Time to Examine Tennessee's Collateral Source Rule

By William Walton on Sat, 12/01/2012 - 12:00am

Taking Another Look at Fye v. Kennedy

Damages in tort law are designed to compensate for injury and, in the words of one court, "only for that."[1] On the other hand, few bastions of the Tennessee personal injury bar are more vigorously defended (and heartily embraced) than the "Collateral Source Rule." No one marches under the rule's banner more proudly than a personal injury lawyer who has successfully excluded evidence concerning the amount of actual "paid" medical expenses when compared to the amount of the "billed" medical expenses in a personal injury case. Conversely, no one squeals louder than a defense practitioner buffaloed into paying a substantial personal injury settlement based upon phantom "billed" medical expenses that all parties acknowledge will never be paid.

The expansion of government-mandated health care (and the attendant growing dictation of what medical expenses can, and cannot, be recovered by a health care provider), as well as the heavy influence of government reimbursement rates on private health care insurers,[2] suggest that it is time for Tennessee courts and the Tennessee General Assembly to revisit the operation of the Collateral Source Rule in Tennessee. Specifically, the Collateral Source Rule should be re-examined to the extent that it allows submission to (and recovery of) phantom medical expenses from a jury, but prevents the same jury from considering the amount of medical expenses actually "paid." In today's rapidly changing and complex health care environment, both figures are relevant to a jury in determining whether medical expenses are "reasonable" and "necessary."

The question of the reasonableness and necessity of medical expenses as an element of damages in a personal injury action is a question of fact for the jury.[3] Existing precedent, however, prevents Tennessee juries from considering relevant evidence as to the actual medical expenses that are paid for an injury.[4] In Tennessee, relevant evidence is defined as "evidence having any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence."[5] Evidence of the amount accepted in satisfaction of a bill for medical services provided to an injured plaintiff is relevant, and consequential as to whether the medical expense is "reasonable." Yet, Tennessee courts routinely exclude evidence of "paid" medical expenses from jurors in personal injury cases under the guise that such evidence would violate the Collateral Source Rule.[6]

The Collateral Source Rule provides that if any injured plaintiff receives medical or other monetary benefits from a source independent of the alleged tort-feasor, a jury may not hear evidence of the payments from the independent source to reduce or otherwise offset the damages or other expenses sought from the tort-feasor.[7] Comment b of the Restatement (Second) of Torts § 920A (1979) explains the rule as follows:

> If the plaintiff was himself responsible for the benefit, as by maintaining his own insurance or by making advantageous employment arrangements, the law allows him to keep it for himself. If the benefit was a gift to the plaintiff from a third party or established by law, he should not be deprived of the advantage that it confers

While the Collateral Source Rule has been recognized in various forms in Tennessee common law for more than 75 years,[8] and it has been abrogated to a certain extent in medical malpractice cases for more than 30 years,[9] Comment b of the Restatement (Second) of Torts § 920A (1979) was formally "adopted" in personal injury cases by the Tennessee Court of Appeals in *Fye v. Kennedy*.[10]

The result in *Fye* well illustrates the extreme operation of the rule. *Fye* involved a wrongful death action in which Erlanger Medical Center generated a medical bill for $748,384.08. Erlanger subsequently submitted the same statement to Medicaid and received payment in the amount of $75,264. The balance of the bill in the amount of $673,120.08 was written off or otherwise legally forgiven in accordance with Medicaid regulations.[11]

Judge Susano, writing for the *Fye* Court, observed that Tennessee focuses on the reasonable "value" of the "necessary" medical services. Since the bill in the case represented charges for "necessary" treatment, the court reasoned that it was "clear" that the billed amount, too, was "reasonable."[12] Without extensive discussion, the Fye Court concluded that the jury was "not entitled to know that the bill had been partially forgiven."[13] It stated further that the "collateral source rule precludes a defendant from attempting to prove that a 'reasonable' charge for a necessary service actually rendered, has been, or will be, paid by another —

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not the defendant or acting on someone on his behalf …"[14] Judge Susano did not comment or otherwise distinguish between allowing the introduction of evidence that an amount has been paid (as evidence as to the reasonableness and necessity of the charge) as compared to identifying the source of the reduction. With little comment, and less discussion, subsequent courts have left the ruling in Fye undisturbed.[15]

In the past, Tennessee juries have been instructed that the "plaintiff may recover for reasonable and necessary expenses for medical care, services, and supplies actually given in the treatment of a party as shown by the evidence …"[16] An "expense" arguably suggests that the personal injury plaintiff should actually incur (or be likely to incur) the expense or cost, rather than simply receiving a medical bill that will never be paid.[17] More current Tennessee pattern jury instructions inform jurors that "medical expenses are the cost of medical care, services and supplies reasonably required and actually given in the treatment of the plaintiff as shown by the evidence …"[18]

The growing disparity between the amount of "paid" expenses compared to the amount of "billed" expenses is recurrent in personal injury litigation. The advent of expanded health care under the federal Affordable Care Act of 2009[19] and extension of Medicaid programs by various states foretell the increasing (and required) acceptance of "discounted" medical expenses by medical providers. Unlike benefits that an individual plaintiff may have "negotiated" or purchased from a collateral source, the federal and state governments have long set the rates which medical providers who honor public insurance programs must accept for certain medical services.[20]

Different states address the submission of "billed" medical expenses to a jury (as compared to "paid" medical expenses) in personal injury cases in various ways. There are generally three approaches as to how states address this issue.[21] First, some states, including Tennessee, appear to apply a "reasonable value of medical services" analysis. Other states may employ an "actual amount actually paid" analysis.[22] Finally, a third category of jurisdictions appear to utilize a "benefit of the bargain" analysis.[23]

Fye illustrates a "reasonable value of medical services" approach. The latter generally allows plaintiffs to recover the entire amount of medical expenses originally billed, including amounts "written off" by health care providers.[24] As indicated by *Fye*, the reasonable value of services approach relies upon "comment b" to Restatement (Second) of Torts § 920A, and applies the Collateral Source Rule even when the source of the payment is a public social insurance entitlement program provided by law.[25]

Fye's exclusion of evidence of "paid" medical expenses from a jury is not without its supporters. For example, the Colorado Supreme Court in *Wal-Mart v. Crossgrove*,[26] recently addressed what it deemed to be the "tension between the collateral source rule and reasonable value rules" in personal injury cases. In Crossgrove, the medical providers billed almost $250,000 for their services.

The plaintiff's insurer, however, paid the providers $40,000 in full satisfaction of the bills.[27] In a 2 to 1 decision, the Colorado Supreme Court ruled that the trial court's admission of the paid expenses (along with the amount of billed expenses) constituted error. Because of the "nature of modern health care billing practices," the majority in Crossgrove concluded that "a reasonable juror could easily infer the existence of a collateral source if presented with evidence, for example, that a provider accepted $40,000 in satisfaction of a $250,000 medical bill."[28]

In a spirited dissent, Colorado Justice Eid observed that, had the plaintiff (rather than an insurer) negotiated the discount in medical expenses, there would have been no question that the jury could have heard both the paid and billed amount in determining the reasonable value of services.[29] Justice Eid further noted that such an example "demonstrates the danger of tying the reasonable value calculation to who paid the medical provider rather than to the medical provider's acceptance of the payment."[30] He further advocated for submission of evidence of the amount paid (but not including the source of payment) as a relevant factor for consideration of jurors.

The Kansas Supreme Court recently reached a similar conclusion in its decision of *Martinez v. Milburn Enterprises*.[31] The Martinez Court recognized Kansas's use of the "reasonable value approach." However, it determined that the Collateral Source Rule does not bar evidence of the amount originally billed by a health care provider, nor does it bar evidence of the reduced amount accepted by the provider in full satisfaction of the amount billed. The Martinez decision reasoned that both amounts are relevant to jurors in addressing the reasonableness and necessity of medical expenses which may be awarded to an injured plaintiff. At the same time, evidence of the collateral source of the payments was deemed inadmissible.[32]

Discussing the complexities of the health care pricing structure, the Martinez Court observed that one can not reasonably conclude that the amount of "billed" medical services is determinative of the reasonableness and necessity of such services. The Kansas Supreme Court further noted that the price that a medical provider is prepared to accept for the medical services rendered is relevant to the determination of reasonable medical expenses,[33] and, "if a higher stated medical bill, an amount that never was, and never will be paid, is admitted without evidence of the lower reimbursement rate, the jury will be basing their verdict on 'mere speculation or conjecture."[34]

Rejecting the concerns expressed by the majority in Crossgrove that jurors would "infer" the existence of the plaintiff's collateral source if they know a smaller amount was paid, the Martinez Court observed that such inferences may exist in virtually any case, yet jurors are routinely entrusted with considering liability and determining damages.[35]
Regardless of the approach used or analysis employed, all of these decisions reflect that the amount of "billed" medical expenses in most modern personal injury cases has very little rational relationship to the amount of "paid" medical expenses.

The fundamental principle underlying tort law is to afford compensation for injuries sustained by one person as a result of the conduct of another. Permitting recovery of illusory medical expenses that have never been paid by the plaintiff or a third-party

insurer (and for which the plaintiff incurs no liability) while, at the time, depriving a Tennessee jury of relevant evidence of the amount of medical expenses paid (and accepted) for such services, contradicts the idea that an injured party should not be overcompensated for an injury. The Restatement (Second) of Torts § 911, comment h, states the more equitable proposition as follows:

> When a plaintiff seeks to recover for expenditures made or liability incurred to third persons for services rendered, normally the amount recovered is the reasonable value of services rather than the amount paid or charged. If however the injured person paid less than the exchange rate he can recover no more than the amount paid except when the low rate was intended as a gift to him.

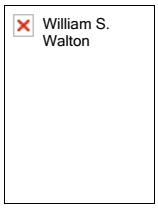
The *Fye* decision did not specifically address the fact that it is possible to submit medical expense payment information to jurors in Tennessee without identifying the source of such payment. Consequently, there may be hope for reform — but, such reform will require prodding. Defense practitioners are encouraged to "make a record," in the future to present a more expansive record to the appellate court as to why the submission of "paid" medical expenses is relevant in personal injury action concerning the reasonableness and necessity of medical expenses. Other commentators have argued that practitioners should also consider challenging the introduction of unpaid medical expenses by using professional repricing services to determine usual and customary reasonable expenses for medical services in the community.[36]

Although *Fye* remains the law in Tennessee, it should be revisited by the courts and, if necessary, by the General Assembly. Damages for injury should reasonably compensate for the injury, and "only for that."

Notes

1. See e.g., *Harris v. Standard Accident Insurance Company*, 297 F.2d 627,631-632 (2d Cir. 1961) cert den. 369 U.S. 843 (1962).
2. The Medicare social insurance program initially utilized a "reasonable-cost" payment system to determine reimbursements to provider hospitals. Under the early system, providers reported the total costs of providing services to Medicare beneficiaries and were reimbursed if such costs were determined to be reasonable. This reimbursement system was replaced entirely in 1983 with the Prospective Payment System, 42 U.S.C. § 1395ww (d)(1)-(4). The Prospective Payment System requires classification of each payment into a "diagnosis related group" or "DRG." See e.g. Michigan Dept of *Community Health v. Sec. of Health and Human Services*, No. 11-1905, 2012 WL 3608610 at 1 (6th Cir. 2012)(unpublished). DRGs are now also widely used by private insurers in calculating reimbursement rates under private health insurer plans.
3. TPI-Civil No. 14.11 (Medical Expenses), 7th edition.
4. *Fye v. Kennedy*, 991 S.W.2d 754, 764 (Tenn. Ct. App. 1998), reh'ing denied, application to appeal denied (1998).
5. Rule 401, Tenn. R. Evid.
6. *Fye v. Kennedy,* 991 S.W.2d 754, 764 (Tenn. Ct. App. 1998).
7. See 22 Am. Jur. 2d "Damages" § 392.
8. See e.g., *Globe v. Rutgers Fire Insurance Co. v. Cleveland*, 34 S.W.2d 1059, 1060 (Tenn. 1931); *Donnell v. Donnell,* 220 Tenn. 169, 415 S.W.2d 127, 134 (1967).
9. See *Tenn. Code Ann*. § 29-26-119. Discussion of the application of the Collateral Source Rule in medical malpractice cases is beyond the scope of this article.
10. *Fye v. Kennedy,* 991 S.W.2d 754 (Tenn. Ct. App. 1998), reh'ing denied, application to appeal denied (1998).
11. *Id.*
12. *Id.* at p. 764.
13. *Id*.
14. *Id* at p.765.
15. The use of the term "forgiven" in *Fye* is subject to debate. As noted in the decision, the provider was precluded from seeking additional reimbursement due to federal regulations.
16. TPI-Civil No. 14.11 (Medical Expenses), 7th edition (2007).
17. Discussing the term "expense" in a domestic relations dispute, the Tennessee Court of Appeals noted that "the word 'expense' actually encompasses a range of closely related meanings. The first of the four separate definitions of 'expense' … in the *American Heritage Dictionary of the English Language* is 'the cost involved with some activity; a sacrifice, a price.' The general definition in *Black's Law Dictionary* (5th ed. 1979) reads, 'that which is expended, laid out or consumed. An outlay; charge; cost; price. The expenditure of money, time, labor, resources, and thought." *Jones v. Jones*, 2009 WL 4017163 *3 (Tenn. Ct. App. 2009) (unpublished).
18. T.P.I.-Civil No. 14.01 (Compensatory Damages) 11th Edition (2011).
19. Pub.L.111-148 (2010)
20. See generally, 42 CFR 412 (2012) [describing the extensive procedure used by Medicare to establish federal prospective medical reimbursement payment rates for inpatient services using varied factors as qualifying diagnosis related groups (DRGs), geographic regions and wage index information.
21. See e.g., *Martinez v. Milburn Enterprises*, 233 P.3d 205, 218 (Kan.2010)
22. This minority approach limits a plaintiff's ability to recover any greater expenses than the medical expenses actually paid in full settlement of the bill. See e.g., *Dyet v. McKinley*, 81 P.3d 1236 (Idaho 2003).
23. The benefit of the bargain approach permits plaintiffs to recover the full value of their medical expenses, including the "write off" amount, where it is clear that the plaintiff has paid some consideration for the benefit of the write off. See e.g., *Bozeman v. State*, 879 So.2d 692, 701 (La.2004)[Louisiana]; *Acuar v. Letourneau*, 531 S.E.2d 316 (Va. 2000) (Virginia).
24. See e.g., *Brandon HMA v. Bradshaw*, 809 So.2d 611 (Miss. 2001)[Mississippi]; *Halselden v. Davis*, 579 S.E.2d 293 (S.C. 2003)[South Carolina]; *Koffman v. Leichtfuss*, 630 N.W.2d 201 (Wisc. 2001)[Wisconsin].
25. See *Martinez*, surpra, at p. 218.
26. *Wal-Mart v. Crossgrove*, 276 P.3d 562 (Colo. 2012)

27. *Crossgrove*, 276 P. 3d at p. 563.
28. *Id*. at p. 567.
29. The similar result would follow in *Fye*. See e.g., *Fye*, supra at p. 764.
30. *Id*.
31. *Martinez v. Milburn Enterprises*, 233 P.3d 205 (Kan. 2010).
32. *Id*. at p. 229.
33. Id. at p. 229 (citing *Scott v. Garfield*, 912 N.E.2d 1000 (Mass. 2009)(concurring opinion).
34. *Id*. at 229 (quoting with approval, *Leitinger v. DBart*, 736 N.W.2d 1 (Wisc., 2007)[Roggensack dissenting].
35. 3d. at p. 228.
36. See e.g., Selg, H., "Billed versus Paid," *Claims Managemen*t, vol. 8. August 2012, p.16.



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