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 squeals louder than a defense practitioner buffalooed into paying a substantial personal injury settlement based upon phantom “billed” medical expenses that all parties acknowledge will never be paid.

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 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.”

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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]

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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 —
Fye analysis. [23] “actual amount actually paid” analysis. [22] Finally, a third category of jurisdictions appear to utilize a “benefit of the bargain” approach to determine medical expenses, including Tennessee, which applies a “reasonable medical services” approach. Other states may employ an analysis based on the reasonable value of medical services. [20]

Permitting recovery of illusory medical expenses that have never been paid by the plaintiff or a third-party, yet jurors are routinely entrusted with considering liability and determining damages. [35] 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...

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 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] The modern approach to the payment of medical expenses 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 modern personal injury cases has very little rational relationship to the amount of “paid” medical expenses.

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]
Although reasonable expenses for medical services in the community.

Notes

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.
5. Rule 401, Tenn. R. Evid.
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.
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.
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).
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.
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., Dyell 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., Buzeman v. State, 879 So.2d 692, 701 (La.2004)(Louisiana); Acuar v. Letourneau, 531 S.E.2d 316 (Va. 2000) (Virginia).
25. See Martinez, surpura, at p. 218.
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.
32. Id. at p. 229.
33. Id. at p. 229 (citing Scoté v. Garfield, 912 N.E.2d 1000 (Mass. 2009)(concurring opinion).
34. Id. at 229 (quoting with approval, Leitinger v. D'Bar, 736 N.W.2d 1 (Wis., 2007)(Roggensack dissenting).
35. 3d. at p. 228.

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