

ARTHUR v. CATOUR IN THE WORLD OF COMPENSATORY DAMAGES

A CONSIDERATION OF ARTHUR v. CATOUR IN THE CONTEXT OF ITS ANCESTORS AND ITS PROGENY

By: David B. Mueller
Cassidy & Mueller
Peoria, IL

INTRODUCTION

Arthur v. Catour, 216 Ill.2d 72 (2005) is well known to all personal injury attorneys. It brought the same evidentiary reality of “reasonableness” to paid discounted medical bills as applies to unpaid bills. There the issue was the amount of recoverable medical expenses where the billed price for the services was greater than the sums accepted by the providers. In its decision the court focused upon the objectively determined “reasonable value” of those services without regard to what was billed or paid. The variance between the two amounts, or the so-called “discount”, is the product of current healthcare economics as driven by federally sponsored Medicare.

From the legal perspective the value phenomenon is one whose roots lie deep in the soil of our civil reparations system. The purpose of this article is to consider *Arthur v. Catour* in the context of its ancestors and progeny in hopes that the discussion will lead to deeper thought on the plump question of compensatory damages. As the prefatory paragraph of each pattern damage instructions states:

If you decide for the plaintiff on the question of liability, you must then fix the amount of money which will reasonably and *fairly compensate him for any of the following elements of damages proved by the evidence to have resulted*. . . (Italics supplied). Illinois Pattern Jury Instructions (Civil, 2006 ed., 30.01).

During the course of the discussion we will consider the fundamental underpinnings: (1) of damages commensurate with loss; (2) the condemnation of double recovery, and (3) the

collateral source rule. Each of these interrelated principles has been the focus of recent decisions in the area of recovery for medical damages which have been paid by third parties, such as insurers and governmental agencies. While the courts in each case have been asked to decide whether the amount billed, or the amount paid or some other amount should be awarded, the concept of restitution for loss controls.

ANCESTORS OF *ARTHUR* v. *CATOUR*

As the preceding damages instruction demonstrates, the objective of compensatory damages is to substitute monetary relief for the loss sustained by the plaintiff through the negligence or other fault of the defendant. To the extent that intangibles such as “pain and suffering” can be reduced to a dollar amount, the goal is to balance the scales of justice by compensation which is equivalent to the loss. As stated by the supreme court in *Peterson v. Lou Bachrodt Chevrolet Co.*, 76 Ill.2d 353, 363 (1979):

The purpose of compensatory tort damages is to compensate (Restatement (Second) of Torts sec. 903, comment *a* (1979)); it is not the purpose of such damages to punish defendants or bestow a windfall upon plaintiffs. The view that a windfall, if any is to be enjoyed, should go to the plaintiff (*Grayson v. Williams* (10th Cir. 1957), 256 F.2d 61, 65) borders too closely on approval of unwarranted punitive damages, and it is a view not espoused by our cases.

Section 903 of the Restatement (Second) of Torts provides that compensatory damages are the equivalent of “. . . compensation, indemnity or restitution for harm sustained by . . .” the plaintiff. This is in contradistinction to Section 901(c) which describes as one objective of damages the punishment of wrongdoers and thereby deterrence of wrongful conduct. By definition that is the function of punitive or exemplary damages. (Illinois Pattern Jury Instructions 35.01). Unfortunately, and as becomes apparent in the following discussion of the

“collateral source rule”, the distinction between compensatory damages and punitive damages is sometimes lost in the analysis.

From the perspectives of social engineering and public policy the rationale behind compensatory damages is well grounded. That same foundation demonstrates why recovery should be limited to restitution. Unlike other societies in which significantly injured individuals become wards of the state and thereby of the taxpayers, our system of reparations places the economic burden of loss upon the malefactor. However, that burden is commonly shifted to the public in the form of the increased cost of goods and services. Vehicle operators, manufacturers, physicians, attorneys, *et al.* purchase liability insurance to cover potential civil exposures. The premiums which are paid for that insurance are a cost of doing business which is passed on to the consumers of the goods and services which are provided. As otherwise expressed, “there is no free lunch”. The public, albeit on a broad base, ultimately foots the bill for such damages as a plaintiff may recover from a defendant. Consequently, there is no more reason for the public to overpay to benefit a claimant than to assign him a winning ticket in the state lottery.

Consistent with the philosophy of equating the amount of a recovery to the damages which were actually suffered is the prohibition against “double recovery”. That limitation is based upon the concept that a plaintiff shall have only one recovery for an injury. As stated in *Dial v. City of O’Fallon*, 81 Ill.2d 548, 558 (1980):

However, the courts in Illinois have long recognized the legal principle that a plaintiff shall have only one satisfaction for an injury (*Meneghin v. Thunander* (1962), 36 Ill.App.2d 452; *DuPree v. Terry* (1971), 1 Ill.App.3d 169; *Kurth v. Ameer, Inc.* (1972), 3 Ill.App.3d 506), irrespective of the availability of multiple theories that recovery for the injury can be sought under. In other words, if a party is injured by another he can bring the actions under several theories, *i.e.*, negligence, product liability, intentional torts, ect.; however, he will only be eligible for one recovery for his injury when seeking compensatory tort damages.

The purpose of compensatory tort damages is to compensate for the injury suffered, not to punish defendants or bestow a windfall upon plaintiffs. . .

Therefore, payments by one tortfeasor may serve as a credit or offset to any damages recovered against other tortfeasors. That principle applies regardless of the ingenuity used by the settling parties in characterizing their agreement. *Popovich v. Ram Pipe & Supply Co.*, 82 Ill.2d 203, 208-209 (1980) and *Blagg v. Illinois F.W.D. Truck & Equipment Co.*, 143 Ill.2d 188, 195 (1991).

THE COLLATERAL SOURCE RULE

It is not uncommon for an injured plaintiff to have all or a portion of his medical expenses paid by an insurance policy or plan which he purchased or which is provided as a fringe benefit of his employment. In those instances the collateral source rule provides that the damages which are recoverable from the defendant are not decreased by the insurance proceeds. The reasoning behind the rule is straightforward. The injured party, either directly or indirectly, paid the premiums for that coverage. *Wilson v. The Hoffman Group, Inc.*, 131 Ill.2d 308, 320-321 (1989). As a corollary, the rule is also underpinned by the reasoning that “. . . the wrongdoer should not benefit from the expenditures made by the injured party or take advantage of contracts or other relations that may exist between the injured party and third persons.” *Hoffman Group*, 131 Ill.2d at 320.

Consistent with the public policy from which the doctrine derives, the collateral source rule will *not* be applied where the injured party paid nothing for the benefit. In *Peterson v. Lou Bachrodt Chevrolet Co.*, 76 Ill.2d 353, 362-364 (1979) the plaintiff attempted to recover the value of charitable services which were rendered by the Shriners' Hospital for Crippled Children. Peterson paid nothing for those services. He nonetheless argued that they were a proper element of damage under the collateral source rule. In large part that argument was

bottomed on the contention that *if* recovery were denied the defendant would benefit from its misconduct. Rejecting that argument the court distinguished between “*expenditures made by the injured party*” [italics in the original] and gratuitous services for which no payment was required. On that point it prioritized the fact that compensatory damages require an injury or loss which is to be compensated, as opposed to either punishing the tortfeasors or bestowing “. . . a windfall upon plaintiff.” *Peterson*, 76 Ill.2d at 363. As discussed *supra*, that distinction is the bedrock of our civil reparations system.

ARTHUR v. CATOUR

Health Care Economics 101

Arthur v. Catour, 216 Ill.2d 72 (2005) focused legal consideration in an evidentiary sense upon the inflationary spiral of medical expenses. That focus, albeit significant in litigation, involves only one manifestation of the problem without considering the problem itself. The fundamental inquiry is and should be why are there different prices for the same services by the same healthcare provider? Alternatively expressed, why does the cost of healthcare vary from patient to patient? Does the *value* of a procedure fluctuate inversely to a patient’s ability to pay?

In *Arthur v. Catour* the injured plaintiff received medical bills totaling \$19,355.25. Those bills were satisfied in full for \$13,577.97 by Blue Cross, the group insurance carrier for her husband’s employer. The dispute involved whether her provable damages were the amount of the bills or the amount which was paid to satisfy them. The supreme court sidestepped the issue by relying upon the well-recognized rule that a plaintiff is entitled to recover “. . . the reasonable expenses of necessary medical care”. What is “reasonable” is a matter of proof. The fact that the bills have been paid does not *ipso facto* mean that the charges are reasonable where the providers

have settled for less than the amounts which are charged. The door is therefore open to the question of what is the reasonable value of medical services in a multi-tiered system where one amount is billed but the amount which is accepted in payment is wholly dependent upon the payor? As recognized by the *Arthur* court the problem is one of proof which goes to the value, i.e. reasonableness of the services which were rendered:

Applying these principles to the present case, plaintiff cannot make a *prima facie* case of reasonableness based on the bill alone, because she cannot truthfully testify that the total billed amount has been paid. Instead, she must establish the reasonable cost by others means—just as she would have to do if the services had not yet been rendered, *e.g.*, in the case of required future surgery, or if the bill remained unpaid. Defendants, of course, are free to challenge plaintiff's proof on cross-examination and to offer their own evidence pertaining to the reasonableness of the charges.

The pregnant questions are (1) what is the reasonable value and (2) how is it proved. This requires a basic understanding of healthcare economics and how it has evolved over the past 25 years.

As the following discussion demonstrates, there is no recognized yardstick by which the intrinsic value of medical services generally or specifically can be determined. Nor can it be done on a provider by provider basis. Instead, it is necessary to extrapolate from various schedules and in doing so to understand the genesis and reasons for the differences. Those differences are the product of leverage in the healthcare marketplace. That leverage explains why patients who are least able to pay incur medical obligations which are far greater than those whose economic circumstances give them the leverage to pay less. As a rule of thumb it may be said that the greater the leverage the smaller the bill. Conversely, the less the leverage the greater the bill.

The healthcare crisis which accounts for disparate bills for identical services began in the early 1980's when Medicare went to the diagnosis related group (DRG) method of reimbursement. Surgical procedures, physician medical care and hospitalizations were compartmentalized by the nature of the surgery, illness or care which was given. Each "compartment" was given a value or "DRG" which then defined the amount of money which the government would pay. For example, before the adoption of DRG's the government paid on a fee for service basis. An appendectomy might have a hospital component of \$1,000. When DRG's were instituted the government would only pay the arbitrary value which it assigned to that procedure. At first, and for the purposes of the example, the DRG for an appendectomy might be \$1,000. The second year it was reduced to \$900 and thereafter it continued to drop to the point where Medicare may pay the hospital only \$500. Medicare is responsible for approximately 50% of all healthcare dollars and therefore it has the "leverage" to force providers to accept its rate of reimbursement.

Not surprisingly, Medicare's imposition of DRG's started a cost shifting phenomenon. Hospitals that otherwise would have charged \$1,000 but were forced to accept \$500 had to make up the difference by charging other patients more than \$1,000. The phenomenon is akin to squeezing a balloon on one end. The end that is squeezed contracts but the air is forced to the other end which expands. The more that Medicare reduced its rate of reimbursement the more healthcare providers charged their other patients.

Ours is an employer centered healthcare system. That is to say, most healthcare benefits are provided by employers who pay premiums for healthcare coverage for their employees. As the balloon was increasingly squeezed by Medicare, employers saw the healthcare component of

their employee benefits rise in multiples of the rate of inflation. To counter that progression employers moved in two directions. First, they increased their employees' share of the cost through deductibles and co-pays. Second, they also exerted leverage by entering into preferred provider agreements (PPO's) by which they controlled employee access to healthcare providers in exchange for reduced charges. These employer discounts then squeezed the healthcare balloon even more. Correspondingly, the opposite end expanded to an even greater extent.

The less that Medicare and contracted payors pay for healthcare the more the bills rise to the non-discounted patient. Using the example of the \$1,000 appendectomy, Medicare reimburses only \$400, the employer/PPO pays \$600 and the non-leveraged patient pays \$2,000. In that setting it is difficult, if not impossible, to say what the fair and reasonable charge for the appendectomy actually is. If the provider is willing to accept \$400 or \$600, it is difficult to see how or why any patient should be obligated to pay \$2,000. In the same respect there is absolutely no reason why a defendant or his insurance carrier should be obligated to pay the non-discounted amount as compensatory damages where the physician or hospital accepted payment in full from Medicare or the plaintiff's employer or healthcare insurer.

Collateral Source Considerations

The plaintiff in *Arthur v. Catour* argued that she was entitled to recover more than the healthcare providers received because the bills were paid by her own group health insurance carrier, which was a "collateral source". Following a discussion of the collateral source rule and its public policy underpinnings, the court denied that contention. It did so on the basis that the "collateral source" was ". . . the insurance company and not the so-called 'discount'." More succinctly the opinion states:

. . . to restate the obvious: the plaintiff did not receive a discount from the provider. Rather, plaintiff received the benefit of her bargain with her insurance company – full coverage for incurred medical expenses.

The impact of *Arthur v. Catour* is purely evidentiary. Where a collateral source is involved, with or without a lien or the right of subrogation, an injured plaintiff is entitled to recover the “reasonable value” of the medical services which were received. However, that value cannot be proved simply by admitting the bills into evidence as “paid”. Instead, and is the case with unpaid medical bills, the plaintiff must prove the “reasonable cost” of the services which were rendered.

The Progeny Of *Arthur v. Catour*

Arthur v. Catour left at least two major questions open to debate. First, to what type of “discounts” does it apply? Second, how does a plaintiff go about proving the reasonable value of the services which were provided and billed? In the latter respect what can a defendant do to impeach, rebut and overcome the plaintiff’s evidence? While the law is undoubtedly evolving in these areas, two recent decisions provide insights and guidance.

WILLS v. FOSTER

Medicare and Medicaid

In *Wills v. Foster*, 2007 WL 1192144 the Fourth District considered the application of *Arthur v. Catour* in the setting of medical expenses which were paid by Medicare and Medicaid. The amount billed was \$80,163.47 and the amount paid by the respective governmental agencies totaled \$19,005.50. The plaintiff claimed that the collateral source rule applied and that she was entitled to the non-discounted amount which was billed.

Procedurally, the trial court denied the defendant's motion in limine and allowed the jury to consider \$80,163.47 as the amount of the medical expenses. In post judgment proceedings the defendant's motion to reduce the jury's award from \$80,163.47 to \$19,005.50 was allowed, subject to the following order:

In the event plaintiff's medical providers seek to recover from plaintiff the difference between the amount shown on the ledgers and the amount paid by the Illinois Department of Public Aid or Medicare, plaintiff may within one year from the date of this order petition the court for a revision of this order.¹

On the qualification level the court held that benefits which are paid through Medicaid or Medicare do not fall within the collateral source rule. On that issue it reasoned: “. . . that because the benefits conferred upon plaintiff did not result from a bargained-for exchange with a third party who provided the benefits, the collateral source rule does not apply.”

Having made that distinction the court then adopted the rationale of *Peterson v. Lou Bachrodt Chevrolet Co., supra*. Thereby it held that where the plaintiff is not obligated for the expense he is not entitled to recover its value, as there is no injury to be compensated. At that point in the opinion it would appear that a plaintiff whose medical bills were paid by a governmental agency without recourse against him would not be entitled to seek recovery in any amount. Consistent with that conclusion is the following reasoning which equates the gratuitous provision of healthcare services in *Peterson* with Medicaid and Medicare payments:

With our supreme court's decision in *Peterson*, it appears Illinois has aligned itself with the former set of cases and intends to exclude Medicaid and Medicare payments as “collateral source” within the meaning of the rule. Akin to the plaintiff in *Peterson*, those individuals, like plaintiff here, covered by Medicaid or Medicare do not make “expenditures” and have not bargained for their coverage. A covered plaintiff's liability is nonexistent as well because by accepting

¹ This articles does not consider the impact of the Medicare super lien (42 USC § 1395(y), 42 CFR § 411.1 *et seq.*) or the Illinois Public Aid Code (305 ILCS 5/11-22, 5/11-22a and 5/11-22b.

payments from DHFS, Medicare, or Medicaid, health-care providers have agreed such payments constitute full satisfaction of their fees. See 305 ILCS 5/11-13 (West 2004); 89 Ill. Adm. Code § 140.12(i), as amended by 24 Ill. Reg. 18320 (eff. December 1, 2000).

Without explanation or a discussion of the difference to the plaintiff of free services versus those which are paid by the government, the *Wills* court concludes that the plaintiff is precluded from recovering the billed amounts but is entitled to recover amounts which were paid by Medicaid and Medicare. Implicit in the decision is the limitation of *Arthur v. Catour* to discounted bills which are paid by a collateral source, *i.e.*, ones to which the plaintiff directly or indirectly contributed. Missing is the explanation of how or why a plaintiff would be entitled to seek as damages amounts which he neither paid nor was obligated to pay. While not expressed, the inclusion of those payments is undoubtedly the result of the subrogation and reimbursement provisions of the Federal and State legislation and regulations.

For the purpose of comprehending the current state of Illinois damages law, at least in the Fourth District, it is sufficient to understand two things: First, the collateral source rule does not apply to medical expenses which are paid through non-contributory governmental programs and therefore, *Arthur v. Catour, supra* is not implicated. Second, a plaintiff who has received Medicare or Medicaid benefits is limited to the amount which was paid, as opposed to the amount which was billed. Moreover, the limitation appears to be one of law, as opposed to evidence. Consequently, a plaintiff would be precluded from offering the non-discounted bills or contradicting the amount which was paid by testimony or exhibits the reasonable value was otherwise.

KUNZ v. LITTLE COMPANY OF MARY HOSPITAL

Proof of Reasonable Value

In *Kunz v. Little Company of Mary Hospital*, 2007 WL 1309558, the First District considered the type of expert testimony which can be used to prove the reasonableness of past and future medical expenses. While *Kunz* does not involve discounted medical bills which were paid by through a collateral source, the court cites the general rule of *Arthur v. Catour* with approval. As discussed *supra*, *Arthur v. Catour* eliminated the evidentiary distinction between proving the reasonable value of medical expenses which were paid by a collateral source and unpaid bills. Thus, the standard which was approved in *Kunz* for unpaid bills would also apply to the former.

Kunz was a medical malpractice action in which the plaintiff's injuries were the result of the continued administration of the nephrotoxic antibiotic, gentamicin. As a consequence of renal failure the plaintiff required regular dialysis. One of her liability experts, Dr. Vincent Pateras, was also offered as a witness on the reasonableness of her unpaid past and future medical bills. That testimony was barred by the trial court on grounds that Dr. Pateras lacked knowledge of the billing practices of the respective providers. In reversing and allowing a new trial on damages the appellate court held that a sufficient foundation is laid if the expert testifies that he has knowledge of the usual and customary charges for the type of services which were rendered and are required in the same geographic area.

Kunz v. Little Company of Mary Hospital shows that the same evidentiary rule which is addressed in *Arthur v. Catour* applies to discounted bills in collateral source cases and unpaid bills. The reasonable "costs" of the healthcare services which were received by the plaintiff is properly the subject of expert testimony in both instances. A foundation is sufficient which

shows that the witness is aware of those costs in the same geographic area where they have been or will be provided to the plaintiff.

CONCLUSION

In *Arthur v. Catour* the court simply applied the same evidentiary rule to discounted bills which were paid by a qualified collateral source as pertains to the proof of unpaid medical expenses. The test is one of reasonableness and the proof best comes from either the treating physician or a medically qualified witness who is aware of those costs in the relevant geographic market. However, the reasoning of the *Arthur v. Catour* court penetrates far deeper into the soil of compensatory damages, particularly in its consideration of the collateral source rule. That reasoning holds firm the major premise that compensatory damages and *ergo* their proof are limited to placing the plaintiff in the same position the plaintiff would have occupied “but for” the defendant’s wrongful conduct. In other words, the objective is “not to punish defendants or bestow a windfall upon plaintiffs.” *Peterson v. Lou Bachrodt Chevrolet Co.*, 76 Ill.2d 353, 363 (1979).