches by state courts in the United States and the implications collateral source rule approaches may have on the work of life care planners.

A person who is injured by another's negligence may recover damages from the other person for all past, present and prospective harm (*Singh v. Larry Fowler Trucking, Inc.*, 2012). In this recovery process, a plaintiff may recover two types of damages: economic (or pecuniary) damages and non-economic (or personal) damages (2012). Economic damages include past medical expenses, future medical expenses, lost wages, and lost earning potential. Included in the prospective harm for which damages may be recovered is the reasonable cost of the medical services that will probably be incurred because of the lingering effects of the injuries caused by the negligent person (2012). The measure of damages generally recoverable is "the amount which will compensate for all the harm, losses and damages proximately caused" by the tort.

To sustain an award of future medical expenses, the claimant must present evidence to show there is a reasonable probability the medical expenses will be incurred and the reasonable costs of such care (*Columbia Med. Ctr of Las Colinas v. Bush*, 2003; *Ibrahim v. Young*, 2008). Medical expenses are the costs of doctors' services, hospital services, medicines, medical supplies and medical tests and any other charges for medical services.

The payment is the fair and reasonable value of such medical expenses. A life care plan is a useful tool in forecasting future medical expenses. A life care plan is defined:

> The life care plan is a dynamic document based upon published standards of practice, comprehensive assessment, data analysis, and research, which provides an organized, concise plan for current and future needs with associated costs for individuals who have experienced catastrophic injury or have chronic health care needs." (International Academy of Life Care Planners, 2015, p. 5)

Inherent in the definition of a life care plan is the concept of costs for healthcare and related services.

For decades in the United States, the reasonableness of the medical costs was rarely disputed in litigation. Life care planners involved in litigation may have had different opinions about what was contained in the plan, but the reasonableness of the cost was typically not discussed. A review of 13 years (1991 through 2003) of The Neurolaw Letter (HDI Publishers 1991-2003), a monthly publication devoted to attorneys and professionals who provide services to survivors of brain injury and spinal cord injury found fewer than a dozen articles discussing life care planning in general and no articles discussing the usual, customary or reasonableness of medical costs. In fact, in 1999, life care planner Robert Voogt wrote "A dollar amount can easily be assigned to physician visits, in-home healthcare, medication, therapy, equipment and surgeries," (Voogt, 1999, p. 5) implying that assignment of cost could be easily performed.

Following the 1993 United States Supreme Court landmark decision in (*Daubert v. Merrell Dow Pharmaceuticals*, 1993), critical attention was drawn to the methodology the life care planner employed in preparing the plan. Litigants fought over issues of the life care planner's qualifications (*Kent Village Associates Joint Venture v. Smith*, 1995; *Norwest Bank, NA v. Federal Kemper Life Ins. Co.*, 2000) and competency to testify; hearsay (*Gourley v. Nebraska Methodist Health System*, 2003; *Tornatore v. Cohen*, 2018); whether a specific service was reasonable or even necessary; if the plaintiff needed 24-hour care and if so, whether that care should be provided by a family member, home health agency or privately hired worker; or whether licensed practical nurses were needed to perform intermittent catheterization or tube feeding (Deutsch, 2011). However, the question of the reasonableness of the medical cost estimates, the medical coding system, or medical database relied upon was rarely raised.

However, this all changed in 2011 when the California Supreme Court decided the case of *Howell v. Hamilton Meats & Provisions, Inc.* (2011). In the Howell case, the Court held that a plaintiff could only recover damages based upon the discounted amount paid by the insurance company, rather than the amount charged by the provider, as the plaintiff never incurred the economic damages equivalent to the charged amount. After the Howell decision, assignment of costs to healthcare services included in the life care plan was no longer considered to be an easy task and in courts throughout the United States, the issue of life care planning costing became a topic for argument.

Collateral Source Rule

In 1854, the United States Supreme Court first recognized what is now known as the Collateral Source Rule in *The Propeller Monticello v. Mollison* (1854), which involved a

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collision between two vessels. The collateral source rule precludes a defendant from presenting evidence that an injured plaintiff's medical expenses have been paid by an independent source. Because the individual plaintiff procures insurance at their expense, in a transaction that in no ways involves the defendant party, historically courts deemed that any proceeds from an insurance policy received by a plaintiff were collateral" to any recovery from the wrongdoer, hence the term "collateral source rule".

Normally, of course, in an action for damages in tort, the fact that the plaintiff has received payments from a collateral source, other than the defendant, is not admissible in evidence and does not reduce or mitigate the defendant's liability (*Fye v. Kennedy*, 1998). While the rule may effectively allow a plaintiff to receive a double recovery:

> [t]he collateral source rule expresses a policy judgment in favor of encouraging citizens to purchase and maintain insurance for personal injuries and for other eventualities. The theory behind the collateral source rule is that a wrongdoer should not have the benefit of insurance independently procured by the injured party and to which the wrongdoer was not privy (*Brown v. Am. Transfer & Storage Co.*, 1980).

In the late 1980's and 1990's, a major piece of the tort reform movement centered on attacking the collateral source rule. Defendants, manufacturers and insurance companies argued that plaintiffs should not recover for incurred or to be incurred medical expenses covered by third parties such as private insurance or Medicare/Medicaid. States began enacting legislation to eliminate recovery for medical expenses paid or payable by private insurance (NJ Rev Stat § 2A:15-97, 2013). By 2007, it was noted that 44 of the 50 states had taken legislative steps to limit the collateral source rule (Zorogastua, 2007). In 2011, the California Supreme Court decided the case of *Howell v. Hamilton Meats & Provisions, Inc.* In Howell, the California Supreme Court wrote, "The collateral source rule precludes certain deductions against otherwise recoverable damages, but does not expand the scope of economic damages to include expenses the plaintiff never incurred" (Howell v. Hamilton Meats & Provisions, Inc., p. 548) (*Howell v. Hamilton Meats & Provisions, Inc.*, 2011, p. 548).

As of 2021, there is no consensus among state courts. State courts have taken essentially four approaches of whether to admit undiscounted medical bills into evidence when the bills have been satisfied for less. These are (1) the "actual amount paid" approach, which allows into evidence only the actual amount paid for medical care; (2) the "benefit of the bargain" approach, which allows the undiscounted medical bills into evidence if the plaintiff paid meaningful consideration for the insurance or other collateral source from which payment was made (3) the "reasonable value" approach, which allows admission of undiscounted medical bills without restriction as at least evidence of the medical services' value (*Dedmon v. Steelman*, 2017; *Weston v. Akhappy Time LLC*, 2019); and (4) a hybrid approach. However, the vast majority of states adhere to the "reasonable value" approach. Table 1 below outlines the four primary approaches state courts are currently taking along with states where the approach is followed as of the time that this manuscript was prepared. Not all 50 states are included in this chart.

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Table 1

Four Approaches to Collateral Source Rule

Approach	**Basis for Calculation**	**States Currently Following Approach**
Actual Amount Paid	Only the actual amount paid for medical care is allowed in evidence	California New York Pennsylvania Michigan Texas Idaho
Benefit of the Bargain	Undiscounted medical bills if plaintiff paid for insurance or other collateral source from which payment was made	Delaware Louisiana
Reasonable Value	Undiscounted medical bills without restriction	Alaska Virginia Hawaii Illinois Kansas Montana Kentucky Oregon South Dakota West Virginia Wisconsin Tennessee Massachusetts Arizona Arkansas Colorado Maine Maryland
Hybrid	Plaintiffs submit full, undiscounted medical bills and defendants submit evidence that the plaintiff's medical providers accepted less than the full bills (without mention of insurance)	Ohio Missouri Indiana

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The "Actual Amount Paid" Approach

Howell v. Hamilton Meats & Provisions, Inc. (2011), provides an excellent example of the actual amount paid approach. In *Howell*, the issue presented was whether an injured plaintiff whose medical expenses were paid through private health insurance could recover as economic damages the amount billed by the medical provider, or were they limited to the actual amount paid by the insurer? The California Supreme Court ruled a plaintiff could not recover as economic damages more than the discounted amount paid by the private insurer. The Court reasoned:

> Because they do not represent an economic loss for the plaintiff, they are not recoverable in the first instance. The collateral source rule precludes certain deductions against otherwise recoverable damages, but does not expand the scope of economic damages to include expenses the plaintiff never incurred. The rule that a plaintiff's expenses, to be recoverable, must be both incurred and reasonable accords, as well, with our damages statutes. 'Damages must, in all cases, be reasonable (Civil Code, § 3359)....' But if the plaintiff negotiates a discount and thereby receives services for less than might reasonably be charged, the plaintiff has not suffered a pecuniary loss or other detriment in the greater amount and therefore cannot recover damages for that amount (Civil Code, §§ 3281, 3282). The same rule applies when a collateral source, such as the plaintiff's health insurer, has obtained a discount for its payments on the plaintiff's behalf.

The Court concluded that plaintiff's recovery was limited to the discounted value of the medical expenses. The Court did acknowledge that a tortfeasor who injured an individual insured under a managed care insurance policy would pay less than if the injured person was uninsured.

As of the writing of this article, it is noted that six states have adopted the actual amount paid approach. These states include California, New York, Pennsylvania, Michigan, Texas and Idaho.

The "Benefit of the Bargain" Approach

A few states have adopted an alternative sometimes called the "benefit of the bargain" approach.

Under the benefit of the bargain approach, the plaintiff who has purchased insurance is assumed to have paid for the "negotiated rate differential" as much as for the actual cash payments made by the insurer to medical care providers. However, plaintiffs who did not pay for the benefit of discounted rates and write-offs (e.g., beneficiaries of Medicare and Medicaid) may not introduce their undiscounted billings. In these cases, the court "treat[s] the amount paid by Medicare [or Medicaid] as dispositive of the reasonable value of healthcare provider services" (*Bozeman v. State*, 2004; *Stayton v. Delaware Health Corporation*, 2015; *Weston v. Akhappy Time LLC*, 2019).

As of the writing of this article, it is noted that two states have adopted the benefit of the bargain approach. These states include Delaware and Louisiana.

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The "Reasonable Value" Approach

The reasonable value approach allows the admission of undiscounted medical bills without restriction, as evidence of medical services' value. Courts following this approach "adhere to the traditional collateral source rule, as outlined in Section 920A of the Restatement (Second) of Torts § 920A (American Law Institute, 1977). that tortfeasors should be responsible for all the damage they cause and that plaintiffs, not tortfeasors, should benefit from any negotiated discount" (*Weston v. Akhappy Time LLC*, 2019, p. 1026).

Some of these courts emphasize that because the value of medical services is a fact-intensive question, juries should receive all relevant evidence, including undiscounted medical bills. An example is *Arthur v. Catour*, (2005). In this case, all of plaintiff's bill were paid by health insurance. Defendant moved for partial summary judgment, seeking to limit plaintiff's claim for medical expenses to the amount paid rather than the amount billed. The Illinois Supreme Court rejected defendant's argument, upheld the collateral source rule, and determined Plaintiff could present to the jury the amount that her healthcare providers initially billed for services rendered.

The Tennessee Supreme Court decision in *Dedmon v. Steelman* (2017)is illustrative of this approach. In this case, defendants filed a motion to limit plaintiff's recovery for past medical expenses to those amounts actually accepted by medical providers. The Tennessee Supreme Court reviewed the approaches taken by courts throughout the United States and rejected abrogating the collateral source rule, holding:

> All of the alternative common-law approaches have the effect of undermining the collateral source rule and the significant public policies it continues to serve. A decision to depart from the established precedent of the collateral source rule would have to be supported by the firm belief that justice dictates a different path. None of the common-law alternatives to the collateral source rule give us such a firm belief.
>
> Importantly, we have no assurance that adoption of any of the alternative approaches would result in a more just and accurate assessment of the reasonable value of medical services received by plaintiffs in personal injury cases. The discounted amount of medical services does not necessarily, and in fact probably does not, reflect the true value of services rendered... A discounted rate, however, generally reflects the third-party payor's negotiating power and the fact that providers enjoy prompt payment, assured collectability...
>
> We also decline to alter existing law in Tennessee regarding the collateral source rule. Consequently, the Plaintiffs may submit evidence of Mrs. Dedmon's full, undiscounted medical bills as proof of her "reasonable medical expenses," and the Defendants are precluded from submitting evidence of discounted rates for medical services accepted by medical providers as a result of Mrs. Dedmon's insurance. The Defendants remain free to submit any other competent evidence to rebut the Plaintiffs' proof on the reasonableness of Mrs. Dedmon's medical expenses, so long as the Defendants' proof does not contravene the collateral source rule.

In essence, the Dedmon Court decision reaffirmed the reasonable value approach whereby a plaintiff may recover the amount of the full (undiscounted) medical bill.

In deciding the case, the Dedmon Court acknowledged the increasing complexity of healthcare pricing, stating:

> During this same period since adoption of the rule, the pricing, payment, and reimbursement system for health care providers has become exponentially more complex. The rise of managed care organizations has 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.... As observed by the Court of Appeals below, all of these developments have caused "the issue of what constitutes a reasonable medical charge or expense [to become] the subject of increased litigation due to the increased involvement of government payors, the complexity of health care reimbursement provisions, financial pressures on hospitals, and the significance of medical expense recovery in personal injury litigation" (p.452).

As of the writing of this article, it is noted that 18 states continue to follow the reasonable value approach. These states include Alaska, Arkansas, Arizona, Colorado, Hawaii, Illinois, Kansas, Kentucky, Massachusetts, Maine, Maryland, Montana, Oregon, South Dakota, Tennessee, Virginia, West Virginia, and Wisconsin.

Hybrid Approach

A few courts 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 (*Patient Protection and Affordable Care Act of 2010*, 2010; *Robinson v. Bates*, 2006). To date, Ohio, Indiana and Missouri have adopted this approach.

Future Medical Costs

While there has been a great deal of litigation activities around past medical expenses, there has been less about the admissibility of future medical expenses. Whether these expenses are contained in a life care plan or simply testified to by a healthcare provider, there is no reason to expect that future medical costs will be treated by the courts in a different manner from past medical expenses. A look at court decisions regarding reimbursement of past medical expenses will prove a reasonable roadmap as to where the courts will go in deciding the reasonableness of future medical costs contained in life care plans. The 2017 case *Cuevas v. Contra Costa County* is an example of a case where the court addressed the future costs included in a life care plan (*Cuevas v. Contar Costa County*, 2017).

In *Cuevas v. Contra Costa County* (2017), plaintiff disclosed a life care plan, in which the life care planner provided her opinion as to the kind of medical and rehabilitative care plaintiff would need for the rest of his life, along with the projected cost for each specific care

item. Her plan was based on the recommendations of medical specialists who testified on plaintiff's behalf. As to future medical costs, the plan did not account for service discounts associated with Medi-Cal, even though plaintiff was currently receiving Medi-Cal benefits. Nor did it reflect negotiated discounts that would potentially be available under insurance procured through the Patient Protection and Affordable Care Act of 2010 (ACA). Instead, plaintiff's life care planner determined future costs for medical care by referencing a national database that reflected the average charges billed for each type of service.

Defendant's life care planner prepared life care plans based on services recommended by a defense pediatric neurologist. In contrast to plaintiff's life care plan, defendant's life plan reflected three alternate cost scenarios, including one in which plaintiff would continue to be covered by Medi-Cal; one in which plaintiff would procure private insurance under the Affordable Care Act; and one in which he would pay for his expenses out of pocket. With respect to the private pay scenario, defendant's life care planner did not rely on amounts billed by health care providers in calculating future medical expenses. Instead, she contacted local health care providers and asked them how much individuals without insurance are required to pay. These rates typically are less than what providers would state on a bill.

Defendant's life care planner's alternative plans reflected the wide variations that exist in medical charging practices. The Medi-Cal life care plan reflected reimbursement rates that were substantially lower than the rates paid by persons without insurance. For example, one category of expenses reflected a more than 60 percent difference between the private pay rate and the Medi-Cal rate. Within the three plans, she also took into consideration the free benefits that plaintiff was currently entitled to receive from the regional center and public school system.

Defendant's life care planner prepared a report comparing the costs for the services itemized in plaintiff's life care plan with the Medi-Cal payment rate for the same goods and services, revealing that the plaintiff's life care costs were substantially higher. For example, the cost for a wide variety of physician visits listed in plaintiff's plan were four to six times higher than the corresponding Medi-Cal rates.

In keeping with California's long judicial history (*Hanif v. Housing Auth. Of Yolo County*, 1988) of limiting reimbursement for medical expenses to that which was accepted by the provider, the Court ruled in defendant's favor and ruled defendant could introduce evidence of the effect of the Affordable Care Act. The Court (*Cuevas v. Contar Costa County*, 2017) instructed,

> For insured plaintiffs, the reasonable market or exchange value of medical services will not be the amount billed by a medical provider or hospital, but the 'amount paid pursuant to the reduced rate negotiated by the plaintiff's insurance company (p.179) . . . . [W]hile an injured plaintiff is entitled to recover the reasonable value of medical services that are reasonably certain to be necessary in the future, evidence of the full amount billed for past medical services cannot support an expert opinion on the reasonable value of future medical services (p.182).

For readers interested in an analysis of potential problems with projecting future costs based upon discounting pricing, the reader is referred to De Saint Phalle and Clay (2018), which discusses the methodologies of calculating future medical costs after the Cuevas decision.

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Implications for Life Care Planning

Based upon the most recent life care planning role and function study (May & Moradi-Rekabdarkolaee, 2020) only 5 of 212 (2.36%) life care planners participating in the study held a juris doctorate. As early as 2015, Field et al. (2015) stated that legal decisions that impact the collateral source rule are outside the role and function of a life care planner. Nevertheless, life care planners must contend with the issues outlined above pertaining to collateral source approaches in the courts. To assist life care planners with these issues, it is recommended that life care planners consult life care planning guiding documents such as standards of practice (International Academy of Life Care Planners, 2015); read previously-published materials on the Collateral Source Rule (Field, Johnson, Choppa, & Fountaine, 2015)and usual, customary and reasonable pricing; inquire about previous court decisions related to life care planning issues; and understand the individual approach of the court where each life care plan is prepared.

Guidance from Life Care Planning Documents

Previously-published life care planning documents provide guidance to life care planners on methodological issues as well as collateral source issues. For example, the *Standards of Practice for Life Care Planners, 3rd edition* states that the life care planner "Develops recommendations for content of the life care plan cost projections for each evaluee and a method for validating inclusion or exclusion of content" (International Academy of Life Care Planners, 2015, p. 9). Some may argue that choosing what is included or excluded in a plan based upon a jurisdiction's collateral source approach is deviation from standard life care planning methodology. However, these authors contend that one's life care planning method, that is, record review, consultations with evaluees and healthcare professionals, development of a narrative and tables, and report dissemination will not change based upon collateral source jurisdictional differences. A similar assertion was made in 2015 by Field et al., who concluded, "Life care planners cannot know with reliability what the courts or legislative bodies may choose to do in the future; the traditional life care planning methodology remains the same" (p.7).

Rather, some of the data *allowed by the court* to be presented to the jury, and therefore included in the life care plan, may vary. As a result of jurisdictional differences, the same life care planner may include the full charge of a healthcare service in a life care plan that is venued in Delaware but only the adjusted amount in a life care plan venued in California. This is based upon the jurisdictional requirement as established by the court and does not amend the method by which the life care planner prepares their report and presents testimony.

In 2015, Johnson et al. noted that jurisdictional variations should be noted when considering collateral source rules in life care planning. Additionally, life care planning *Majority and Consensus Statements* (C. B. Johnson et al., 2018, p. 15) state: "Life Care Planners shall have knowledge of relevant laws and regulations as well as local and national care standards." It is recommended, therefore, that life care planners gain familiarity with various collateral source rule approaches by courts to understand what the court will or will not allow to be presented to the jury in terms of past and/or future medical expenses (Field, Johnson, & Choppa, 2015). Failure to do so may result in the life care plan being excluded.

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Over six years ago, Johnson et al. (2015, p. 48) stated the following about collateral source rules in life care planning, "There is nothing in the *Standards of Practice* or *Consensus and Majority Statements* indicating we cannot provide a variety of information regarding costs and collateral sources if requested". Based upon a review of current life care planning documents, the current authors conclude that years later, this statement holds true. For life care planners who work within litigated systems, consideration of the jurisdictional requirements governing admissibility of life care planning testimony must be undertaken.

Gain Education about Collateral Sources Rules within each Jurisdiction

Life care planners who prepare life care plans within litigation must follow the rule of the specific jurisdiction, regardless of their personal beliefs. However, it is certainly within the purview of the life care planner, at time of referral, to refuse to accept the referral if they conclude that inclusion, for example, of only the adjusted healthcare cost is not consistent with their life care planning process. For life care planners who work in various jurisdictions, gaining knowledge about jurisdictional requirements at the time of case referral is recommended. Just as life care planners are skilled in conducting consultation with healthcare professionals to discuss recommendations for future care included in the life care plan, it is recommended that life care planners ask relevant questions of referral sources about collateral source approaches in the case's jurisdiction.

During the referral conversation, if the life care plan will be used in litigation, it is advisable that the life care planner gain an understanding of prior life care planning-related court opinions within that same venue. Looking to previously decided cases is a method by which the life care planner can obtain this education. An example of state court cases that limited recovery to the amount paid by insurance is seen below in *Markow v. Rosner* (2016) and *Madrigal v. United States* (2021).

In *Markow*, plaintiffs' life-care planning expert, estimated that the amount billed for *Markow*'s future hospitalizations would be approximately $2 million. Based on her research, knowledge, and experience, plaintiff's expert testified that the amount actually paid is usually 50 to 75 percent of the total amount billed. She also testified that with respect to one particular hospitalization, the cost was reimbursed at a much lower rate of 12.9 percent. The jury's award of $1.3 million was approximately 65 percent of the estimated future billing amount of $2 million, or roughly halfway between the 50 to 75 percent reimbursement testified to by plaintiff's life care planner.

The appellate court held:

> Substantial evidence supports the jury's award. While [Plaintiff's life care planner] acknowledged that in one instance a hospital accepted a reimbursement rate much lower than 50 to 75 percent, she also testified that reimbursement rates vary and that there is no one "across-the-board, set percentage." [Plaintiff's life care planner] testified that she has been doing life care planning for almost seven years. In addition to her experience as a life-care planner, she has a bachelor's degree in critical care nursing, and a master's degree in business administration with a specialty in health care management; she is also a certified hemodialysis nurse and is licensed as both an R.N. and a public health nurse. The jury could reasonably find [her] testimony on the reimbursement rate to be credible. Ac-

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> cordingly, we find that substantial evidence supports the jury's award of future economic damages (*Markow v. Rosner*, 2016, p. 1051).

Madrigal v. United States (2021) provides another illustration where both plaintiff and defense experts' approaches were rejected by a federal court applying California law. There, plaintiff's expert physicians unilaterally relied on their assignment of value of future medical treatment. On the other hand, defendant's expert in reasonable value analytics opined "on the fair market value" of Plaintiff's medical care. In reaching her conclusions, the expert applied a multiplier to data extracted from the Medicare Physician Fee Schedule Database, a comprehensive source of information on fees for medical services. The Court without much discussion rejected the testimony of plaintiff's physicians. With regard to the defense, the Court held:

> The Court finds [defense expert's] methodology to be more probative of the reasonable value of medical services but nevertheless problematic. While her methodology more nearly pinpoints the reasonable value, it concerns a singular "fair market value." The Court is not convinced that the relevant market for Plaintiff's treatment is precisely aligned with the market identified in [defense expert's] methodology. That is, [defense expert's] methodology encompasses those rates negotiated by payers who may have more bargaining power than Plaintiff. Accordingly, the Court does not adopt [defense expert's] conclusions but accords reasonable values for Plaintiff's medical services more closely tied to figures proffered by [defense expert's] (*Madrigal v. United States*, 2021).

In other states that have applied the reasonable value approach, the life care planner will need to determine what the reasonable undiscounted amount that will be charged by the provider of the service.

Understand Costing Concepts Relevant to Life Care Plan preparation

It is noted that a court's approach to the collateral source rule may affect not only the content of the items in the plan (e.g., the inclusion or exclusion of available community resources) but also the source of the cost data contained in the life care plan. It is likely the cost of the healthcare items will be the factor that will have the most variation among venues, as a result of differing collateral source rule approaches. That is, if the jurisdiction only allows for the jury to consider the allowable cost of a healthcare service, the court may only allow the life care planner to testify to such data sources.

Life care planning literature has extensively addressed the process of costing items contained in a life care plan. Life care planning Majority and Consensus Statements (C. Johnson et al., 2018, p. 17) state: "Life Care Planners shall gather geographically relevant & representative prices." Variation in how courts are handling the collateral source rule may impact how life care planners treat the word "representative". Historically in life care planning, the prevalent concept was that the life care plan would contain prices for items that an evaluee would reasonably expect to pay. However, with the current variation in collateral source approaches by courts, the *representative* price that may be presented by the life care planner may be dictated by the courts, rather than the life care planner. Again, *Majority and*

Consensus Statements (C. Johnson et al., 2018, p. 17) state that best life care planning practice includes obtaining "Non-discounted/market rate prices" (p.17). However, the life care planner may lose the ability to include the full charge of a medical office visit if they are preparing a life care plan in a venue that does not allow charges (i.e., non-discounted rates) to be introduced. Again, we argue that it is not a deviation from standard life care planning methodology to use the adjusted cost in certain jurisdictions, if that is what is required for the life care plan to be deemed admissible. This would involve, as (Field, Johnson, Choppa, & Fountaine, 2015, p. 8) described an additional step to identify collateral source offsets. This is similar to the concept expressed by Field, Johnson, and Choppa (2015) in a collateral source rule discussion when they stated, "Life Care Planners are permitted to provide useful information to the parties as requested" (p.48). Additionally, the Standards of Practice for Life Care Planners (3rd edition) (International Academy of Life Care Planners, 2015, p. 10) state that the life care planner who engages in forensic applications, "Acts as a consultant to legal proceedings related to determining care and needs and costs in the role of an impartial advisor to the court." Based upon a 2021 review of life care planning documents, there was nothing found that would preclude the life care planner from providing a variety of data points reflecting costs and collateral sources, if this is requested.

It is, therefore, incumbent upon the life care planner to understand the sources of healthcare costs and demonstrate the ability to adequately explain their approach to life care planning costing. Some life care planners utilize the usual, customary and reasonable (UCR) pricing when costing items contained in a life care plan. The concept of UCR has been adopted by the American Medical Association (2013) with the following definitions:
Usual: Fee usually charged for a given service to a private patient
Customary: Fee is within the range of usual fees currently charged by physicians with similar training and experience, for the same service within the geographic area
Reasonable: Fee meets above 2 criteria and is justifiable without regard to payments that have been discounted (American Medical Association, 2013).
It behooves the life care planner to understand and be able to clearly communicate the concept of UCR, a concept that has been previously published in life care planning literature (Busch, 2018; Maniha & Watson, 2019). A full discussion of UCR is beyond the scope of these article, but interested readers are referred to the Busch (2018) and Maniha and Watson (2019) for a complete discussion of the topic. If the life care planner possesses an understanding of charge vs. cost, paid vs. adjusted amounts, UCR and non-discounted cost, the life care planner should be well positioned to educate the parties involved of such concepts. For some life care planners who may be required by jurisdictional requirements to include "paid" amounts in the life care plan, explaining what the market rate amount was and how the adjusted amount was derived will likely assist the trier of fact when damages arguments are presented. The life care planner should also be prepared to discuss how an individual evaluee may not be afforded the same ability to adjust the amount charged for a medical good or service, as is customary for third party payors, whether private or public.

Proceed According to Jurisdictional Requirements

Once a life care planner has agreed to accept a referral for a life care plan for litigation and they have educated themselves on the collateral source rule approach within the venue where the plan will be developed, they must proceed accordingly. In a venue where the

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"actual amount paid" approach is controlling, life care plans developed within these states may expect that future medical costs included in the plan may reflect only adjusted amounts, rather than the charge amount. Such approach may require analysis of prior medical bills and adjustments made on previously incurred medical expenses. Again, a reader is referred to Busch (2018) for a complete explanation of the revenue cycle for this process.

In a venue where the "reasonable value" is the approach adopted by the courts, life care planners may include the actual charge, or the amount a physician or other provider actually billed, without consideration of adjustments or reimbursed amounts.

In a venue where the "benefit of the bargain" is the approach adopted, if the plaintiff paid for insurance, the amount included in the plan may only include undiscounted medical bills. If they did not pay for insurance, the amount included would likely be what is reasonable, taking into account what medical insurance would pay or what was actually paid.

In a venue where the hybrid approach is adopted, there may be multiple life care planners involved. While the plaintiff's life care planner may include full charge costing in the plan, it is likely the defendant-retained life care planner will include only what was paid in medical expenses or what is expected to be paid in the future. An example of this approach is reflected in the California case *Cuevas v. Contra Costa County* discussed above.

Conclusion

Over the last 30 years, courts throughout the United States have developed divergent approaches to collateral source rules that govern presentation of evidence to juries regarding damages. Four primary approaches have been developed which are: Reasonable Value; Benefit of the Bargain; Actual Amount Paid; and a Hybrid approach. Given the various approaches outlined above, the question becomes, what source should the planner utilize in determining the cost of the proposed treatment? Unfortunately, the Courts have not provided clear guidance to answer this question.

Familiarity with collateral source approaches by courts has historically not been an area of contention in life care planning. However, as courts have grown disparate in their approaches to the collateral source rule, life care planners have been asked to present life care planning data based upon the court's jurisdictional approach. A life care planner should understand the jurisdictional approach to the collateral source rule that affects life care plan development in order to properly comply with jurisdictional requirements.

As life care plans must be lifelong, flexible, and based upon current research and standards, so too must life care planning as a specialty practice be flexible and stay abreast of jurisdictional requirements in which we practice. As Field, Johnson, and Choppa (2015, p. 48)concluded about collateral source rule issues, "We are not making a statement about what is the "right" cost to use, or who should pay. The jury and/or judge will do that."

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