*****FOR PUBLICATION*****

IN THE SUPREME COURT OF THE STATE OF HAWAIʻI

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JOSEPH BYNUM and LILA BYNUM, Plaintiffs-Appellees

vs.

JOANNA H. MAGNO, M.D., Defendant-Appellant

NO. 25834

CERTIFIED QUESTION FROM THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF HAWAIʻI
(CIV. NO. 99-00927 KSC)

NOVEMBER 18, 2004

ACOBA, J., CIRCUIT JUDGE POLLACK, IN PLACE OF NAKAYAMA, J., RECUSED, AND CIRCUIT JUDGE DEL ROSARIO, ASSIGNED BY REASON OF VACANCY; AND MOON, C.J., DISSENTING, WITH WHOM LEVINSON, J., JOINS

OPINION OF THE COURT BY ACOBA, J.

We have jurisdiction pursuant to Hawaiʻi Rules of Appellate Procedure (HRAP) Rule 13(a) (2000)[1] to answer the

[1] HRAP Rule 13(a) provides in relevant part as follows:

> **(a) When certified.** When a federal district or appellate court certifies to the Hawaiʻi Supreme Court that there is involved in any proceeding before it a question concerning the law of Hawaiʻi that is determinative of the cause and that there is no clear controlling precedent in the Hawaiʻi judicial decisions, the Hawaiʻi Supreme Court may

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following certified questions by the United States District Court for the District of Hawai‘i (the district court)[2] to this court:

> Where a plaintiff's healthcare expenses are paid by Medicare and/or Medical, does the discounted amount paid to a healthcare provider by [Medicare[3]] and Medi-Cal constitute the amount that should be awarded as medical special damages to a plaintiff in a negligence action? In this circumstance, is evidence of amounts billed in excess of the amount[]paid irrelevant and inadmissible?

For the reasons set forth herein, the answer to both questions is "no."

I.

The questions posed arise out of a medical malpractice action in which Plaintiffs-Appellees Joseph Bynum (Joseph) and his wife Lila Bynum (Lila) (collectively the Bynums), sued to recover damages for injuries Joseph allegedly suffered in connection with coronary artery bypass grafting surgery.

While vacationing on the Big Island of Hawai‘i in July of 1998, Joseph experienced chest pains. Initially, Joseph went to North Hawai‘i Community Hospital for treatment, and was later transferred to the Queen's Medical Center (Queen's) in Honolulu, for further treatment. Dr. Joana Magno (Magno), a cardiologist at Queen's, assumed responsibility for coordinating Joseph's care

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[1](...continued)
answer the certified question by written opinion.

[2] With the consent of both parties, this case was reassigned to Magistrate Judge Kevin S.C. Chang, pursuant to 28 U.S.C. § 636(c)(1).

[3] Although the district court question actually used the term "Medicaid," it appears the district court meant to use the term "Medicare" as previously stated. Inasmuch as Medi-Cal is a "Medicaid" program, as explained infra, the use of "Medicaid" appears redundant. See infra Part III.

as his attending physician. Magno consulted with Dr. Michael Dang (Dang), a cardiovascular surgeon, and Dr. John Callan (Callan), a pulmonologist, and recommended that Joseph undergo bypass surgery on an urgent basis. Magno did not advise the Bynums that Joseph could try alternate treatments, such as medical therapy or angioplasty, but presented surgery as his only option. At the time Magno recommended bypass surgery, she knew Joseph had experienced respiratory failure two years earlier, and recognized that his history of lung disease was a "red flag" to bypass surgery.

During the bypass surgery performed by Dang, Joseph suffered respiratory distress, which required him to be placed on mechanical ventilation for the remainder of his life. After spending three months in Queen's, Joseph was transferred to six different intensive care facilities in California.

From the time of the surgery, Joseph was eligible for Medicare, which initially paid for his medical bills. However, to allow Joseph to become eligible for Medi-Cal, California's Medicaid program, and to protect their life savings from the costs of Joseph's ongoing hospitalization, the Bynums legally divorced on February 11, 1999.[4]

[4] The Bynums maintain that although they were forced to "legally divorce," they did not divorce "in reality," and Lila continued to support Joseph throughout the remainder of his life.

Joseph lived in intensive care facilities for over 1,314 days after the surgery, and was dependent upon the ventilator for the rest of his life, passing away on February 21, 2002.

II.

The Bynums filed a lawsuit against Magno, Dang, Callan, and Queen's (hereinafter, collectively, Defendants), on December 30, 1999, prior to Joseph's death.[5] During discovery, the Bynums produced medical bills, which reflected the "standard" or "customary" charges (hereinafter "standard rates") for the services provided by the medical facilities in which Joseph had resided. Prior to trial, the parties entered into a stipulation regarding those bills,[6] in which they agreed, inter alia, that the medical bills "reflect[ed] medical treatment for [Joseph] that was necessary for medical conditions that existed during the time of treatment[,]" and were for amounts "similar to charges made by similar or comparable health care providers for like services in the same geographical area."

On February 6, 2001, Magno and Callan filed a motion in limine to limit Joseph's recovery of his medical expenses to only

[5] Joseph died during the litigation of this dispute, and thus, the "Special Administrator" was substituted as a party to the action while it was pending before the Ninth Circuit Court of Appeals.

[6] The "Stipulation and Order Re: Statements Reflecting Medical Expenses" was filed on January 18, 2001.

those fees actually paid to his healthcare providers as full and final payment for the services. In this regard, Defendants sought to preclude the Bynums from introducing, as evidence of special damages, the standard rates for Bynum's medical care that might have been billed to other patients for comparable treatment. Additionally, Defendants asserted that "a patient cannot be held liable for any medical expenses that exceed the amount approved by Medicare or actually paid by Medicare and Medi-Cal payments to a healthcare provider."

The district court denied the motion, and did not limit the evidence of special damages to the amount charged by Medicare/Medicaid. Accordingly, when the jury trial commenced on March 13, 2001, the medical bills introduced reflected amounts similar to charges made by comparable health care providers for like services in the same geographical area.

The jury returned it's verdict on April 4, 2001, and on May 2, 2001, the district court entered judgment against Magno in the amount of $2,063,750.00 for Joseph ($1,462,500.00 in special damages and $601,250 in general damages), and $107,250 for Lila (in general damages). Additionally, the district court dismissed with prejudice all claims against Callan, Dang, and Queen's, pursuant to a stipulation for partial dismissal.

Magno appealed the judgment to the United States Ninth Circuit Court of Appeals (the Ninth Circuit), asserting, inter

alia, that "the district court erred by submitting the amount of the medical expenses billed by [Joseph's] healthcare providers to the jury as the reasonable value of their services, instead of the lesser amount negotiated by [Medicare/Medicaid]." The Ninth Circuit reversed the district court's judgment and remanded the case for a new trial.[7] Declining to resolve the issue of special damages, the Ninth Circuit posited that

> the novel question under Hawai'i law whether the discounted amount paid to a healthcare provider by Medicaid[8] and Medi-Cal reflects the amount that should be awarded to a plaintiff in a negligence action might well be a suitable candidate for certification.

Accordingly, the district court, upon remand, submitted its certified questions to this court.

III.

Joseph's healthcare providers, as required of provider participants in the Medicare[9] and/or Medicaid[10] (hereinafter

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[7] The Ninth Circuit issued its decision on March 13, 2003, in an unpublished memorandum opinion.

[8] It is presumed the Ninth Circuit meant "Medicare." See supra note 3.

[9] Medicare is the federally funded medical insurance program for the elderly and disabled established as part of the Social Security Act, and is funded and administered solely by the federal government. 42 U.S.C. §§ 1395 et seq (hereinafter, the Medicare Act); Fischer v. United States, 529 U.S. 667, 671-75 (2000).

[10] Medcaid is a medical insurance program jointly funded by the federal and state governments, but administered by the individual states. 42 U.S.C. §§ 1396 et seq (1973) (hereinafter the Medicaid Act); 42 C.F.R § 430.0 (2004); Children's Hosp. & Health Ctr. v. Belshe, 188 F.3d 1090, 1093-94 (9th Cir. 1999). Medicaid "authorizes the payment of federal funds to states to defray expenses incurred in providing medical assistance to low-income individuals," id. at 1093, namely on behalf of families with dependent children, and of aged, blind, or disabled individuals. 42 U.S.C. §§ 1396 et seq.; 42 C.F.R. § 430.0. "Medi-Cal" is California's Medicaid program, as

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Medicare/Medicaid) programs, agreed in advance to accept the Medicare/Medicaid approved payments as full and final payment for their services. Such payments are set at rates lower than the standard rates that providers might charge other patients who did not participate in these programs. These payments then, by definition and as posed by the Ninth Circuit, are "discounted" from the standard rates otherwise charged for comparable medical treatment. Joseph's healthcare providers, as participants in these programs, were statutorily prohibited from "balance billing" Joseph or any other source for amounts above the Medicare/Medicaid approved charges.

IV.

In response to the certified questions presented, the parties raise several arguments. Magno argues that a plaintiff whose health care expenses are covered by Medicare/Medicaid, is entitled to recover the amount of the Medicare/Medicaid approved payments, and nothing more, because (1) principles of compensatory damages do not permit recovery for more than the actual costs incurred for medical services; (2) the collateral source rule does not entitle a plaintiff to recover amounts in

[10](...continued)
administered by the California Department of Health. Welf. & Inst. §§ 14000 (1991) et seq; Cal. Code Regis. tit. 22, §§ 51501 (2004) et seq. Similarly, Hawai'i participates in the Medicaid program, as administered by the Hawai'i Department of Human Services. See generally Hawai'i Revised Statutes (HRS) chapter 346; Hawai'i Administrative Rules (HAR) chapter 17.

excess of the Medicare/Medicaid approved payments, inasmuch as (a) the amount of the Medicare/Medicaid "discount" is not a "benefit" belonging to the plaintiff under the collateral source rule, (b) limiting a plaintiff's recovery to the amount of the approved payments does not result in a windfall to the defendant, and (c) unlike private insurance arrangements where the collateral source rule has been applied, this case does not involve the payment of premiums by the plaintiff; and (3) amounts billed in excess of the Medicare/Medicaid approved payments are irrelevant and inadmissible in a tort action.

The Bynums, on the other hand, assert that Joseph's recoverable medical expenses should be based upon the standard rates, because (1) the policies behind the recovery of damages for personal injury tort victims are not analagous to the principles of "compensatory damages" in property damage cases; (2) the collateral source rule applies, inasmuch as (a) the "'discount[s]' created by the lower fee schedules" are "unquestionably a benefit to Medicare/Medicaid recipients[,]" (b) the programs "benefitted" Joseph by preventing the providers from "balance billing" him for the full amount, (c) if Joseph was not eligible for Medicare/Medicaid, "he would have been liable for the full amount of his medical bills," and thus, (d) "allowing [Magno] to reduce her liability by virtue of [Joseph's] participation in Medicare/Medicaid would indeed result

in a windfall for [Magno], which is exactly what Hawai‘i collateral source rule prohibits"; and (3) because the collateral source rule applies to all Medicare/Medicaid benefits, evidence of standard rates is relevant and admissible for (a) determining the reasonable value of medical services, (b) understanding the extent of the plaintiff's injuries, and (c) providing a foundation for future medical care and expenses.

AARP filed an amicus brief in this case. It maintains that millions of elderly and low income individuals rely on Medicaid for their health care, and urges this court to follow jurisdictions which have applied the collateral source rule to Medicare/Medicaid benefits. Essentially, ARRP argues two primary reasons for applying the collateral source rule. First, AARP notes that a "court can either reward the tortfeasor by making them [sic] responsible for an amount less than the full amount of the plaintiff's medical services or a court can award the entire amount of damages to the injured person even though the victim did not pay for the services[; thus, i]f there is a windfall, the innocent plaintiff should benefit, not the defendant." Secondly, citing Joseph M. Engle, Comment: Gratuitous Nursing Services Rendered by Extended Family Members and Other Third Parties: Can Injured Parties Receive Reimbursement Under Wisconsin's Collateral Source Rule?, 85 Marq. L. Rev. 1003, 1009-10 (2002), AARP asserts that "[a]llowing a plaintiff to recover from

collateral sources ensures that the plaintiff will be fully compensated[, a]n injured party can never be fully compensated for permanent injuries[,]" and, "[t]hus, while the collateral source rule may allow a plaintiff to receive a larger award than he or she appears entitled, the amount the plaintiff actually receives comes closer to full compensation for [the] loss."

V.

Inasmuch as the questions presented involve the scope of special compensatory damages, the underlying principles relating to damages in the personal injury context are pertinent. Compensatory damages seek to "compensate the injured party for the injury sustained," Kuhnert v. Allison, 76 Hawai‘i 39, 44, 868 P.2d 457, 462 (1994), in hopes of "restor[ing] a plaintiff to his or her position prior to the tortious act[,]" Zanakis-Pico v. Cutter Dodge, Inc., 98 Hawai‘i 309, 327, 47 P.3d 1222, 1240 (2002) (Acoba, J., concurring). The law divides such "damages into two broad categories–general and special." Ellis v. Crockett, 51 Haw. 45, 50, 451 P.2d 814, 819 (1969). General damages "encompass all the damages which naturally and necessarily result from a legal wrong done[,]" id., and include such items as "pain and suffering, inconvenience, and loss of enjoyment which cannot be measured definitively in monetary terms." Dunbar v. Thompson, 79 Hawai‘i 306, 315, 901 P.2d 1285, 1294 (App. 1995) (citation omitted). Special damages are "the

natural but not the necessary result of an alleged wrong[,]" Ellis, 51 Haw. at 50, 451 P.2d at 819, and are "often considered to be synonymous with pecuniary loss and include such items as medical and hospital expenses, loss of earnings, and diminished capacity." Dunbar, 79 Hawai‘i at 315, 901 P.2d at 1294.

The "collateral source rule,"[11] in general, provides that benefits or payments received on behalf of a plaintiff, from an independent source, will not diminish recovery from the wrongdoer. Ellsworth v. Schelbrock, 611 N.W.2d 764, 767 (Wis. 2000). "Under the collateral source rule, a 'tortfeasor is not entitled to have its liability reduced by benefits received by the plaintiff from a source wholly independent of and collateral to the tortfeasor[.]'" Sam Teague, Ltd. v. Hawai‘i Civil Rights Comm'n, 89 Hawai‘i 269, 281, 971 P.2d 1104, 1116 (1999) (quoting Sato v. Tawata, 79 Hawai‘i 14, 18, 897 P.2d 941, 945 (1995)).

Similarly, the Restatement (Second) of Torts: Damages (hereinafter Restatement) § 920A, entitled "Effect of Payments Made to [an] Injured Party," establishes that, under the collateral source rule, "[p]ayments made to or benefits conferred on the injured party from other sources are not credited against the tortfeasor's liability, although they cover all or part of the harm for which the tortfeasor is liable." Restatement

[11] The Restatement comment d explains that "[t]he collateral[]source rule is of common law origin." Restatement (Second) of Torts § 920A cmt. d (1979).

§ 920A(2) (emphasis added).[12] Comment b to § 920A, entitled "Benefits from collateral sources," further explains that although double compensation may result to the plaintiff, such a benefit should redound to the injured party rather than "become a windfall" to the party causing the injury:

> The injured party's net loss may have been reduced correspondingly, and to the extent that the defendant is required to pay the total amount there may be a double compensation for a part of the plaintiff's injury. But it is the position of the law that a benefit that is directed to the injured party should not be shifted so as to become a windfall for the tortfeasor.

Restatement § 920A cmt. b (emphases added). Ultimately, comment b explains that "it is the tortfeasor's responsibility to compensate for all harm that he causes, not confined to the net loss that the injured party receives." Id.

While acknowledging that "[p]erhaps there is an element of punishment of the wrongdoer" in the rule, the Restatement indicates that "[p]erhaps also this is regarded as a means of helping to make the compensation more nearly compensatory to the

[12] This court has many times relied on the Restatement (Second) of Torts as persuasive authority. See, e.g., Hac v. Univ. of Hawai'i, 102 Hawai'i 92, 106, 73 P.3d 46, 60 (2003) (adopting elements and approach of Restatement (Second) of Torts § 46 (1965) for tort of intentional infliction of emotional distress); Knodle v. Waikiki Gateway Hotel, Inc., 69 Haw. 376, 386, 742 P.2d 377, 384 (1987) (relying on Restatement (Second) of Torts § 314(A) (1965) to establish the duty of innkeeper to guest "to take reasonable action to protect the latter against unreasonable risk of physical harm"); Ono v. Applegate, 62 Haw. 131, 137-38, 612 P.2d 533, 539 (1980) (citing Restatement (Second) of Torts § 285 (1965) to hold that Hawaii's "liquor control statute does impose a duty upon a tavern keeper not to serve a person under the influence of liquor"); Stewart v. Budget Rent-A-Car Corp., 52 Haw. 71, 75, 470 P.2d 240, 243 (1970) (adopting Restatement (Second) of Torts § 402A (1965) for strict products liability); and Chun v. Park, 51 Haw. 462, 468, 462 P.2d 905, 909 (1969) (adopting Restatement (Second) of Torts § 552 (Tentative Draft No. 12, 1966) as "a fair and just restatement of the law on the issue of negligent misrepresentation").

injured party." Id. The Restatement further declares that the rule "that collateral benefits are not subtracted from the plaintiff's recovery applies to the following types of benefits: . . . [g]ratuities[] . . . [and s]ocial legislation benefits." Restatement § 920A cmt. c(3)-(4) (emphasis added). As to social legislation benefits, the Restatement explains that "[i]f the benefit was . . . established . . . by law, [the plaintiff] should not be deprived of the advantage that it confers." Restatement § 920A cmt. b.

With the aforementioned authorities in mind, we consider the certified questions.

VI.

In an action to recover medical expenses caused by a defendant's negligence, a plaintiff must show that the medical services obtained were necessary and the charges were reasonable as required for the injuries sustained. See Reinhardt v. County of Maui, 23 Haw. 524, 527 (1916). In that connection, the "reasonable value"[13] of a plaintiff's medical services may be recovered. See Kometani v. Heath, 50 Haw. 89, 95, 431 P.2d 931,

[13] The term "reasonable value," in the context of awarding damages for medical expenses, has not expressly been defined in this jurisdiction. Black's Law Dictionary 1265 (6th ed. 1990) defines "reasonable" as "[f]air, proper, just, moderate, suitable under the circumstances. Fit and appropriate to the end in view. Having the faculty of reason; rational; governed by reason; . . . Not immoderate or excessive, being synonymous with rational, honest, equitable, fair, suitable, moderate, tolerable." (Citation omitted.) Black's Law Dictionary describes "value" in part as, "[t]o estimate the worth of; to rate at a certain price; to appraise; or to place a certain estimate of worth on in a scale of values." Id. at 1551 (citation omitted).

936 (1967) (affirming that it was proper for the jury to consider the "reasonable value" of future medical expenses); Walsh v. Chan, 80 Hawai'i 188, 193, 907 P.2d 774, 779 (App.) (acknowledging the lower court's jury instructions as stating that a plaintiff is entitled to damages for the "reasonable value of the medical services"), rev'd on other grounds, 80 Hawai'i 212, 218, 908 P.2d 1198, 1204 (1995).

Although the parties do not dispute that the medical bills introduced at trial reflected medical services necessary for Joseph's medical condition, they disagree, as previously mentioned, on how to calculate the "reasonable value" of such services in light of the Medicare/Medicaid benefits.

VII.

A.

Magno points to cases which have concluded that the Medicaid/Medicare programs and rates do not fall within the scope of the collateral source rule. Such cases have based their decisions on essentially two grounds: (1) no one incurs liability for any charges above the Medicare/Medicaid payments,[14] see Suhor v. Lagasse, 770 So. 2d. 422, 427 (La. Ct. App. 2000);

[14] This is essentially the dissent's position. See dissenting opinion at 3-5, 10-11. The proposition that a plaintiff's "recovery of medical expenses must be limited to the amount he or she has paid or became legally obligated to pay," id. at 4, fails to acknowledge our adoption of the collateral source rule. Hence, "recovery" under our own case law is not necessarily coincident with the amount a plaintiff "has paid or became legally obligated to pay," id., as the dissent would argue.

Terrell v. Nanda, 759 So. 2d 1026, 1031 (La. Ct. App. 2000); Hanif v. Housing Auth., 246 Cal. Rptr. 192, 195-97 (Ca. App. 1988); Dyet v. McKinley, 81 P.3d 1236, 1239 (Idaho 2003), and (2) because no consideration is exchanged, Medicare/Medicaid discounts are not "benefits of the bargain" received by beneficiaries as a result of obtaining Medicare/Medicaid insurance. See Suhor, 770 So. 2d. at 427. Inasmuch as the collateral source rule applies to both gratuities and social legislation benefits, we believe such arguments are not determinative of the applicability of the rule.

B.

As previously noted, the Restatement declares that the collateral source rule applies to "gratuities," explaining, for example, that "the fact that the doctor did not charge for his services or the plaintiff was treated in a veterans hospital does not prevent his recovery for the reasonable value of the services." Restatement § 920A, cmt. c(3). See Pryor v. Webber, 263 N.E.2d 235, 240 (Ohio 1970) (explaining that the great weight of authority is that the payment of wages, whether the result of a contract or simply a gratuity does not reduce the damages otherwise recoverable); see also Roundhouse v. Owens-Illinois, Inc., 604 F.2d 990, 994 (6th Cir. 1979) (explaining that the collateral source rule applies even if payments are gratuitous). Hence, whether anyone incurs liability for any charges, or

whether such benefits are "bargained for" or contractual in nature, is not determinative as to whether the rule applies. See Ellsworth, 611 N.W.2d at 767-69 (concluding that the collateral source rule allows recovery of the reasonable value of medical services without consideration of gratuitous medical services rendered or payments made by outside sources on the plaintiff's behalf). Gratuitous services and payments, by their very nature, are given without consideration, are not "benefits of the bargain," and do not impose any legal obligation of repayment.

Rather, because a plaintiff would be able to recover the "reasonable value" of medical services if such services were rendered gratuitously, it would appear to follow that a plaintiff should be allowed to recover the "reasonable value" of such services, even if Medicare/Medicaid had already paid a part, or a discounted amount, of the "reasonable value" of such services. See Pryor, 263 N.E. 2d at 238-39 (acknowledging that the collateral source rule has been applied to "gratuitous physician's fees" as well as medical expenses gratuitously paid by a plaintiff's brother). Because a plaintiff like Joseph is not required to pay the difference between the standard rate and the Medicare/Medicaid payment, that part of such medical services attributable to such difference could be viewed conceptually as gratuitous service to the plaintiff, so as to come within the collateral source rule.

C.

But, as previously observed, the Restatement applies the collateral source rule to certain "types" of benefits such as social legislation benefits, listed as "social security benefits, welfare payments, pensions under special requirement acts." Restatement § 920A, cmt. c(4). Medicare/Medicaid are medical insurance programs for those in need, such as the elderly, disabled, and low-income individuals. See Suhor, 770 So. 2d at 424 (explaining that "Medicare is our country's basic health insurance program for people 65 or older and many people with disabilities"); Children's Hosp. & Health Ctr. v. Belsche, 188 F.3d 1090, 1093-94 (9th Cir. 1999) (relating that Medicaid provides federal and state funds to "defray expenses incurred in providing medical assistance to low-income individuals").

As aptly described by the North Carolina Supreme Court, "Medicaid is a form of insurance paid for by taxes collected from society in general. The Medicaid program is social legislation; it is the equivalent of health insurance for the needy." Cates v. Wilson, 361 S.E.2d 734, 737-38 (N.C. 1987) (citation omitted); see also Ellsworth, 611 N.W. 2d at 768; Suhor 770 So. 2d at 424; Children's Hosp. & Health Ctr., 188 F.3d at 1093-94. Likewise, this court has recognized that the "purpose of medicaid is to provide assistance to those whose income and resources are inadequate to meet the costs of necessary medical services."

Barham by Barham v. Rubin, 72 Haw. 308, 312, 816 P.2d 965, 967 (1991). Thus, Medicare/Medicaid payments are a "type" of social legislation benefits.

Accordingly, we cannot agree with Magno's assertion that Medicare/Medicaid programs are simply fee "agreements between the government and healthcare providers for their mutual benefit, independent of the interests of Medicare/Medicaid recipients." (Emphasis added.) Although Medicare/Medicaid programs involve fee agreements that are mutually beneficial to the government and the participating healthcare providers, such accommodations appear secondary to the essential purpose of Medicare/Medicaid, which is to provide medical assistance to the needy.

This court has followed the same approach. In Sam Teague, this court agreed with the United States Supreme Court that unemployment benefits paid by the state to the plaintiff, "were not made to discharge any liability or obligation of respondent, but to carry out a policy of social betterment for the benefit of the entire state," which "plainly show[s] the benefits to be collateral." 89 Hawai‘i at 283, 971 P.2d at 1118. In much the same way, the Medicaid/Medicare programs provide benefits for plaintiffs "from a source wholly independent of and collateral to the tortfeasor[.]" Id. at 281, 971 P.2d at 1116 (citations omitted). Because the Medicare/Medicaid program

prohibits "balance billing," the difference between the standard rate and the Medicare/Medicaid payment may be viewed as a part of the "benefits conferred on the injured party" within the scope of the collateral source rule. Restatement § 920A(2).

Inasmuch as Medicare/Medicaid are social legislation programs, we conclude that the collateral source rule applies to prevent the reduction of a plaintiff's award of damages to the discounted amount paid by Medicare/Medicaid.[15] See Haselden v. Davis, 579 S.E.2d 293, 294 n.3 (S.C. 2003) (holding that "the collateral source rule applies to Medicaid payments); Brandon HMA, Inc. v. Bradshaw, 809 So. 2d 611, 619 (Miss. 2001) (holding, by the Supreme Court of Mississippi, "that Medicaid payments are subject to the collateral source rule"); Ellsworth, 611 N.W.2d at 767 (applying the collateral source rule to medical expenses paid directly by Medicaid); Cates, 361 S.E.2d at 738 (explaining that Medicaid is "social legislation; it is the equivalent of health insurance for the needy" and "is an acceptable collateral source"); Thoreson v. Milwakuee & Suburban Transp. Co., 201 N.W.2d 745, 752 (Wis. 1972) (holding that the collateral source

[15] Of course, no "new category of damages" is created as the dissent would contend. Dissenting opinion at 8. Under our law, the "reasonable value" of medical expenses may be awarded as special damages and the collateral source rule will apply under the appropriate circumstances. Hence, such an application of our law does not "deviat[e] from . . . precedent." Id. at 9. The "policy" considerations sought by the dissent, see id., inhere in the rationale set forth in the authorities referred to and quoted and our discussion herein.

rule applies to Medicare, and "is not limited to paid-for benefits but applies to gratuitous medical services provided or paid for by the state"); see also Restatement § 920A cmt. c (explaining that "social legislation benefits" are subject to the collateral source rule); cf. Sato, 79 Hawai'i at 18, 897 P.2d at 945 (referring to the collateral source rule and HRS § 386-8 in prohibiting evidence of compensation benefits for the sole purpose of reducing the amount of the plaintiff's recovery). Therefore, we hold that the collateral source rule prohibits reducing a plaintiff's award of damages to reflect the discounted amount paid by Medicare/Medicaid.[16]

VIII.

Other jurisdictions have applied similar rationale in deciding that the reasonable value of medical services should be

[16] The dissent is incorrect in asserting that allowing Joseph to "recover more than . . . he is legally obligated to pay contravenes Hawaii's compensatory special damages law by restoring him to a position better than he would have been had the wrong not been committed–i.e., Joseph will be overcompensated." Dissenting opinion at 6 (emphases in original). In Sam Teague, the employer argued "that the circuit court erred by failing to reduce the award of back pay by the amount of unemployment benefits received by [employee]" covering the same period as the back pay. 89 Hawai'i at 281, 971 P.2d at 1116. The circuit court in Sam Teague had "affirmed the Commission's back pay award of $16,900 . . . [although the employee] received $8,322 in unemployment insurance benefits." Id. This court held that "unemployment benefits should not be deducted from awards of back pay under our employment discrimination law." Id. at 283, 971 P.2d at 1118. This was because "[a]lthough collateral source payments represent additional benefits to [the employee], as between the employer, whose action caused the discharge, and the employee, who may have experienced other noncompensable losses, it is fitting that the burden be placed on the employer." Id. at 282, 971 P.2d at 1117 (internal quotation marks and citation omitted). Despite the dissent's attempt to limit Sam Teague, dissenting opinion at 12-14, this court expressly confirmed that under the collateral source rule, the plaintiff does recover additional compensation and arguably is placed in a position better than he or she would be in were the collateral source rule not applied, inasmuch as the wrongdoer should not profit from third party benefits.

determined in light of the standard rates, rather than the amount paid to Medicare/Medicaid. See Ellsworth, 611 N.W.2d at 767-70; Haselden, 579 S.E.2d at 294-95. Ellsworth exemplifies these jurisdictions. In Ellsworth, as in the present case, the parties disputed whether the "reasonable value" of "medical assistance" benefits provided by the government[17] should be limited to the actual amount paid to the health care provider, or the reasonable value of such medical service which was substantially higher. Ellsworth, 611 N.W.2d at 766-68. The court there indicated that "Medical Assistance is a means of providing gratuitous medical services paid for by the state . . . for certain low-income individuals" that is "funded jointly by the federal and state governments." Id. at 767. The Supreme Court of Wisconsin rejected the tortfeasor's argument that "because [the plaintiff] did not personally incur any liability for her medical expenses she is not entitled to an award of damages . . . or to the benefit of . . . the collateral source rule." Id. at 768.

It explained that "[t]he general rule is that a plaintiff who has been injured by the tortious conduct of the defendant is entitled to recover the reasonable value of medical and nursing services reasonably required by the injury. This is a recovery for their value and not the expenditures actually made or obligations incurred." Id. at 769 (quoting 22 Am. Jur. 2d

[17] From the references in the case, such benefits would include Medicare, Ellsworth, 611 N.W. at 767, and Medicaid, id. at 768.

Damages § 207 (1965) (emphases added)). According to the Wisconsin court, under this general rule, "medical and nursing services rendered gratuitously . . . [would] not preclude the injured party from recovering the value of those services as part of his compensatory damages. Id. (quoting 22 Am. Jur. 2d Damages § 207). Hence, it held that "the injured plaintiff may recover the reasonable value of gratuitous medical services as part of his compensatory damages." Id.

As to defendant's argument "that recovery for past medical expenses should be limited to the amount paid by Medical Assistance because this amount is the reasonable value of services provided," id., the Wisconsin court declared that "in most cases" the reasonable value of medical costs "is the actual expense, but in some cases it is not. But the test is the reasonable value, not the actual charge." Id. (emphasis in original).

It explained that "[t]he collateral source rule seeks to place upon the tortfeasor full responsibility for the loss he has caused," such that the tortfeasor "is not entitled to reap the benefit of [plaintiff's] eligibility for public assistance or from the government's economic clout in the health care market place." Id. Hence, the Ellsworth court rejected the defendant's arguments that the "reasonable value" of medical services should be limited to the "amount paid" by Medicaid. Id.

Similarly, the Supreme Court of South Carolina, in Haselden, held that "the collateral source rule applies to Medicaid payments," 579 S.E.2d at 294 n.3, indicating that an award for medical damages should reflect the standard rates for medical services, and should not be reduced to the discounted amount paid by Medicaid. The appellate court declared that "[c]learly, the amount actually paid for medical services does not alone determine the reasonable value of those medical services[, n]or does it limit the finder of fact in making such a determination." Id. at 295 (emphasis added) (citations omitted). The court explained that limiting "damages in the amount actually paid by Medicaid is contrary to the purposes behind the collateral rule and would result in a windfall to the defendant tortfeasor." Id. Thus, the South Carolina Supreme Court determined that recovery for medical expenses was "not limited by the amounts paid by Medicaid." Id. at 294 n.3.

IX.

While other jurisdictions have limited medical special damages to medical expenses paid, these decisions appear to have rested upon the courts' interpretation of specific language in a state statute,[18] to have misapplied the Restatement,[19] or to have

[18] See Horton v. Channing, 698 So. 2d 865, 868-69 (Fla. App. 1997) (relying on Florida damages statute, Section 768.21, which states that recovery for damages is permitted for "[m]edical . . . expenses due to the decedent's injury . . . that were paid by or an behalf of [a] decedent"); Hanif, 246 Cal. Rptr. at 195-97 (relying on Cal. Civ. Code § 3359, interpreting "reasonable value" as "a term of limitation, not aggrandizement," (continued...)

been criticized or narrowed in their own jurisdictions.[20]

Two such jurisdictions, as relied on by Magno, have held that the "reasonable value" of medical services, in the context of awarding damages, is limited to the amount paid by Medicare/Medicaid. See Hanif, 246 Cal. Rptr. at 193-97 (interpreting medical expenses, in a case involving Medicaid, as "representing actual pecuniary loss"); Moorhead v. Crozer Chester Med. Ctr., 765 A.2d 786, 790 (Pa. 2001) (concluding, in a case involving Medicare, that the reasonable value of medical services

[18](...continued)
and relying on Cal. Civ. Code § 1431.2(b)(1), interpreting medical expenses as "representing actual pecuniary loss"); Nishihama v. City & County of San Francisco, 112 Cal. Rptr. 2d 861, 866 (Cal. App. 2001) (relying on Hanif, supra, and Cal. Civ. Code § 1431.2(b)(1)); Olszewski v. Scripps Health, 135 Cal. Rptr. 2d 1, 25 (Ca. 2003) (relying on Hanif, supra, and Cal. Civ. Code, but urging a change).

[19] See Hanif, 246 Cal. Rptr. at 196-97 (relying on Restatement § 911 cmt. h); Nishihama, 112 Cal. Rptr. 2d at 866 (relying on Hanif); Olszewski, 135 Cal. Rptr. 2d at 25 (relying on Hanif, supra, but urging a change); Moorhead v. Crozer Chester Med. Ctr., 765 A.2d 786, 790 (Pa. 2001) (relying on Restatement § 911 cmt. h (1977), which specifically references the reasonable exchange value of "services tortiously obtained by the defendant's fraud or duress, or for the value of services rendered in an attempt to mitigate damages").

[20] See McAmis v. Wallace, 980 F. Supp. 181, 185 (W.D. Va. 1997)(mem.) (holding that plaintiff was not entitled to recover amounts "written off" under Virginia law), no longer good law following decision in Acuar v. Letourneau, 531 S.E.2d. 316, 322-23 (2000) (holding that under Virginia law plaintiff may present evidence of the full amount of his reasonable medical expenses without any reduction to reflect discounted amounts).
See also Bates v. Hogg, 921 P.2d 249, 253 (Kan. Ct. App. 1996)(precluding application of the collateral source rule when the provider contracted with Medicaid), restricted by Rose v. Christi, 78 P.3d 798, 803 (Kan. 2003) (limiting Bates decision to Medicaid only); Griffin v. Louisiana Sheriff's Auto Risk, Ass'n, 802 So. 2d 691, 714-15 (La. Ct. App. 2001)(distinguishing Suhor, 770 So. 2d 422, and Terrell v. Nanda, 759 So. 2d 1026, and cases decided by the third and fifth Louisiana circuits as having been based on federal law, and concluding that the collateral source rule is applicable to contractual write-offs and that evidence of these amounts are to be excluded from a jury's consideration).

was limited to the amount paid). Such cases are not persuasive, for aside from being distinguishable, both the Hanif and Moorhead courts relied on the explanation of the term "value" described in Restatement § 911, comment h. See Hanif, 246 Cal. Rptr. at 196-97; Moorhead, 765 A.2d at 789.

But as employed in § 911,[21] the term "value" means "the exchange value," and that

> the exchange value of property or services is the amount of money for which the subject matter could be exchanged or procured if there is a market continually resorted by traders, or if no market exists, the amount that could be obtained in the usual course of finding a purchaser or hirer of similar property or services.

(Emphases added.) Comment h only pertains to the "value of services rendered" in the context of ascertaining the "measure of recovery of a person who sues for the value of his services tortiously obtained" or when a plaintiff "seeks to recover for expenditures made or liability incurred to third persons for services rendered." (Emphases added.) This definition of "value of services rendered" is inapplicable, for the present case does not involve a provider who is suing for the value of the medical services provided or who seeks to recover expenditures incurred to third persons.

On the other hand, Restatement § 924, entitled "Harm to the Person," is directly applicable to determining the reasonable

[21] Restatement § 911, entitled "Value," falls within Chapter 47 on "Damages."

value of medical services for an injured person. That section is part of the Restatement's topic of "Compensatory Damages for Specific Types of Harm." Restatement § 924 provides that "[o]ne whose interests of personality have been tortiously invaded[22] is entitled to recover damages for the past or prospective . . . reasonable medical and other expenses." Restatement § 924(c). Restatement § 924, comment f, entitled "Expenses," reaffirms that "an injured person is entitled to damages for all expenses and the value of services reasonably made necessary by the harm." (Emphasis added.) In line with the collateral source rule, comment f cites to § 920A, and instructs that "[t]he value of medical services made necessary by the tort can ordinarily be recovered although they have created no liability or expense to the injured person, as when a physician donates his services."[23] Id. (emphasis added). Hence, we believe Restatement § 911, comment h, is not germane to the questions posed.

[22] Restatement § 924, comment a, refers to the definition of "invasions of interests in personality, as defined in the Introductory Note to Chapter 2." The Introductory Note lists examples of "interests of personality" including, among others, "freedom from harmful bodily contact," and explains that "the freedom from bodily harm is given the greatest protection. It is protected not only against intentional invasion but against invasions caused by negligence, and also against invasions caused unintentionally and without negligence by activities so dangerous that the law requires them to be carried on at the risk of those whose activities they are." Restatement, Chapter 2, Introductory Note.

[23] However, a statute may provide a third party with the right to apparently sue directly for recovery of expenses paid. Hence, comment f also provides that "there can be no recovery for services for which a third person may recover, as when a worker's compensation act gives an employer or insurance carrier a claim against the tortfeasor for medical expenses incurred on account of a worker." Restatement § 924 cmt. f.

X.

We concur, then, with those jurisdictions that have held that a plaintiff, injured by the tortious conduct of a defendant, is entitled to recover the reasonable value of medical services and is not limited to the expenditures actually paid by Medicaid/Medicare. See Ellsworth, 611 N.W.2d at 769 (explaining that "the test" for determining an award of medical expenses "is the reasonable value, not the actual charge"); Haselden, 579 S.E.2d at 295 (explaining that the amount actually paid for medical services does not alone determine the reasonable value of those medical services); see also Restatement § 920A, cmt. b (explaining that "it is the tortfeasor's responsibility to compensate for all harm that he causes, not confined to the net loss that the injured party receives").[24]

[24] Contrary to the dissent's contention, dissenting opinion at 6-9, no precedent is overturned inasmuch as the issue at hand has not been decided in this jurisdiction. Indeed, none of the parties argue that a decision such as this one, consistent with other decisions reaching the same or similar results, would result in overturning Hawai'i law. Both Bynum and Magno, in fact, agree that the reasonable value of medical services is a measure of medical special damages. Magno recognizes that "[t]he reasonable value of the services is an upper limit on the amount recoverable," although relying on Restatement § 911 cmt. h (1979).

Moreover, the compelling justification standard as to overturning precedent is inapplicable. That standard has been applied where specific precedent is overturned. See, e.g., State v. Garcia, 96 Hawai'i 200, 207, 29 P.3d 919, 926 (2001) (reaffirming and refusing to overrule Grav v. Admin. Dir. of the Court, State of Hawai'i, 84 Hawai'i 138, 931 P.2d 580 (1997) and State v. Wilson, 92 Hawai'i 45, 987 P.2d 268 (1999), where State has not demonstrated any compelling justification); Dairy Rd. Partners v. Island Ins. Co., 92 Hawai'i 398, 421-22, 992 P.2d 93, 116-17 (2000) (overruling Hawaiian Ins. & Guar. Co. v. Blanco, 72 Haw. 9, 804 P.2d 876 (1990) and Hawaiian Ins. & Guar. Co. v. Brooks, 67 Haw. 285, 686 P.2d 23 (1984)); Francis v. Lee Enters., Inc., 89 Hawai'i 234, 239, 971 P.2d 707, 712 (1999) (overruling Dold v. Outrigger Hotel, 54 Haw. 18, 501 P.2d 368 (1972)).

XI.

Such a conclusion is consistent with the established practice in Hawai‘i courts for determining special damages for medical services, as embodied in Hawai‘i Civil Jury Instruction No. 8.9.[25] The instruction does not limit special damages to the amount charged, but instructs that plaintiffs are entitled to damages for "the reasonable value of the the medical services provided." Hawai‘i Civil Jury Instruction No. 8.9 (emphasis added). Jurors are thus instructed that plaintiffs are entitled to compensation for medical treatment, but these damages are not limited to out-of-pocket expenses. Id.[26]

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[25] Hawai‘i Civil Jury Instruction No. 8.9 states, in relevant part that:

> If you find for plaintiff(s) on the issue of liability, plaintiff(s) is/are entitled to damages in such amount as in your judgment will fairly and adequately compensate him/her/them for the injuries which he/she/they suffered. In deciding the amount of such damages, you should consider:
> . . . .
> (3) The reasonable value of the medical services provided by physicians, hospitals and other health care providers, including examinations, attention and care, drugs, supplies, and ambulance services, reasonably required and actually given in the treatment of plaintiff(s) and the reasonable value of all such medical services reasonably probable to be required in the treatment of plaintiff(s) in the future.

(Emphases added.) The "reasonable value" formulation has been used in this jurisdiction for at least thirty-five years. See Kometani, 50 Haw. at 95, 431 P.2d at 936 (affirming that it was proper for the jury to consider the "reasonable value" of future medical expenses).

[26] There is no "sidestepping our long standing damages law and instead rel[ying] on the Restatement (Second) of Torts," as the dissent claims. Dissenting opinion at 9. As mentioned previously, (1) the collateral source rule is well established in our jurisdiction; (2) the Restatement is an authoritative source relied on in our case law; (3) decisions from other

(continued...)

XII.

Moreover, allowing a particular plaintiff to recover the reasonable value of medical services leads to a more just result. The consequences of a contrary approach may penalize the recipient of Medicare/Medicaid payments. AARP reports in its amicus curiae brief, that "[Medicare/Medicaid], parts of the Social Security Act, together compromise the nation's largest source of public health insurance . . . and long term care services for the poorest and most vulnerable in society." AARP maintains that "[a]pplying the collateral source rule helps to ensure that low-income elderly and disabled individuals are treated equitably vis a vis privately insured individuals by compensating for aspects of the [Medicare/Medicaid] programs that would substantially limit, if not completely eliminate, the beneficiary's recovery of special damages." Cf. Masaki v. Columbia Cas. Co., 48 Haw. 136, 142, 395 P.2d 927, 930 (1964) (citing Kopp v. Home Mut. Ins. Co., 6 Wis. 2d 53, 57, 94 N.W. 2d 224, 225 (1959) for the proposition that "[i]t would lead to a highly absurd and socially undesirable result to construe the medical payments coverage clause of the defendant's [automobile] policy so as to hold that recovery for the costs of hospital services provided to the insured may be recovered in [the] case"

[26](...continued)
jurisdictions support the same holding; and (4) our trial practice, as reflected in jury instructions, is consistent with the outcome.

where a person purchases an insurance policy that provides reimbursements, but not by a person enrolled in a group plan in which affiliated hospitals agree to provide certain hospital services for the payment of a premium).

AARP observes that "federal and state law[s] require, as a condition of Medicaid eligibility, that beneficiaries assign rights to third party payment for medical expenses, including tort recovery. 42 U.S.C. § 1396k(a) (2003); [HRS] § 346-37 (2003).[27] . . . Only after the federal and state governments are reimbursed for medical expenses, is the [Medicare/Medicaid] beneficiary entitled to payment. 42 U.S.C. § 1396k(b) (2003)." In this regard, AARP reasons that, "[b]ecause the tort recovery of individuals receiving care paid by private payers is not subject to a setoff by the government, [Medicare/Medicaid] beneficiaries will always be entitled to less special damages." (Emphasis added.) Hence, AARP argues that "[a]pplying the collateral source rule in these cases helps to ameliorate the

[27] HRS § 346-37(d), entitled "Recovery of Payments and Costs of Medical Assistance," provides in pertinent part:

> (d) The department [of Human Services], as to this right of reimbursement, shall also be subrogated to all rights or claims that a claimant has against the third person for all damages not to exceed the full extent of the costs of medical assistance . . . furnished or to be furnished by the department. The department's right to full reimbursement of the costs of medical assistance . . . as a subrogee of a claimant shall not be diminished by the recovery of any judgment, settlement, or award of an amount less than the value of the original or settled claim as perceived or calculated by the claimant or any other person.

substantial gap in recovery of damages" between Medicare/Medicaid beneficiaries, and those who are privately insured.

XIII.

The dissent contends that the majority's holding "allows the recovery of an amount which does not fall within one of the permissible categories of damages," thereby "creating a new category of damages without justification." Dissenting opinion at 9. This contention rests upon the dissent's conclusion that "[a]s a form of compensatory special damages," an award of "medical expenses is limited to the pecuniary loss" incurred by the plaintiff. Id. at 3. Despite the dissent's protestations to the contrary, no existing precedent in this jurisdiction has so held. This case comes before us by way of certified question based upon the Ninth Circuit and the federal district court's determination that the special damages issues certified herein presents a "novel question under Hawai‘i law."

Moreover, limiting medical expenses to the pecuniary loss suffered by a plaintiff would mean, for example, that injured plaintiffs who received gratuitous medical services, were treated at a veteran's hospital, or were covered by medical insurance plans such as offered to Kaiser Hospital patients would not be entitled to recover any monetary amount from the tortfeasor (except perhaps nominal out-of-pocket fees), see Masaki, 48 Haw. at 138-39, 395 P.2d at 928, because, according to the dissent, plaintiff's recovery is limited to pecuniary loss,

which would not be present in these situations. Not only would such an approach be contrary to the "great weight of authority in this country," Pryor, 263 N.E. 2d at 240, but this approach is contrary to this jurisdiction's long established approach to allowing an injured plaintiff to recover for the "reasonable value of the medical services." See discussion supra part XI.

Finally, adoption of the dissent's position would create various new categories of plaintiffs, similarly injured whose recovery would depend upon the type of their insurance coverage, and not upon the nature of their injuries. The incongruity of the dissent's position is further evident for its effect on future medical expenses. Patients such as those receiving treatment at military hospitals and Kaiser would not be entitled to future medical expenses. This would inevitably invite trial disputes regarding the plaintiff's continuing indigency or the likelihood of a plaintiff's change in insurance coverage in the future and its consequential effect on the amount of recovery. See infra Part XIV.

XIV.

Therefore, in answer to the district court's first question, the amount of medical special damages awardable to a plaintiff in a negligence action is not limited to the discounted amount paid to a healthcare provider by Medicare/Medicaid. Inasmuch as we hold that the collateral source rule prohibits reducing a plaintiff's award of medical special damages to

reflect the discounted amount paid by Medicare/Medicaid, we consider the district court's second question.

Because the "reasonable value" in awarding damages to a plaintiff for medical services is not limited to the amount billed to healthcare providers by Medicare/Medicaid, the answer to the district court's second question is, "No." As indicated previously, the standard rates are relevant and should be admissible for establishing the reasonable value of medical costs constituting such special damages. See Haselden, 579 S.E.2d at 294 n.3 (holding that "the collateral source rule applies to Medicaid payments); Ellsworth, 611 N.W.2d at 767 (applying the collateral source rule to medical expenses paid directly by Medicaid); Cates, 361 S.E.2d at 738 (explaining that Medicaid is "social legislation; it is the equivalent of health insurance for the needy" and "is an acceptable collateral source"); Thoreson, 201 N.W.2d at 752 (holding that the collateral source rule applies to Medicare, and "is not limited to paid-for benefits but applies to gratuitous medical services provided or paid for by the state"); Brandon HMA, Inc., 809 So. 2d at 619 (holding, by the Supreme Court of Mississippi, "that Medicaid payments are subject to the collateral source rule"); see also Restatement § 920A, comment c (explaining that "social legislation benefits" are subject to the collateral source rule).

Moreover, we agree with the statement of the Supreme Court of Ohio that receipt of such payments should not be

admitted in evidence to reduce damages "[s]ince, by the collateral source rule, the receipt of collateral source benefits is deemed irrelevant and immaterial on the issue of damages[.]" Pryor, 263 N.E.2d at 239. The Ohio court reasoned that "[t]he entire theory of the collateral source rule is to keep the jury from learning anything about the collateral income so that it will not influence the decision of the jury" for the purpose of reducing the award of damages. Id. (quoting Wolfe v. Whipple, 251 N.E.2d 77, 82 (Ill. App. Ct. 1970).

Further, in regard to future public benefits, the Supreme Court of North Carolina opined persuasively that the collateral source rule should also preclude "defendants from offering evidence demonstrating that plaintiffs can mitigate their damages by using public resources" such as Medicaid. Cates, 361 S.E.2d at 738. In so holding, the court explained that the "goal of the law of damages is to place an injured party in as nearly the same position as he would have been had he not been injured." Id. In deciding that a plaintiff's future medical costs should not be limited to the rates charged by Medicaid, the Supreme Court of North Carolina reasoned that a contrary rule would detract from full recovery.

> Forced dependence on public charity because of injuries tortiously inflicted puts the injured party in a position more disadvantageous than if he were freed from his dependence. Full compensation that frees the injured party from dependence on charity is more in keeping with the compensatory goal of tort recovery. . . . The Plaintiff should be able to recover the cost of future medical services, since he is likely to prefer private care, and it is his "right" to have it. It may be that he will employ the free care for which he is eligible and thereby receive a

> "windfall," but . . . at the time of suit there is no way of knowing what he will choose to do.

Id. (emphases added) (citations omitted). Additionally, the court noted that "the collateral source rule should apply to possible future public benefits because (1) "the lack of certainty characterizing the availability of public resources renders it unwise to allow mitigation of damages premised on their continued existence," and (2) the "utilization of many of these benefits hinges on a plaintiff's continued indigency." Id. at 738-39. Hence, on the grounds set forth herein, "the amounts billed in excess of the" Medicare/Medicaid "amount paid" are not irrelevant or inadmissible on the issue of medical special damages.

XV.

Accordingly, for the reasons discussed herein, the answer to each of the district court's certified questions is, "No."

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