Let's Be **Reasonable**

Medical Expense Write-Offs and the Impact of the Collateral Source Rule

By Martin A. Levinson and Christopher N. Snow

With the advent of President Obama's sweeping healthcare legislation and other recent state and federal healthcare initiatives, availability and affordability of quality healthcare are at the forefront of many people's minds. Unfortunately, while significant time and effort have been expended to correct some of the problems with our healthcare system, one of the most obvious and egregious examples of unfairness and inflation affecting healthcare and insurance costs remains — claimed medical expenses.

Generally, when a plaintiff seeks to recover medical expenses in a tort action, the plaintiff must demonstrate that the claimed value of the medical services is reasonable and that the plaintiff's need for the medical services was proximately caused by the defendant's negligence. The purpose of compensatory damages such as those for medical expenses is to compensate the plaintiff, not to punish the defendant or to give the plaintiff a windfall.

Nonetheless, many states still permit plaintiffs who bring personal injury lawsuits to recover the full amount of medical expenses billed by the plaintiff's medical providers, regardless of whether those amounts have been or ever will be paid. Although this problem is well known and understood by those involved in handling personal injury claims and lawsuits, it remains largely outside the public eye.

How It Works

The typical situation where this problem arises begins when a person visits a medical provider, receives treatment for a covered injury or ailment, and is billed for that treatment. The patient pays a small co-payment or office visit fee, while the balance is submitted to an insurer or other benefits provider on the patient's behalf. The insurer or benefits provider then determines how much it will pay to satisfy the covered portion of the bill and pays that amount to the medical provider. In most if not all cases, a significant portion of the bill remains that is not covered by the insurer or benefits provider and is written off by the medical provider. Regardless, in most such cases, the bill is satisfied by the insurer's payment, the patient owes nothing and the written-off portion of the original bill is never paid.

In some jurisdictions, however, plaintiffs are permitted under the collateral source rule to blackboard, present evidence of, and even recover the entire amount billed for any claimed medical expenses, even where large portions of the amounts billed were written off by an insurer or benefits provider due to contractual rate reductions or by statute, have never been paid, and will never be paid. This appears to be the rule in at least fourteen states (Arizona, Colorado, Delaware, Georgia, Hawaii, Illinois, Louisiana, Mississippi, Missouri, Oregon, South Carolina, South Dakota, Virginia and Wisconsin) and the District of Columbia. While some of these jurisdictions at least permit a defendant to obtain a post-verdict set-off for any write-offs, other jurisdictions, including Arizona and Louisiana, permit plaintiffs to recover the full amount billed, including any amount written off.

In those jurisdictions, defendants may not present any proof of — and, thus, the jury cannot consider — the amount actually paid or owed for the medical services provided to the plaintiff. As a result, plaintiffs routinely recover double, triple or exponentially more than the amount of any medical bills actually incurred as a result of the defendant's negligence. Of course, even where a post-verdict set-off is allowed, permitting plaintiffs to blackboard written-off amounts and represent to the jury that those sums actually

were or will be incurred by the plaintiff can result in a larger verdict after the set-off than would be otherwise be awarded. The rationale relied on by proponents of the collateral source rule is that the defendant should not receive a windfall for payments made (or written off) by someone else.

Today's Reality

This approach is simply out of touch with the modern realities of healthcare. The amounts paid for medical services by private insurers and public benefit programs now are based primarily or wholly on predetermined, contractually agreed-upon amounts — most typically, the Relative Value Units (RVU) system, a standardized approach relied upon by many insurers and governmental entities for determining the amount to be paid for particular medical procedures and services. Under this system, each medical procedure or service is assigned a "relative value" based on the effort involved in terms of time, support staff/office/overhead expenses, and the cost of professional liability/malpractice insurance, multiplied by a geographic adjustment factor for the applicable geographic region. Each RVU is then multiplied by a standard conversion factor to determine the amount to be reimbursed for the procedure or service. Many private insurers contract with medical providers for a particular percentage of amounts payable under the RVU system for all services and procedures rendered to their insureds. That percentage is then applied to each charge to determine the amount to be paid by the insurer for any covered medical procedure or service by that provider.

Given the pervasive use of the RVU system and similar schemes today, the reasonable value of the medical services rendered to a plaintiff cannot be determined merely by considering the amount billed by the plaintiff's medical providers. Rather, the reasonable value of a medical service is the amount the provider will agree to accept in payment for that service.

Although the excessive amounts recovered by plaintiffs under the collateral source rule are initially paid by defendants and their insurers, the cost is passed on to other Americans through increased overall insurance premiums. Another unsatisfying side effect is that an injured person who files suit can recover more for the same medical treatment than an injured person who seeks reimbursement from his own health insurer. Anyone handling cases in jurisdictions where plaintiffs are permitted to blackboard and recover the entire billed amount of their medical bills should take that into account when evaluating a claim and any potential settlement and verdict ranges.

Looking Ahead

The good news is that there has been a movement in recent years to bring the law into sync with the realities of the modern healthcare and insurance systems. This reform has resulted in the modification or complete abrogation of the collateral source rule in at least 37 states, while another 15 states have done away with the collateral source rule in medical malpractice cases. Maine has eliminated the collateral source rule except in professional negligence actions involving personal injury, while Alabama has limited the rule's applicability to product liability actions. Numerous courts, including the federal Seventh and Eighth Circuit Courts of Appeals and state appellate courts in Minnesota, Georgia, Arkansas and Mississippi, have held that evidence of payments received from a collateral source may be used to impeach a witness's credibility.

Where the collateral source rule has been eliminated, defendants may present evidence of collateral source benefits received by a plaintiff to reduce any damage award at trial, and plaintiffs can no longer recover amounts paid by a collateral source, such as their own health insurance. The hope is that these reforms represent a larger trend toward allowing plaintiffs to recover only those economic damages actually incurred, rather than providing plaintiffs with a windfall in the form of double or multiple recovery of their actual, reasonable medical expenses.

The Supreme Courts of California and Texas recently held that where a medical provider accepts less than the amount billed in full payment for particular services rendered, the plaintiff may only recover the amount accepted by the provider. Similarly, appellate courts in Florida, Idaho, Indiana, Ohio and Pennsylvania have held that a jury is entitled to hear evidence of the amount of medical expenses actually paid by an insurer or other benefits provider and may decide to award only that amount. Evidence of any write-offs is presented to the jury, who may then decide that the reasonable value of the plaintiff's medical care is the amount billed, the amount accepted as payment or anywhere in between. In this way, the jury is supplied with all available facts and is tasked with determining what portion of the bills was reasonable and necessary.

In reaching these holdings, courts have focused largely on the fact that write-offs are never actually paid by anyone. These courts have decided that plaintiffs are only entitled to recover the reasonable value of the medical services received, regardless of how much was originally billed. The end result is the equitable treatment of all parties involved — plaintiffs are fairly compensated, while defendants are not unfairly penalized.

Practically speaking, the important point to take away is that the same amount of medical bills — indeed, the exact same medical bills — can be worth significantly more in one jurisdiction than another, depending on which of the above rules the jurisdiction follows. Be sure to know the rules applicable to your particular jurisdiction so you do not make the mistake of undervaluing (or overvaluing) a particular claim. LM

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