IN THE
MISSOURI COURT OF APPEALS
SOUTHERN DISTRICT

Appeal No. SD29799

90628

FILED AS IS

NOV - 4 2009

SANDRA L. SKINNER, Clerk
MISSOURI COURT OF APPEALS
SOUTHERN DISTRICT

EDITH C. DECK,

Plaintiff/Appellant,

vs.

DELMAR TEASLEY

Defendant/Respondent.

FILED

JAN 22 2010

Thomas F. Simon
CLERK, SUPREME COURT

Appeal from the Circuit Court of Greene County, Missouri
Hon. Michael J. Cordonnier, Circuit Judge
Case No. 31106CC4970

RESPONDENT'S BRIEF

ORAL ARGUMENT REQUESTED

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JURISDICTIONAL STATEMENT

The Court of Appeals has jurisdiction to hear this appeal as it relates to Points Relied On I, II and V. If this Honorable Court is unable to reach a decision and disposition of this case without deciding the constitutionality of section 490.715, then it must transfer this case to the Missouri Supreme Court.

The Missouri Supreme Court has exclusive jurisdiction of cases involving the constitutionality of a state law. Art. V § 3, Mo. Const. ***Jackson County Board of Election Commissioners v. Paluka***, 13 S.W.3d 684, 689 (Mo. W.D. 2000), (*citing, **State v. Ralls**, 1999 WL 382906 (Mo.App.1999)*, overturned on other grounds. This Honorable Court has no jurisdiction to decide the constitutionality of the statutory scheme. If it is necessary that the constitutionality of the statutes be adjudicated, then transfer of this case to the Missouri Supreme Court is appropriate.

STATEMENT OF FACTS

Introduction

In addition to the statement of facts in appellant's brief, respondent states supplemental facts.

Facts Relevant to Points I, II, III and IV

In the evidentiary hearing on respondent's motion to determine the value of medical treatment rendered, the Court heard testimony from St. John's Health System customer care supervisor Mr. Michael Bell, St. John's Physicians & Clinics reimbursement specialist Ms. Janie Mitchell, and healthcare consultant Mr. Gary Smith. (Tr. P. 3-55). Mr. Bell testified that he was the records custodian of medical billing for St. John's Health System and that the St. John's Health System medical bills pertaining to treatment, identified as defendant's Exhibit A, were complete and accurate. (Tr. P. 3 Line 22 – P. 6 Line 17; Appendix, Exhibit A). Ms. Mitchell testified that she was the records custodian of medical billing for St. John's Physicians & Clinics and that the St. John's Physicians & Clinics medical bills pertaining to treatment, identified as defendant's Exhibit B, were complete and accurate. (Tr. P. 19, Line 3 – P. 21 Line 17; Appendix, Exhibit B). The testimony of Mr. Bell and Ms. Mitchell established the amount actually paid for medical treatment rendered by Medicare, private insurance and appellant. (Tr. P. 5 Line 16 – P. 7 Line 11; P. 20 Line 20 – P. 22 Line 18). Mr. Bell and Ms. Mitchell testified that the balance due on all medical billing of St. John's Health System and St. John's Physicians & Clinics was $0.00. (Tr. P. 7, Line 12 – P. 8 Line 12; P. 22 Line 19 – P. 23 Line 12; P. 33 Lines 3-14). The testimony of Mr. Bell and Ms.

Mitchell was the foundation for admission into evidence of an itemized summary of payments by all entities and balance due on medical billing by all healthcare providers of appellant, identified as defendant's Exhibit C. (Tr. P. 11 Line 10 – P. 17 Line 13; P. 23 Line 13 – P. 27 Line 19; Appendix, Exhibit C). Mr. Bell and Ms. Mitchell testified that the medical bills of St. John's Health System and St. John's Physicians & Clinics were satisfied in full, and that appellant had no obligation to pay those healthcare providers or other entity. (Tr. P. 7 Line 12 – P. 8 Line 12; P. 33 Lines 3-14). Through the testimony of Mr. Bell and Ms. Mitchell, it was established that $9,904.28 was the amount actually paid for medical treatment rendered plaintiff, and that the balance due following payment was $0.00. (Tr. P. 27 Lines 17-19; Appendix, Exhibit C).

The testimony of Mr. Smith was presented by appellant, and on cross examination, he testified he had no knowledge of the medical treatment provided appellant and that he had no knowledge of the medical billing procedure of appellant's healthcare providers. (Tr. P. 53 Lines 7-19; P. 48 Line 3 – P. 49 Line 1). Mr. Smith testified he had no knowledge of actual payments made for medical treatment rendered appellant, no knowledge of actual payments made in relation to appellant's medical bills and no knowledge of any remaining financial obligations of appellant to any healthcare provider or entity. (Tr. P. 53 Line 7 – P. 54 Line 8; P. 48 Line 3 – P. 49 Line 8). Under questioning by the court, Mr. Smith testified that reimbursement payments by Medicare are in accordance with government regulation and rates, and that payment is made independent and regardless of the amount stated on the face of the medical bill. (Tr. P. 49 Line 11 – P. 50 Line 20). Mr. Smith also testified that contractual agreements

between private insurance companies and healthcare providers are often based on Medicare reimbursement rates and that the amount actually paid bears no relation to the amount stated on the medical bill. (Tr. P. 50 Line 21 – P. 51 Line 11).

Facts Relevant to Point V

The testimony of Dr. Thomas Kelso, M.D. was presented at trial by appellant. Dr. Kelso was the treating orthopedic surgeon who performed arthroscopic surgery to repair injury to appellant's right shoulder on March 15, 2005. (L.F. at 43, Kelso deposition P. 24 Lines 10-16). Dr. Kelso testified he diagnosed appellant's shoulder injury, that he performed the arthroscopic surgery to the shoulder, and that he provided post surgery examination and treatment. (L.F. at 41, Kelso deposition P. 14 Lines 5-12; L.F. at 43-47, Kelso deposition P. 24-37). Under cross examination, Dr. Kelso testified that four months following surgery, appellant was "nearly 100 percent improved". (L.F. at 44, Kelso deposition P. 28 Line 17 – P. 29 Line 9). Dr. Kelso further testified that on September 25, 2006, one year and six months following surgery, appellant appeared with a complaint of pain when sleeping on the shoulder, and lifting above her head. (L.F. at 45, Kelso deposition P. 31 Lines 4-12). Dr. Kelso testified that this visit resulted in a medical records entry that appellant stated litigation was pending and that appellant "would like to line this up". (L.F. at 45, Kelso deposition P. 31 Line 22 – P. 32 Line 13). Dr. Kelso testified that he ordered an MRI be performed on September 25, 2006, to determine whether a full thickness rotator cuff tear had developed after surgery, stating "if there was one there, then I would have had to take her back and operated on her

again." (L.F. at 47, Kelso deposition P. 38 Line 18 – P. 39 Line 12). Dr. Kelso testified there was no indication of a rotator cuff tear or other condition requiring additional surgery or medical treatment. (L.F. at 46, Kelso deposition P. 36 Lines 6-20; L.F. at 48, Kelso deposition P. 41 Lines 3-11).

Appellant presented testimony of Dr. Shane Bennoch. The testimony of Dr. Bennoch established that he examined appellant on one occasion, and that this examination occurred on November 21, 2007, two years and eight months after appellant had arthroscopic shoulder surgery. (Tr. P. 202 Lines 21-24; P. 242 Lines 18-20). The examination by Dr. Bennoch was for evaluation and testimony at trial. (Tr. P. 240 Lines 13-16). Dr. Bennoch testified that if a repeat MRI he was recommending showed further deterioration, he would refer appellant to a shoulder specialist, and that possible future surgery would be decided upon the evaluation and opinion of the referred specialist. (Tr. P. 228 Line 16 – P. 229 Line 3).

Dr. Bennoch testified in a subsequent offer of proof that he never consulted with Dr. Kelso or any other physician regarding appellant and that his testimony regarding future medical treatment was speculation. (Tr. P. 271 Line 7 – P. 272 Line 5).

The testimony of Dr. Kelso was that appellant underwent arthroscopic surgery to the right shoulder for shoulder impingement, shoulder acromioclavicular joint arthrosis, shoulder labral tear, type I SLAP lesion, and a partial thickness articular surface rotator cuff tear. (L.F. at 40, Kelso deposition P. 12 Lines 3-22; L.F. at 41, Kelso deposition P. 14 Lines 5-12). This arthroscopic surgical procedure included debridement of bone in the shoulder. (L.F. at 40, Kelso deposition P. 12 Lines 3-22). Dr. Bennoch testified that, in

his opinion, any possible future surgery would be arthroscopic debridement of the labrum and bone. (Tr. P. 229 Lines 13-24).

The amount representing the value of medical treatment rendered and admitted into evidence was $9,904.28. (Tr. P. 281 Lines 5-11; Appendix, Exhibit C). The $9,904.28 total included the cost of arthroscopic surgery performed by Dr. Kelso. (Tr. P. 281 Lines 5-11; Appendix, Exhibit C).

POINTS RELIED ON

I.

THE TRIAL COURT DID NOT ERR IN RULING THAT APPELLANT'S CLAIM FOR PAST MEDICAL EXPENSES WAS THE AMOUNT ACTUALLY PAID FOR THE MEDICAL TREATMENT RENDERED, BECAUSE APPELLANT FAILED TO REBUT THE PRESUMPTION IN RSMO. §490.715.5(1) THAT THE DOLLAR AMOUNT NECESSARY TO SATISFY THE FINANCIAL OBLIGATIONS TO HEALTHCARE PROVIDERS CONSTITUTES THE VALUE OF MEDICAL TREATMENT RENDERED, IN THAT APPELLANT PRESENTED INSUFFICIENT EVIDENCE THAT THE DOLLAR AMOUNT PAID TO SATISFY THE FINANCIAL OBLIGATION TO THE HEALTHCARE PROVIDERS WAS NOT THE VALUE OF THE MEDICAL TREATMENT RENDERED.

§490.715.5 RSMo.

***Nelson v. Waxman, M.D.**, 9 S.W.3d 601 (Mo. banc 2000)*

***State ex rel. Thompson-Stearns-Roger v. Schaffner**, 489 S.W.2d 207(Mo.App. S.D. 1973)*

***Weeks-Maxwell Construction Co. v. Belger Cartage Service, Inc.**, 409 S.W.2d 792 (Mo.App. W.D. 1996)*

II.

THE TRIAL COURT DID NOT ERR IN RULING THAT APPELLANT'S CLAIM FOR PAST MEDICAL EXPENSES WAS THE AMOUNT ACTUALLY PAID FOR MEDICAL TREATMENT RENDERED, BECAUSE THE TRIAL COURT PROPERLY APPLIED RSMO. §490.715.5, IN THAT THE TRIAL COURT ADMITTED AND CONSIDERED ALL EVIDENCE AS TO THE VALUE OF MEDICAL TREATMENT RENDERED IN ACCORDANCE WITH THE MANDATE OF RSMO. §490.715.5 (2).

§490.715.5 RSMo.

In re J.B., *58 S.W.3d 575 (Mo.App. E.D. 2001)*

Nelson v. Crane, *187 S.W.3d 868 (Mo. banc 2006)*

Rose v. Falcon Communications, Inc., *6 S.W.3d 429 (Mo.App. S.D. 1999)*

III.

THE TRIAL COURT DID NOT ERROR IN RULING THAT APPELLANT'S CLAIM FOR PAST MEDICAL EXPENSES WAS LIMITED TO THE AMOUNT ACTUALLY PAID FOR THE MEDICAL TREATMENT APPELLANT RECEIVED, BECAUSE R.S.M.O. §490.715 DOES NOT VIOLATE APPELLANT'S RIGHT TO A TRIAL BY JURY GUARANTEED IN ARTICLE I, SECTION 22(a) OF THE MISSOURI CONSTITUTION, IN THAT THE DETERMINATION OF THE VALUE OF MEDICAL TREATMENT RENDERED IS A PROPER FUNCTION OF THE TRIAL COURT.

The Propeller Monticello v. Mollison, *58 U.S. 152 (1854)*

Collier v. Roth, *434 S.W.2d 502, 506-07 (Mo.1968)*

Washington by Washington v. Barnes Hospital, *897 S.W.2d 611 (Mo. banc 1995)*

IV.

THE TRIAL COURT DID NOT ERROR IN RULING THAT APPELLANT'S CLAIM FOR PAST MEDICAL EXPENSES WAS LIMITED TO THE AMOUNT ACTUALLY PAID FOR THE MEDICAL TREATMENT APPELLANT RECEIVED, BECAUSE R.S.M.O. §490.715 IS NOT UNCONSTITUTIONAL AND COMPLIES WITH ARTICLE III, SECTION 23 OF THE MISSOURI CONSTITUTION, IN THAT HOUSE BILL 393 CONTAINS A SINGLE SUBJECT RELATED TO CLAIMS FOR DAMAGES WHICH IS CLEARLY EXPRESSED IN ITS TITLE.

***Hammerschmidt v. Boone County**, 877 S.W.2d 98, 102 (Mo. banc 1994)*

***Missouri State Medical Association v. Missouri Department of Health**,*

39 S.W.3d 837 (Mo. banc 2001)

***St. Louis Health Care Network v. State of Missouri**, 968 S.W.2d 145 (Mo. banc 1998)*

***State of Missouri v. Salter**, 250 S.W. 3d 705 (Mo. banc. 2008)*

V.

THE TRIAL COURT DID NOT ERR IN EXCLUDING EXPERT TESTIMONY PERTAINING TO APPELLANT'S POSSIBLE FUTURE MEDICAL CONDITION AND TREATMENT, BECAUSE SUCH EVIDENCE OF POSSIBLE FUTURE MEDICAL TREATMENT WAS ADMITTED TO THE TRIER OF FACT FOR EVALUATING THE NATURE AND EXTENT OF APPELLANT'S INJURIES, IN THAT SUCH EVIDENCE WAS PRESENTED BY APPELLANT THROUGH EXPERT WITNESS DR. SHANE BENNOCH.

***Bank of America NA v. Stevens**, 83 S.W.3d 47 (Mo.App. S.D. 2002)*

***Hahn v. McDowell**, 349 S.W.2d 479 (Mo.App. E.D. 1961)*

***Stephens v. Guffey**, 409 S.W.2d 62 (Mo. 1966)*

***Swartz v. Gale Webb Transportation Co.**, 215 S.W.2d 127(Mo. banc 2007)*

ARGUMENT

I.

THE TRIAL COURT DID NOT ERR IN RULING THAT APPELLANT'S CLAIM FOR PAST MEDICAL EXPENSES WAS THE AMOUNT ACTUALLY PAID FOR THE MEDICAL TREATMENT RENDERED, BECAUSE APPELLANT FAILED TO REBUT THE PRESUMPTION IN RSMO §490.715.5(1) THAT THE DOLLAR AMOUNT NECESSARY TO SATISFY THE FINANCIAL OBLIGATIONS TO HEALTHCARE PROVIDERS CONSTITUTES THE VALUE OF MEDICAL TREATMENT RENDERED, IN THAT APPELLANT PRESENTED INSUFFICIENT EVIDENCE THAT THE DOLLAR AMOUNT PAID TO SATISFY THE FINANCIAL OBLIGATION TO THE HEALTHCARE PROVIDERS WAS NOT THE VALUE OF THE MEDICAL TREATMENT RENDERED.

A. Standard of Review.

The standard of review is abuse of discretion. Abuse of discretion is established when the ruling of the trial court "is clearly against the logic of the circumstances then before the court and is so arbitrary and unreasonable as to shock the sense of justice and indicate a lack of careful consideration". ***Shirrell v. Missouri Edison Co.***, *535 S.W.2d 446, 448 (Mo. banc 1976);* ***State ex rel. Davis v. Shinn***, *874 S.W.2d 403, 408 (Mo.App. W.D. 1994).*

B. Argument.

Appellant contends that under RSMo. §490.715, the value of appellant's medical treatment was the total amount of billed medical expenses, and that the trial court erred in ruling that the value of appellant's medical treatment was the dollar amount necessary to satisfy the financial obligation to healthcare providers. Appellant maintains that by presenting evidence that the billed medical expenses were reasonable and necessary, appellant rebutted the statutory presumption that the dollar amount necessary to satisfy the obligation to the healthcare provider represents the value of the medical treatment rendered. Appellant's argument is a misreading and misapplication of the requirements of RSMo. §490.715.

In appellant's brief, only selected language from RSMo. §490.715 is referenced in argument. RSMo. §490.715.5 is the specific provision at issue and a proper analysis of the trial court decision requires that this section be considered in its entirety. RSMo. §490.715.5, including section title, states:

> **490.715 Damages paid by defendant prior to trial may be introduced but is waiver of credit against judgment (collateral source rule modified).**
>
> * * *
>
> 5. (1) Parties may introduce evidence of the value of the medical treatment rendered to a party that was reasonable, necessary, and a proximate result of the negligence of any party.
>
> (2) In determining the value of the medical treatment rendered, there shall be a rebuttable presumption that the dollar amount necessary to satisfy the financial obligation to the health care provider represents the value of the medical treatment rendered. Upon motion of any party, the court may

> determine, outside the hearing of the jury, the value of the medical treatment rendered based upon additional evidence, including but not limited to:
>
> (a) The medical bills incurred by a party;
>
> (b) The amount actually paid for medical treatment rendered to a party;
>
> (c) The amount or estimate of the amount of medical bills not paid which such party is obligated to pay to any entity in the event of a recovery.

The evidentiary standards in paragraph 5 align the collateral source rule with the law of damages. The well established law states that damages in tort should be compensatory only. ***Porter v. Toys'R'Us-Delaware, Inc.***, *152 S.W.3d 310, 319 (Mo.App. W.D. 2004) (citing* ***Washington v. Barnes Hospital,*** *897 S.W.2d 611, 619 (Mo. banc 1995).* The general rule of compensatory damages holds:

> a person who has sustained loss or injury may receive no more than just compensation for the loss or injury sustained. He is not entitled to be made more than whole, and he may not recover from all sources an amount in excess of the damages sustained . . . .

Weeks-Maxwell Construction Co. v. Belger Cartage Service, Inc., *409 S.W.2d 792, 796 (Mo.App. W.D. 1996).*

Prior to the enactment of RSMo. §490.715, the collateral source rule is an exception to this general rule. ***Kelley v. Kelly Residential Group, Inc.***, *945 S.W.2d 544, 551 (Mo.App. E.D. 1997).* Under the collateral source rule, damages are not reduced by proving that plaintiff has received or will receive compensation or indemnity from a collateral source independent of the tort feasor. ***Id,*** *at 552.* However, prior to the

enactment of RSMo. §490.715.5, a plaintiff could recover damages for medical expenses billed plaintiff, but satisfied by a collateral source for a compromised amount. The result was that plaintiff received a "windfall" in a damages award after presenting a medical expense claim to a jury that was not fully paid, and for which there was no obligation for full payment. It is well established that "a party should be fully compensated for its loss, but never recover a windfall". ***Ameristar Jet Charter, Inc. v. Dodson Intern'l Parts, Inc.***, *155 S.W.3d 50, 54 (Mo. banc 2005)*. The evidentiary standards established in RSMo. §490.715.5 prevent this recovery of a windfall, while maintaining the general principle of the collateral source rule. An analysis of these standards negates appellant's argument that the value of medical treatment rendered is established by the pre- RSMo. §490.715.5 "reasonable and necessary" testimony.

RSMo. §490.715.5 (1) affirms the common law requirement that medical treatment must be "reasonable, necessary, and a proximate result of any party". Sub-paragraph (1) does not state that value is established by evidence the treatment was simply reasonable and necessary. RSMo. §490.715.5 (2), ignored in appellant's brief, clearly states the evidentiary guidelines and procedure for determining the value of medical treatment that is reasonable and necessary. Sub-paragraph (2) first states:

> In determining the value of the medical treatment rendered, there shall be a rebuttable presumption that the dollar amount necessary to satisfy the financial obligation to the healthcare provider represents the value of the medical treatment rendered.

Sub-paragraph (2) then establishes the procedure for the determination of value.

The evidentiary guidelines for the court determination of value, subject to the rebuttable presumption, are then stated as follows:

> The court may determine . . . the value of the medical treatment rendered based upon additional evidence, including but not limited to:
>
> (a) The medical bills incurred by a party;
>
> (b) The amount actually paid for medical treatment rendered to a party;
>
> (c) The amount or estimate of the amount of medical bills not paid which such party is obligated to pay any entity in the event of a recovery.

Accordingly, RSMo. §490.715.5 establishes two requirements for the admission of evidence of medical treatment rendered. First, the medical treatment must be reasonable, necessary and proximately caused. Second, the value of the medical treatment must be determined subject to the stated rebuttable presumption of value. A full review of the evidence before the trial court clearly establishes that appellant failed to rebut the presumption of value.

Respondent presented all medical bills of appellant, authenticated as accurate and complete by the records custodians for medical billing of the healthcare providers. (Tr. P. 3 Line 22 - P. 6, Line 17; P. 19 Line 3 – P. 21 Line 17; Appendix, Exhibits A and B.) Respondent then presented evidence, through the testimony of the aforementioned records custodians for medical billing, Chris Bell of St. John's Health System and Janie Mitchell of St. John's Physicians and Clinics, as to amounts actually paid for medical treatment, and amounts not paid for which payment obligations remained. (Tr. P. 3-8; P. 19-28). The testimony of each records custodian established all amounts actually paid,

and appellant had no obligation to pay any entity in the event of recovery. (Tr. P. 5 Line 16 – P. 7 Line 11; P. 20 Line 20 – P. 22 Line 18). The testimony of each records custodian established the foundation for admission into evidence of a complete itemization of appellant's medical expenses, with designations of amounts charged, payments by Medicare and private insurance, adjustments by Medicare and private insurance, and amounts paid specifically by appellant. (Tr. P. 11 Line 10 – P. 17 Line 13; P. 23 Line 13 – P. 27 Line 19; Appendix, Exhibit C). Through the testimony of Mr. Bell and Ms. Mitchell, it was established that $9,904.28 was the amount actually paid for medical treatment rendered plaintiff, and that the balance due following payment was $0.00. (Tr. P. 27 Lines 17-19; Appendix, Exhibit C). Furthermore, each records custodian testified that there were no outstanding medical bills for which appellant would be obligated to pay in the event of a recovery. (Tr. P. 7 Line 12 – P. 8 Line 12; P. 33 Lines 3-14).

The only evidence of value offered by appellant was the testimony of healthcare consultant, and former hospital administrator, Gary Smith. (Tr. P. 39-55). As noted in appellant's brief, Mr. Smith basically testified that, in his opinion, the face value of a medical bill is a better indicator of value than the amount paid under government regulations and contractual agreements. (Tr. P. 47 Lines 4-23). Mr. Smith also testified that the charges stated in the medical bills were "fair and reasonable", in his opinion. (Tr. P. 52 Line 7-24). Mr. Smith testified he had no specific knowledge of the treatment, billing, payment or remaining payment obligations relating to appellant or the healthcare providers. (Tr. P. 48, Line 3 – P. 49 Line 8; P. 53 Line 8 – P. 54 Line 8). Mr. Smith also

acknowledged, under questioning by the court, that reimbursement by Medicare would be by a mandated government rate, and that this is regardless of the amount stated on the face of the medical bill. (Tr. P. 49 Line 11 – P. 50 Line 20). Additionally, Mr. Smith testified that contractual agreements for payment with private insurance companies are often based on Medicare reimbursement rates, and that the amount paid bears no relation to the amount stated on the medical bill. (Tr. P. 50 Line 21 – P. 51 Line 11).

The argument by appellant that the presumption of value was rebutted represents a severe misreading and misapplication of RSMo. §490.715.5. At best, appellant presented evidence establishing that the medical treatment was necessary and reasonable, meeting the requirement of sub-paragraph (1). However, appellant presented frivolous evidence of value under the requirements of sub-paragraph (2). The evidence before the trial court conclusively established that the amount actually paid for medical treatment rendered appellant was $9,904.28. The evidence further established that appellant had no obligation to pay or reimburse any entity for medical expenses in the event of recovery. Appellant presented no evidence of additional payment, obligations, or other evidence necessary to rebut the presumption established in sub-paragraph (2). The trial court properly determined the value of medical treatment rendered under RSMo. §490.715.

Even if appellant's strained argument is accepted that the presumption of value was rebutted, the trial court determination of value was not abuse of discretion. Again, RSMo. §490.715.5 (2) not only establishes the standard of a rebuttable presumption, it designates a procedure and evidentiary requirements for trial court determination of value. Sub-paragraph (2) specifically states that the court may determine value, and the

evidence the court must consider includes the medical bills, the amount actually paid for medical treatment rendered, and the amount of medical bills not paid which a party is obligated to pay any entity in the event of a recovery. The uncontroverted evidence before the trial court was that the total amount paid for medical treatment rendered was $9,904.28, and that appellant had no obligation to any entity for medical bills not paid. Appellant's evidence of reasonable and necessary medical treatment meets the threshold requirement for admission stated in sub-paragraph (1), but is of minimal significance to a determination of value under sub-paragraph (2). Under the clear standards of sub-paragraph (2), the evidence is overwhelming in support of the trial court determination that the value of medical treatment rendered was $9,904.28. This result is consistent with the only Missouri appellate decision, to date, to address the mandate of RSMo. §490.715.5.

On October 27, 2009, the Missouri Court of Appeals Eastern District handed down its opinion in ***Berra v. Danter***, *No. E.D. 92279,* addressing RSMo. §490.715.5. In ***Berra***, the court held that the trial court properly "considered the amount reflected in plaintiff's billing statements in determining the reasonable value of plaintiff's medical treatment". ***Id*** emphasis added. The court further held "the presumption of value can be rebutted by substantial evidence establishing a different value" and that this additional evidence "includes, but is not limited to, the medical bills incurred by a party". ***Id*** emphasis added. The ***Berra*** court rejected the appellant/defendant's argument that medical bills "incurred" means medical bills actually paid, noting this is not the definition of "incur". This is not the argument or position of respondent in the case at bar.

In ***Berra,*** the court specifically holds that a trial court is not limited in the evidence it considers to determinate value. The ***Berra*** court holds that the presumption is rebutted by "substantial evidence" establishing a different value. The ***Berra*** court does not hold that "reasonable and necessary" testimony rebuts the presumption as a general rule. In the case at bar, appellant's "reasonable and necessary" testimony is not substantial in the totality of evidence considered by the trial court. The holding in ***Berra*** is entirely consistent with the decision of the trial court in the case at bar.

"The admissibility of evidence lies within the sound discretion of the trial court and will not be disturbed absent abuse of discretion." ***Nelson v. Waxman, M.D.***, *9 S.W.3d 601, 603, 604 (Mo. banc 2000) citing* ***Kansas City v. Keene Corp.***, *855 S.W.2d 360, 367 (Mo. banc 1993).* "The trial court abuses its discretion when its ruling is clearly against the logic of the circumstances then before the trial court and is so unreasonable and arbitrary that the ruling shocks the sense of justice and indicates a lack of careful deliberate consideration." ***Id,*** *at 604, quoting* ***Oldaker v. Peters,*** *817 S.W.2d 245, 250 (Mo. banc 1991).* "If reasonable persons can differ about the propriety of the action taken by the trial court, then it cannot be said that the trial court abused its discretion." ***Williams v. Trans States Airlines, Inc.***, *281 S.W.3d 854, 872 (Mo.App. E.D. 2009), quoting* ***Sheerar v. Zipper,*** *98 S.W.3d 628, 632 (Mo.App. W.D. 2003).* Deference to the trial court "is not limited to the issue of credibility of witnesses, but also includes the conclusions of the trial court". ***H.S. v. Board of Regents, Southeast Missouri State University,*** *967 S.W.2d 665, 671 (Mo.App. E.D. 1998), citing* ***Kitchens v. Missouri Pacific Railroad Co.,*** *737 S.W.2d 219, 222 (Mo.App. W.D. 1987).*

The trial court determination of the value of medical treatment rendered is firmly within the boundaries of discretion. This determination of value meets the purpose and requirements of RSMo. §490.715 and is consistent with well established law that damages be compensatory. The value established by the trial court prevents any windfall to plaintiff in the awarding of damages. By contrast, appellant's argument that reasonable and necessary evidence rebuts the statutory presumption and establishes value of medical treatment rendered would result in appellant obtaining a damages windfall, and negate the legislative intent to make the collateral source rule consistent with the law of compensatory damages. Under appellant's argument, RSMo. §490.715.5 would have no effect, and be rendered meaningless. "The legislature will not be charged with having done a meaningless act." ***State ex rel. Thompson-Stearns-Roger v. Schaffner***, *489 S.W.2d 207, 212 (Mo.App. S.D. 1973).*

Appellant's argument is a severe misreading and misapplication of RSMo. §490.715, and must fail.

II.

THE TRIAL COURT DID NOT ERR IN RULING THAT APPELLANT'S CLAIM FOR PAST MEDICAL EXPENSES WAS THE AMOUNT ACTUALLY PAID FOR MEDICAL TREATMENT RENDERED, BECAUSE THE TRIAL COURT PROPERLY APPLIED RSMO. §490.715.5, IN THAT THE TRIAL COURT ADMITTED AND CONSIDERED ALL EVIDENCE AS TO THE VALUE OF MEDICAL TREATMENT RENDERED IN ACCORDANCE WITH THE MANDATE OF RSMO. §490.715.5 (2).

A. Standard of Review

The standard of review for statutory construction is a question of law, with the review de novo. ***Nelson v. Crane,*** *187 S.W.3d 868, 869 (Mo. banc 2006).*

B. Argument

Appellant asserts that the trial court "misinterpreted" RSMo. §490.715 as creating an "irrebutable presumption that the reasonable value of medical treatment is the amount paid for said treatment", and that RSMo. §490.715 was "misapplied" as a result. The misapplication and misinterpretation is by appellant, and not the trial court. The application of the statute by the trial court was proper and appellant misinterprets the analysis of the evidence, and the rationale of the trial court in determining the value of medical treatment rendered.

In appellant's brief, the conclusory assertion is made that the court refused to consider the amount of the medical bills incurred. Appellant argues the trial court "ruled" that "we cannot turn over to the healthcare providers the ability to govern the

estimate of what a plaintiff's damages are", and that this establishes failure by the trial court to consider all the evidence. However, this isolated sentence quoted by appellant is not the full ruling of the trial court. A proper analysis of the decision and rationale of the trial court requires that the full text of the bench ruling be reviewed in relation to the requirements of RSMo. §490.715.5. The laws of statutory construction will establish that the complete ruling of the trial court was a proper interpretation and application of the statute.

As noted earlier in this brief, paragraph 5 of RSMo. §490.715 is the determinative provision at issue. Appellant relies solely on sub-paragraph (2)(a) in arguing that the trial court refused to consider evidence of the medical bills incurred. The isolation of this one sub-paragraph from the complete text of the statute is misleading. As this court noted in ***Hillyard v. Hunter Oil Co.,*** *978 S.W.2d 75, 79 (Mo.App. S.D. 1998),* "[i]t is fundamental that a section of a statute should not be read in isolation from the context of the whole act." ***Id,*** *at 79, quoting* ***State v. Haskins,*** *950 S.W.2d 613, 615 (Mo.App. S.D. 1997).* Accordingly, RSMo. §490.715.5, in its entirety, states:

> **490.715 Damages paid by defendant prior to trial may be introduced but is waiver of credit against judgment (collateral source rule modified).**
>
> * * *
>
> 5. (1) Parties may introduce evidence of the value of the medical treatment rendered to a party that was reasonable, necessary, and a proximate result of the negligence of any party.
>
> (2) In determining the value of the medical treatment rendered, there shall be a rebuttable presumption that the dollar amount necessary to satisfy the financial obligation to the health care

> provider represents the value of the medical treatment rendered. Upon motion of any party, the court may determine, outside the hearing of the jury, the value of the medical treatment rendered based upon additional evidence, including but not limited to:
>
> (a) The medical bills incurred by a party;
>
> (b) The amount actually paid for medical treatment rendered to a party;
>
> (c) The amount or estimate of the amount of medical bills not paid which such party is obligated to pay to any entity in the event of a recovery.

It is well established that "the primary rule in statutory construction is to ascertain the intent of the legislature from the language used, to give effect to that intent if possible, and to consider the words in their plain and ordinary meaning". ***Nelson v. Crane,*** *187 S.W.3d 868, 869 (Mo. banc 2006);* ***State ex rel. Riordan v. Dierker,*** *956 S.W.2d 258, 260 (Mo. banc 1997).* "Appellate courts must give effect to statutes as they are written." ***Rose v. Falcon Communications, Inc.,*** *6 S.W.3d 429, 431 (Mo.App. S.D. 1999), citing* ***McDermott v. Carnahan,*** *934 S.W.2d 285, 287 (Mo. banc 1996).* "When a court considers the meaning of legislation, it must not be guided by a single sentence but should look to the provisions of the whole law and its object and policy." ***Rose v. Falcon Communications, Inc.,*** *6 S.W.3d 429, 431 (Mo.App. S.D. 1999), citing* ***Williams v. Mo. Dep't of Soc. Serv.,*** *978 S.W.2d 491, 494 (Mo.App. S.D. 1998).*

The intent of the legislature is clear in RSMo. §490.715.5. Paragraph 5 establishes the requirements and procedure for admitting evidence of the value of medical treatment under the collateral source rule. Sub-paragraph (1) states that parties may introduce

"evidence of the value of medical treatment rendered" with the requirement that the medical treatment "was reasonable, necessary, and a proximate result of the negligence . . . ." Sub-paragraph (1) does not state that evidence of reasonable and necessary medical treatment establishes value.

Sub-paragraph (2), states the basis for determining value, as follows:

> In determining the value of the medical treatment rendered, there shall be a rebuttable presumption that the dollar amount necessary to satisfy the financial obligation to the health care provider represents the value of the medical treatment rendered.

Sub-paragraph (2) then states that the determination of value may be made by the court, outside the hearing of the jury, and establishes evidentiary guidelines for this determination, stating:

> The court may determine . . . the value of the medical treatment rendered based upon additional evidence, including but not limited to:
>
> (a) The medical bills incurred by a party;
>
> (b) The amount actually paid for medical treatment rendered to a party;
>
> (c) The amount or estimate of the amount of medical bills not paid which such party is obligated to pay to any entity in the event of a recovery.

The language of RSMo. §490.715.5 clearly establishes an intent to correlate value of medical treatment rendered to satisfaction of the financial obligations to healthcare providers. The statute does not limit evidence of value, but it is specifically stated the trial court must consider the amount actually paid for medical treatment, and the amount of medical bills not paid which must be paid in the event of recovery, in addition to the

billed medical expense. This intent that value represents satisfaction of financial obligations is consistent with the modification of the collateral source rule, as stated in the statute title. Furthermore, it is consistent with the law of damages, which holds:

> As a general rule, a person who has sustained loss or injury may receive no more than just compensation for the loss or injury sustained. He is not entitled to be made more than whole, and he may not recover from all sources an amount in excess of the damages sustained, or be put in a better condition than he would have been had the wrong not been committed.

Weeks-Maxwell Construction Co. v. Belger Cartage Service, Inc., *409 S.W.2d 792, 796 (Mo.App. W.D. 1996).*

The evidence before the trial court establishes proper interpretation and application of RSMo. §490.715.5 by the trial court. All billing by appellant's healthcare providers was authenticated as accurate and complete. (Tr. P. 3 Line 22 – P. 6 Line 17; P. 19 Line 3 – P. 21 Line 17; Appendix, Exhibits A and B). The uncontroverted evidence established the amount actually paid for medical treatment rendered totaled $9,904.28 and that the balance due following payment was $0.00. (Tr. P. 27 Lines 17-19; Appendix, Exhibit C). The uncontroverted testimony of the record custodians was that there were no medical bills not paid for which appellant would be obligated to pay, in the event of recovery. (Tr. P. 7 Line 12 – P. 8 Line 12; P. 33 Lines 3-14). Appellant offered no evidence contesting the $9,904.28 actual payment, or that any financial obligations to healthcare providers had not been satisfied. Appellant offered no evidence of medical bills not paid for which there would be an obligation to pay, in the event of a recovery. Instead, appellant offered opinion evidence from a healthcare consultant and a hired consulting physician that the amount stated on a medical bill is a better indicator of value

than the amount paid, or obligations remaining. (Tr. P. 47 Lines 4-23; P). Appellant further offered through retained witnesses the opinion that the medical bills were "fair and reasonable". (Tr. P. 52 Line 7-24; P. 260 Line 22 – P. 261 Line 9). In response to questioning by the court, the healthcare consultant presented by appellant, Gary Smith, acknowledged that payment by Medicare to a healthcare provider bears no relation to the amount billed the patient by that provider. (Tr. P. 49, Line 11 – P. 50 Line 20).

As previously noted, appellant extracted a portion of one sentence from the trial court order, and states this to be the "ruling" of the trial court. The full text of the decision by the trial court establishes otherwise. The court held:

> This court would find that the presumption has not been rebutted and that the value of the medical expenses, the medical – well, the medical expense would be that as set forth in subpart 5(b) of the statute, that is the amount actually paid for the medical treatment rendered to the party coupled with that set forth in parts 5(c) of the statute, and that is the amount or an estimate of the amount of medical bills not paid but for which the party is obligated to pay in the event of a recovery.
>
> My thinking on that is more than I will say at this time but it is generally that the amount actually charged by a health care provider is arbitrary in our society. And as Mr. Smith pointed out, it matters not what the doctors charge to a Medicaid – or Medicare patient. They are going to recover an X amount of dollars. It doesn't matter.
>
> So we may have ourselves in a position where some providers actually charge more if only to dramatize the difference between what their value is or what they would like to think their value is and what they are actually getting paid. It is this Court's opinion that we cannot turn over to the health care providers the ability to govern the estimate of what a Plaintiff's damages are.
>
> So my view is, to give effect to this statute where it says value, we must give effect in how it affects the Plaintiff in their actual damages.

> It is my desire for the Plaintiff to be afforded the benefit of the tort legal system, and that is to be compensated in full for her damages. It is not my desire for the plaintiff to experience a windfall, and were this Court to allow damages in excess of the amount Medicare paid and an amount well in excess of what the Plaintiff is obligated to repay would be to provide her that windfall.

(Tr. P. 59 Line 10 – P. 60 Line 25).

The trial court specifically stated in its ruling that appellant's evidence failed to rebut the presumption, and that value is based on the actual amount paid for medical treatment, and any amount of medical bills not paid for which an obligation of payment remains. The trial court stated "[t]he amount actually charged by a healthcare provider is arbitrary in our society" and noted that appellant's healthcare consultant, Mr. Smith, acknowledged the amount paid by Medicare bears no relation to the amount on the medical bill. The trial court then stated the arbitrary billing practices of healthcare providers cannot be the basis for determining the estimate of damages, and that "to give effect to this statute where it says value" the actual damages must be the basis of value. Accordingly, the full text of the trial court ruling establishes that the trial court did not refuse to consider the evidence offered by appellant. As the review of the evidence and ruling of the trial court establish, the evidence offered by appellant was insufficient to establish value under the mandate of RSMo. §490.715.5.

Appellant's interpretation of the statute would result in an application of RSMo. §490.715 that is totally contrary to the intent of the legislature. Appellant maintains that evidence the medical bills are "reasonable and necessary" rebuts the statutory presumption, and establishes value of medical treatment rendered. This standard is

nothing more than the same standard that existed prior to the enactment of RSMo. §490.715. This is illogical. Appellant's interpretation refuses to acknowledge evidence of the satisfaction of financial obligations, and would result in an absurd misapplication of this statute and a windfall to plaintiffs. If appellant's position is accepted, the practical result would be that RSMo. §490.715(2) establishes a rebuttable presumption that value is the dollar amount necessary to satisfy the financial obligation to healthcare providers, with RSMo. §490.715.5(2)(a) allowing appellant to rebut the presumption and establish value by introducing the billed amount of medical expenses. This would be an absurd application resulting in a waste of the trial courts time, and would be in complete contradiction of the intent of the legislature. Appellant would recover amounts never paid, obtain a windfall, and RSMo. §490.715 would be rendered meaningless. "A party should be fully compensated for its loss, but never receive a windfall." ***Ameristar Jet Charter, Inc. v. Dodson Intern'l Parts, Inc.***, *155 S.W.3d 50, 54 (Mo. banc 2005).* "It is presumed that the legislature does not intend to enact absurd laws." ***Kansas City Star Co. v. Fulson***, *859 S.W.2d 934, 938 (Mo. App. W.D. 1993);* ***David Ranken, Jr. Tech. Inst. v. Boykins***, *816 S.W.2d 189, 192 (Mo. banc 1991).* As the court stated in ***In re J.B.,*** *58 S.W.3d 575 (Mo.App. E.D. 2001),* "[w]e will not construe a statute so as to work an unreasonable, oppressive or absurd result. (citation omitted). We construe the provisions of a legislative act together and if reasonably possible, all provisions must be harmonized." ***Id*** *at 578.* "The legislature will not be charged with having done a meaningless act." ***State ex rel. Thompson-Stearns-Roger v. Schaffner***, *489 S.W.2d 207, 212 (Mo. 1973).*

As noted under Point I, the Missouri Court of Appeals Eastern District handed down its opinion in ***Berra v. Danter***, *No. E.D. 92279*, on October 27, 2009. In ***Berra***, the appellant/ defendant argued that medical bills "incurred" is defined as medical bills actually paid. The court rejected this argument, holding:

> Defendant's interpretation of 'incurred' in sub-section (a) of Section 490.715.2 (sic) as the amount 'paid' is not only inconsistent with the prior definition given to 'incurred' by our courts, but also this interpretation would make sub-section (b) of §490.715.2 (sic) which specifically allows evidence of the amount actually paid for medical treatment, superfluous.

The rejected "incur" argument in ***Berra*** is analogous to the "reasonable and necessary" argument of appellant in the case at bar. In both instances, RSMo. §490.715.5 is subjected to an absurd result, and the statute is rendered meaningless. As stated under Point I, the ***Berra*** opinion holds that a trial court is not limited in the evidence it considers to determine value, and that the presumption of value is rebutted by "substantial evidence" establishing a different value. This is precisely the standard applied by the trial court in the case at bar. As the ruling of the trial court establishes, the totality of the evidence was considered under the mandate of RSMo. §490.715.5, and appellant failed to present sufficient evidence of value.

The interpretation of RSMo. §490.715.5 by the trial court was correct, and the application of the statue was proper. The trial court determined the value of medical treatment rendered in accordance with the procedure and requirements of RSMo. §490.715.5. The trial court determined value based upon the evidentiary rules stated in §490.715.5(2). The ruling of the trial court was consistent with the legislative intent to preserve the collateral source rule and admit evidence of value consistent with the general

law of compensatory damages, and prevent recovery for damage not sustained. As this court stated in ***Hillyard v. Hunter Oil Co.***, *978 S.W.2d 75 (Mo.App. S.D. 1998)*:

> When interpreting legislation, 'a proper analysis . . . considers the context in which the words are used and, importantly, the problem the legislature sought to address with the statute's enactment.

Id, at 79, quoting ***Mabin Const. Co., Inc. v. Historic Constructors, Inc.,*** *851 S.W.2d 98, 100 (Mo.App. 1993).*

This court also has held:

> In construing a statute, a court must endeavor to suppress the mischief sought to be cured thereby, repress subtle inventions and evasions for the continuance of that mischief, and advance the remedy intended by the legislature.

Rose v. Falcon Communications, *6 S.W.3d 429, 431 (Mo.App. S.D. 1999).* The interpretation and application of RSMo. §490.715 by the trial court properly addresses the problem the legislature sought to address with the statute's enactment. Appellant's argument is a subtle invention and evasion for the continuance of that mischief.

Finally, appellant argues that the trial court interpretation and application of RSMo. §490.715 violates respondent's constitutional rights of due process. Appellant maintains the trial court denied appellant a fair opportunity to rebut the presumption, stating that the evidentiary hearing was "stacked to a predetermined conclusion before it began". This argument also fails.

Appellant bases the allegations of due process violation on the premise that the trial court interpretation and application of the statute established an "irrebuttable presumption" under RSMo. §490.715.5 (2). As established by the laws of statutory

construction, and the full analysis of the evidence before the trial court, appellant's allegations of "irrebuttable" presumption and "stacked" hearing procedure is without merit. Appellant was afforded a full and fair opportunity to present evidence of the value of medical treatment rendered under the standards of RSMo. §490.715.5 (2). The record on appeal clearly establishes that the trial court did not reject, or refuse to consider, the evidence offered by appellant. As extensively outlined above, the attempt by appellant to isolate one sentence in the statute, and one sentence from the narrative ruling of the trial court is inadequate to establish misinterpretation and misapplication of the statute. This argument also fails to establish the violation of constitutional rights of due process.

The full and complete text of the statute and the full and complete review of the evidence, establish a proper interpretation and application of RSMo. §490.715 by the trial court. The decision of the trial court must be affirmed.

III.

THE TRIAL COURT DID NOT ERROR IN RULING THAT APPELLANT'S CLAIM FOR PAST MEDICAL EXPENSES WAS LIMITED TO THE AMOUNT ACTUALLY PAID FOR THE MEDICAL TREATMENT APPELLANT RECEIVED, BECAUSE R.S.M.O. §490.715 DOES NOT VIOLATE APPELLANT'S RIGHT TO A TRIAL BY JURY GUARANTEED IN ARTICLE I, SECTION 22(a) OF THE MISSOURI CONSTITUTION, IN THAT THE DETERMINATION OF THE VALUE OF MEDICAL TREATMENT RENDERED IS A PROPER FUNCTION OF THE TRIAL COURT.

A. **Standard of Review.**

The standard of review for a constitutional challenge to a statute is *de novo.* ***City of Arnold v. Tourkakis****, 249 S.W.3d 202, 204 (Mo. banc 2008).* The trial court in this matter did not address the constitutionality of section 490.715, but found that plaintiff/appellant failed to rebut the presumption "that the value of medical expenses...would be that as set forth in subpart 5(b) of the statute, that is, the amount actually paid for the medical treatment rendered to the party coupled with that set forth in parts 5(c) of the statute, and that is the amount or an estimate of the amount of medical bills not paid but for which the party is obligated to pay in the event of a recovery." (Tr. 59:10-20).

A statute is presumed to be constitutional and will not be held to be unconstitutional unless it clearly and undoubtedly contravenes the constitution. A statute will be enforced by the courts unless it plainly and palpably affronts fundamental law

embodied in the constitution. ***Blaske v. Smith & Entzeroth, Inc.***, *821 S.W.2d 822, 828 (Mo. banc 1991), citing* ***Winston v. Reorganized School District R-2, Lawrence County,*** *636 S.W.2d 324, 327 (Mo. banc 1982).* When the constitutionality of a statute is attacked, the burden of proof is upon the party claiming that the statute is unconstitutional. ***Blaske,*** *821 S.W.2d at 828-29, citing* ***Schnorbus v. Director of Revenue,*** *790 S.W.2d 241, 243 (Mo. banc 1990).*

B. Argument

1. Introduction.

In 2005, as a response to the perceived crisis involving tort litigation, the Missouri legislature passed and the governor approved House Bill 393 which provided major changes to claims for damages in Missouri. Among those changes included an addition to the statute which previously set out a modified version of the common law doctrine of the collateral source rule. The treatment of the collateral source rule has consistently been a rule of evidence and has traditionally been used to prevent certain facts from reaching the jury.

Historically, the collateral source rule has operated to prohibit defendants from submitting evidence and facts to juries regarding payment from collateral source that operates to redress a plaintiff's damages. The common law collateral source rule has developed amid the policy that a tortfeasor should not have the damages to which he is liable reduced by proving that plaintiff has received or will receive compensation or indemnity for the loss from a collateral source, wholly independent of the tortfeasor.

At the same time, it has consistently been stated that the damages associated with the conduct of the tortfeasor are meant to compensate the injured person only for those damages that he has actually sustained. It begs the question then: *how is the law to reconcile these two competing policies that are clearly at odds with one another*? If the law prohibits the trial court from considering the actual amount of the medical damages as it relates to the actual amount that plaintiff has paid or will be responsible to pay, then is it necessary to restate the policy that holds damages in tort are meant to be compensatory?

The Missouri legislature modified the common law treatment to the collateral source rule in 1987. But those changes did not fundamentally change the application of the collateral source rule as it was used at common law.

In 2005, the Missouri Legislature again modified the application of the common law collateral source rule; but still have not fundamentally changed the application of the rule vis-à-vis a jury trials. Moreover, those legislative changes to the modified collateral source rule (Rev. Mo. Stat. §490.715) do not violate Article I, §22(a) of the Missouri Constitution, just as the application of the collateral source rule both at common law and in relation to Rev. Mo. Stat. 490.715 did not violate Article I, §22(a) of the Missouri Constitution prior to the passage of House Bill 393.

The common law application of the collateral source rule, as it was applied in Missouri remains intact as it existed prior to the passage of House Bill 393. Before, 2005, defendants were prevented from submitting evidence to the jury of any collateral source unless such evidence comported with Rev. Mo. Stat. §490.715. That is, a

defendant could introduce evidence that some other person other than plaintiff had paid certain amounts of plaintiff's special damages. The defendant took a chance in introducing such evidence that such payments would not act as a credit against any judgment entered pursuant to Rev. Mo. Stat. § 490.710.

The addition in 2005 of Rev. Mo. Stat. §490.715.5 provides the trial court with the ability to determine the value of the medical treatment actually provided and leaves intact the rule that a wrongdoer is not entitled to have the damages to which he is liable reduced by providing evidence to the jury that plaintiff has received or will receive compensation or indemnity for the loss from a collateral source. The plaintiff will continue to present evidence of damages, but she will be prevented from submitting evidence that is inconsistent with the actual damages sustained by her. A defendant will still be precluded from informing the jury that the plaintiff received a benefit from a collateral source.

Appellant simply ignored this important weighing of interests; plaintiff receiving a windfall and exclusion of collateral sources. The following case law and development of the collateral source rule clearly support Missouri legislative actions and the trial court's decision.

2. **The Development of the Collateral Source Rule.**

The collateral source rule, since its first use in the United States in ***The Propeller Monticello v. Mollison***, *58 U.S. 152 (1854)*, has been used as an evidentiary rule that prohibits certain facts from reaching the jury. In ***Monticello***, the Supreme Court of the United States considered a collision on Lake Huron between the Monticello and a

schooner owned by Mollison. ***Id,*** *at 153.* As part of its Answer, Monticello asserted that the schooner and is cargo had been insured, and, because the insurance had been paid to the libellant (complainant in an Admiralty case), then such payment operated as an abandonment of the claim. ***Id,*** *at 154.* The Court acknowledged at common law a "wrongdoer cannot be allowed to set up as a defense the equities between the insurer and insured....[H]e is bound to make satisfaction for the injury he has done." ***Id,*** *at 155.*

In Missouri, the collateral source rule has been an exception to the general rule that damages in tort should be compensatory only. ***Overton v. United States,*** *619 F.2d 1299, 1306 (8th Cir.1980).* Historically, Missouri courts have stated the collateral source rule as providing that

> a wrongdoer is not entitled to have the damages to which he is liable reduced by proving that plaintiff has received or will receive compensation or indemnity for the loss from a collateral source, wholly independent of him, or, stated more succinctly, the wrongdoer may not be benefited by collateral payments made to the person he has wronged.

Collier v. Roth, *434 S.W.2d 502, 506-07 (Mo.1968)*

The first use of the common law collateral source rule in Missouri was in ***Burens v. Wolfe Wear-U-Well Corp.,*** *158 S.W.2d 175 (Mo. App. 1942).* In that case, plaintiff obtained a judgment in the amount of $800.00 in actual damages and $200.00 in punitive damages finding defendant/appellant had wrongfully refused to issue plaintiff a service letter in violation of Missouri law. ***Id,*** *at 176.*

Defendant appealed the verdict for actual damages of $800.00 alleging it was excessive because it was more than plaintiff's wages would have amounted to during his period of unemployment, after deducting $100 which he earned in that period and the

amount of unemployment compensation which he had received. Plaintiff responded that since the amount of unemployment compensation was neither shown nor considered by the jury, any alleged excessiveness of the verdict was not capable of ascertainment and the matter could not be cured by a remittitur. ***Id,*** *at 178.*

In stating what amounts to the collateral source rule, the Court held that Defendant was not entitled to the benefit of any mitigation because there was no plea to that effect. ***Id.*** But, the court went on to note:

> it would not have been proper for defendant to plead and prove unemployment compensation received by plaintiff, [because] [s]uch compensation is not a proper subject of mitigation. [Unemployment compensation] is a grant allowed according to a beneficent economic policy of the state, designed to alleviate adversity and promote the public welfare. It is not earned income of a recipient during a period of unemployment to be used in mitigation of a wrong responsible for the loss of employment. A wrongdoer cannot diminish his liability to the extent of such contributions, nor will he be permitted to benefit by payments made to the injured person from collateral sources, whether in compensation or as gratuities.

Id, *at 178-179,* citing 8 Ruling Case Law, sec. 105, pages 554, 555; 25 C.J.S., Damages, § 99, page 648.

In ***Washington by Washington v. Barnes Hospital,*** *897 S.W.2d 611 (Mo. banc 1995)*, the Missouri Supreme Court was presented with the issue of whether the collateral source rule precluded a defendant from introducing mitigation evidence regarding the availability of free public special education. The Missouri Supreme Court remanded the case for a new trial on the issue of damages holding that defendant should have been permitted to introduce mitigation evidence of free educational services and therapies available through the public special education program. ***Id,*** *at 612.*

In ***Washington by Washington***, Valerie Washington was approximately 32 weeks pregnant with twins on January 30, 1987. After delivery, it was discovered that one of the twin boys had experienced a complete placental abruption sometime prior to birth, depriving him of oxygen. ***Id,*** *at 612-613.* The Washingtons brought a medical malpractice action against Barnes Hospital.

During a pretrial conference plaintiffs made a verbal motion *in limine* concerning evidence defendants might introduce as to the availability of free education and therapies through the public special education system. ***Id,*** *at 613.* Plaintiffs based the objection upon the collateral source rule. ***Id.***

Defendants' argued that the collateral source rule did not apply, both because plaintiffs had not prepaid for such services, as with insurance, and because special education is available to the public at large without consideration of financial need. ***Id.*** The trial court sustained plaintiffs' motion. ***Id.***

At trial, Plaintiffs called Alan Spector as an expert to testify regarding the child's future needs for special education and therapy. ***Id.*** Mr. Spector testified that, in order to be cared for at home, the child would need: physical therapy, occupational therapy, and speech and language therapy twice weekly; special education at a private school; weekly visits from a nurse; a lifetime supply of diapers, bedliners and bibs; a personal attendant eight hours a day on school days and twelve hours a day on weekends and holidays; someone to provide counseling and support for Ms. Washington; a case manager until age 21; remodeling of a home, including a heated garage and special fire doors; a van

with a wheelchair lift; and a computer. Mr. Spector also testified as to the child's needs should he be institutionalized. ***Id,*** *at 614.*

Also, during his testimony, Mr. Spector several times injected comments regarding Ms. Washington's financial need. He stated that plaintiffs were renting their home, and that they previously had to move because of financial reasons. In answer to a question whether the family has a wheelchair, he nonresponsively replied, "No, I'm not sure that the mother has an automobile at all. Maybe she's not able to afford one." Later, he implied that the child was transported in a stroller because the family could not afford a wheelchair. ***Id,*** *at 614-615.*

Defendants requested they be allowed to present evidence to the jury of available free public special education because plaintiffs' "had opened the door with this evidence," but the court refused the request. ***Id,*** *at 619.*

The Supreme Court noted, in ***Washington by Washington***, there are many different factual situations in which the collateral source rule has been applied in Missouri. ***Id.*** It has been said, the collateral source rule is not a single rule but rather, a combination of rationales applied to a number of different circumstances to determine whether evidence of mitigation of damages should be precluded from admission. ***Id,*** *citing* Note, ***Unreason in the Law of Damages: The Collateral Source Rule,*** *77 Harv.L.Rev. 741, 748-53 (1964)*; and Joel K. Jacobsen, ***The Collateral Source Rule and the Role of the Jury,*** *70 Or.L.Rev. 523 (1991).*

The Court in ***Washington by Washington*** examined Missouri's treatment of the collateral source rule and its application throughout the years. It found that some courts

have stated that plaintiffs who contract for insurance or other benefits with funds they could have used for other purposes are entitled to the benefit of their bargain. ***Id,*** *citing* ***Kickham v. Carter,*** *335 S.W.2d 83, 90 (Mo.1960)*; ***Overton v. United States,*** *619 F.2d at 1306.* Other courts enforce the collateral source rule to punish the tortfeasor. *See, e.g.,* ***Roth v. Chatlos,*** *97 Conn. 282, 116 A. 332, 334 (1922)*; ***Hubbard Broadcasting, Inc. v. Loescher,*** *291 N.W.2d 216, 222 (Minn.1980).* Other courts opine that, if one party will receive a windfall, it should be the plaintiff. *See, e.g.,* ***Werner v. Lane,*** *393 A.2d 1329, 1336 (Me.1978)*; ***Grayson v. Williams,*** *256 F.2d 61, 65 (10th Cir.1958)).*

The ***Washington by Washington*** Court found additional rationales supporting the collateral source rule. ***Washington by Washington,*** *897 S.W.2d at 619* stating: to protect plaintiffs against the inadequacy of public benefits or the uncertainty of their future availability, ***Northern Trust Co. v. County of Cook,*** *135 Ill.App.3d 329, 90 Ill.Dec. 157, 481 N.E.2d 957, 960 (1985)*; to recognize that the plaintiff, not the tortfeasor, was the intended beneficiary of gratuitous services, ***Kaiser v. St. Louis Transit Co.,*** *108 Mo.App. 708, 84 S.W. 199, 200 (1904)*; to compensate plaintiff for legal fees and expenses, ***Hudson v. Lazarus,*** *217 F.2d 344, 346 (D.C.Cir.1954);* and to avoid prejudice in the eyes of the jury because plaintiff was attempting to recover for an item for which he had not paid, ***Kickham v. Carter,*** *335 S.W.2d at 90.*

The Court noted in ***Washington by Washington*** that Missouri courts have applied the collateral source rule to prevent defendants from informing juries of insurance policies contracted for and paid for by plaintiffs, *see, e.g.,* ***Iseminger v. Holden,*** *544 S.W.2d 550, 553 (Mo. banc 1976)*; ***Kickham v. Carter,*** *335 S.W.2d at 90*; ***Protection***

Sprinkler Co. v. Lou Charno Studio, Inc., *888 S.W.2d 422, 424 (Mo.App.1994)*, ***Blessing v. Boy Scouts of America***, *608 S.W.2d 484, 488-89 (Mo.App.1980)*; contracted for payments, *see* ***Collier v. Roth***, *434 S.W.2d 502, 507 (Mo.1968)*, in accordance with an agreement with its supplier, plaintiff received payments that diminished its damages; and worker's compensation benefits from plaintiffs' employers, *see* ***Douthet v. State Farm Mut. Auto Ins. Co.***, *546 S.W.2d 156, 159-60 (Mo. banc 1977)*; ***Leake v. Burlington Northern R. Co.***, *892 S.W.2d 359, 363 (Mo.App.1995)*, disability pension benefits; ***Mateer v. Union Pacific Systems***, *873 S.W.2d 239, 245 (Mo.App.1993)*, retirement benefits; ***Beck v. Edison Bros. Stores, Inc.***, *657 S.W.2d 326, 330-31 (Mo.App.1983)*, employer's medical plan; and ***Siemes v. Englehart***, *346 S.W.2d 560, 563-64 (Mo.App.1961)*, sick leave.

The Supreme Court in ***Washington by Washington*** illustrated that Missouri courts have also found evidence regarding some governmental benefits to be subject to the collateral source rule. These include both governmental benefits contingent upon plaintiff's financial need or special status, such as Medicare and Medicaid, and those at least partially contingent upon plaintiff's former service or payments, such as veterans' benefits and social security. ***Id,*** *citing,* ***Cornelius v. Gipe***, *625 S.W.2d 880, 882 (Mo.App.1981)*, in dicta, found social security, Medicare and Medicaid to be collateral sources; ***Hood v. Heppler***, *503 S.W.2d 452, 454-55 (Mo.App.1973)*, veterans' benefits; ***Weeks-Maxwell Const. Co. v. Belger Cartage Service, Inc.***, *409 S.W.2d 792, 796 (Mo.App.1966)*, social security.

And lastly, the Supreme Court stated in ***Washington by Washington***, that Missouri courts have split on the issue of whether the collateral source rule applies to evidence of gratuitous services rendered to a plaintiff. ***Id,*** *at 62,* comparing ***Kaiser v. St. Louis Transit Co.,*** *84 S.W. 199, 200 (Mo.App.1904),* holding that a plaintiff still was entitled to damages, even though he was nursed gratuitously by his wife and daughter, and ***Aaron v. Johnston,*** *794 S.W.2d 724, 726-27 (Mo.App.1990),* holding that gratuitous continuation of wages by plaintiff's employer would be a collateral source, with ***Morris v. Grand Ave. Ry. Co.,*** *46 S.W. 170 (Mo.1898),* holding that a plaintiff was not permitted to recover for services for which he did not pay, and ***Gibney v. St. Louis Transit Co.,*** *204 Mo. 704, 103 S.W. 43, 48 (1907),* holding that an injured mother could not collect damages for daughters' gratuitous nursing services.

The Court in ***Washington by Washington*** held that it was reversible error for the trial court to exclude evidence of the free public school programming that would be available to plaintiffs to mitigate their damage. ***Id,*** *at 621.* The Court concluded the "various rationales that support the applications of the collateral source rule in a number of other circumstances are not persuasive here." ***Id.*** In reaching its decision, the Court found that plaintiffs did not purchase the public school benefits; did not work for them as an employment benefit; and did not contract for them. ***Id.*** The "benefit of the bargain" rationale does not apply. ***Id.*** The Court rejected the concept that the collateral source rule should be utilized solely to punish the defendant and stated damages in our tort system are compensatory not punitive. ***Id.***

It appears as though this decision is an attempt at common law to reconcile the two competing policies that section 490.715 (2005) attempts to resolve by statute: that is, that damages in tort are meant to be compensatory **and** that a tortfeasor should not benefit from a plaintiff's collateral source. At the very least, the Supreme Court's conclusion that it was error to prohibit the defendant from submitting what amounts to collateral source of resources in the form of free public education does not violate the right to a trial by jury under Article I, §22(a) of the Missouri Constitution.

Furthermore, the Court in ***Washington by Washington*** found that the admission of mitigation evidence was also justified when "the plaintiffs opened the door by injecting the issue of Ms. Washington's financial status into the case." ***Id.*** Ms. Deck certainly opens the type of door discussed in ***Washington by Washington.*** Ms. Deck wanted to submit medical bills with the purpose of informing the jury that such medical bills were evidence of the charges sustained by her knowing that such charges had not been paid and knowing that such charges never would be paid. ***Washington by Washington*** would suggest that fairness would require that the defendant be allowed to show the jury that the medical charges actually paid were substantially lower than what was billed, and that the medical provider billed such an amount to justify its charges for other reasons. Of course, showing a jury evidence of the reduced payment would run afoul of the common law collateral source rule. The Missouri Legislature, with the passage of House Bill 393, has created a procedure by which "opening the door" is not a concern for the trial courts and it reconciles the policies that damages in tort are meant to compensatory and a tortfeasor should not benefit from a collateral source. Moreover, it's not the only area of

the law where the Missouri Legislature has been dealing with the issue of the actual payment of medical bills.

Just prior to the changes in the law brought about by House Bill 393, the Western District of Missouri considered a case alleging error where the trial court had excluded evidence that a plaintiff's medical bills were satisfied by less than the amount charged, as well as the admission of evidence regarding all charged medical expenses. ***Porter v. Toys 'R' US-Delaware, Inc.***, *152 S.W. 3d 310 (Mo. W.D. 2004).* In that case, the defendant claimed that the trial court erred in excluding evidence that Ms. Porter's medical bills were satisfied by less than the amount charged. Defendant argued that it should have been able to ask questions to show that Ms. Porter's medical expenses were satisfied by substantially less than the $33,000 bill submitted by her to the jury, which was directly probative to the reasonableness of her medical bills. ***Id,*** *at 319.* In a related point, the defendant argued that the trial court erred in admitting into evidence the full amount Mrs. Porter was charged for medical care asserting that the medical expenses that were billed were satisfied for much less than the billed amount. ***Id.***

The Western District noted that medical insurance purchased by a plaintiff and governmental benefits contingent upon a plaintiff's financial need or special status, such as Medicare and Medicaid, are independent sources that are subject to the collateral source rule, and, thus, a defendant may not inform the jury of such sources. ***Id,*** *see also,* ***Washington by Washington,*** *897 S.W.2d at 619-20.* The rationale for such application of the collateral source rule is that "plaintiffs who contract for insurance or other benefits with funds they could have used for other purposes are entitled to the benefit of their

bargain." ***Id,*** at 619, *citing* ***Kickham v. Carter****, 335 S.W.2d 83, 90 (Mo.1960)*, and ***Overton****, 619 F.2d at 1306.*

The court states, however, application of the collateral source rule is not simple; the rule constitutes a combination of rationales applied in a number of different circumstances to determine whether evidence of mitigation of damages should be precluded from admission as evidence and noted that Missouri's courts are not uniform on whether the rule applies where gratuitous services were rendered to a plaintiff as a result of that person's special status. ***Id****, at 619, 620.*

Furthermore, while ***Porter*** was pending on appeal, The Missouri Supreme Court handed down ***Farmer-Cummings v. Personnel Pool of Platte County****, 110 S.W.3d 818 (Mo. banc 2003)*. In that case, the Labor and Industrial Relations Commission awarded Ms. Farmer-Cummings medical expenses incurred because of her asthmatic condition, which resulted from her work environment. ***Id,*** *at 820*. However, the Commission did not allow Ms. Farmer-Cummings to recover fees her healthcare providers adjusted or "wrote-off" from the original bills. ***Id.***

In ***Farmer-Cummings***, the Supreme Court believed the "real issue" was whether the original medical bills remain "fees and charges' collectible by the employee or whether the bills had been written off. ***Id,*** *at 821*. The Court stated:

> if [the employer] establishes by a preponderance of the evidence that the healthcare providers allowed write-offs and reductions for their own purposes and [the employee] is not legally subject to further liability, [the employee] is not entitled to any windfall recovery.

Id, *at 823*. The Court also explained,

> [i]t is a defense [of the employer] to establish that [the employee] was not required to pay the billed amounts, that her liability for the disputed amounts was extinguished, and that the reason that her liability was extinguished does not otherwise fall within the provisions of section 287.270.

Id.

In arriving at such a conclusion, the Supreme Court cited two workers' compensation cases in which the reviewing court determined that an employee was not entitled to compensation for healthcare provider write-offs: (1) ***Mann v. Varney Construction***, *23 S.W.3d 231, 233 (Mo.App. E.D.2000)*, wherein "[t]he court ruled that an employee is not entitled to compensation for Medicaid write-off amounts when the total amount submitted to Medicaid will never be sought from claimant"; and, (2) ***Lenzini v. Columbia Foods***, *829 S.W.2d 482, 487 (Mo.App. W.D.1992)*, wherein the court reduced a workers' compensation award by amount already written-off by health care providers. ***Farmer-Cummings***, *110 S.W.3d. at 821*.

What is significant in ***Porter*** is that the Western District was prepared to consider the amount of actual medical bills paid, prior to the passage of Rev. Mo. Stat. 490.715 (2005). The Western District believed the decision in ***Farmer-Cummings*** rested solely on the basis of the Court's construction of two workers' compensation statutes. ***Porter***, *152 S.W.3d at 321*. In ***Porter***, defendant Toys 'R" US argued that the holding in the ***Farmer-Cummings*** case had application beyond a workers' compensation setting so as to provide Toys 'R' US with the same type of evidence regarding the actual amount of medical bills paid. The Western District court declined to follow ***Famer-Cummings*** stating issues raised by defendant "is handicapped due to the fact that Ms. Porter's

medical exhibits and bills complained of are not a part of the record on appeal." ***Porter***, *152 S.W.3d at 322*. The Western District's refusal to consider the holding of ***Farmer-Cummings*** may have been different if the trial court considered the amount of medical bill actually paid.

3. Development of Rev. Mo. Stat. § 490.715.

In 1987, the Missouri Legislature passed section 490.715 which purports to modify the collateral source rule. The rule, as stated at common law is different than as stated in the statute, however, the application of section 490.715 does not change the overall application of the collateral source rule as it existed at common law. The 1987 rule was stated thus:

> **490.715 Damages paid by defendant prior to trial may be introduced but is waiver of credit against judgment (collateral source rule modified)**
>
> 1. No evidence of collateral sources shall be admissible other than such evidence provided for in this section.
>
> 2. If prior to trial a defendant or his insurer or authorized representative, or any combination of them, pays all or any part of a plaintiff's special damages, the defendant may introduce evidence that some other person other than the plaintiff has paid those amounts. The evidence shall not identify any person having made such payments.
>
> 3. If a defendant introduces evidence described in subsection 2 of this section, such introduction shall constitute a waiver of any right to a credit against a judgment pursuant to section 490.710.
>
> 4. This section does not require the exclusion of evidence admissible for another proper purpose.

Mo. Rev. Stat. §490.715 (1987).

House Bill 393 repealed and enacted a new Section 490.715 to read as follows:

490.715 Damages paid by defendant prior to trial may be introduced but is waiver of credit against judgment (collateral source rule modified).

1. No evidence of collateral sources shall be admissible other than such evidence provided for in this section.

2. If prior to trial a defendant or his or her insurer or authorized representative, or any combination of them, pays all or any part of a plaintiff's special damages, the defendant may introduce evidence that some other person other than the plaintiff has paid those amounts. The evidence shall not identify any person having made such payments.

3. If a defendant introduces evidence described in subsection 2 of this section, such introduction shall constitute a waiver of any right to a credit against a judgment pursuant to section 490.710.

4. This section does not require the exclusion of evidence admissible for another proper purpose.

5. (1) Parties may introduce evidence of the value of the medical treatment rendered to a party that was reasonable, necessary, and a proximate result of the negligence of any party.

(2) In determining the value of the medical treatment rendered, there shall be a rebuttable presumption that the dollar amount necessary to satisfy the financial obligation to the health care provider represents the value of the medical treatment rendered. Upon motion of any party, the court may determine, outside the hearing of the jury, the value of the medical treatment rendered based upon additional evidence, including but not limited to:

(a) The medical bills incurred by a party;

(b) The amount actually paid for medical treatment rendered to a party;

(c) The amount or estimate of the amount of medical bills not paid which such party is obligated to pay to any entity in the event of a recovery.

> Notwithstanding the foregoing, no evidence of collateral sources shall be made known to the jury in presenting the evidence of the value of the medical treatment rendered.

The Legislature left intact the collateral source rule as it existed prior to House Bill 393. The collateral source rule has not been supplanted or changed in any substantive way.

The addition of subdivision 5 of 490.715 is the Legislature's attempt to bring equity to the courts by establishing the policies that damages in tort are to be compensatory and the tortfeasor should not benefit from the payment to plaintiff by a collateral source.

4. Treatment of Collateral Source Rule in Other States.

There has long been a continuing debate over the merits of the common law collateral source rule which has been adequately summarized by Professor Michael F. Flynn, ***Private Medical Insurance And The Collateral Source Rule: A Good Bet?*** *22 U.Tol.L.Rev. 39 (1990).*

> Proponents of the Collateral Source Rule primarily argue that an injured plaintiff under tort law is entitled to recover the full value of the harm caused by the culpable defendant. Proponents reason that without the Rule a guilty defendant would be relieved of liability to the extent of the injured plaintiff's insurance coverage ... Moreover, allowing collateral sources to reduce a wrongdoer's liability penalizes an injured party for purchasing insurance ... The insured party does pay a cost ... the prospect of increased premiums.
>
> Opponents of the Collateral Source Rule primarily contend that the Rule sanctions a double recovery for an injured, insured party. By allowing a plaintiff to recover from a wrongdoer for injuries fully compensated by insurance coverage, the plaintiff is paid twice for a single harm ... They further reason that the Rule defeats the purpose of tort litigation by compensating an injured party for more than the actual loss sustained.

22 U.Tol.L.Rev. at 43-45.

In recent years, more than 30 U.S. states have passed some form of legislation to modify or abrogate the collateral source rule. L. Olsen & Pat Wasson, ***Is the Collateral Source Rule Applicable to Medicare and Medicaid Write-Offs?***, *71 Def. Couns. J. 172, (2004).* Among these statutes, there are a variety of substantive and procedural differences. ***Id.*** A number of states permit the introduction of collateral source evidence in all personal injury tort cases, but others limit such evidence to medical malpractice cases. ***Id.*** Some states permit collateral source evidence to be introduced during trial, while others limit introduction to post-verdict proceedings. ***Id.*** Alaska, Colorado, Connecticut, Florida, Hawaii, Illinois, Iowa, Michigan, Minnesota and Montana permit mandatory reduction of compensatory damages by collateral source payments in some circumstances. ***Id.*** In contrast, Alabama, Arizona, California, Delaware, Georgia, Indiana, Maryland, Missouri, Oregon, South Dakota and Washington allow courts the discretion to reduce damages based on payments received from collateral sources. ***Id.*** See, also, ***Narayen v. Bailey***, *130 Md.App. 458, 468-469, 747 A.2d 195, 201, n.4 & n.5 (Md. App. 2000).* Of guidance are the following out-of-state cases.

Maryland considered its treatment of the collateral source rule in a case involving a medical malpractice claim. ***Narayen v. Bailey***, *130 Md.App. 458, 747 A.2d 195 (Md. App. 2000).* The parties waived arbitration and appellee filed an action in the Circuit Court for Baltimore City, which was tried before a jury. ***Id,*** *at 460, 197.* Appellee's medical expenses, which totaled $399.539.00, were stipulated to, and the jury returned a

verdict in favor of appellee for $787,613.20. The jury had been given a special verdict sheet, pursuant to CJP § 3-2A-06(f), on which it itemized damages as follows:

A.	Past Medical Expenses		
	(1)	Bills	$399,539.00
	(2)	Supplies & Expenses	$6,535.00
B.	Lost Wages		$31,539.00
C.	Non-Economic Losses		$350,000.00

Id, *461, 197.* Dr. Narayen filed a Motion for Remittur, or in the alternative a Motion for New Trial requesting a reduction of damages because appellee's medical bills had been paid by Blue Cross Blue Shield. ***Id.*** The Maryland court examined its own treatment of collateral source evidence. It noted:

> Since 1899, the collateral source rule has been applied in [Maryland] to permit an injured person to recover in tort the full amount of his provable damages regardless of the amount of compensation which the person has received for his injuries from sources unrelated to the tortfeasor.' ***Motor Vehicle Admin. v. Seidel,*** *326 Md. at 253, 604 A.2d 473* (footnote omitted). 'The purpose of the Collateral Source Rule is to preserve an injured party's right to seek tort recovery from a tortfeasor without jeopardizing his or her right to receive insurance payments for medical care.' ***Flynn, supra,*** *22 U.Tol.L.Rev. at 4.*
>
> The collateral source rule prohibits a defendant in a medical malpractice action from introducing evidence that the plaintiff has or will recover his medical expenses from sources unrelated to the tortfeasor, such as a private insurer, government insurance (Medicare), liability insurance, worker's compensation, and the like. Consequently, actual or possible recovery of medical expenses from a collateral source may not be considered in awarding damages.

Id, *at 466, 200.*

The Maryland Court then examined what it described as an insurance crisis which began in the 1970s. ***Id,*** *at 467, 200.* It quoted the California Supreme Court in a 1984 decision warning of the medical malpractice crisis stating:

> [T]he insurance companies which issued virtually all of the medical malpractice insurance policies in California determined that the costs of affording such coverage were so high that they would no longer continue to provide such coverage as they had in the past. Some of the insurers withdrew from the medical malpractice field entirely, while others raised the premiums which they charged to doctors and hospitals to what were frequently referred to as "skyrocketing" rates. As a consequence, many doctors decided either to stop providing medical care with respect to certain high risk procedures or treatment, to terminate their practice in this state altogether, or to "go bare," i.e., to practice without malpractice insurance. The result was that in parts of the state medical care was not fully available, and patients who were treated by uninsured doctors faced the prospect of obtaining only unenforceable judgments if they should suffer serious injury as a result of malpractice.

American Bank & Trust Co. v. Community Hospital, *36 Cal.3d 359, 371, 204 Cal.Rptr. 671, 683 P.2d 670, 677-78 (1984); see also* ***Barme v. Wood,*** *37 Cal.3d 174, 207 Cal.Rptr. 816, 689 P.2d 446 (1984).*

Like the other states listed in Footnote 4 & 5, Maryland's General Assembly enacted House Bill 1593 in 1987 in response to the perceived insurance crisis, and modified CJP §§ 3-2A-05(h) and 3-2A-06(f), to reduce medical malpractice awards and liability insurance premiums. ***Narayen,*** *130 Md. App at 471, 747 A.2d at 203.* It stated the law thus:

> CJP § 3-2A-06(f) permits a defendant who files a motion for remittitur or new trial to introduce evidence that the plaintiff 'has been or will be paid, reimbursed, or indemnified to the extent and subject to the limits stated in § 3-2A-05(h) of this subtitle.' CJP § 3-2A-05(h) permits a defendant to 'request that damages be reduced to the extent that the claimant has been or will be paid, reimbursed, or indemnified under statute, insurance, or

> contract for all or part of damages assessed.' In the event a new trial is ordered, § 3-2A-06(f) provides that such evidence is admissible and that the jury be instructed to consider such evidence. Thus, in a medical malpractice action, collateral source evidence is permitted in post-verdict proceedings, and it is within the discretion of the presiding judge or the jury to reduce the damages awarded accordingly.

Alabama's treatment of the collateral source rule was stated in ***Marsh v. Green***, *782 So.2d 223 (Al. 2000)*. There, the Alabama Supreme court held that the statute abrogating the collateral source rule in civil tort cases did not violate the right to trial by jury or other constitutional rights. ***Id,*** *at 233*. In that case, Ms. Marsh challenged the constitutionality of the Section 6-5-545 Ala. Code (1975) which provided:

> (a) In all actions where damages for any medical or hospital expenses are claimed and are legally recoverable for personal injury or death, evidence that the plaintiff's medical or hospital expenses have been or will be paid or reimbursed shall be admissible as competent evidence. In such actions upon admission of evidence respecting reimbursement or payment of medical or hospital expenses, the plaintiff shall be entitled to introduce evidence of the cost of obtaining reimbursement or payment of medical or hospital expenses.
>
> (b) In such civil actions, information respecting such reimbursement or payment obtained or such reimbursement or payment which may be obtained by the plaintiff for medical or hospital expenses shall be subject to discovery.
>
> (c) Upon proof by the plaintiff to the court that the plaintiff is obligated to repay the medical or hospital expenses which have been or will be paid or reimbursed, evidence relating to such reimbursement or payment shall be admissible.

Id, *at 230.*

The Alabama Court noted that Section 6-5-545 abolished in medical malpractice claims the common law rule known as the collateral source rule; which it explained as follows:

> the courts generally have held that benefits received by the plaintiff from a source wholly independent of and collateral to the wrongdoer will not diminish the damages otherwise recoverable from the wrongdoer. This is known as the 'collateral source rule.' Under it, the wrongdoer cannot take advantage of the contracts or other relation that may exist between the injured person and third persons. Thus, while a plaintiff's recovery under the ordinary negligence rule is limited to damages which will make him whole, the collateral source rule allows a plaintiff further recovery under certain circumstances even though he has suffered no loss.

Id, *at 230.*

The Idaho Supreme Court held that a litigant was not permitted to recover Medicare write-offs. ***Dyet v. McKinley,*** *139 Idaho 526, 81 P.2d 1236 (Id. 2003).* The issue in that case was the admissibility of evidence of reductions in the charges for medical services due to Medicare "write downs," and the question of whether the award should be reduced by the amount the plaintiff received for underinsured motorist benefits from her own insurance company. ***Id,*** *at 527, 1237.*

On October 27, 2000, Hansen and Dyet (Plaintiffs) were traveling in the same car on a highway near Idaho Falls. ***Id.*** McKinley was traveling the opposite direction on the same highway and attempted to make a left turn in front of Hansen and Dyet at an intersection. ***Id.*** The cars collided and Hansen and Dyet sustained serious injuries; Dyet's right hip and left femur were fractured; and her injuries required multiple surgeries, including the insertion of a new right artificial hip, replacing an artificial hip that had been inserted in 1987. ***Id.*** In spite of successful surgeries, she had some remaining impairments as a result of the injuries. ***Id.*** The charges from the medical providers for Dyet's care totaled $89,367.71. ***Id.*** However, because Dyet was a Medicare patient, the bill was mandatorily reduced by $67,655.22 to $21,712.49. ***Id.***

Subsequently, Dyet also received $75,000 in Underinsured Motorist Benefits from her own insurance company. ***Id,*** *at 528, 1238.*

Dyet sued McKinley for damages arising from his alleged negligent driving. ***Id.*** She filed a motion *in limine* requesting that all evidence be excluded at trial relevant to whether she was insured and relevant to whether she "received monies from *any* source such as Medicare, Medicaid, underinsured insurance, or private health insurance." ***Id.*** The district court granted the motion *in limine,* allowing Dyet to introduce the charges for the medical services but not allowing any evidence during trial as to the amount she actually paid for the services or the write off required by Medicare. ***Id.*** McKinley made an offer of proof during trial showing that Dyet's medical bills were reduced by $67,655.22 due to Medicare regulations and federal law. ***Id.***

The jury returned a special verdict finding McKinley and Hansen, a non-party, both negligent and apportioning 88% of the fault to McKinley and 12% to Hansen. ***Id.*** The jury awarded Dyet $400,000 in damages, which amount included $89,367.71 for medical expenses. ***Id.*** The district court reduced the verdict by $48,000 for comparative negligence on the part of Hansen and by another $67,665.22 for the reduction in charges required by Medicare regulations and federal law, leaving a net judgment of $284,334.78. ***Id.*** The district court refused to reduce the verdict by the $75,000 paid for underinsured motorist coverage. ***Id.*** Both parties appealed wherein Dyet maintained the verdict should not have been reduced. ***Id.*** McKinley maintained that he should have been allowed to offer evidence at trial of the actual amount paid for medical expenses and that

the verdict should have been reduced by the $75,000 paid as underinsured motorists benefits. ***Id.***

The Court concluded that the district court correctly refused to allow McKinley to present evidence to the jury regarding the amounts actually paid to Dyet's medical providers. It reasoned Idaho Code § 6-1606, entitled "Prohibiting double recoveries from collateral sources" states:

> [I]n any action for personal injury or property damage, a judgment may be entered for the claimant only for damages which exceed amounts received by the claimant from collateral sources as compensation for the personal injury or property damage, whether from private, group or governmental sources, and whether contributory or noncontributory. For purposes of this section, collateral sources shall not include benefits paid under federal programs which by law must seek subrogation ... Evidence of payment by collateral sources is admissible to the court after the finder of fact has rendered an award. Such award shall be reduced by the court to the extent the award includes compensation for damages, which have been compensated independently from collateral sources.

Id, *at 529, 1239.*

The Court treated the case as whether or not Medicare write-offs are a collateral source under I.C. § 6-1606 or, if not, if the write-offs should be treated the same as a collateral source. ***Id.*** It stated: I.C. § 6-1606 is clearly a statute that was designed to prevent double recovery. In the Statement of Purpose accompanying House Bill 745, currently I.C. § 6-1606, the legislature stated that:

> This bill would modify the collateral source rule of evidence in certain circumstances in which the court determines that a double payment will exist [sic] the court is given the authority to modify an award of damages so that the damages would be paid once but not twice.

Id.

The Court found the district court followed a rule adopted by many states with statutes similar to that of Idaho. Citing ***Kastick v. U-Haul***, *740 N.Y.S.2d 167, 292 A.D.2d 797 (2002)* and ***Loncar v. Gray***, *28 P.3d 928 (Alaska 2001)*, the district court stated that "these jurisdictions hold that while Medicare write-offs are technically not payments from a collateral source, plaintiffs may not recover the amount of the write-off from a tortfeasor because it was not an item of damages for which the plaintiff ever became obligated." ***Id.***

The court noted that:

> Neither the language of I.C. § 6-1606 nor its Statement of Purpose specifically deal with write-offs, but the district court's reasoning is sound. By treating a Medicare write-off as a collateral source, the danger of prejudice contemplated in I.R.E. 403 is avoided, and the jury will not be influenced by the existence of Medicare. At the same time, the policy of I.C. § 6-1606 contained in both the statute and the legislative history to prevent a double payment for the damages is preserved. Although the write-off is not technically a collateral source, it is the type of windfall that I.C. § 6-1606 was designed to prevent. As reasoned by the New York court in ***Kastick***, 'Although the write-off technically is not a payment from a collateral source within the meaning of [the collateral source statute], it is not an item of damages for which plaintiff may recover because plaintiff has incurred no liability therefore.' ***Id***, *740 N.Y.S.2d at 169, 292 A.D.2d at 798.*

Id.

The Illinois Supreme Court considered application of the collateral source rule in ***Arthur v. Catour***, *833 N.E. 2d 847 (Il. 2005)*. In ***Arthur***, the court was presented with a certified question:

> Whether the Plaintiff who was charged $19,355.25 in medical bills for medical services related to her injuries can present that amount of bills as medical expenses in the case or, whether the Plaintiff shall be limited to presenting only $13,577.97 in medical bills to the jury because that is the

> amount that was paid by the Plaintiff and Blue Cross/Blue Shield, who was an insurance carrier for the Plaintiff and who paid the Plaintiff's medical bills pursuant to insurance contracts at a substantially reduced rate with the medical providers and which the providers accepted as payment in full.

Id, *at 855.* In concluding that plaintiff could present the amount of the bills as charged, the court stated:

> 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 other 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.

Id, *at 854.*

Plaintiff, Joyce Arthur, brought a personal injury action in the circuit court of Henry County against defendants Laurie Catour and Stenzel Brothers Auction Services, Inc. ***Id,*** *at 849.* Plaintiff alleged that on October 2, 1999, defendant Stenzel Brothers was conducting an auction on a farm that defendant Catour owned. ***Id.*** Plaintiff further alleged that, while attending the auction, she stepped in a hole in Catour's yard, fell, and was injured. ***Id.*** Plaintiff alleged negligence on the part of each defendant and sought damages. Each defendant filed an answer denying negligence or liability. ***Id.***

In her answers to defendant Stenzel Brothers' interrogatories, plaintiff stated that she fractured her leg just below the knee, which required surgery. ***Id,*** *at 850.* Plaintiff also disclosed the categories of damages that she sought. ***Id.*** Included in this list was: "Incurred medical to date-$19,314.07." The parties did not dispute that through February 2002, plaintiff received services from various health-care providers valued at $19,355.25

and that Plaintiff had private, group health insurance with Blue Cross/Blue Shield through her husband's employer. ***Id.***

Blue Cross had contractual agreements with plaintiff's health-care providers. ***Id.*** Through this arrangement, many of the charges for health-care services rendered were discounted. ***Id.*** Blue Cross and plaintiff actually paid a total of only $13,577.97 to satisfy the $19,355.25 of billed health-care services rendered. ***Id.***

Defendants filed a motion for partial summary judgment, seeking to limit plaintiff's claim for medical expenses to the amount paid rather than the amount billed. Granting defendants' motion, the circuit court's order stated in part:

> The [trial] court does not find that the collateral source rule applies to the present set of facts, and to allow the plaintiff to seek and recover $19,355.25 worth of medical damages when she was only charged for and became liable for $13,577.97 would only serve to punish the defendants punitively and provide a windfall for the plaintiff.

Id. The trial court ruled that "plaintiff will be limited to seeking compensatory damages not exceeding those actually paid to her medical providers." ***Id.***

The Illinois Supreme Court examined the certified question in light of the collateral source rule. ***Id, at 645.*** The Court stated Illinois' treatment of the rule in relation to the case thus:

> Under the collateral source rule, benefits received by the injured party from a source wholly independent of, and collateral to, the tortfeasor will not diminish damages otherwise recoverable from the tortfeasor. ***Wilson v. The Hoffman Group, Inc.***, *131 Ill.2d 308, 320, 137 Ill.Dec. 579, 546 N.E.2d 524 (1989)*; see ***Beaird v. Brown***, *58 Ill.App.3d 18, 21, 15 Ill.Dec. 583, 373 N.E.2d 1055 (1978)*, quoting ***Bireline v. Espenscheid***, *15 Ill.App.3d 368, 370, 304 N.E.2d 508 (1973)*; 11 Ill. Jur. *Personal Injury & Torts* § 5:62, at 354 (2002). *Defendants do not dispute that the collateral source rule protects the $13,577.97 that Blue Cross paid and plaintiff's health-care*

providers accepted as payment in full. Rather, defendants contend that the collateral source rule does not apply to the $5,777.28 difference between the amount billed and the amount paid. Plaintiff contends that the collateral source rule protects the entire $19,355.25 initially billed.

Id. Emphasis added.

The Illinois Court examined the rule as it is frequently used:

A situation in which courts frequently apply the collateral source rule is where the defendant seeks a reduction of damages because the plaintiff has received insurance benefits that partly or wholly indemnifies the plaintiff for the loss. ***Wilson**, 131 Ill.2d at 320, 137 Ill.Dec. 579, 546 N.E.2d 524*; ***Peterson v. Lou Bachrodt Chevrolet Co.**, 76 Ill.2d 353, 362, 29 Ill.Dec. 444, 392 N.E.2d 1 (1979)*; accord 1 D. Dobbs, Remedies § 3.8(1), at 373 (2d ed.1993). The rule is well established that damages recovered by the plaintiff from the defendant are not decreased by the amount the plaintiff received from insurance proceeds, where the defendant did not contribute to the payment of the insurance premiums. ***Peterson**, 76 Ill.2d at 362, 29 Ill.Dec. 444, 392 N.E.2d 1*; see ***Biehler v. White Metal Rolling & Stamping Corp.**, 30 Ill.App.3d 435, 444, 333 N.E.2d 716 (1975).* 'The justification for this rule is 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.' ***Wilson**, 131 Ill.2d at 320, 137 Ill.Dec. 579, 546 N.E.2d 524*; see 11 Ill. Jur. *Personal Injury & Torts* § 5:63 (2002). Also: 'Calling attention to the fact that a plaintiff had such insurance can be prejudicial error because the jury may conclude that plaintiff sustained no damages for which he was entitled to recover if his medical bills were paid by insurance.' ***Biehler**, 30 Ill.App.3d at 444, 333 N.E.2d 716*; accord ***Boden**, 196 Ill.App.3d at 76, 142 Ill.Dec. 546, 552 N.E.2d 1287.*

***Id**, at 646.* The court held that the collateral source rule at a duel nature and stated:

The traditional approach is to treat [the collateral source rule] as having substantive and evidentiary components. The substantive component is a rule of damages. This component bars a defendant from reducing the plaintiff's compensatory award by the amount the plaintiff received from the collateral source. The evidentiary component bars admission of evidence of the existence of the collateral source or the receipt of benefits. The concern here is that the trier of fact may use that evidence improperly

to deny the plaintiff the full recovery to which he is entitled. J. Fischer, Understanding Remedies § 12(a), at 77 (1999).

Id.

In applying the dual principals above in reference to receiving evidence, the court stated:

> In Illinois, the question of damages is peculiarly one of fact for the jury. ***Flynn v. Vancil,*** *41 Ill.2d 236, 240, 242 N.E.2d 237, 240 (1968).* The rules regarding the admissibility of evidence of medical expenses and the burden of proving medical expenses are well established. In order to recover for medical expenses, the plaintiff must prove that he or she has paid or become liable to pay a medical bill, that he or she necessarily incurred the medical expenses because of injuries resulting from the defendant's negligence, and that the charges were reasonable for services of that nature. See ***North Chicago Street Ry. Co. v. Cotton,*** *140 Ill. 486, 498, 29 N.E. 899, 902 (1892);* ***Wicks v. Cuneo-Henneberry Co.,*** *319 Ill. 344, 349, 150 N.E. 276, 279 (1925).*
>
> When evidence is admitted, through testimony or otherwise, that a medical bill was for treatment rendered and that the bill has been paid, the bill is *prima facie* reasonable. ***Flynn v. Cusentino,*** *59 Ill.App.3d 262, 266 [16 Ill.Dec. 560], 375 N.E.2d 433, 436 (1978).* A party seeking the admission into evidence of a bill that has not been paid can establish reasonableness by introducing the testimony of a person having knowledge of the services rendered and the usual and customary charges for such services. Once the witness is shown to possess the requisite knowledge, the reasonableness requirement necessary for admission is satisfied if the witness testifies that the bills are fair and reasonable. ***Diaz v. Chicago Transit Authority,*** *174 Ill.App.3d 396 [123 Ill.Dec. 853], 528 N.E.2d 398 (1988).*
>
> The *prima facie* reasonableness of a paid bill can be traced to the enduring principle that the free and voluntary payment of a charge for a service by a consumer is presumptive evidence of the reasonable or fair market value of that service. See ***Wicks,*** *319 Ill. at 349, 150 N.E. at 279;* ***Lanquist v. City of Chicago,*** *200 Ill. 69, 73-74, 65 N.E. 681, 683 (1902).* The premise is that a consumer will not willingly pay an unreasonable or unusual charge for a service. When a bill has been paid, there is little reason to suspect that the charge is collusive or speculative. The defendant may rebut the *prima facie* reasonableness of a medical expense by presenting proper evidence casting suspicion upon the transaction. It must be emphasized that offering a paid

> bill or the testimony of a knowledgeable witness that a bill is fair and reasonable merely satisfies the requirement to prove reasonableness. The proponent must also present evidence that the charges were necessarily incurred because of injuries caused by the defendant's negligence. ***Cotton,*** *140 Ill. at 498-99, 29 N.E. at 902.* Only then have the evidentiary requirements for admission into evidence been satisfied. Moreover, it is axiomatic that merely satisfying the minimum requirements for the admission of a bill into evidence does not conclusively establish that the amount of the bill in its entirety must be awarded to the plaintiff. The admission of the bill into evidence simply allows the jury to *consider* whether to award none, part, or all of the bill as damages. (Emphasis in original.) ***Baker v. Hutson,*** *333 Ill.App.3d 486, 493-94, 266 Ill.Dec. 791, 775 N.E.2d 631 (2002).*

Id, *at 853-854.*

This framework is an extraordinary hybrid approach to the competing policies of how to best harmonize the law of compensatory damages with the principles underlying the collateral source rule. The Illinois court allowed plaintiff to present to the jury the amount that her health-care providers initially billed for services rendered. ***Id,*** *at 855,* Marrow, J. dissenting. Despite the holding, however, the court found that, because plaintiff's health-care providers accepted a discounted amount from her insurance carrier as payment in full, then plaintiff could not truthfully testify that the total billed amount has been paid. ***Id.*** Therefore, the Illinois court concludes that a plaintiff may establish the reasonable cost of the health-care services provided to her by employing unspecified "other means." ***Id.*** Then the court held that defendants are free to challenge plaintiff's proof on cross-examination and "to offer their own evidence pertaining to reasonableness of the charges." ***Id.***

What is also notable from ***Arthur*** is the Illinois Supreme Court was considering the collateral source rule independent of any statute. On the other hand, in the case at

bar, as well as the other cases cited above, considered the collateral source rule in relation to a specific statute passed by the respective legislature. Each of those cases dealt with a long-standing rule of evidence in the context of an insurance crisis.

5. **Conclusion**.

Section 490.715.5 does not violate the right to a trial by jury. Section 490.715.5 does not change the common law collateral source rule in that it does not operate to reduce or mitigate the plaintiff's damages from a source other than defendant. Ms. Deck never sustained the damages which she sought to introduce to the jury. An invoice was submitted to Medicare and an insurance company, stating an arbitrary number for the procedures, services and medicine received by Ms. Deck. The amount that was stated on the invoices is not the amount that was paid and the hospital submitting those invoices knew it would never receive the amount that was stated on the invoice. Ms. Deck wants to submit to the jury those invoices as evidence of damages she alleges she sustained. But those invoices contain arbitrary numbers as Judge Cordonnier found from the evidence and testimony:

> the amount actually charged by a health care provider is arbitrary in our society. And as Mr. Smith pointed out, it matters not what the doctors charge to a Medicaid -- or Medicare patient. They are going to recover an X amount of dollars. It doesn't matter. So we may have ourselves in a position where some providers actually charge more if only to dramatize the difference between what their value is or what they would like to think their value is and what they are actually getting paid. It is this Court's opinion that we cannot turn over to the health care providers the ability to govern the estimate of what a Plaintiff's damages are.

(Tr. P. 59 Line 23 – P. 60 Line 12).[1]

To allow appellant to present evidence to the jury that is arbitrary is anathema to fairness and justice. Moreover, accepting appellant's evidence with admittedly arbitrary numbers (Mr. Smith was plaintiff's witness) while barring evidence of the actual payment for the procedures, services and medicine as though it were a collateral source only exacerbates such abomination. The collateral source rule has never operated in a way as to allow a plaintiff to exaggerate the damages they allege. It is used to prevent a defendant from reducing the actual damages they are responsible for when those damages have been paid by a collateral source. In this instance, the plaintiff's actual damages in medical bills were $9,904.28.

The hearing required by 490.715.5 does not interfere with the right to trial by jury, does not violate the collateral source rule and it effectuates the principal that damages in tort are to be compensatory. The trial court determined the value of the medical

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[1] The Trial Court had for its review Defendant's Exhibit A which was the St. John's Health Systems Billing record for Ms. Deck. (Tr. 6). A review of the March 15, 2005 itemized billing demonstrates Judge Cordonnier's conclusion that the billings were arbitrary. Ms. Deck was charged $14.00 for 2 pair of sterile surgical gloves, item number 61372 and was charged $10.00 for 2 pair of sterile surgical gloves, item number 61372. In addition, there was 6 pair of surgical gloves at $2.00 a piece for a total of $12.00. A specimen container cup was billed at $23.00. Ms. Deck received a prescription of Famotidine, or Pepcid AC, of 1 tablet for which she was billed $6.00.

procedures, services and medicine actually sustained by the plaintiff. To make such determination, the court had the authority to consider evidence of the actual value of the procedures, services and medicine by considering: (a) the medical bills incurred by a party; (b) The amount actually paid for medical treatment rendered to a party; (c) The amount or estimate of the amount of medical bills not paid which such party is obligated to pay to any entity in the event of a recovery. Rev. Stat. Mo. §490.715.5(2)a-c. Subdivision (2) concludes by stating "Notwithstanding the foregoing, no evidence of collateral sources shall be made known to the jury in presenting the evidence of the value of the medical treatment rendered." ***Id.*** The hearing ensures that plaintiff is not permitted to submit evidence to a jury that is arbitrary and the jury does not hear evidence of collateral source.

Both parties in this case were permitted to submit evidence at the hearing to demonstrate the actual value of the procedures, which amounts to the actual damages sustained by plaintiff. In this instance, Judge Cordonnier heard from two persons associated with billing at St. John's Health Systems and the witness engaged by plaintiff. The parties submitted the actual medical bills as exhibits and the bills were discussed at length. The court also received evidence showing the amount actually paid to St. John's Health Systems. Judge Cordonnier's ruling simply concluded that the actual damages as ascertained at the time of the hearing which was the day before trial were $9,904.28 in medical bills.

At trial, plaintiff was allowed to submit evidence of the actual amount of damages she sustained in relation to medical bills and no evidence of a collateral source was

admitted to the jury. Plaintiff's right to a trial by jury was not violated. The damages received by plaintiff fully compensated her and the defendant did not reduce the damages for which he was responsible from a collateral source.

IV.

THE TRIAL COURT DID NOT ERROR IN RULING THAT APPELLANT'S CLAIM FOR PAST MEDICAL EXPENSES WAS LIMITED TO THE AMOUNT ACTUALLY PAID FOR THE MEDICAL TREATMENT APPELLANT RECEIVED, BECAUSE R.S.M.O. §490.715 IS NOT UNCONSTITUTIONAL AND COMPLIES WITH ARTICLE III, SECTION 23 OF THE MISSOURI CONSTITUTION, IN THAT HOUSE BILL 393 CONTAINS A SINGLE SUBJECT RELATED TO CLAIMS FOR DAMAGES WHICH IS CLEARLY EXPRESSED IN ITS TITLE.

A. **Standard of Review**.

The standard of review for a constitutional challenge to a statute is *de novo*. ***City of Arnold v. Tourkakis***, *249 S.W.3d 202, 204 (Mo. banc 2008)*. The trial court in this matter did not address the constitutionality of section 490.715, but instead found that plaintiff/appellant failed to rebut the presumption "that the value of medical expenses...would be that as set forth in subpart 5(b) of the statute, that is, the amount actually paid for the medical treatment rendered to the party coupled with that set forth in parts 5(c) of the statute, and that is the amount or an estimate of the amount of medical bills not paid but for which the party is obligated to pay in the event of a recovery." (Tr. P. 59 Lines 10-20).

A statute is presumed to be constitutional and will not be held to be unconstitutional unless it clearly and undoubtedly contravenes the constitution. A statute will be enforced by the courts unless it plainly and palpably affronts fundamental law embodied in the

constitution. ***Blaske v. Smith & Entzeroth, Inc.***, *821 S.W.2d 822, 828 (Mo. banc 1991), citing* ***Winston v. Reorganized School District R-2, Lawrence County***, *636 S.W.2d 324, 327 (Mo. banc 1982)*. When the constitutionality of a statute is attacked, the burden of proof is upon the party claiming that the statute is unconstitutional. ***Blaske***, *821 S.W.2d at 828-29, citing* ***Schnorbus v. Director of Revenue***, *790 S.W.2d 241, 243 (Mo. banc 1990)*.

B. Argument

House Bill No. 393 does not violate Article III, § 23 of the Missouri Constitution. It addresses claims for damages; its title is "Claims—Damages—Payment." The revisions and additions to Missouri statutes as specified in House Bill No. 393 each are related to a litigant or potential litigant presenting and perfecting claims for damages. To be sure, there are many different Titles of the Revised Missouri Statutes that are dealt with in House Bill 393, but in reference to House Bill 393, each revision applies to or touches on the single subject of "Claims—Damages—Payment."

An act of the legislature carries a strong presumption of constitutionality. ***Hammerschmidt v. Boone County***, *877 S.W.2d 98, 102 (Mo. banc 1994)*. The Court resolves all doubts in favor of the procedural and substantive validity of legislative acts. ***Id.*** Attacks against legislative action founded on constitutionally imposed procedural limitations are not favored. ***Id.*** An act of the legislature must clearly and undoubtedly violate a constitutional procedural limitation before the Supreme Court will hold it unconstitutional. ***Id.*** Finally, the Court will attempt to avoid an interpretation of the Constitution that "will limit or cripple legislative enactments any further than what is

necessary by the absolute requirements of the law." ***State v. Miller***, *45 Mo. 495, 497 (1870).*

Article III, §23 of the Missouri Constitution provides: "[n]o Bill shall contain more than one subject which shall be clearly expressed in its title ...." The Missouri Supreme Court has stated that Article III, §23 places two distinct limitations on the procedures by which the general assembly may pass legislation: (1) a bill cannot contain more than one subject and (2) the subject must be clearly stated in its title. ***Carmack v. Director, Mo. Dept. of Ag.***, *945 S.W.2d 956, 959 (Mo. banc 1997).* House Bill 393 involves the single subject of making a claim for damages; and that subject is clearly identified in the title of the bill.

1. **The One Subject Rule**.

House Bill 393 does not contain more than one subject. ***Hammerschmidt*** teaches the first step is to look to the title of the bill to determine its subject. To the extent the bill's original purpose is properly expressed in the title to the bill, the Court need not look beyond the title to determine the bill's subject. ***Hammerschmidt***, *877 S.W. 2d at 102.* "Since the single subject rule first appeared in a Missouri Constitution, [the Supreme] Court has consistently attempted to avoid an interpretation of the Constitution that will 'limit or cripple legislative enactments any further than what was necessary by the absolute requirements of the law." ***Id***, (quoting ***Miller***, *45 Mo. at 497*).

The words "one subject" must be broadly read, but not so broadly that the phrase becomes meaningless. ***Id.*** The test for determining whether a bill violates the single subject requirement of Article III, section 23, has remained virtually the same since 1869.

Id. Provided "the matter is germane, connected and congruous," the law does not violate the single subject rule. ***State v. Mathews****, 44 Mo. 523, 527 (1869).* The Supreme Court has further stated: "[t]he test to determine if 'a bill contains more than one subject is whether all provisions of the bill fairly relate to the same subject, have a natural connection therewith or are incidents or means to accomplish its purpose.'" ***Westin Crown Plaza Hotel Co. v. King****, 664 S.W.2d 2, 6 (Mo. banc 1984).*

In ***Hammerschmidt,*** the Court concluded that a "subject" within the meaning of Article III, section 23, includes all matters that fall within or reasonably relate to the general core purpose of the proposed legislation. ***Hammerschmidt****, 877 S.W.2d at 102.*

In ***Hammerschmidt,*** the Court considered whether House Committee Substitute for House Bills 551 and 552 (H.C.S.H.B.s 551 and 552), enacted by the 87th General Assembly, First Regular Session (1993 Laws of Mo.) (West's No. 102, 1993 Vernon's Missouri Legislative Service No. 4, 668-676), violated the constitutional limitation imposed by Article III, §23. On January 20, 1993, two members of the House of Representatives introduced House Bills 551 and 552 as separate items of legislation. House Bill 551 permitted voter registration by mail and was entitled, "An Act To repeal section 115.159, RSMo 1986, relating to elections, and to enact in lieu thereof one new section relating to the same subject." House Bill 552 amended "The Mail Ballot Election Act" and bore the title: "An Act to repeal sections 115.652 and 115.660, RSMo Supp.1992, relating to elections, and to enact in lieu thereof two new sections relating to the same subject." ***Id, at 99.***

The Speaker of the House referred both bills to the House Elections Committee. After hearings, the committee combined the bills into a single piece of legislation, and reported House Committee Substitute for House Bills ("H.C.S.H.B.") 551 and 552 to the full House of Representatives with a "do pass" recommendation. ***Id.***

However, when the full House took up H.C.S.H.B.s 551 and 552, another representative offered an amendment on the House floor containing seven subsections that, provided that certain counties could adopt an alternative form of government and frame a county constitution. ***Id,*** *at 100.* The House approved the amendment and attached it to the bill as section 2. The new title of the bill read: "An Act To repeal section 115.159, RSMo 1986, and sections 115.562 and 115.660, RSMo Supp.1992, relating to elections, and to enact in lieu thereof five new sections relating to the same subject." ***Id.***

On March 3, 1993, the bill was read for the third time and passed the House as amended. The Senate adopted the bill on May 4, 1993 and the governor approved the bill on June 14, 1993. It took effect on August 28, 1993.

The Court in ***Hammerschmidt*** examined several purposes behind the requirement that a bill contain only one subject. But in the end the Court decided the case upon the conclusion that adopting a county constitution is not related to elections, and therefore H.C.S.H.B. 551 and 552 violated Article III, §23 of the Missouri Constitution in that the Bill contained two subjects. ***Id,*** *at 103.*

In ***Missouri State Medical Association v. Missouri Department of Health,*** *39 S.W.3d 837 (Mo. banc 2001),* the Court again was presented with a challenge to a law on

the grounds that it contained multiple subjects in violation of Article III, §23 of the Missouri Constitution. ***Id,*** *at 840.* In that case, the Court reiterated the test is "whether all provisions of [the bill] 'fairly relate to the same subject, have a natural connection therewith or are incidents or means to accomplish its purpose." ***Id,*** *citing* ***Hammerschmidt****, 877 S.W.2d at 102.*

The ***Missouri State Medical Association (MSMA)*** case involved a challenge to H.B. 191 which was entitled "an Act Relating Health Insurance coverage for cancer early detection." ***Missouri State Medical Association****, 39 S.W.3d at 839.* A provision within the law required standard information on the advantages, disadvantages, and risks, including cancer of breast implantation. ***Id.*** The final version of the act was entitled: An Act to repeal §§...relating to health services. ***Id.*** MSMA challenged the law suggesting, among other things, that the law violated Article III, § 23 because it covered multiple subjects. ***Id****, at 840.*

The Court concluded that MSMA failed to "clearly and undoubtedly" show that H.B. 191 contained multiple subjects. ***Id****, at 841*. In reaching this conclusion, the Court found that "[h]ealth insurance, medical records, and standard information are (at least) incidents or means to health services." ***Id.***

In the present case, the title of House Bill 393 clearly involves the single subject of claims for damages. A review of the bill reflects that all of the revisions to Missouri statutes as directed by House Bill 393 involve the process by which a litigant or a potential litigant present their claims for damages. Certainly, presenting claims for damages includes issues related to service of process, venue, parties, affirmative

defenses, immunities, judgments and interest thereon, joint and several liability and the bonds, if any, associated with the appellate process. Appellant directs the Court's attention to provisions within this bill that are not reflected by the revisions that are identified in House Bill 393. That is, a review of the bill reflects that all changes, deletion or additions touch on, are incidents to, or are germane to the subject of making a claim for damages.

2. **The Clear Title provision**.

Appellant suggests that the title to HB 393 is "so broad and amorphous in scope that it fails to give notice of its content, which effectively renders the 'single subject' requirement meaningless and obscures the actual subject of the legislation." Appellant's Brief, p. 45. In support of this proposition, appellant cites ***St. Louis Health Care Network v. State of Missouri***, *968 S.W.2d 145 (Mo. banc 1998).*

In ***St. Louis Health Care Network***, the court decided the case on the so-called clear title requirement. In order to survive a clear title challenge, a bill's title need not give specific details of a bill, but need indicate only generally what the act contains. *See* ***Lincoln Credit Co. v. Peach***, *636 S.W.2d 31, 39 (Mo. banc 1982).* The title cannot, however, be so general that it tends to obscure the contents of the act. ***Fust v. Attorney General***, *947 S.W.2d 424, 429 (Mo. banc 1997).* In addition, the title cannot be so broad as to render the single subject mandate meaningless. S*ee* ***Missourians to Protect the Initiative Process v. Blunt***, *799 S.W.2d 824, 832 (Mo. banc 1990).*

The 'clear title' provision ... was designed to prevent fraudulent, misleading, and improper legislation, by providing that the title should indicate in a general way the kind

of legislation that was being enacted." ***Fust, 947 S.W.2d at 429.*** The title may omit particular details of the bill, so long as neither the legislature nor the public is misled. ***Lincoln Credit, 636 S.W.2d at 39.*** A bill's multiple and diverse topics, absent specific itemization, can only be clearly expressed by their commonality--by stating some broad umbrella category that includes all the topics within its cover. ***National Solid Waste Mgmt. Ass'n v. Director of Dep't of Natural Res., 964 S.W.2d 818, 821 (Mo. banc 1998).***

In its most recent statement on this subject, the Court in ***State of Missouri v. Salter, 250 S.W. 3d 705 (Mo. banc. 2008)*** rejected a challenge to Missouri's Workers' Compensation statute asserting that it violated Article III, §23 of the Missouri Constitution.

Mr. Salter, having once been convicted of a misdemeanor for failing to procure workers' compensation insurance, was again tried and convicted of failing to procure workers' compensation insurance. ***Id, at 708.*** Because this was Mr. Salter's second time facing this charge, the violation was enhanced to a class D Felony. Mr. Salter was tried and convicted by a jury and was sentenced to 1 year in jail and fined in the amount of $5,000 pursuant to chapter 558 and was fined $25,000.00 under chapter 287. Mr. Salter challenged House Bill 1237 as unconstitutional for violating Article III, §23 of the Missouri Constitution.

The Supreme Court reiterated in ***Salter*** that "the purpose of the clear title requirement is to keep legislators and the public fairly apprised of the subject matter of pending laws. ***Trout v. State, 231 S.W.3d 140, 144-45 (Mo. banc 2007).*** This requirement

is violated when the title is underinclusive or too broad and amorphous to be meaningful. ***Jackson County Sports Complex Auth. v. State,*** *226 S.W.3d 156, 161 (Mo. banc 2007).* The only cases where the Supreme Court has found a title to be too broad and amorphous are those in which the title could describe the majority of all the legislation that the General Assembly passes. ***Id.*** "In all other cases in which the bill's title 'does not describe most, if not all, legislation enacted' or include nearly every activity the state undertakes, the Court has rejected arguments that a title was overinclusive." ***Id.***

Mr. Salter argued that the enactment of H.B. 1237, which was entitled "An Act to repeal [27 sections] relating to workers' compensation, and to enact in lieu thereof twenty-nine new sections relating to the same subject, with penalty provisions" was unconstitutional because it contained more than one subject. ***Id,*** *at 710.* The Supreme Court noted the bill set forth substantive provisions of the workers' compensation law, the means for enforcing that law, the penalties for noncompliance, and programs that further the purpose of the law. ***Id.*** The Court concluded the subject matter contained in H.B. 1237 fairly related to its title and found the contested bill did not contain more than one subject. ***Id,*** *at 710.*

Mr. Salter also argued the title of the bill did not clearly express the subject contained therein. ***Id.*** The Supreme Court noted the following cases in which it found that the titles did not violate the clear title requirement:

> relating to 'political subdivisions,' ***Id,*** at 162; 'general not for profit corporations,' ***State ex rel. St. John's Mercy Health Care v. Neill,*** *95 S.W.3d 103, 106 (Mo. banc 2003);* 'relating to health services,' ***Mo. State Med. Ass'n v. Mo. Dept. of Health,*** *39 S.W.3d 837, 841 (Mo. banc 2001);* 'relating to transportation,' ***C.C. Dillon Co.,*** *12 S.W.3d at 329;* and 'relating

to environmental control,' ***Corvera Abatement Tech., Inc. v. Air Conservation Comm'n,*** *973 S.W.2d 851, 861-62 (Mo. banc 1998).*

Id.

The court found that "the title "An Act to repeal [27 sections] relating to workers' compensation ..." was not so broad that it describes most of the legislation that the legislature enacts. The title contains one subject-workers' compensation. The title fully apprises the public and the legislature of the subject matter within the statute.

3. **House Bill 393.**

Appellant has myopically focused on single sentences, subdivisions or provisions of the revised statutes within House Bill 393 to suggest that it violates Article III, §23 of the Missouri Constitution.

Indeed, as appellant states in her Brief, §355.176 is a statute dealing with non-profit entities. But that section does deal with claims for damages in that it directs a potential litigant on the statutory requirements for serving process, notices or demands required or permitted by law on such non-profit entities. Accordingly, its treatment within House Bill 393 is appropriate because it is related to the subject of claims for damages.

Section 512.099, in all cases in which there is a count alleging a tort –which is a claim for damages—sets the limitations of the bond required during the pendency of an appeal. Likewise, the section's treatment within House Bill 393 is appropriate because it is related to the subject of claim for damages.

As appellant notes in her Brief, HB 393 revises the law on interest calculations pursuant to RSMo. §408.040. It provides that in tort actions, interest is allowed on all money due upon any judgment or order of any court from the date the judgment is entered by the trial court until full satisfaction, provided the claimant makes the demand for damages under specific conditions.

House Bill 393 revises section 490.715 to modify the collateral source rule. In addition, it adds provisions related to the introduction of evidence related to the value of medical treatment rendered. The introduction of the value of medical bills, whatever the calculation yields, certainly encompasses a claim for damages.

All of the other statutes enacted in House Bill 393 deal with areas of the law regarding claims for damages. The other House Bill 393 statutes are as follows:

a. Section 508.010 deals with the venue for a cause of action seeking damages, and sets out specifically actions in tort.

b. Section 508.010.4 Section 508.011 simply provides priority of any conflict between Mo. Sup. Ct. R. 51.03 and any provision of the chapter regarding any tort claim.

c. Section 510.163 deals with bifurcated trials for claims asserting punitive damages, including tort actions based upon improper health care.

d. Section 510.265 was added to set the limitation on the award of punitive damages.

e. Section 516.105 was revised to include a provision limiting the cause of action of negligent failure to inform of medical tests, which is a claim for damages.

f. Section 537.035 was amended to address interviews and memoranda associated with peer review committees in medical malpractice claims and prevented disclosure of such interviews and memoranda by way of discovery or subpoena; and if such interviews or memoranda were disclosed to any person, entity, including but not limited to governmental agencies, then such disclosure did not operate as a waiver of such privilege in any action for damages.

g. Section 537.067 was revised to change the treatment of joint and several liability in tort cases where litigants are making claims for damages.

h. Section 537.090 was revised to include a calculation of damages in wrongful death actions by establishing a rebuttable presumption of the value of care provided for minor children or elder persons over sixty-five as equal to one hundred ten percent of the states average weekly wage, as computed in RSMo. §287.250.

i. Section 538.205 was revised to include those licensed under chapter 198 (convalescent, nursing and boarding homes) within the definition of health care provider and to amend the definition of punitive damages; all of which deal with claims for damages.

j. Section 538.210 was amended to modify the calculation of non-economic damages in claims for damages relating to health care providers.

k. Section 538.220 modified the requirements for payment of future medical damages.

l. Section 538.225, was revised to include a definition of a "legally qualified health care provider" in actions for damages for personal injury against a health care provider.

m. Section 538.228 was added to provide immunity to certain health care professionals from claims for damages when such health care professional is performing work at a non-profit community health center or solely providing free health care services.

n. Section 538.229 was added in actions for damages against health care providers to preclude the introduction of evidence in such cause of action, of any statements, writings or acts of benevolent gestures expressing sympathy to the pain or death of a person to that person's family.

o. Section 538.232 was added to address venue in actions for damages against health care providers.

p. Section 532.300 was revised to restrict the application of certain statutes to claims for damages arising under 538.205 to 538.230.

It is clear from a reading of the statutes affected by House Bill 393, each were enacted --by either addition or modification-- for the purposes of legislating claims for damages. The title of House Bill 393 clearly involves the single subject of claims for damages. A review of the bill reflects that all of the revisions to Missouri statutes as directed by House Bill 393 involve the process by which a litigant or a potential litigant presents their claims for damages.

As stated above, presenting claims for damages includes issues related to lawful demands, service of process, venue, parties, affirmative defenses, immunities, judgments and interest thereon, joint and several liability, evidentiary issues and the bonds, if any, associated with the appellate process.

Appellant directs the Court's attention to provisions within this bill that are not reflected by the revisions that are identified in House Bill 393. That is, a review of the bill reflects that all changes, deletion or additions touch on, are incidents to, or are germane to the subject of making a claim for damages.

V.

THE TRIAL COURT DID NOT ERR IN EXCLUDING EXPERT TESTIMONY PERTAINING TO APPELLANT'S POSSIBLE FUTURE MEDICAL CONDITION AND TREATMENT, BECAUSE SUCH EVIDENCE OF POSSIBLE FUTURE MEDICAL TREATMENT WAS ADMITTED TO THE TRIER OF FACT FOR EVALUATING THE NATURE AND EXTENT OF APPELLANT'S INJURIES, IN THAT SUCH EVIDENCE WAS PRESENTED BY APPELLANT THROUGH EXPERT WITNESS DR. SHANE BENNOCH.

A. Standard of Review

The standard of review is abuse of discretion. ***Swartz v. Gale Webb Transportation Co.***, *215 S.W.2d 127, 129-130 (Mo. banc 2007).* The trial court has broad discretion in determining the admission or exclusion of evidence, and review is for an abuse of that discretion. ***Porter v. Director of Revenue, State of Mo***, *168 S.W.3d 147, 150 (Mo.App. S.D. 2005).*

B. Argument

1. Rule 84.04(d).

Appellant argues that the trial court committed error by refusing to admit testimony by appellant's retained medical expert, Dr. Shane Bennoch, as to possible future surgery and the estimation of the cost of that possible surgery. Appellant maintains this is error which requires reversal of the trial court verdict. However, the trial court did not exclude evidence of possible future surgery.

Appellant's point relied on states "the trial court erred in excluding expert testimony pertaining to appellant's possible future medical condition and treatment . . . ." This point is a broad misstatement of the ruling or action of the trial court. This broad generalization of error forces respondent to assume that the alleged error is the trial court's refusal to admit evidence of the estimated cost of possible future shoulder surgery.

Respondent notes "a point relied on written contrary to the mandatory requirements of Rule 84.04(d), which cannot be comprehended without resorting to other portions of the brief, preserves nothing for appellate review". ***Storey v. State**, 175 S.W.3d 116, 126 (Mo. banc 2005) (citing **State v. Dodd**, 10 S.W.3d 546, 556 (Mo.App. W.D. 1999).* Rule 84.04(d) requires an appellant "identify the trial court ruling or action that the appellant challenges". ***Columbia Mutual Ins. Co. v. Long**, 258 S.W.3d 469, 473 (Mo.App. W.D. 2008) citing* Rule 84.04(d)(1)(A). As this court noted in ***Bishop v. Metro Restoration Services, Inc.**, 209 S.W.3d 43 (Mo.App. S.D. 2006)*:

> The purpose of this rule is to give notice to the opposing party as to the precise matter that must be contended with and to inform the court of the issues presented for review.

***Id**, at 46, citing **Harrison v. Woods Supermarkets, Inc.**, 115 S.W.3d 384, 387 (Mo.App. S.D. 2003).* Furthermore, this court has held "an appellate court is obligated to determine only those questions stated in the points relied on". ***Bishop**, at 47 quoting **McMillan v. Wells**, 924 S.W.2d 33, 37 (Mo.App. S.D. 1996); **Winter v. Winter**, 167 S.W.3d 239 (Mo.App. S.D. 2005); **Richmond v. Springfield Rehab and Healthcare**, 138 S.W.3d 151 (Mo.App. S.D. 2004).*

Appellant's point relied on does not comply with Civil Rule 84.04 and the established law of this court. Assuming that this Court of Appeals will exercise discretion and choose to review appellant's point on appeal, respondent argues accordingly.

2. Exclusion of Estimated Cost of Possible Future Surgery.

Appellant states that the trial court committed error by the "exclusion of the evidence of the possible future consequences of the injury". This is erroneous. As will later be discussed in greater detail, the trial court did admit evidence and allow argument of possible future medical consequences. (Tr. P. 330 Line 17 – P. 331 Line 1). The standard cited by appellant in ***Swartz v. Gale Webb Transportation Co.***, *215 S.W.3d 127 (Mo. banc 2007)*, was, accordingly, not violated. The trial court did not admit testimony by appellant's retained medical expert Dr. Bennoch, as to his estimated cost of any possible future surgery. A complete review of the evidence before the trial court establishes that the exclusion of this cost estimate was not an abuse of discretion which justifies reversal of the trial court verdict.

Not mentioned in appellant's brief is the testimony of Dr. Thomas Kelso, M.D., the treating orthopedic surgeon who performed surgery for repair of the shoulder injury at issue. The testimony of Dr. Kelso establishes that any cost estimate of possible future surgery by Dr. Bennoch was speculative and inadmissible under Missouri law. Furthermore, the testimony of Dr. Kelso clearly establishes that the cases cited by appellant are clearly distinguishable from the facts and evidence in the case at bar.

The videotaped deposition of Dr. Kelso was presented at trial by appellant. (Tr. P. 282 Lines 9-10). Dr. Kelso testified that he diagnosed appellant's shoulder injury, that he performed the arthroscopic surgery to the shoulder and that he provided post surgery examination and treatment. (L.F. at 41, Kelso deposition P. 14 Lines 5-12; L.F. at 43-47, Kelso deposition P. 24-37). On cross examination, Dr. Kelso testified that four months following surgery, appellant was "nearly 100 percent improved". (L.F. at 44-45, Kelso deposition P. 28 Line 17 – P. 29 Line 9). Dr. Kelso further testified under cross examination that appellant came back one year and two months later on September 25, 2006 with a complaint of pain when sleeping on the shoulder, and lifting above her head. (L.F. at 45, Kelso deposition P. 31 Lines 4-12). Dr. Kelso testified this visit resulted in a medical records entry of litigation pending and that appellant "would like to line this up". (L.F. at 45, Kelso deposition P. 31 Line 22 – P. 32 Line 13). Dr. Kelso testified that an MRI was performed at that time, September 25, 2006, to determine whether a full thickness rotator cuff tear had developed after surgery, stating "if there was one there, then I would have had to take her back and operated on her again. But it didn't show up." (L.F. at 47, Kelso deposition P. 38 Line 18 – P. 39 Line 12).

The testimony of appellant's retained medical expert, Dr. Bennoch, established that he saw appellant on November 21, 2007, for examination and evaluation. (Tr. P. 202 Lines 21-24). Dr. Bennoch also testified he only saw appellant on one occasion, that he did not provide any treatment or other medical services, and that he only saw appellant for the purpose of giving opinions and testifying about those opinions. (Tr. P. 240 Lines 1-16). Dr. Bennoch testified that he is a family practice physician, with board

certifications in pediatrics, advanced cardiac life support, and advanced trauma life support. (Tr. P. 197 Line 6 – P. 198 Line 24). Dr. Bennoch testified he does not perform arthroscopic shoulder surgery. (Tr. P. 228 Line 16 – P. 229 Line 9).

The testimony of Dr. Bennoch regarding possible future shoulder surgery, preceding the objection and exclusion of estimated cost, is placed in proper context when reviewed in full. Dr. Bennoch testified as follows:

Q. Now, I want you to assume for a moment that according to Edie that the right shoulder is getting worse and not better even since she saw you, and she saw you on November 21st, 2007; is that right?

A. Correct.

Q. Now, if in fact that's true, it's getting worse, her right shoulder, than better, what future medical studies would you recommend?

A. Well, I think she needs a repeat MRI, and once she has that done, if she was my patient and I was going to direct her care, then I would send her to – there are several, but there's a physician I send patients to in St. Louis who does only shoulders, and he is extremely good at them. And I think if you combine the fact that she's had previous surgery and she is older, then you want to try and get the best success you can, if she needs surgery.
She may not need surgery. And I would be real reluctant to recommend surgery because of her age unless you're seeing, you know, at this – certainly at this stage, but now if she's just getting gradually worse then she may need surgery.

Q. Now, what is the cost of an MRI of the right shoulder?

A. It's around $1500. It varies.

Q. Now, if that MRI shows further deterioration in the joint consistent with her increasingly – her shoulder getting increasingly worse, what surgical procedure is a possibility?

A. Well, I mean, again, they would have to do much more extensive debridement of the labrum. They probably would also have to do

debridement of the bone, perhaps even the cysts, the subchondral cysts, because those could be irritating things. They shouldn't have to do anything to the rotator cuff specifically. It all appears to be labrum that's causing a problem now.

Q. That could all be done arthroscopically?

A. Most of the time. I mean you can never say for sure. Sometimes you have to do it as – arthroscopically just means you go through little, little tiny holes and you do it with glasses, and so – but occasionally you have to do it with an open procedure where you cut them and open it up, but most the time it can be done arthroscopically.

Q. What would be the fair value of – reasonable value of that arthroscopic surgery be?

(Tr. P. 228, Line 10 - 230, Line 10).

As this testimony clearly reflects, Dr. Bennoch testified that if a repeat MRI showed further deterioration, he would refer appellant to an orthopedic specialist, noting "You want to try and get the best success you can, if she needs surgery. She may not need surgery." (Tr. P. 229 Lines 2-3). Dr. Bennoch continues to testify as to surgery being dependent upon the evaluation and opinion of referred shoulder specialists. (Tr. P. 228 Line 16 – P. 229 Line 9). Following Dr. Bennoch's testimony before the jury, he provided additional testimony in the offer of proof referenced in appellant's brief. Dr. Bennoch testified that if an additional MRI showed further deterioration of the joint, another shoulder surgery "Is, in my opinion, a possibility."[2] (Tr. P. 267 Line 20 – P. 268

[2] It must also be noted that the "possibility then becomes a certainty" testimony, referenced in appellant's brief, occurred after the sustained objection and was not part of the offer of proof. (Tr. P. 230 Line 9 – P. 231 Line 8). Aside from the fact this isolated

Line 4). On cross examination in the offer of proof, Dr. Bennoch testified he never consulted with treating orthopedist Dr. Kelso, that he never consulted with any other physicians regarding appellant, and that any testimony he gave regarding future medical treatment was speculation. (Tr. P. 271 Line 7 – 272 Line 6).

The full review of expert medical testimony places the issue of future medical treatment in the proper context, and clearly distinguishes the case at bar from the cases cited in appellant's brief. In each case cited by appellant, ***Swartz v. Gale Webb Transportation Co.,*** *215 S.W.3d 127 (Mo. banc 2007),* ***Breeding v. Dodson Trailer Repair, Inc.,*** *679 S.W.2d 281 (Mo. banc 1984),* ***Bynote v. National Supermarkets, Inc.,*** *891 S.W.2d 117 (Mo. banc 1995),****Emery v. Wal-Mart Stores, Inc.,*** *976 S.W.2d 439 (Mo. banc 1998),* and ***Stephens v. Guffey,*** *409 S.W.2d 62 (Mo. 1966)* the expert medical evidence was not inconsistent and in conflict. In each case except one, there were two medical experts in agreement as to the increased risk or possibility of future surgery. In ***Breeding,*** *679 S.W.2d 281,* there was only one medical expert, and he provided the only testimony as to possible future surgery. The rationale of these cases strongly suggests

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"yes" answer to a leading question is inconsistent with the pre-objection and offer of proof testimony, it occurred after the objection was sustained and there was no further attempt by appellant's attorney to elicit a cost estimate of surgery. The request for a cost estimate did not occur before this testimony, as is inferred in appellant's brief. Accordingly, this testimony is of minimal significance.

that consistent expert testimony supports admission of evidence of possible future medical treatment.

In ***Stephens,*** *409 S.W.2d 62,* the Supreme Court noted that a complete review of consistent medical evidence supports admission, stating "[s]uch evidence when reviewed in entirety rather than in isolated bits removes this case from speculative situations such as causes from a burn when the only testimony admitted of a 'possibility'." ***Id,*** *at 70 citing* ***Hahn v. McDowell,*** *349 S.W.2d 479, 482 (Mo.App. E.D. 1961).* In ***Breeding,*** the ***Hahn*** opinion was also noted as a guide for determining inadmissible speculation. In ***Breeding***, the evidence established possible future surgery "to be a legitimate medical alternative to the conservative treatment that the plaintiff was receiving". ***Id,*** *at 284.* This follows the holding in ***Hahn***, where the court stated:

> It is undoubtedly true that in an action to recover damages for personal injuries, testimony of experts as to the future consequences which are expected to follow the injury are competent, but to authorize such evidence, however, the apprehended consequences must be such as in the ordinary course of nature, are reasonably certain to ensue.

Id, *at 482.*

The medical evidence in the case at bar, reviewed in entirety rather than isolated bits, establishes that the trial court followed the ***Stephens, Breeding*** and ***Hahn*** rationale. The treating orthopedic surgeon, Dr. Kelso, performed a post-surgery MRI, and found no injury or condition to warrant future surgery. (L.F. at 46, Kelso deposition, P. 36 Lines 6-20; L.F. at 48, Kelso deposition P. 41 Lines 3-11). Dr. Bennoch's testimony, based on one examination for evaluation and testimony, recommended a second post surgery MRI, and possible referral to a shoulder specialist for possible determination of future surgery.

(Tr. P. 228 Line 16 – P. 229 Line 9). When compared to the testimony of Dr. Kelso, this evidence does not suggest an apprehended consequence, in the ordinary course of nature, reasonably certain to ensue. This does not suggest a legitimate medical alternative to the treatment received from orthopedic surgeon Dr. Kelso.

Furthermore, the Supreme Court in ***Swartz, Emery,*** and ***Bynote,*** specifically notes that the medical experts agreed to the increased risk or possible need for future surgery. In ***Swartz***, the Court stated the experts agreed the plaintiff "was reasonably certain to have an increased risk of needing back surgery in the future". ***Id, at 130.*** This is not the evidence in the case at bar. The treating orthopedist Dr. Kelso does not recommend future surgery, while the retained consultant Dr. Bennoch testified future surgery was possible, based on contingencies. Under Missouri law, the estimated cost of future surgery is inadmissible speculation.

"A trial court will be found to have abused its discretion when a ruling is clearly against the logic of the circumstances then before the court and is so arbitrary and unreasonable as to shock the sense of justice and indicate a lack of careful consideration." ***Swartz,*** *215 S.W.2d 127, at 130.* "The trial court has discretion to determine an expert's qualifications to testify on specific matters." ***Bynote,*** *891 S.W.2d 117, at 125.* The medical evidence and qualifications of medical experts Dr. Kelso and Dr. Bennoch, viewed in entirety and not in isolated bits, establishes that the trial court did not abuse discretion.

As previously noted, appellant erroneously argues that the trial court excluded evidence of possible future surgery and possible future medical consequences. Appellant

maintains that the trial court committed reversible error by failing to follow the standard in ***Swartz***. A thorough review of the holding in ***Swartz*** and the transcript in the case at bar establish otherwise.

In ***Swartz***, the Supreme Court held that risk of possible future surgery or possible future complications "is admissible to aid the jury in assessing the extent and value of plaintiff's present injuries, even if those future consequences are not reasonably certain to occur". This is specifically acknowledged and stated in appellant's brief. In the case at bar, Dr. Bennoch's testimony of possible future surgery or possible future consequences was admitted and argued. (Tr. P. 228 Line 10 – P. 230 Line 8; P. 330 Line 17 – P. 331 Line 1). Only testimony of estimated cost of possible future surgery was excluded as speculation. (Tr. P. 230 Line 9 – P. 231 Line 1). This is clearly established in the transcripted proceedings to determine limitations on closing argument. (Tr. p. 324 Line 19 – 331 Line 1). The trial court overruled respondent's objection to argument as to possible future medical, noting that this related to a "matter of general damages". (Tr. P. 330 Line 17 – P. 331 Line 1). Appellant was only prevented from arguing the estimated cost of future surgery – and, as earlier established, this testimony was excluded as inadmissible speculation.

In ***Swartz***, the Supreme Court held a jury can consider evidence that an injured party must cope "with not knowing whether she is going to have surgery in the future" and with the possibility of additional complications arising, as it determines compensation. Such evidence was before the jury in the case at bar.

Even if appellant's argument is accepted that cost testimony must accompany evidence of possible future medical treatment, the decision of the trial court to exclude Dr. Bennoch's cost estimate is at worst harmless error, and more accurately no error at all.

The testimony of Dr. Bennoch was that the possible future surgery would be arthroscopic debridement of the labrum and bone. (Tr. P. 229 Line 13-24). Appellant's attorney requested an estimate of the "reasonable value of that arthroscopic surgery". (Tr. P. 230 Lines 9-10). The surgery performed by Dr. Kelso, appellant's treating orthopedic surgeon, was arthroscopic debridement, including the bone, and decompression to repair shoulder impingement, acromioclavicular joint arthrosis, shoulder labral tear, type I SLAP lesion, and a partial thickness articular surface rotator cuff tear. (L.F. at 40, Kelso deposition, P. 12 Lines 3-22; L.F. at 41, Kelso deposition P. 14 Lines 5-12). The cost of appellant's past medical treatment, including the extensive arthroscopic shoulder surgery was before the jury. The testimony of possible future surgery by Dr. Bennoch described an arthroscopic procedure far less extensive than the arthroscopic procedure performed by Dr. Kelso. Accordingly, it strains credibility for appellant to argue that any cost estimate by Dr. Bennoch was improperly excluded in the face of the known cost of a past arthroscopic shoulder surgery. The cost estimate sought by appellant came from a retired family practice physician who never performed arthroscopic shoulder surgery and would be based on one examination for evaluation and testimony. The cost estimate by Dr. Bennoch would not be subject to the standards for determination of value under RSMo. §490.715.5. Accurate evidence of the cost of an

arthroscopic surgery to the shoulder was before the jury in the form of established value of the arthroscopic surgery and treatment provided by Dr. Kelso. The exclusion of the cost estimate testimony of Dr. Bennoch was not error and even if technically considered "error" under the ***Swartz*** rationale, the error was harmless.

"The admission or exclusion of evidence, especially expert evidence, is a matter of trial court discretion." ***Newell Rubbermaid, Inc. v. Efficient Solutions, Inc.***, *252 S.W.3d 164, 170 (Mo.App. E.D. 2007),* quoting ***Twin Chimneys Home Owners Ass'n v. JE Jones Const. Co.***, *168 S.W.3d 488, 504 (Mo.App. E.D. 2005).* Upon finding an abuse of discretion, reversal will occur only if prejudice results from the improper admission of evidence, and such prejudice is outcome determinative. ***Williams v. Trans States Airlines, Inc.***, *281 S.W.3d 854, 872, citing* ***State v. Barriner***, *34 S.W.3d 139, 150 (Mo. banc 2000).* As this court has held in ***Bank of America NA v. Stevens***, *83 S.W.3d 47 (Mo.App. S.D. 2002)*, reversal requires more than trial court error. "Reversal is only mandated if the trial court's error materially affected the merits of the action." ***Id***, *at 56, citing* ***Lewis v. Wahl***, *842 S.W.2d 82, 84-85 (Mo. banc 1992).* Appellant "must not only show error, but that such error was prejudicial". ***Id***, *at 56, citing* ***Duffy v. Director of Revenue***, *966 S.W.2d 372, 379 (Mo.App. 1998);* ***Jerry Bennett Masonry, Inc. v. Crossland Constr. Co., Inc.***, *171 S.W.3d 81 (Mo.App. S.D. 2005);* ***Porter v. Director of Revenue State of Mo.***, *168 S.W.3d 147 (Mo.App. S.D. 2005);* ***Pruett v. Pruett***, *280 S.W.3d 749 (Mo.App. S.D. 2009).*

Assuming arguendo that it was error for the trial court to exclude testimony from Dr. Bennoch estimating the cost of possible future shoulder surgery, appellant has failed

to establish prejudice mandating reversal. Substantive evidence of the cost of arthroscopic shoulder surgery was before the jury, based on the credibility of the treating orthopedic surgeon, and tested by the value standards of RSMo. §490.715.5. The cost estimate sought by appellant suggested windfall damages, offered through a source with questionable qualifications and credentials. Any argument by appellant to the contrary is illogical and incredible. Appellant's argument must fail.

CONCLUSION

The trial court did not err in ruling that appellant's claim for past medical expenses was the amount actually paid for medical treatment rendered in the amount of $9,904.28. Appellant failed to rebut the presumption in RSMo. §490.715.5. The uncontroverted evidence established that the dollar amount necessary to satisfy the financial obligations to appellant's healthcare providers was $9,904.28. Accordingly, the trial court determined the value of medical treatment rendered in accordance with the mandate of RSMo. §490.715.5.

Section 490.715 does not violate Article I, §22(a) of the Missouri Constitution and plaintiff has not been denied a trial by jury. The hearing required by 490.715.5 does not interfere with the right to trial by jury, does not violate the collateral source rule and it effectuates the principal that damages in tort are to be compensatory. Plaintiff is allowed to present the actual dollar amount in medical damages which are known and ascertained to the jury. Defendant is not allowed to inform the jury that plaintiff recouped payment for those actual medical bills from a collateral source.

House Bill 393 does not violate Article III, §23 of the Missouri Constitution. House Bill 393 clearly involves the single subject of claims for damages. A review of the Bill reflects that all of the revisions to Missouri statutes as directed by House Bill 393 involve the process by which a litigant or a potential litigant presents their claims for damages.

The trial court admitted evidence of possible future medical conditions in accordance with the rationale of ***Swartz v. Gale Webb Transportation Co.***, *215 S.W.2d*

127(Mo. banc 2007). The trial court did not err by refusing to admit testimony of the estimated cost of possible future surgery, under Missouri law.

For the aforementioned reasons, respondent respectfully moves the Court for its holding affirming the verdict of the trial court.

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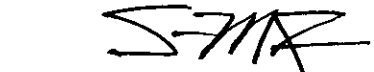
CERTIFICATE OF COMPLIANCE

Appellant hereby certifies that this Respondent's Brief complies with the limitations set forth in Rule 84.06(b) and contains 27,015 words and 2,682 lines of type, according to the tool count in Word for Windows, the word processing software used to prepare the foregoing brief.



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CERTIFICATE OF SERVICE

The undersigned hereby certifies that one true and accurate copy and one CD-ROM of the foregoing was mailed, postage prepaid, this 4th day of November, 2009, to:

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