

## MEDICAL DEFENSE AND HEALTH LAW

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### IN THIS ISSUE

*The authors review two recent developments in which a Vermont court and the Iowa legislature denied recovery by medical malpractice plaintiffs of medical expenses which were neither paid for nor required to be satisfied.*

## Recovery of Medical Bills: “Face Amount” vs. “Amount Paid”: Medical Malpractice Plaintiff May Not Recover More Than the Defendant was Actually Paid for Treating Plaintiff

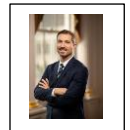
### ABOUT THE AUTHORS



**Walter Judge** represents businesses in the state and federal courts of Vermont, Massachusetts, and Maine in commercial matters (contract disputes, unfair competition, etc.), intellectual property litigation (enforcement of copyright, trademark, and trade secret rights) and in products liability and personal injury defense. He defends retail establishments, premises owners, trucking companies, institutions, and individuals against negligence and personal injury claims. In 2019 Walter obtained a \$3.6 million jury verdict in federal court on behalf of an aviation company against a competitor. He is a member of IADC, DRI, and FDCC. He can be reached at [WJudge@drm.com](mailto:WJudge@drm.com).



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### ABOUT THE COMMITTEE

The Medical Defense and Health Law Committee serves all members who represent physicians, hospitals and other healthcare providers and entities in medical malpractice actions. The Committee added a subcommittee for nursing home defense. Committee members publish monthly newsletters and *Journal* articles and present educational seminars for the IADC membership at large. Members also regularly present committee meeting seminars on matters of current interest, which includes open discussion and input from members at the meeting. Committee members share and exchange information regarding experts, new plaintiff theories, discovery issues and strategy at meetings and via newsletters and e-mail. Learn more about the Committee at [www.iadclaw.org](http://www.iadclaw.org). To contribute a newsletter article contact:



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*The International Association of Defense Counsel serves a distinguished, invitation-only membership of corporate and insurance defense lawyers. The IADC dedicates itself to enhancing the development of skills, professionalism and camaraderie in the practice of law in order to serve and benefit the civil justice system, the legal profession, society and our members.*

Recent weeks have seen significant developments in two states in relation to the determination of recoverable medical expense damages in medical malpractice cases. In May, a Vermont superior court held that a medical malpractice plaintiff cannot recover from the defendant hospital more in medical specials damages than the amount the hospital received in payment for treating the plaintiff. See DeGraff Spear, et al. v. The University of Vermont Medical Center et al., Docket 239-3-18 Cncv (Toor, J) (May 12, 2020). Then, on July 1, a new Iowa statute took effect which limits the medical specials that a jury may consider in medical malpractice cases to only those amounts actually paid or owing to the health care provider. Iowa Code Annotated § 622.4 (2020). This article reviews these two developments.

### **Background**

For years a battle has been raging in the United States over whether a personal injury plaintiff can recover from the tortfeasor, by way of medical specials, (1) the “face amount” of her medical bills for accident-related treatment – which amount typically includes a portion that the healthcare provider has “written off” and agreed not to pursue from the patient/plaintiff) – or (2) only the lesser amount that the healthcare provider, after applying its write-off, accepted in full satisfaction of those bills from an insurance company or other third-party payor, or government benefit (e.g., Medicaid or Medicare), i.e., the “amount

actually paid.” The answer depends upon the jurisdiction, and comprises a spectrum. On one end, some states hold either by judicial ruling or by statute that a plaintiff cannot recover more than her healthcare provider(s) accepted in full satisfaction of the bills. See, e.g., Stayton v. Delaware Health Corp., 117 A.3d 521, 530 (De. 2015) (common law ruling that the amount paid by Medicare or Medicaid is dispositive of the reasonable value of healthcare services, and collateral source rule does not require otherwise); Howell v. Hamilton Meats and Provisions, Inc., 52 Cal.4th 541 (2011) (same); Hanif v. Housing Authority, 200 Cal.App.3d 635 (1988) (same); Iowa Code §§ 622.4, 668.14A (new statute limiting plaintiff’s recovery to amount actually paid; discussed below in the context of medical malpractice cases); Tex. Civ. Prac. & Rem. Code § 41.0105; Haygood v. Garza de Escabedo, 356 S.W.3d 390 (Tex. 2011) (confirming that Texas statute limits plaintiff’s recovery to only the discounted amount, and limits evidence of medical expenses to the amount paid); W. Va. Code § 55-7B-9d (2015) (mandating a verdict reduction in medical malpractices cases to award only those past medical expenses paid by or on behalf of the plaintiff, and those not yet paid but for which an obligation to pay remains).

On the other end, some states hold that a plaintiff can recover the full “face amount” of her bills and a defendant cannot introduce evidence of the “amount actually paid.” See

Lopez v. Safeway Stores, Inc., 129 P.3d 487 (Ariz.Ct.App. 2006).

In between, some states hold that a plaintiff can recover the “reasonable value” of her accident-related medical treatment, and it is up to the jury to determine that amount and that the jury may consider both the “face amount” and the “amount actually paid.” See Robinson v. Bates, 112 Ohio St. 3d 17, 857 N.E.2d 1195 (2006) (in Ohio, “[b]oth the original medical bill rendered and the amount accepted as full payment are admissible to prove the reasonableness and necessity of charges rendered for medical and hospital care”); see also Law v. Griffith, 457 Mass. 349, 930 N.E.2d 126 (Mass. 2010) (plaintiff may introduce bills showing “face amount” as evidence of reasonable value and defendant may introduce contrary evidence of reasonable value but may not introduce “amount actually paid” as such evidence is contrary to collateral source rule).

Jurisdictions that have allowed a plaintiff to recover the full “face amount” of the bills and refuse to allow the defendant to introduce evidence of the “amount actually paid” typically do so – wrongly, in our view – under the “collateral source rule.” The collateral source rule holds that a tortfeasor cannot benefit, i.e., limit its damages exposure, from the fact that a third-party payor (e.g., insurance) paid the plaintiff’s

medical bills.<sup>1</sup> Otherwise, the theory goes, the tortfeasor avoids some amount of liability by the fortuity that the plaintiff was insured. Lopez, supra.

The Vermont Supreme Court has not addressed the “face amount” vs. “amount actually paid” issue, but does follow the collateral source rule, and most Vermont superior judges who have addressed this issue have cited that rule in refusing to allow the defendant to limit a plaintiff’s recovery of medical specials to the amount actually paid for medical services.

It is questioned whether this is properly analyzed as a collateral source rule issue. Restatement (Second) Torts § 920A (1979). We advocate for approaching the issue not as a question of whether a third-party payor (insurance, Medicaid, etc.) paid for all or part of a plaintiff’s medical bills but, rather, a damages issue: what is the reasonable value of the medical services provided as established by how much the medical treatment actually cost? A defendant who is seeking to limit a plaintiff’s recovery of medical specials to the amount actually paid and accepted as full payment is not seeking to avoid liability for the specials but is only seeking to prevent a plaintiff from recovering more than the treatment actually cost, i.e., from obtaining a windfall, through the artifice of presenting the jury with medical bills that show a false dollar figure

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<sup>1</sup> By way of comparison, West Virginia’s Medical Professional Liability Act provides for separate verdict reductions for non-qualifying medical expenses (i.e., those neither paid for nor

required to be yet satisfied), and certain payments from collateral sources. Compare, W. Va. Code 55-7B sections 9a (collateral source) and 9d (medical expenses).

for the treatment rendered. We believe this amounts to misleading the jury into awarding an unfairly high damages award in the medical specials category—effectively a form of punitive damages without the requisite showing of malice. See e.g., Howell v. Hamilton Meats and Provisions, Inc., 52 Cal.4th 541 (2011) (limiting the amount of plaintiff’s recoverable medical specials to the amount paid by plaintiff’s insurer in full satisfaction of the medical bills does not violate collateral source rule).

### **The Medical Malpractice Context**

But what about the situation where (a) the defendant and (b) the healthcare provider that treated the plaintiff and whose bills are at issue are one and the same? This is exactly the situation in the typical medical malpractice case. A Vermont superior court addressed the question in DeGraff Spear, ruling in the defendant hospital’s favor.

### **The DeGraff Spear Case**

It’s important to understand the basic facts. The plaintiff was treated at the University of Vermont Medical Center hospital (UVMC) and experienced complications. She subsequently was treated extensively at another hospital. At both facilities she incurred substantial medical bills. The bills from both UVMC and the subsequent hospital were paid by Medicare and her husband’s military health insurance, for a fraction of the face amount of the bills and in full satisfaction of those bills, so the plaintiff owed the two hospitals nothing.

She sued UVMC for malpractice, alleging that her lengthy treatment at UVMC and at the subsequent hospital was due to UVMC’s negligence. She sought to recover the full face amount of the bills issued from both UVMC and the subsequent hospital. UVMC moved to limit the plaintiff’s recovery to the amount paid by Medicare and the military insurer for the bills from both hospitals.

As to the bills from the second hospital, the Vermont court predictably followed the conventional analysis and treated the issue as a “collateral source” issue, and ruled that the plaintiff can recover the full face amount. The court rejected UVMC’s argument that government payments, such as Medicare, should be treated differently from private insurance under the collateral source rule.

But as to the bills from UVMC, the court concluded that the collateral source rule does not apply, and that it would be unfair for UVMC to have to pay back to the plaintiff the full face amount of UVMC’s bills when UVMC itself had “written off” a huge portion of those bills and accepted a much lower amount from Medicare and the military insurer in full payment. Accordingly, UVMC’s liability on its own bills will be limited to the amount actually paid.

The collateral source rule only prevents an alleged tortfeasor (here, the medical malpractice defendant, UVMC) from benefitting from a third party’s (typically, an insurer’s) payments to a third party health

care provider, to cover the plaintiff's damages caused by the tortfeasor. To constitute a collateral source, there must have been a payment made by an unrelated third-party on behalf of the plaintiff. Helfend v. Southern Cal. Rapid Transit Dist., 2 Cal.3d 1 (1970). In a typical case, the defendant-tortfeasor is not permitted to benefit from that third-party payment by way of reducing its damages liability to the plaintiff. But where the defendant is "connected with" the payment, the collateral source rule does not apply. In a medical malpractice case the defendant hospital is not an unrelated third party and is "connected with" the reduced bill when it writes off the amount of the bill that is not paid by the third-party (insurance or Medicare, etc.). This written-off amount is essentially a partial payment of the bill by the defendant hospital and is therefore "outside the collateral source rule." Therefore the court concluded that the plaintiff can only recover the amount of UVMHC's bill paid by Medicare. In this situation, to rule otherwise would force UVMHC to give back to the plaintiff, in the form of medical specials, approx. \$300,000 more than it received and accepted in payment for those specials.

It would be unreasonable for UVMHC to have to pay to plaintiff in medical expenses an amount that UVMHC already incurred and "paid" on plaintiff's behalf by writing those expenses off and accepting a lower payment from Medicare. (It should be noted

that we are only discussing the category of damages known as "medical specials." A personal injury plaintiff is of course free to seek whatever amount of *general* damages, such as pain and suffering, etc., that she can persuade the jury is fair and just under the circumstances.) To the extent there is any benefit to the plaintiff from the defendant's write-off, that benefit was provided by the defendant, at the defendant's own expense. A few other courts have ruled the same way on similar facts, or indicated that they would do so. See Williamson v. St. Francis Med. Ctr., Inc., 559 So. 2d 929 (La. Ct. App. 1990); see also Hardi v. Mezzanotte, 818 A.2d 974 (D.C. 2003) (discussing and distinguishing earlier decision holding that application of the collateral source rule where "medical services [were] provided by the tortfeasor itself ... would have required, in effect, double payment.").

#### Iowa Code § 622.4

Like the Vermont court's decision as it related to the defendant hospital, Iowa's newly enacted statute seeks to strike a fair balance between compensating plaintiffs for losses incurred in the form of medical expenses, without overcompensating them by awarding amounts not actually paid nor required to be paid. Unlike Vermont, Iowa now accomplishes this end by way of an evidentiary limitation rather than a verdict restriction. The actual text of Iowa Code Ann. § 622.4 (2020)<sup>2</sup> is as follows:

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<sup>2</sup> See also, I.C.A. § 668.14A, a similar provision applicable to personal injury cases *outside*

the realm of medical malpractice actions, which took effect the same day as § 622.4.

Evidence offered to prove past medical expenses shall be limited to evidence of the amounts actually paid to satisfy the bills that have been satisfied, regardless of the source of payment, and evidence of the amounts actually necessary to satisfy the bills that have been incurred but not yet satisfied. Evidence of the amounts actually necessary to satisfy the bills that have been incurred shall not exceed the amount by which the bills could be satisfied by the claimant's health insurance, regardless of whether such health insurance is used or will be used to satisfy the bills. This section does not impose upon any party an affirmative duty to seek a reduction in billed charges to which the party is not contractually entitled.

This succinct statute is comprised of three primary elements. First, it restricts introduction of bills for medical expenses at the trial of a medical malpractice case, to only those amounts which were either paid or are owed to health care providers and required to be paid. Thus, the plaintiff may “blackboard” for the jury the amounts of those medical expenses for which the plaintiff actually paid, the amounts paid on behalf of the plaintiff such as by private health, and those amounts not yet paid but for which a requirement to pay remains.<sup>3</sup> Amounts contractually written off or otherwise uncollectable are not admissible.

The second significant element of the Iowa statute is its provision that the amount of medical expenses sought by the plaintiff

cannot exceed the amount that *could be* satisfied by the plaintiff's health insurance, even if the health insurance is not used. This provision prevents plaintiffs from artificially maximizing the amounts yet required to be satisfied by simply delaying or foregoing submission of the expenses to a third-party payor. Under the Iowa method, the amounts recoverable are limited to what the health insurance would have paid, even if a claim for payment was never submitted.

Lastly, the final sentence of the statute operates to protect plaintiffs by expressly disavowing any affirmative duty to seek a reduction of damages sought in accordance with this statute. Thus, in practical effect, while the plaintiff is not *entitled* to recover the amounts of medical expenses in excess of those paid or required to be satisfied, the burden of seeking evidentiary exclusion of the inadmissible “charged” expenses falls to the defendant.

### Conclusion

The DeGraff Spear decision and the Iowa statute are significant steps trending in the direction of upholding the intent of medical malpractice jurisprudence, which is to restore the plaintiff to the pre-injury status quo as much as possible, but not to create a windfall by reimbursing expenses the plaintiff never actually incurred. The Vermont court's ruling is significant for that species of med mal cases where: (1) the plaintiff is not seeking recovery of medical

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<sup>3</sup> Iowa has a separate statute that governs the application of the collateral source rule in

medical malpractice cases. See I.C.A. § 147.136 (2020).



bills from a third party health care provider that treated her to address the defendant healthcare provider’s alleged malpractice (or not *only* from such a third party), but the medical bills from the defendant itself; and (2) the “face amount” and “amount actually paid” differential is significant. DeGraff Spear establishes precedent that in such a case the plaintiff cannot seek to recover a greater amount of damages, in the form of

medical specials, than the defendant was actually paid for treating the plaintiff. The Iowa statute accomplishes the same end, in any medical malpractice case in which past medical expenses are at issue, by way of an evidentiary exclusion of medical expenses neither paid nor required to be satisfied.

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