BILLED V. PAID – WHY THE AMOUNT BILLED BY A MEDICAL PROVIDER IS THE ONLY AMOUNT A JURY SHOULD CONSIDER IN DETERMINING THE REASONABLE VALUE OF MEDICAL CARE IN A NORTH DAKOTA PERSONAL INJURY ACTION

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ABSTRACT

In almost every North Dakota personal injury trial, a jury must decide the reasonable value of an injured plaintiff's medical care in determining damages. Despite settled case law, there is disagreement about the evidence a jury should be allowed to consider in making the determination. Specifically, parties argue whether a jury should be allowed to consider the amounts *billed* by a plaintiff's medical providers, the amounts *paid* by a plaintiff's health insurer, or both. North Dakota district courts have not universally reached the outcome supported by long-standing North Dakota Supreme Court precedent interpreting the State's collateral source statute. As a result, this Article details how North Dakota law and principles of equity and public policy support the conclusion that a district court should only allow a jury to consider the amounts *billed* by a plaintiff's medical providers in determining the reasonable value of the plaintiff's medical care.

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I. INTRODUCTION

In almost every trial of a personal injury claim brought in North Dakota, a jury must decide the reasonable value of an injured plaintiff's medical care in determining damages. But what evidence should the jury be allowed to consider in making that determination: the amounts *billed* by a plaintiff's medical providers, the amounts *paid* by a plaintiff's health insurer, or both? Interestingly, this question already has been directly decided by the North Dakota Supreme Court.[1] It is an issue that should be consistently decided in favor of plaintiffs because of clear, long-standing North Dakota Supreme Court precedent interpreting North Dakota's collateral source statute.[2] Specifically, juries should only be allowed to consider the amounts *billed* by a plaintiff's medical providers. North Dakota district courts, however, have not universally reached this outcome.

In an effort to prevent unanimity among North Dakota district courts, defendants attempt to offer evidence of the amounts *paid* by a plaintiff's health insurer as the reasonable value of the medical care. Defendants often cite to a muddled decision rendered before both the enactment of the State's collateral source statute and the foremost Supreme Court decision interpreting it.[3] While many North Dakota district courts are correctly ruling in favor of plaintiffs on this issue with increasing frequency,[4] other North Dakota district courts

1. Dewitz *ex rel.* Nuestel v. Emery, 508 N.W.2d 334, 340-41 (N.D. 1993).

2. *Id.*; N.D. CENT. CODE § 32-03.2-06 (2019). The collateral source statute was enacted in 1987. Act of Apr. 9, 1987, ch. 404, § 6, 1987 N.D. Laws 989, 991.

3. *See generally* Klein v. Harper, 186 N.W.2d 426 (N.D. 1971).

4. *See generally* Order Granting Motion in Limine to Exclude Collateral Source Payments, Steele v. DeRosier, No. 08-2018-CV-00621 (N.D. S.C. Jud. Dist. May 3, 2019) [hereinafter Steele]; Orders Relating to Plaintiffs Motions in Limine, Siefke v. Jensen, No. 27-2017-CV-00327 (N.D. N.W. Jud. Dist. May 3, 2019) [hereinafter Siefke]; Order Granting Motion in Limine, Evans v. Schwols, No. 08-2017-CV-01414 (N.D. S.C. Jud. Dist. Sept. 7, 2018) [hereinafter Evans]; Order on Motion in Limine to Exclude Collateral Source Payments, Bilharz v. T.K. Stanley, Inc., No. 53-2016-CV-00233 (N.D. N.W. Jud. Dist. June 1, 2017) [hereinafter Bilharz]; Order Granting Motion in Limine to Exclude Insurance Information, Svoboda v. Holmes Enter., LLC, No. 18-2014-CV-00612 (N.D. N.E.C. Jud. Dist. Aug. 27, 2015) [hereinafter Svoboda]; Order on Motions in Limine,

continue to misapply the law and reach incorrect evidentiary rulings. As a result, it has created uncertainty across the State in what should be a very certain and predictable area of the law.

The incorrect decisions run counter to North Dakota statutory law, North Dakota case law, and principles of equity and public policy. Hoping to prevent inconsistent rulings across the State, this Article makes clear that North Dakota district courts should only admit evidence of the amounts *billed* by a plaintiff's medical providers and exclude any evidence of the amounts *paid* by a plaintiff's health insurer in determining the reasonable value of a plaintiff's medical care. It can serve as a guidepost for North Dakota courts to universally reach this conclusion.

II. CONFUSION

The most common way this issue is addressed in cases across North Dakota is through pre-trial motions in limine. A motion in limine is a motion directed to the court before evidence is received or offered by an opposing party. "A motion in limine is a procedural tool to ensure that potentially prejudicial evidentiary matters are not discussed in the presence of the jury."[5]

In evaluating this issue in the context of a motion in limine, courts, typically, are confronted with evidentiary arguments based in relevance. Plaintiffs argue the amount billed by a medical provider is the only relevant amount a jury should consider in evaluating the reasonable value of a plaintiff's medical care. Defendants argue a jury should consider the amount paid by a health insurer or *both* the amount billed and paid. Unsurprisingly, the amounts billed by a plaintiff's medical providers universally exceed any amounts paid by a plaintiff's health insurer, creating obvious incentives for both parties to argue in favor of their preferred position.

Important to the analysis, there is long-standing precedent that prevents a jury, generally, from hearing references to, or evidence concerning, insurance.[6] Specifically, as it relates to this issue, courts prevent parties from

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Voegele v. Fenton, No. 29-2013-CV-0013 (N.D. S.C. Jud. Dist. Apr. 24, 2014) [hereinafter Voegele]; Memoranda Decision and Order Denying Motion to Exclude Expert Evidence Relating to Life Care Plan and Relating to the Limitation of Past and Present Med. Damages, Weiler v. Field, No. 08-10-C-998 (N.D. S.C. Jud. Dist. Nov. 30, 2011) [hereinafter Weiler]; Order Granting Motion in Limine, Hutton v. Moore, No. 18-08-C-501 (N.D. N.E.C. Jud. Dist. May 14, 2009) [hereinafter Hutton]; Memorandum Opinion and Order, Grindberg v. MeritCare Med. Grp., No. 09-05-C-02578 (N.D. E.C. Jud. Dist. June 12, 2007) [hereinafter Grindberg].

5. Williston Farm Equip., Inc. v. Steiger Tractor, Inc., 504 N.W.2d 545, 550 (N.D. 1993).

6. Ceartin v. Ochs, 516 N.W.2d 651, 653-54 (N.D. 1994); N.D. R. EVID. 411 (stating, "Evidence that a person was or was not insured against liability is not admissible to prove whether the person acted negligently or otherwise wrongfully. But the court may admit this evidence for another purpose, such as proving a witness's bias or prejudice or proving agency, ownership, or control.").

introducing references to, or evidence concerning, whether a plaintiff had health insurance.[7]

Within these limitations, the parties typically confuse the issue by first basing their arguments on a relevance standard,[8] although there is clear North Dakota statutory and Supreme Court precedent that answers the question without having to engage in a Rule 401 relevance argument or a Rule 403 balancing test.[9] Instead, the issue should be decided by analyzing North Dakota's collateral source statute and the North Dakota Supreme Court's decision in *Dewitz ex rel. Nuestel v. Emery*.[10]

Like all cases, there are facts. To better understand this issue, let's discuss a common set in the following hypothetical.

III. THE CRASH

Ellie jumped into her freshly-washed, black car. She left her rural North Dakota driveway excited for her lunch date. The sun shined bright. The air was crisp. The color of the leaves on the trees made for a beautiful autumn cocktail—a perfect day during the best time of the year.

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7. Neigum v. BNSF Ry. Co., No. 1:06-CV-026, 2008 WL 1049905, at *1 (D.N.D. Apr. 8, 2008) (granting motion in limine to exclude evidence of plaintiff's wife's medical insurance coverage because it "is not relevant or admissible pursuant to the collateral source rule"); *see also* Campbell v. BNSF Ry. Co., No. 4:09-CV-49, 2011 WL 794383, at *1 (D.N.D. Mar. 2, 2011) (discussing railroad disability benefits); Magelky v. BNSF Ry. Co., No 1:06-CV-025, 2008 WL 238451, at *7 (D.N.D. Jan. 28, 2008) (discussing medical records).

8. *See* N.D. R. EVID. 401. Under Rule 401, relevant evidence is evidence having any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence. *Id*. Generally, relevant evidence is admissible unless there is a rule or other provision justifying its exclusion. N.D. R. EVID. 402.

9. N.D. R. EVID. 403. The equivalent federal rule mirrors North Dakota's rule. *See* FED. R. EVID. 403. Rule 403, which provides reasons for excluding relevant evidence, states:

> The court may exclude relevant evidence if its probative value is substantially outweighed by a danger of one or more of the following:
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> (a) unfair prejudice;
> (b) confusing the issues;
> (c) misleading the jury;
> (d) undue delay;
> (e) wasting time; or
> (f) needlessly presenting cumulative evidence.

N.D. R. EVID. 403. The North Dakota Supreme Court has stated relevant evidence may be excluded under Rule 403 if its "probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the jury, or by considerations of undue delay, waste of time, or needless presentation of cumulative evidence." State v. Procive, 2009 ND 151, ¶ 9, 771 N.W.2d 259 (quoting N.D. R. EVID. 403); State v. Schmeets, 2009 ND 163, ¶ 15, 772 N.W.2d 623 (quoting N.D. R. EVID. 403). A district court is given wide discretion in its determination of whether relevant evidence should be excluded because of the risk of unfair prejudice. *Procive*, 2009 ND 151, ¶ 8, 771 N.W.2d 259.

10. 508 N.W.2d 334 (N.D. 1993).

Phyllis lived in the city. She, too, could not wait for her monthly lunch. She loved the routine of it and the company. Plus, it provided a great reason to leave her apartment. Almost more than the lunch, she looked forward to the depth of conversation she would enjoy with her granddaughter in the shiny, black car.

Ellie greeted Phyllis with a hug at the door. She escorted her grandmother to the car that had continued to run since she arrived in the parking lot. She opened the front passenger-side door and helped Phyllis get seated. They immediately enjoyed an overflowing conversation during the short drive to their favorite restaurant. As they approached their destination, Ellie slowed to a stop because of the red light in front of them.

Neither remembers the crash. They both lost consciousness at the scene. When they awoke, their bodies hurt. Their heads hurt. Ellie's black car no longer shined. The rear of it was smashed and unrecognizable. The investigating officer cited the other driver for failing to stop at a red light and causing the rear-end crash. Ellie and Phyllis were battered, but lucky to be alive.

Local paramedics transported the pair by ambulance to the local emergency room. It would be the first day of medical care in what was sure to be a long road ahead. Over time, both women received extensive medical care for their injuries and, as expected, their doctors and nurses did not work for free. Instead, Ellie and Phyllis both incurred substantial medical bills.

Initially, Ellie's automobile insurer paid for each of their medical bills. North Dakota law required it.[11] It is called "no-fault insurance."[12] Once each of their total medical bills reached the magic number – $30,000 – their no-fault coverage had been exhausted and their no-fault insurer no longer had to pay for their ongoing medical care.[13] Due to the severity of their injuries, each woman incurred medical bills of $100,000 for the treatment they received as a result of the crash.

Prior to the crash, Phyllis had purchased private health insurance. Despite being a grandmother, she did not yet qualify for Medicare insurance benefits. By contrast, Ellie was between jobs and had not secured health insurance, public or private, to protect herself. After Phyllis exhausted her no-fault benefits, her medical providers began billing her health insurer for her care. Without health

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11. N.D. CENT. CODE §§ 26.1-41-06, -41-13 (2019).

12. N.D. CENT. CODE ch. 26.1-41 (2019). No-fault benefits are also called personal injury protection ("PIP") benefits. *See generally* Hiltner v. Owners Ins. Co., 2016 ND 45, 876 N.W.2d 460. *Compare, e.g.*, N.D. CENT. CODE ch. 26.1-41 (2019), *with* N.D. CENT. CODE § 26.1-40-15.4(1)(b).

13. N.D. CENT. CODE § 26.1-41-01(2), -41-13 (2019). Under North Dakota law, a no-fault insurer may choose to "coordinate benefits" with a health insurer after the payment of the first $10,000 toward an injured person's medical care. N.D. CENT. CODE § 26.1-41-13 (2019). Under such a scenario, the health insurer becomes the primary payor and the no-fault insurer the secondary payor on all medical bills in excess of the first $10,000, not to exceed a total of $30,000 in payments by the no-fault insurer. *Id.*; N.D. CENT. CODE § 26.1-41-01(2) (2019).

insurance, Ellie's medical providers began billing her. As their recovery progressed and their medical bills piled up, Ellie and Phyllis began to explore their legal rights against the at-fault driver for causing their damages.

North Dakota law provides a remedy for people injured due to the fault of another.[14] The most common type of claim is based in negligence. Should Ellie and Phyllis proceed to trial, a jury would be required to determine the issues of liability/fault and damages.

Despite being in the same car and in the same crash, and despite suffering similar injuries resulting in similar medical treatment, Ellie and Phyllis soon will find themselves in very different situations if they each pursue a personal injury claim against the at-fault driver.

IV. NORTH DAKOTA LAW

A personal injury plaintiff in North Dakota may recover economic damages, including "damages arising from medical expenses and medical care," among other damages.[15] Plaintiffs and defendants disagree about the interpretation of the phrase "medical expenses" used in the statute. Specifically, plaintiffs interpret it to mean the amount of the "medical bills" or the "medical charges" for the services rendered by a medical provider. Defendants, on the other hand, interpret it to mean the amount of the medical billing that is "paid" by a health insurer, which represents an amount far lower than the medical billing. It is not uncommon for the discounted rate to be 50% or more of the billing because of contractual agreements between each medical provider and each health insurer.[16] These agreements are negotiated long before a plaintiff receives their medical care, and the plaintiff is not included or involved in the negotiation. The difference between the amount of a medical bill from a provider and the amount paid by a health insurer is called the "service benefit."

Plaintiffs and defendants disagree about who should receive the service benefit. Plaintiffs believe they should receive it because they paid health insurance premiums to secure the coverage that provided the benefit.

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14. N.D. CENT. CODE § 32-03-01 (2019).

15. N.D. CENT. CODE § 32-03.2-04 (2019). The statute states:

> In any civil action for damages for wrongful death or injury to a person and whether arising out of breach of contract or tort, damages may be awarded by the trier of fact as follows:
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> 1. Compensation for economic damages, which are damages arising from medical expenses and medical care, rehabilitation services, custodial care, loss of earnings and earning capacity, loss of income or support, burial costs, cost of substitute domestic services, loss of employment or business or employment opportunities and other monetary losses.

Id. (Emphasis added).

16. This is true for both private and public insurers, as well as for North Dakota Workforce Safety & Insurance ("WSI"), in this author's experience.

Defendants argue they should receive it because it would otherwise result in a plaintiff receiving an amount greater than what was paid by a health insurer for the plaintiff's medical care.

Resolution of this disagreement requires application of the "collateral source rule." North Dakota courts have long recognized this rule, "which originated in common law."[17] "The general principle behind the collateral source rule is that negligent defendants are responsible for any damages they cause, and they cannot take advantage of the fact that someone else may have repaired the damage without charge, contributed to the costs of the injured party, or generously replaced damaged property."[18] "[T]he wrongdoer should not benefit at the expense of an innocent party, even where the injured party subsequently receives reimbursement from someone other than the wrongdoer."[19]

By its plain language, North Dakota's collateral source statute supports plaintiffs' argument that they should receive the service benefit, stating:

> After an award of economic damages, the party responsible for the payment thereof is entitled to and may apply to the court for a reduction of the economic damages to the extent that the economic losses presented to the trier of fact are covered by payment from a collateral source. A "collateral source" payment is any sum from any other source paid or to be paid to cover an economic loss which need not be repaid by the party recovering economic damages, but does not include life insurance, other death or retirement benefits, or any insurance or benefit purchased by the party recovering economic damages.[20]

The legislative history of the collateral source statute and the North Dakota Supreme Court's decision in *Dewitz* also support the argument that the amount of a plaintiff's medical bills, and not the amount paid by a health insurer, is the only measure by which a jury should consider the reasonable value of a plaintiff's medical care.[21]

In *Dewitz*, the plaintiff alleged the defendant caused a motor vehicle crash that resulted in injuries to him.[22] After a trial, the court adjudged the plaintiff's damages to be in excess of $116,000 after it reduced the verdict based upon the jury's finding of plaintiff's comparative fault.[23] On appeal,

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17. Bilharz, *supra* note 4, at ¶ 7 (citing Keller v. Gama, 378 N.W.2d 867, 868 (N.D. 1985)).
18. *Id*.; *see also* Dewitz *ex rel*. Nuestel v. Emery, 508 N.W.2d 334, 340-41 (N.D. 1993).
19. *Keller*, 378 N.W.2d at 868.
20. N.D. CENT. CODE § 32-03.2-06 (2019) (emphasis added).
21. *Dewitz*, 508 N.W.2d at 340.
22. *Id*. at 335.
23. *Id*. at 336.

the defendant argued the district court erred by failing to further reduce the jury award for collateral source payments and the award should have been reduced to the amount actually paid by the plaintiff's health insurer rather than the amount billed by the medical providers to the plaintiff.[24] Specifically, the defendant argued the district court should have reduced the jury award by over $54,000, which was the amount the plaintiff's health insurer had already paid him.[25] The defendant argued, alternatively, the jury award should have been reduced by approximately $4,800 to account for the "service benefit" agreement between the plaintiff's health insurer and his medical providers.[26]

The North Dakota Supreme Court disagreed. In discarding both arguments, the Court reviewed the legislative history of the collateral source statute and concluded "[t]he legislative history of N.D.C.C. [§] 32-03.2-06 indicates the personal insurance exception was included in the statute to encourage people to secure personal insurance."[27] The Court also concluded the Legislature did not intend to penalize insureds for purchasing health insurance or to benefit negligent defendants by reducing their liability just because an injured plaintiff secured insurance coverage.[28] The Court further concluded, "to the extent the [plaintiff] benefited from the service benefit agreement between [his health insurer] and [his] health care providers, the benefit is traceable to [the plaintiff's] insurance policy" and "the benefit is properly included in the personal insurance exception of [the collateral source statute]."[29] Thus, the collateral source statute, as correctly interpreted in *Dewitz*, makes clear that any service benefit that may result from a reduced payment by a health insurer to a medical provider, instead of the full amount of the bill, may not be used by defendants to reduce their obligation to a plaintiff after an award of economic damages for medical expenses.

This is also the clear meaning of *Klein v. Harper*,[30] which was decided *before* both *Dewitz* and the enactment of North Dakota's collateral source statute. Interestingly, though, defendants commonly – but erroneously – rely upon *Klein* in support of their position that a jury should consider evidence of the amount paid by a plaintiff's health insurer.

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24. *Id.* at 340.
25. *Id.*
26. *Id.*
27. *Id.* (citing *Report of Tort Reform Subcomm., H. Judiciary Comm.*, 50th Legis. Assemb., Reg. Sess. 3 (N.D. 1987)).
28. *Id.*
29. *Id.*
30. 186 N.W.2d 426 (N.D. 1971).

In *Klein*, the personal injury plaintiff moved to admit the medical *bills* he had incurred as a result of the injuries he sustained in an automobile crash.[31] The defendant contended, *inter alia*, the medical bills were not "fair and reasonable" in relation to the plaintiff's injuries.[32] The district court admitted them over the defendant's objection.[33] The court concluded the medical bills were evidence of the reasonable value of the plaintiff's medical treatment and admitted them for the jury to consider.[34]

On appeal, the defendant argued the district court erred in admitting the medical bills because the plaintiff failed to lay a proper foundation for their admission.[35] More specifically, the defendant argued the plaintiff failed to show the treatment evinced by those bills was "necessitated by the collision, the charges were fair and reasonable, and there [was] no showing of what treatment was given for what condition."[36]

The North Dakota Supreme Court disagreed, holding that the "medical bills were admissible in evidence" for the limited purpose of showing a proximate cause between the defendant's conduct and the plaintiff's damages.[37] The Court further concluded, however, the medical bills, standing alone, were not "evidence as to the reasonable value of the services," which is "the proper measure of damages" in such an action.[38] In so holding, the Court expressly noted the defendant's objection was only to lack of foundation and there was no dispute as to the reasonableness of the expenses enumerated in the bills.[39]

Despite this narrow holding, personal injury defendants continue to mistakenly rely on *Klein* to argue for the admission of evidence of the amount paid by a plaintiff's health insurer in determining the reasonable value of a plaintiff's medical care. They also, typically, rely upon North Dakota Pattern Jury Instruction C-70.35, concerning the elements of damages for personal injury claims, which states, in part:

> In arriving at the amount of your verdict for damages arising from personal injury, you may consider and award compensation for economic damages and compensation for non-economic damages, proximately resulting from the injury.

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31. *Klein*, 186 N.W.2d at 431.
32. *Id*.
33. *Id*.
34. *Id*. at 432.
35. *Id*. at 431.
36. *Id*.
37. *Id*. at 431-32.
38. *Id*. at 432.
39. *Id*.

> Economic Damages
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> The term "economic damages" includes damages arising from medical expenses and medical care, rehabilitation services, custodial care, loss of earnings, loss of earning capacity, loss of income, loss of support, cost of substitute domestic services, loss of employment, loss of business, and loss of employment opportunities
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> Compensation for economic damages such as medical expenses and medical care, custodial care, substitute domestic services, and rehabilitation services is measured by the reasonable value, not exceeding the actual cost of the goods or services reasonably required and actually furnished to the injured party or that are reasonably certain to be required in the future.
>
> Compensation for economic damages such as loss of earnings, loss of earning capacity, loss of income, loss of support, loss of employment, loss of business, and loss of business opportunities is measured by the reasonable value of those losses the injured party has sustained and the reasonable value of those losses the injured party is reasonably certain to sustain in the future.[40]

The first emphasized portion of the jury instruction was taken directly from N.D. Century Code section 32-03.2-04 and the second directly from the *Klein* decision.[41] Defendants most often "cherry-pick" two sentences from *Klein* in support of their position, without discussing the facts of the case or the issue presented to the Court. The case details are critical, however, when comparing *Klein* to any personal injury case.

Specifically, defendants cite *Klein* for the proposition that the measure of damages for a plaintiff's medical care is "the reasonable value of the medical services made necessary because of the injuries which resulted from the defendant's fault" and that "[t]he amount paid or the liability incurred is . . . evidence which can go to the jury to assist it in determining the reasonable value of these services."[42] Citing, alone, those two sentences from the opinion, however, does not accurately reflect the relevant holding. Nor can *Klein* be read in a vacuum. Instead, it must be evaluated in light of the facts of the case, the issue presented, the subsequent enactment of the collateral source statute, and the subsequent

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40. N.D. Pattern. Jury Inst. C-70.35 Elements of Damages (Personal Injury N.D. CENT. CODE § 32-03.2-04) (emphasis added).

41. The North Dakota Pattern Jury Instruction Commission, of which this author is part, should review the accuracy of this instruction and its reliance on Klein in light of the subsequent enactment of the collateral source statute and the Dewitz decision interpreting it.

42. *See Klein*, 186 N.W.2d at 432.

North Dakota Supreme Court decisions interpreting the statute, including *Dewitz*.

As noted above, the question regarding medical bills before the North Dakota Supreme Court in *Klein* was a narrow one: whether the plaintiff had laid sufficient foundation for the admission of the medical bills into evidence.[43] The Court answered that narrow question in the affirmative, holding the plaintiff's own testimony laid a sufficient foundation for the bills' admission as evidence that could assist the jury in determining the reasonable value of the plaintiff's medical care.[44] Noticeably absent from the decision was any mention about amounts paid by the plaintiff's health insurer for his medical care or whether those amounts were to be considered as evidence to assist the jury in determining the reasonable value of the plaintiff's medical care.[45] Thus, to the extent *Klein* can be read to say anything at all about whether the amount billed or the amount paid is the proper evidence for determining damages, such analysis is dicta. Its only holding, instead, is that a plaintiff's recovery of medical expenses is limited to their reasonable value.[46]

Even assuming, *arguendo*, that *Klein* has precedential value on the broader question of whether the amount billed or the amount paid is the relevant measure of the reasonableness of a plaintiff's medical care, the opinion makes clear the reasonable value of a plaintiff's medical care is measured by their medical bills.[47] In addition, and most importantly, the subsequent enactment of both the collateral source statute, and the *Dewitz* decision interpreting it, make clear the plaintiff – and not the defendant – should receive the service benefit.

To that end, there are a growing number (nine of which this author is aware) of North Dakota district court decisions, including two as recent as May 3, 2019,[48] that support the argument a jury should only consider the amount of a plaintiff's medical bills and not the amount paid by a health insurer.[49] The most comprehensive analysis of the issue can be found in the *Weiler v. Field* and *Bilharz v. T.K. Stanley, Inc.* decisions.[50]

In *Weiler*, the court denied the defendants' motion in limine to exclude the amounts of the plaintiff's medical bills and, instead, allow into evidence only the amounts paid by the plaintiff's health insurers. In reaching its

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43. *Id.*
44. *Id.*
45. *See generally* Klein v. Harper, 186 N.W.2d 426 (N.D. 1971).
46. *Id.* at 432.
47. *Id.*
48. *See generally* Steele, *supra* note 4; Siefke, *supra* note 4.
49. *See generally* Evans, *supra* note 4; Bilharz, *supra* note 4; Svoboda, *supra* note 4; Voegele, *supra* note 4; Weiler, *supra* note 4; Hutton, *supra* note 4; Grindberg, *supra* note 4.
50. *See generally* Weiler, *supra* note 4; Bilharz, *supra* note 4.

conclusion, the court relied on *Dewitz* and dismissed the defendants' reliance on *Klein*, stating:

> It is evident from the holding in *Dewitz* . . . as well as the language of [the collateral source statute], that it is intended that any benefits resulting in a reduced payment to the health care providers may not be used by the defendants to reduce their obligation to pay the reasonable value of medical expenses, which in essence is the clear meaning of *Klein* . . . . To the extent that it is argued that *Klein* . . . stands for the proposition that the medical expenses of the plaintiffs are limited to the reasonable value but not greater than the actual costs incurred, it is inconsistent with the full holding of *Klein* . . . as well as the exception recognized under [the collateral source statute] and the court's holding in *Dewitz*. . . .[51]

The court also stated its decision was "consistent with the general recognition that a plaintiff's damages generally are not reduced because of payments for treatment under a hospitalization or medical insurance policy if the plaintiff or a family member paid the premiums and the tortfeasor did not."[52] The court further stated its decision was "one embraced by other jurisdictions."[53]

Similarly, in *Bilharz*, the court concluded the amounts paid by a health insurer and by North Dakota Workforce Safety & Insurance ("WSI"), amounts less than the total amounts billed by the plaintiff's medical providers, would not be admitted into evidence.[54] The court relied upon *Dewitz* and its interpretation of the collateral source statute.[55] It stated that, "[i]f discounted payments made by a health insurer cannot be used to reduce the amount of a jury verdict even after trial, it stands to reason that such evidence should be viewed with caution as it relates to determining the reasonable value of medical expenses as a measure of damages" during trial.[56]

The United States District Court for the District of North Dakota has also analyzed *Dewitz* and the collateral source statute, extending their reach to social security disability benefits.[57] The Court noted that social security disability benefits, like health insurance, is "insurance purchased by an individual using a

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51. Weiler, *supra* note 4, at 6.

52. *Id*. (citing 22 AM. JUR. 2D *Damages* § 409 (2019)).

53. *Id*. (citing Papke v. Harbert, 738 N.W.2d 510, 530, 536 (S.D. 2007); Koffman v. Leichtfuss, 630 N.W.2d 201, 209 (Wis. 2001); Leitinger v. DBart, Inc., 736 N.W.2d 1 (Wis. 2007)).

54. Bilharz, *supra* note 4, at ¶ 10.

55. *Id*. at ¶ 11.

56. *Id*. at ¶ 12.

57. Krein v. Industrial Co. of Wy., No. Civ. A1-02-56, 2003 WL 22415867, at *2 (D.N.D. Oct. 21, 2003).

percentage of his or her paycheck" and that it could not "justify creating a windfall for a tortfeasor by finding social security disability benefits within the statutory collateral source rule."[58] It is, therefore, clear that North Dakota statutory law and its case law support the conclusion a district court should only allow a jury to consider the amounts *billed* by a plaintiff's medical providers in determining the reasonable value of the plaintiff's medical care.

V. EQUITY AND PUBLIC POLICY

In addition to North Dakota statutory and case law supporting that conclusion, there are equitable principles and public policy rationales that demand the same result. To best illustrate the equitable principles, let's return to Ellie and Phyllis and their similar, but different, situations.

As a result of the injuries Ellie and Phyllis sustained in the crash, they sought medical treatment from various medical providers. The providers initially billed their services to their no-fault insurer. In this case, it happened to be the same entity, Ellie's automobile insurer, because they were in Ellie's vehicle at the time of the crash. Pursuant to North Dakota law, the no-fault insurer paid for the first $30,000 of each of their medical bills related to the injuries they sustained in the crash. Of note, the no-fault insurer paid the full amount of their medical bills.

Once each woman exhausted her no-fault benefits, the medical providers billed Phyllis' health insurer and Ellie, personally.[59] Phyllis had purchased health insurance that provided her coverage for the medical care she received in excess of her no-fault benefits. Phyllis incurred $70,000 in additional medical care above and beyond the $30,000 billed to, and paid by, her no-fault insurer. Despite being billed $70,000, Phyllis' health insurer only paid $30,000 for her care because of contractual discounts it had negotiated with her medical providers.

Like her grandma, Ellie incurred $70,000 in additional medical care in excess of the $30,000 billed to, and paid by, her no-fault insurer. Because Ellie did not secure health insurance prior to or after the crash, her medical providers billed her $70,000 for the medical care she received. Without insurance, she was expected to pay the full amount, which she did because she did not have a contractual agreement with her medical providers to pay at a significantly discounted rate.

Should Phyllis litigate a personal injury claim and proceed to trial, a court will, inevitably, be faced with the issue of whether to allow a jury to consider the amount Phyllis was *billed* for her medical bills ($100,000), the

58. *Id.*

59. Ellie received the bills because she did not have health insurance coverage.

amount *paid* by her no-fault and health insurer ($60,000), or *both*. The court's decision will dramatically impact the jury's award. For Ellie, there will be no pre-trial issue for a court to decide. She and her no-fault insurer, together, paid the same amount they were billed, $100,000.

In a well-conducted trial, a court will exclude from evidence any reference to, or evidence concerning, whether Ellie or Phyllis had secured automobile or health insurance. If a court allows a jury to consider the amount paid by a health insurer – either instead of, or in addition to, the amount billed – it would introduce evidence of insurance into the case, despite clear North Dakota precedent against it.[60]

Oftentimes, as a proposed compromise, defendants attempt to convince a court that both amounts – the amount billed and the amount paid – should be submitted to the jury for consideration. On its face, it seems like a reasonable option. Adopting such an argument, however, is dangerous and prejudicial for many reasons.

First, it introduces, either directly or indirectly, evidence of insurance into the case, as previously stated. Under such a scenario, the parties will likely present two different amounts of medical expenses to the jury. Phyllis, for example, will present the amount billed (although the jury would not be told that it is the amount billed) as the reasonable value of her medical expenses and care. The defendant will present the amount paid (again, the jury would not be told it is the amount paid) as the reasonable value. The jury will easily infer from the two distinct proposals that Phyllis has health insurance and that such insurance is the reason for the varying proposals.

Second, if a court allowed a jury to consider both amounts, Phyllis would be prejudiced if not allowed to explain to the jury the reason for the different amounts. Specifically, prejudice would occur if she could not explain that she paid health insurance premiums up front for the coverage and, as a result, her insurer did not have to pay the full amount of the bills for her medical care on the back end. Phyllis would also be prejudiced, under this scenario, if not also allowed to present evidence about the amount of her health insurance premiums that secured the coverage and, ultimately, the service benefit of the care. After all, the service benefit is tied to Phyllis' paying health insurance premiums and should not be used by a defendant to reduce their potential damage exposure at

60. Neigum v. BNSF Ry. Co., No. 1:06-cv-026, 2008 WL 1049905, at *1 (D.N.D. Apr. 8, 2008) (granting motion in limine to exclude evidence of plaintiff's wife's medical insurance coverage because it "is not relevant or admissible pursuant to the collateral source rule"); *see also* Campbell v. BNSF Ry. Co., No. 4:09-cv-49, 2011 WL 794383, at *1 (D.N.D. Mar. 2, 2011); Magelky v. BNSF Ry. Co., No 1:06-cv-025, 2008 WL 238451, at *7 (D.N.D. Jan. 28, 2008).

trial, especially because "the benefit is properly included in the personal insurance exception of [the collateral source statute]."[61]

Third, allowing a jury to consider two different amounts at trial – the amount billed and the amount paid – without allowing Phyllis the ability to present evidence about her health insurance coverage and the amount of her premiums, unfairly prejudices her. She would be forced, then, to make an unfair strategic choice between: (1) submitting to the jury the amount of her medical bills, which would be higher than the amount paid by her health insurer, and appearing to "overreach" because she would be restricted from explaining why the amounts are different; or (2) choosing to withhold the amount of the medical bills to prevent the appearance of "overreaching" and, as a result, indirectly agreeing to the amount paid by her health insurer as the only amount for the jury to consider, which is inconsistent with North Dakota statutory law and North Dakota Supreme Court precedent. Phyllis should not have to make this strategic choice at trial. It is especially true because she purchased the health insurance, paid the premiums, and did what a responsible citizen would do to protect herself from the cost of significant medical expenses should she need medical care without having health insurance. Phyllis should not be penalized for prudently purchasing health insurance, to the benefit of a negligent defendant.[62]

Ultimately, as a matter of equity, the amount billed by a plaintiff's medical providers is the only consistent benchmark by which a jury can analyze the reasonable value of a plaintiff's medical care. There is no basis in law or equity to allow a jury to determine the reasonable value of medical services based upon the particular type of insurance, if any, an injured person has procured. To determine otherwise would be prejudicial to an injured plaintiff and result in inconsistent verdicts based upon varying contractual agreements between health insurers and medical providers.

Specifically, if a plaintiff, like Ellie, did not secure health insurance, she would have been billed for, and expected to pay, the full amount of the billing. If a court only allows a jury to consider the full amount of the medical bills, a jury will hear the same amount regardless of whether a plaintiff is insured. It is a fair and consistent result. By contrast, if a court allows a jury to consider an amount paid by a health insurer, either in addition to the amount billed or instead of the amount billed, a jury will consider a different amount depending upon whether a plaintiff had secured health insurance. Under this scenario, and everything else being equal, a plaintiff, like Phyllis,

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61. Dewitz *ex rel.* Nuestel v. Emery, 508 N.W.2d 334, 340 (N.D. 1993).

62. *See id.* (citing *Report of Tort Reform Subcomm., H. Judiciary Comm.*, 50th Legis. Assemb., Reg. Sess. 3 (N.D. 1987)).

with health insurance is treated unequally and unfairly in comparison to a plaintiff, like Ellie, who is in an identical situation, except without health insurance. Phyllis – or any plaintiff – should not be penalized for having the foresight to purchase health insurance, paying a premium for that insurance, and wisely managing her medical affairs by obtaining the insurance.

This is also consistent with prudent public policy. A plaintiff pays health insurance premiums to secure health coverage and the service benefit results from the health insurer paying less than the medical provider's actual bill. To be sure, most every health insurer has secured separate and distinct contractual discounts with each medical provider. In other words, what one health insurer pays at one facility may not be what it pays at another facility. In addition, what one health insurer pays at one facility may not be what a different health insurer pays at the same facility or at a different facility. The disparate amounts are only the result of different agreements between the various health insurers and the various medical providers. It leads to a lack of uniformity in the amount paid by a health insurer when presented with a medical bill.

Conversely, the medical billing constitutes the provider's opinion of the reasonable value of the service and is uniform among patients, regardless of their insurer or lack of insurer. There is also a presumption that a medical provider's bill for each service is reasonable. To conclude otherwise would be to presume that medical providers are billing unreasonable amounts to their patients and that the value of the services received by their patients is unreasonably low in comparison to the bills. It would be, arguably, malpractice and fraud. At best, it would be unethical. As a result, the medical bills are the only benchmark by which a fact-finder should consider the reasonable value of the services provided to an injured plaintiff.[63]

Furthermore, it is dangerous and prejudicial to allow a fact-finder to determine the reasonable value of a medical service based upon a contractually agreed-upon amount paid. The amount paid has nothing to do with the value of the service provided, but, rather, everything to do with the type of "deal" the health insurer struck with the medical provider. In addition, the health insurer's negotiated discount reflects a multitude of factors related to the relationship of the insurer and the medical provider. Those factors will likely bring complex and confusing side issues before the fact-finder that are not related to the value

63. A potential exception would be in a case where a medical provider did not bill for its service, in which event the customary bill for the service would be the only consistent benchmark by which to base the reasonable value of the service. South v. Nat'l R.R. Passenger Corp., 290 N.W.2d 819, 841-42 (N.D. 1980). In fact, the North Dakota Supreme Court has concluded that a plaintiff may recover the "reasonable value of medical care," even if the plaintiff received the service without charge. *Id*.

of the medical services provided and, oftentimes, will lead to the reference – directly or indirectly – of insurance in the case.

In *Dewitz*, the North Dakota Supreme Court rightly advanced this public policy by making clear the service benefit most appropriately belongs to plaintiffs because they paid for the benefit by purchasing health insurance.[64] It is also the right public policy position, consistent with legislative intent, because our society benefits from its citizens responsibly protecting themselves by purchasing insurance, which is one of the primary purposes of the collateral source statute.[65] Any effort by defendants to use the service benefit in their favor is an attempt to circumvent the purpose of the collateral source statute and is contrary to North Dakota Supreme Court precedent. For example, under the statute, a defendant, *after* trial, would be unable to reduce the amount of a verdict based upon a jury's award of economic damages for medical treatment billed to or paid by a health insurer.[66] It makes little sense, then, for a defendant to be able to have a jury consider the amounts paid by a health insurer *during* trial if those discounted payments cannot be used to reduce the amount of a jury verdict *after* trial. Certainly, the North Dakota Legislature did not intend that result.

VI. CONCLUSION

North Dakota statutory law, North Dakota case law, and principles of equity and public policy support the conclusion that a district court should only allow a jury to consider the amounts *billed* by a plaintiff's medical providers in determining the reasonable value of the plaintiff's medical care. The legislative history of the collateral source statute makes clear its purpose is to encourage citizens to make responsible decisions to protect themselves and others by purchasing health insurance. In exchange, it should not, then, be used against the responsible citizen in a personal injury action, to the benefit of a negligent defendant. North Dakota district courts should universally reach this conclusion, consistent with North Dakota precedent, so that injured plaintiffs receive the service benefit for which they have paid and a fair determination of their damages from a jury.

64. *Dewitz*, 508 N.W.2d at 340.
65. *Id*. at 341.
66. *Id*. at 340; Bilharz, *supra* note 4, at ¶ 7; N.D. CENT. CODE § 32-03.2-06 (2019).