The Collateral Source Rule

# New Approaches to Loss Allocation

By Donna P. Moye and William R. Moye

**The practicality of the traditional collateral source rule is wisely being questioned, as many jurisdictions recognize that the original intent of rule—to prevent a windfall to a tortfeasor—is no longer the overriding concern.**

For more than one hundred years, an award of damages in personal injury litigation was governed exclusively by the common law collateral source rule. The traditional application of the collateral source rule prohibits any reduction of a wrongdoer's liability based on benefits that an injured party receives through a party unrelated to the defendant, which is usually an insurance company. It has long been the law's position that a collateral benefit that an injured party receives as an insured beneficiary should not reduce a plaintiff's recovery to create a windfall for the tortfeasor. The reasoning goes that if a plaintiff was responsible for securing the third-party benefit, by maintaining his or her own insurance or making advantageous employment arrangements, for instance, he or she should not be deprived of the advantage that it confers. The rule does not differentiate between the third-party benefits received as long as they did not come from the defendant or a person acting on his or her behalf. In most jurisdictions, the rule has historically functioned to exclude the mere mention of the existence of health insurance or any other third-party benefit such as worker's compensation, charity payments, or uncollectible institutional write-downs during a trial.

The collateral source rule is compatible with principles of fairness and equity, however, only when the damages asserted are genuine. The equitable spirit of the rule is plainly seen, for example, when $1,000 of charged medical services is actually worth $1,000 to the patient. We all know that this pure value is rare in the modern medical billing world, yet the prevailing wisdom of the common law has long ignored the obvious windfall that today's claimants receive when the amount billed to a patient, and assessed to a tortfeasor, far exceeds the amount that the claimant will ever be required to pay.

Nearly every lawyer in every personal injury case has received billing records from medical providers reflecting adjustments in the amounts originally billed based on managed care contracts that the

■ Donna P. Moye is an attorney in the Houston office of Thompson Knight LLP. She is a member of the DRI Medical Liability and Health Care Committee and a past contributor to the committee's *Medlaw Update* regarding property rights associated with fertility treatments. William R. Moye is an equity partner in the Houston office of Thompson Coe Cousins & Irons, where he is head of the office's Casualty Section. He is a member of the DRI Product Liability, Trucking Law, and Trial Tactics Committees.

providers have with a patient's health insurers or other third-party payors. In some instances, the adjustments, discounts, and write-downs can decrease the amount actually paid on a patient's behalf by up to 75–80 percent. It is not to be taken as a harsh comment against the medical provider industry, but it is a widespread and well-known practice for medical providers purposefully to increase the "charged rate" for routine medical services in an original bill to compensate for the perceived financial shortfalls that occur when a medical provider's contract with a third party requires deep discounts or a "negotiated rate," or when an uninsured completely fails to pay a provider.

A recent article in *Time* magazine provided a poignant example of these markups. Although a single generic acetaminophen tablet can be purchased with a provider's bulk buying-power for less than ten cents, the usual and customary billing entry for these tablets is $1.50 each. Such a substantial markup between the actual cost to a provider and what a provider charges to a patient is pervasive and involves almost every single entry on an exemplar bill. Should a personal injury plaintiff be rewarded with a judgment including this massive markup when neither the plaintiff nor anyone else on his or her behalf will ever be required to pay it? The collateral source rule, in its purest form, says "yes."

While the collateral source rule is still prominent in the dustiest of tort casebooks, the tide is beginning to turn. The practicality of the traditional collateral source rule is wisely being questioned, as many jurisdictions recognize that the original intent of the rule—to prevent a windfall to a tortfeasor—is no longer the overriding concern. Many courts in states that have embraced a modicum of tort reform are now focused instead on ensuring that an injured party does not receive a windfall by recovering substantially more in economic damages than what was actually paid to the medical providers.

The following discussion explains modern approaches that jurisdictions have adopted on the collateral source rule. It further outlines strategies and practice points designed to limit both economic and noneconomic damage models regardless of the side that your jurisdiction has chosen in the collateral source rule debate.

## Jurisdictional Overview: What Evidence Is Allowed Where

A fair handful of jurisdictions have held steady to the traditional application of the collateral source rule, including Arizona, Colorado, Connecticut, Delaware, Georgia, Hawaii, Illinois, Kentucky, Louisiana, Massachusetts, Mississippi, Nebraska, Oregon, South Carolina, South Dakota, Tennessee, Virginia, Wisconsin, and the District of Columbia. In these jurisdictions, courts admit only undiscounted bills and do not allow evidence of reductions to form the basis of verdicts or damage awards.

On the opposite end of the spectrum are those states where, either by virtue of statute or case law precedent, only the amounts actually paid are admissible, or they are admissible along with the full amounts billed. The Texas Legislature, for example, codified the state position on the collateral source rule in Texas Civil Practices and Remedies Code Chapter 41.0105, which provides that the "recovery of medical or health care expenses incurred is limited to the amount actually paid or incurred by or on behalf of the claimant." Tex. Civ. Prac. & Rem. Code Ann. §41.0105 (West 2013).

The provision was passed in 2003, but for more than eight years practitioners and judges wrestled with the meaning of those three little words "paid or incurred." Was the proper evidence the amount actually paid by a plaintiff's health insurer to a medical provider, or was it the full amount of the unpaid bill "incurred" by the plaintiff? The Texas Supreme Court clarified this in a relatively recent opinion. In *Haygood v. De Escabedo*, the court unequivocally held that the Texas statute limits a claimant's recovery of medical expenses to those that have been or must be paid by or for the claimant. 356 S.W.3d 390, 391 (Tex. 2011). No longer may the full amount of medical billing be offered into evidence in an attempt to increase a noneconomic damages award only to have a court reduce the award after the jury announces a verdict. Instead, only evidence of recoverable medical expenses is admissible trial evidence. *Id.* at 399–400.

Other states have adopted statutes similar to the Texas statute. In Oklahoma, only evidence of medical expenses actually paid is admissible trial evidence. Okla. Stat. Ann. tit. 12, §3009.1 (West 2012). North Carolina has a similar statute limiting the evidence to prove medical expenses to only the amount paid. *See* N.C. Gen. Stat. Ann. §8C-1, Rule 414 (West 2013). Although not codified, Pennsylvania and Idaho case law also permit only the amounts paid as trial evidence.

**The swelling** judicial tide against the collateral source rule reflects a desire to limit artificially inflated damages in jury verdicts.

In a unique twist, the Missouri Legislature enacted a statute providing a rebuttable presumption that the amount paid for medical services represents the value of the treatment rendered. Mo. Rev. Stat. §490.715(5) (West 2012). *See also Deck v. Teasley*, 322 S.W.3d 536, 538–42 (Mo. 2010). Similarly, Kansas, Indiana, Iowa, and Ohio have established case law permitting juries to evaluate evidence of both the amount billed and the amount actually paid as they decide the reasonableness of the medical expenses.

Taking yet another approach, New York, Florida, and Minnesota allow evidence of the full billed amount, yet they permit postverdict set-offs of the amount actually paid. While seemingly pragmatic, postverdict set-offs are not as simple in application. Questions arise about how to apply the postverdict set-off if a jury awards medical damages in an amount less than what a plaintiff submitted as his or her undiscounted medical bills. If a court does not know how a jury determined the reduced damages award, it cannot know to which providers to apply the set-off or in what proportions. *See Gore v. Faye*, 253 S.W.3d 785, 788 (Tex. App. 2008), *disapproved of by Haygood v. De Escabedo*, 356 S.W.3d 390 (Tex. 2011). Further, the collateral source rule is designed to keep any mention of insurance out of a courtroom, but there is

no guarantee that it will not be mentioned, or even used as a decision-making guidepost, in a jury room during deliberation.

### Measuring Damages: Hardly a Simple Task

The swelling judicial tide against the collateral source rule reflects a desire to limit artificially inflated damages in jury verdicts. Defense practitioners can expect to see strategies from the plaintiffs' bar, fearing that wave of change, designed to magnify and inflate medical treatment values whenever possible. These tactics are based on a long-held, and possibly true, belief that the more economic damages that someone can "blackboard," or prove, during a trial, the more a jury will award for noneconomic damages such as impairment, disfigurement, and mental anguish.

**It is always better** to know if a factoring company is involved at the beginning of your case rather than to be blindsided during a mediation by a plaintiff's inability to negotiate below billed medical expenses, especially after you have conferred with your client about case values and set a reserve.

### Increased Use of "Factoring" Companies

How can plaintiffs' counsel increase the amount of medical billing in "paid or incurred" jurisdictions? Is not the negotiated discount between insurer and provider the end of the story? It might be, if not for a rise in the use of "factoring" companies.

"Factoring" is simply the practice of purchasing accounts receivables owned by others. Factoring companies are known in litigation circles for advertising their ability to purchase annuitized structured settlements from former personal injury plaintiffs that "need cash now." These companies have also marketed their services to medical providers, offering to purchase a provider's accounts receivable as a way to expedite payment on patients' outstanding bills and to manage the provider's cash flow in a more "predictable" manner. This ostensible benefit to a caregiver can also lead to a litigation windfall to a plaintiff.

Plaintiffs' counsel can hire a factoring company to purchase an injured plaintiff's medical accounts receivable directly from the medical providers who performed the services. Counsel can also direct the company to purchase the account at the full billed rate, without any negotiated write-downs and adjustments that someone would normally expect a third-party payor to receive. At the courthouse, the plaintiff's counsel then argues that the billed rate—without any reductions—is the amount that must be submitted to the jury because the full billed amount was "paid or incurred" on behalf of the plaintiff, albeit through a factoring company.

In many instances this clever accounting is not by accident. Many national factoring companies' websites declare that their services can "maximize the amount of your medical damages." These same websites also refer visitors through links to specialized medical care providers for spinal injury and brain injury assessment. Common sense allows a defense practitioner to conclude that a referring factoring company likely has a prearranged relationship with a medical provider to purchase the provider's receivables. As additional encouragement, many of these factoring companies advertise that they will waive their right of reimbursement for purchased receivables if a plaintiff loses a trial.

The business model of factoring companies includes a degree of risk because their repayment is linked to the outcome of a case, and their financial condition is affected when a receivable is purchased but a case is lost. Waiving reimbursement of purchased receivables for lost cases therefore causes factoring companies to lose money on that particular gamble. Any defense practitioner who has walked into a settlement discussion knowing that a factoring company holds the medical receivables understands why this matters. While lienholders of statutory hospital liens for unpaid medical expenses are part of most personal injury cases and are usually willing to allow reasonable rate reductions to resolve a case, factoring companies have no such incentive to settle cases for anything less than what they paid for the receivables. When a factoring company has paid substantial consideration for a receivable, it is less likely to negotiate to accept less than what it is contractually owed. It also has less "room to move" during a mediation because every new lawsuit is a chance to recoup, or at least minimize, any losses experienced in other cases that lost trials.

So what can we do as defense practitioners? It is always better to know if a factoring company is involved at the beginning of your case rather than to be blindsided during a mediation by a plaintiff's inability to negotiate below billed medical expenses, especially after you have conferred with your client about case values and set a reserve. Use discovery to bring this issue to the forefront in the early stages of litigation to identify (1) whether a factoring company has purchased medical debt; (2) which company purchased the debt and when; (3) how much did a factoring company pay for the debt; and (4) whether repayment of purchased accounts receivable is contingent upon a particular settlement or verdict outcome. If a factoring company has purchased the medical debt, it may be necessary to direct third-party discovery to the holder of the receivable. This discovery can open avenues to seek admittance of reduced medical expenses. If, for example, discovery reveals that a factoring company provided written assurances to a medical provider similar to a letter of protection, defense counsel can then argue that the full amount of the expenses charged has not technically been "incurred" because it is only owed on a contingency related to the lawsuit's outcome. At a minimum, in this scenario a defense attorney should argue that the financial assurance letter is admissible trial evidence for the purposes of informing a jury of the true nature of the requested "paid or incurred" amount of the medical billing.

### Attorney-Referred Medical Providers

For decades, plaintiffs' lawyers have referred their clients to doctors that they frequently used for assessments or "their" doctors. Research has proved that juries usually do not view this practice with much disdain if the evidence shows that a plaintiff viewed the referring attorney as his or her trusted confidant and sought the provider's treatment based on the attorney's referral. When using such a doctor, a plaintiff's counsel typically provides the medical provider with a letter of protection to guarantee payment so that the client can receive treatment. Before collateral source rule reform, much of the legal wrangling during trials in medical liability cases focused on the admissibility of letters of protection. Now, commonly medical providers purposefully do not accept available health insurance to cover the costs of care that they render, and plaintiffs often purposefully do not use it either.

The result? A plaintiff's bill for a cervical fusion surgery costs twice the amount that it would have if the plaintiff had used the insurance card in her wallet or if the medical provider had accepted the insurance for the procedure. The legal effect? Adversaries argue that the full medical billing from surgeons to whom they have referred clients, without any reductions, is admissible medical cost evidence. So, how should defense counsel respond? Do not forget to challenge the "reasonable" component of medical cost evidence.

Even in jurisdictions that apply the collateral source rule, evidentiary rules require a plaintiff to show that the medical expenses were a "reasonable" value for the treatment received at the time that the care was rendered. To establish reasonableness in most jurisdictions, a plaintiff typically provides an affidavit or medical declaration from either the physician or the medical billing custodian to verify and swear that the charges were "reasonable." In a case in which a plaintiff, the plaintiff's attorney, or the medical provider purposefully avoided using health insurance, however, the "reasonable" amount sums can differ, producing more than one "reasonable" amount.

A defense attorney can challenge reasonableness using the definition of "reasonable" described in the Medicare statute. By statutory definition, the rates prescribed by Medicare are reasonable as a matter of law. 42 C.F.R. §405.501(a) (2011). Reasonable charges are based on customary charges for similar services in the general local area, and criteria are kept and maintained in a Medicare table. 42 C.F.R. §405.502(a) (2011). It is highly probably that the Medicare table rates for a surgical procedure will be lower than the amount stated on an attorney-referred medical provider's bill. If accessible, a defense attorney can use the Medicare tabulations when cross-examining adverse doctors during pretrial depositions to prove the alternate "reasonable" numbers.

In cases with unquestionable adverse liability coupled with significant past medical damages, defense counsel may minimize the damages model successfully by hiring a certified life care planner to itemize and value the reasonableness of medical expenses. While the standard practice is usually to hire a physician in the same field as the adverse surgeon to provide these services, the advantage to hiring a life care planner is that he or she will have credentialed experience, can swear under oath, provide an analysis of both past and future medical expenses, and bring to bear an analysis of reasonable costs based on prevailing Medicare rates and private insurance rates. These witnesses are essentially pricing experts and are a valuable addition to a case when the opposing litigants do not dispute the necessity of a procedure. Experience has shown that many talented surgeons can testify that the amount that they and their facilities have billed was "reasonable," but many have difficulty offering alternate figures because accounting departments usually do the actual billing. A life care planner can fill these information gaps with ease.

Additionally, it is wise to resist the temptation to call a billing custodian as an expert in lieu of a life care planner. Life care planners are customarily highly trained and credentialed medical witnesses that can withstand *Daubert* challenges. On cross-examination, a billing custodian can swear to the charges incurred but lacks the medical background to offer any greater insight, which impedes his or her testimony. In contrast, life care planners can testify to the reasonableness of charges based on Medicare charts, prevailing rates paid by managed care contracts, and access to nationwide databases that allow them to calculate average pricing of procedures, such as an orthopedic intervention, hardware placement, and significant rehabilitation. While most defense attorneys traditionally use life care planners to establish future care expenses, bringing their expertise to bear to assess past medicals is incredibly helpful when charged medicals differ from the real paid or incurred amount. A life care planner can educate your jury by credibly explaining reasonable expenses in the past and reasonable expenses in the future, and he or she can provide an alternative theory to the one put forward by a plaintiff's own doctors. What is more, a life care planner is usually more accessible for consultation and has more flexibility to schedule and attend a deposition.

**A plaintiff's** purposeful decision not to use his or her insurance may provide an opportunity for defense counsel to argue that the plaintiff failed to mitigate his or her damages.

### Asserting the Defense: A Plaintiff's Failure to Mitigate

A plaintiff's purposeful decision not to use his or her insurance may provide an opportunity for defense counsel to argue that the plaintiff failed to mitigate his or her damages. A plaintiff's counsel would most likely argue that an insured has no contractual obligation to use insurance and that such a defense would direct a jury to assume that insurance was involved. However, if your jurisdiction has no clear authority on the issue, it may be worthwhile to develop this defense. To avoid

an outright disclosure of an insurance policy and invite a motion for a mistrial, a defense attorney must carefully navigate this inquiry while cross-examining a plaintiff or a medical provider. Defense counsel could ask, for example, "Was an opportunity available to the plaintiff to lower the amount of his medical charges?" A defense attorney will also need to develop a strategy, consulting with a life care planner, as mentioned above, to determine specifically how much less than the claimed amount the damages could have been if a plaintiff had mitigated his or her damages. While proponents of the common law collateral source rule may object to the failure to mitigate defense, it can remind a judge that a plaintiff's attorney should not try to use the rule to protect the record from mentioning insurance when a plaintiff purposefully avoids using available insurance to inflate damages willfully.

**Theoretically,** fair proceedings should not need to insulate juries from knowledge of insurance discounts since juries can basically presume that insurance pays for the treatments.

### Additional Tips

Another common concern is which party should gather the evidence of the billed amount versus the amount actually charged after a third-party payor discount. As a Texas practitioner pre-*Haygood*'s requirement of actual payment, that responsibility clearly fell to the defense attorney. The plaintiff's counsel was able to offer the full billed medical amount to the jury. So the challenger had the burden to offer competent evidence of the "paid or incurred" amount to the court for the postverdict set-off.

Competent evidence is the key. While medical bills can be subpoenaed to prove actual amounts paid and "proven up," a term used in Texas, to avoid hearsay or authentication objections, the bills are often so cryptic that a judge might reject them when offered as evidence. In fairness, medical bills are generated for internal medical provider use and not a judge. There are typically no public listings or postings for the type of medical care received by a plaintiff that explain what was charged versus what was paid. To prevent having to defend your interpretation of what a provider's codes actually mean, it is wise to serve a notice of a nonparty deposition on written questions to the provider of the medical bills, if available in your jurisdiction, under Federal Rule of Civil Procedure 31 or a similar provision. Ask simple questions such as these: (1) What was the total amount charged for the services rendered? (2) What was the amount written off, adjusted, or discounted for Medicare or another third-party payor? (3) How much does the patient still owe for the treatment received? It is much easier to offer the sworn questions deposition from the records clerk into evidence than to risk exclusion of an accurate, but confusing medical bill.

If your case is in a jurisdiction such as Texas that follows *Haygood*-like reasoning, someone could argue that a claimant bears the burden to produce evidence of the actual paid amounts, and no records orders would be necessary. This can turn into an "each their own" approach with each party producing its own evidence of medical billing. Depending on the case, it still might be wise to propound your own discovery to third-party providers, if for no other reason than to confirm that the amounts offered in evidence by the other side are the true paid or incurred amounts.

Another frequent concern is future medical treatment. Typically future medical expense amounts are not discounted by write-downs or adjustments based on the involvement of a third-party payor. We suggest that in cases that need a life care planner to assess future damages, the numbers offered into evidence should already reflect the amount of the third-party payor discounts and adjustments.

### Looking to the Future

The Affordable Care Act enacted in 2010 requires that everyone must possess medical insurance in the near future or pay an additional tax. In turn, most future plaintiffs will receive discounts to medical billing negotiated by their insurers. What does this mean for the collateral source rule and its future application? If the point of the collateral source rule is to exclude insurance from the damage model analysis, the universality of medical insurance would nullify the protection that the rule is designed to provide. When most plaintiffs have insurance, the vast majority of past and future medical expenses will be based on established, contracted rates with managed care providers without a great deal of variation. Theoretically, fair proceedings should not need to insulate juries from knowledge of insurance discounts since juries can basically presume that insurance pays for the treatments. In fact, post-trial interviews and mock jury trials show that most of today's jurors already assume that insurance is involved even if it is never mentioned during trials.

Modern tort reform has been motivated by increased social perception that we have become an overly litigious society. The disdain of society—and by "society," we mean the men and women who sit on your juries—for nuisance-type lawsuits and questionable injuries has contributed to trends moving away from the common law application of the collateral source rule. The collateral source rule took decades to evolve, and we can expect additional developments and changes in the intent and application of the rule to take just as long. What is certain, however, is that the future of the collateral source rule is tethered to the continuing evolution of social opinion on litigation and the yet-to-be determined details of how medical care in the United States will be administered in the years to come. FD