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This article examines those states that have deviated from the common law collateral source rule concerning healthcare expenses by limiting admissible evidence to only those amounts that have actually been paid by the plaintiff.

Collateral Source Evidence: Different Approaches to the Admissibility of Evidence of Paid or Incurred Medical Expenses

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This article summarizes the approaches of a few states whose courts have, in varying degrees, weakened the common law collateral source rule in the context of healthcare expenses where the injured party is insured, thus permitting the introduction of at least some evidence of payments by a collateral source (i.e., an insurer). Some states still apply the traditional rule, barring any evidence of insurance payments at all, thereby permitting a plaintiff to prove damages by way of billed medical expenses that, in reality, will only be paid after they are adjusted significantly downward—these jurisdictions are not the focus of this article.[1] The focus of this article is those states at (or approaching) the other extreme, where the only admissible evidence of a plaintiff's medical expenses is the amount actually paid by plaintiff's insurers after negotiations, without regard to the amounts initially billed.

I. A Little Background

Two commonly-discussed national public policy "reforms" are responsible for the focus on the paid-or-incurred discussion: healthcare reform and tort reform.

The shift from traditional, indemnification-based, fee-for-service health insurance to managed care systems (such as the predominant PPO and HMO models[2]—with their discounts and adjustments to participating hospitals' and doctors' bills[3]) exacerbated an evidentiary and substantive remedial problem: what is the basis for a plaintiff's medical damages when his healthcare providers bill him one amount but are paid a lower, adjusted amount by plaintiff's managed care payer? Even in 1854, the Supreme Court could say that the answer was "well established at common law":

> The contract with the insurer is in the nature of a wager between third parties, with which the [tortfeasor] has no concern. The insurer does not stand in the relation of a joint [tortfeasor], so that satisfaction accepted from him shall be a release of others.[4]

Concurrent with healthcare reforms, legislative and judicial tort reform at the state level sought to modify the common law collateral source rule. Under the guise of preventing windfalls and double-recoveries to injured plaintiffs already "made whole" by insurance payments, states have adopted varied positions on the admissibility and use at trial of billed versus paid medical bills.

II. Differing Approaches to Evidence that Contravenes the Collateral Source Rule

What follows is a brief analysis of different states' approaches to the admissibility of paid-or-incurred expenses where evidence of such expenses is permitted. The cases discussed below are by no means exhaustive

[1] The reasonableness and necessity of the medical expenses are the only limiting factors on the pure collateral source rule.

[2] In the United States, managed care enrollment nationwide is anywhere from 70% to 90% depending on the factors used. *See* Managed Care Fact Sheet, *available at* http://www.mcol.com/factsheetindex (last visited June 10, 2014).

[3] *See United States v. Mercy Health Servs.*, 902 F. Supp. 968, 972–73 (N.D. Iowa 1995) (surveying the adoption of managed care practices).

[4] *The Propeller Monticello v. Mollison*, 58 U.S. 152, 155 (1854) (applying the rule sitting in admiralty).

of the spectrum, and are merely illustrative of how the issue is being handled.

1. **Texas**: Only those healthcare expenses "actually paid" are recoverable, and thus admissible

Texas is representative of those states with statutory limitations on the collateral source doctrine. Part of a broader 2003 tort-reform package, Texas law is as follows:

> **Evidence Relating to Amount of Economic Damages**
>
> In addition to any other limitation under law, recovery of medical or healthcare expenses incurred is limited to the amount actually paid or incurred by or on behalf of the claimant.

Tex. Civ. Prac. & Rem. Code § 41.0105.

While clear as to the result with regard to ultimate "recovery," this statute provides no guidance on its evidentiary effect at trial.

The Texas Supreme Court addressed this problem in *Haygood v. De Escabedo*, 356 S.W.3d 390 (Tex. 2012). Haygood sued Escabedo for injuries he sustained in a collision with Escabedo's minivan. *Id.* at 392. Healthcare providers billed Haygood over $100,000, but he was covered by Medicare Part B, which generally "pays no more for . . . medical and other health services than the 'reasonable charge' for such service." *Id.* Accordingly, Haygood's healthcare providers adjusted their bills with credits of over $80,000, leaving a total of around $25,000. *Id.*

Invoking the Texas statute, Escabedo moved to exclude evidence of medical expenses other than those actually paid or owed. Haygood, asserting the traditional collateral source rule, moved to exclude evidence of any amounts other than those billed (including any adjustments or payments). The trial court denied Escabedo's motion and granted Haygood's, ultimately entering judgment on the jury's award of over $100,000 in economic damages.

The intermediate court of appeals reversed, remanding the case for new trial on the basis of section 41.0105, on which the Texas courts had been unanimous. The Texas Supreme Court agreed: "Haygood contends that an adjustment in billed medical charges required by an insurer is a collateral benefit covered by the rule. We disagree. The benefit of insurance to the insured is the payment of charges owed to the health care provider. An adjustment in the amount of those charges to arrive at the amount owed is a benefit to the insurer, one it obtains from the provider for itself, not for the insured." *Id.* at 395. Turning to the evidentiary point—i.e., what to do with evidence of unadjusted bills at trial if only adjusted amounts are ultimately recoverable—the court held: "Since a claimant is not entitled to recover medical charges that a provider is not entitled to be paid, evidence of such charges is irrelevant to the issue of damages." *Id.* at 398. The court rejected Haywood's arguments that evidence of unrecoverable, unadjusted amounts would be probative of the seriousness of his non-economic injuries: "we think that any relevance of such evidence is substantially outweighed by the confusion it is likely to generate, and therefore the evidence must be excluded." *Id.* (citing Tex. R. Evid. 403 balancing test).

The court also addressed problems that occur when there is no bright-line rule regarding the admissibility of medical expenses. For example, parties may dispute whether

expenses are necessarily related to a plaintiff's injury or whether any part of some providers' charges is reasonable. *Id.* at 399. "If the jury awards less than the total of all charges [for medical expense evidence submitted as billed rather than as paid], the trial court may have no way of knowing which charges the jury found reasonable and which it did not. In all these situations, a requirement that the trial court resolve disputed facts in determining the damages to be awarded violates the constitutional right to trial by jury." *Id*

While it may appear harsh in treating insured and uninsured plaintiffs differently at times (uninsured plaintiffs' bills are typically not adjusted because they are not typically paid, as the court acknowledged[5]) and in denying plaintiffs the ability to use large medical bills to prove their non-economic damages, the Texas Supreme Court's interpretation of the state's paid-or-incurred-only statute does give trial courts clear guidance. It also has the benefit of the same rule applying pre- and post-trial, so that the specter of large, but unpaid, medical expenses does not impact negotiations between plaintiff and defendant.

2. **Ohio**: Evidence of both unadjusted and adjusted bills may be admissible

While the Texas statute operates as a bar to the ultimate recovery of non-paid or non-incurred amounts, Ohio's recent statute expressly tackles the evidentiary component of the collateral source rule:

> In any tort action, the defendant may introduce evidence of any amount payable as a benefit to the plaintiff as a result of the damages that result from an injury, death, or loss to person or property that is the subject of the claim upon which the action is based. . . .
>
> Ohio Rev. Code § 2315.20(A) ("Collateral benefits").

Like California (discussed below), Ohio has taken something of a middle ground in refusing to adopt a categorical rule that the reasonable value of medical services is either the amount billed or the amount paid. This was confirmed recently in *Moretz v. Muakkassa*, 998 N.E.2d 479, 497 (Ohio 2013). "Instead, the reasonable value of medical services is a matter for the jury to determine from ***all relevant evidence***." *Id.* (emphasis added).

"We have repeatedly recognized that 'either the bill itself or the amount actually paid can be submitted to prove the value of medical services.'" *Id.* (quoting *Robinson v. Bates*, 857 N.E.2d 1195, 1197 (Ohio 2006)). "The jury may decide that the reasonable value of medical care is the amount originally billed, the amount the medical provider accepted as payment, or some amount in between." *Id.* "[E]vidence of 'write-offs,' reflected in medical bills and statements, [is] prima facie evidence of the reasonable value of medical services." *Id.* at 498.

While the Ohio legislature and courts have declined to set a "categorical rule" in the mode of the Texas Supreme Court interpreting Texas's statute, Ohio's approach

[5] *See Haygood*, 356 S.W.3d at 393 ("Charges for health care, once based on the provider's costs and profit margin, have more recently been driven by government regulation and negotiations with private insurers. A two-tiered structure has evolved: 'list' or 'full' rates sometimes charged to uninsured patients, but frequently uncollected, and reimbursement rates for patients covered by government and private insurance.").

supports the admissibility of evidence of the actual cost of a plaintiff's medical treatment; that is, those bills that were actually paid or incurred by the plaintiff herself or by a third-party payer. Unlike Texas, Ohio's approach means that all parties must approach settlement talks with some degree of uncertainty, since the extent of any adjustments to or payments of medical bills will not typically be clear until later, perhaps even until the evidence is submitted to the jury.

3. **California**: Evidence of paid amounts may be probative of past medical expenses

Like Ohio—but purely as a matter of evidence and common law—California now permits the admission of evidence of the amount actually paid by private insurance as probative of the plaintiff's damages for past medical expenses. *See Howell v. Hamilton Meats & Provisions, Inc.*, 257 P.3d 1130, 1135 (Cal. 2011). Howell was injured in a car accident caused by a Hamilton driver's negligence. At trial, Hamilton conceded liability and the necessity of the medical treatment Howell received, contesting only the amounts of Howell's economic and non-economic damages. As in Texas, the collateral source/paid-or-incurred issue is largely an evidentiary matter of relevancy.[6] Thus, Hamilton moved in limine[7] to exclude evidence of medical bills that neither plaintiff nor her private health insurer, PacifiCare, had paid, and which had been adjusted downward before payment pursuant to agreements between providers and PacifiCare. Under her PPO plan with PacifiCare, she could not be billed for the balance of the original bills (beyond agreed patient copayments). Hamilton argued that, because only the amounts paid by Howell and her insurer could be recovered, the larger amounts billed by the providers were irrelevant and should be excluded. The trial court denied the motion in limine, ruling that Howell could present her full medical bills to the jury, and any reduction to reflect payment of downward-adjusted amounts would be handled through a post-trial motion—i.e., that evidence would not go before the jury. *Howell*, 257 P.3d at 1133–34.

The *Howell* court reiterated that "California decisions have focused on 'reasonable value' in the context of ***limiting*** recovery to reasonable expenditures, not expanding recovery beyond the plaintiff's actual loss or liability. To be recoverable, a medical expense must be both incurred ***and*** reasonable." *Id.* at 1137 (emphases added). In discussing reasonableness, the court continued, "if the plaintiff negotiates a discount and thereby receives services for less than might reasonably be charged, the plaintiff has not suffered a pecuniary loss or other detriment in the greater amount and, therefore, cannot recover damages for that amount. The same rule applies when a collateral source, such as the plaintiff's health insurer, has obtained a discount for its

[6] *See* CAL. EVID. CODE § 350 ("No evidence is admissible except relevant evidence."); *id.* § 352 ("The court in its discretion may exclude evidence if its probative value is substantially outweighed by the probability that its admission will (a) necessitate undue consumption of time or (b) create substantial danger of undue prejudice, of confusing the issues, or of misleading the jury.").

[7] The common practice of California defendants seeking to get around the collateral source rule was to file a pre-trial motion in limine and/or a post-trial verdict reduction motion. Before *Howell*, this motion practice was subject to the whims of trial and appellate courts. *See, e.g., Greer v. Buzgheia*, 141 Cal. App. 4th 1150, 1154 (2006) (denying motions based on *Hanif v. Housing Auth'y*, 200 Cal. App. 3d 635 (1988) and *Nishihama v. City & County of San Francisco*, 93 Cal. App. 4th 298 (2001) and finding waiver or forfeiture of the issue where both motions not filed).

payments on the plaintiff's behalf." *Id.* at 1138.

In discussing whether or not medical bill markdowns are a gratuitous discount in light of the *Restatement* view that a plaintiff may recover the value of donated, or gratuitous, services under the collateral source rule, the court concluded that adjustments are not gifts: "Medical providers that agree to accept discounted payments by managed care organizations or other health insurers as full payment for a patient's care do so not as a gift to the patient or insurer, but for commercial reasons and as a result of negotiations." *Id.* at 1139. Thus, this exception to the limitation on Howell's recovery did not apply.[8]

The court held that "an injured plaintiff whose medical expenses are paid through private insurance may recover as economic damages no more than the amounts paid by the plaintiff or his or her insurer for the medical services received or still owing at the time of trial." *Id.* at 1145. Further, "when a medical care provider has, by agreement with the plaintiff's private health insurer, accepted as full payment for the plaintiff's care an amount less than the provider's full bill, evidence of that amount is relevant to prove the plaintiff's damages for past medical expenses and, assuming it satisfies other rules of evidence, is admissible at trial." *Id.* Stated another way, "where the provider has, by prior agreement, accepted less than a billed amount as full payment, evidence of the full billed amount is not itself relevant on the issue of past medical expenses." *Id.* at 1146.[9]

While there was an early, failed effort to overturn this decision legislatively,[10] California law is now clear: evidence of the full amount of billed medical expenses is irrelevant (and subject to a pre-trial motion in limine to keep it from the jury) when a lower amount was accepted by the provider as full payment.[11]

4. **Massachusetts**: Evidence of amounts actually paid is inadmissible, but evidence of the normal "range" of payments accepted may be admitted

Finally, Massachusetts is presented as an example of a state that allows the admissibility of only a small category of evidence in contravention of the collateral source rule, but does not entirely bar evidence of amounts actually paid or incurred. Under Massachusetts law, a plaintiff's medical bills must be admitted: "an itemized bill and reports, including hospital medical records, relating to medical, dental, hospital services, prescriptions, or orthopedic appliances rendered to or prescribed for a person injured,

[8] Where a plaintiff has incurred liability for the billed cost of services and the provider later "writes off" part of the bill because, for example, the plaintiff is unable to pay the full charge, the court agreed with the dissent: one might argue that the amount of the write-off constitutes a gratuitous benefit the plaintiff is entitled to recover under the collateral source rule. *Howell*, 257 P.3d at 1140 (distinguishing a "write-off" from a "negotiated price"). But that issue was not before the court.

[9] Further, "where a trial jury has heard evidence of the amount accepted as full payment by the medical provider but has awarded a greater sum as damages for past medical expenses, the defendant may move for a new trial on grounds of excessive damages. *Howell*, 257 P.3d at 1146.

[10] *See* California S.B. 1528 (2012), *available at* http://www.leginfo.ca.gov/pub/11-12/bill/sen/sb_1501-1550/sb_1528_cfa_20120827_183745_asm_comm.html (last visited June 10, 2014).

[11] Interestingly, the supreme courts of both California and Texas, representing the two most populous states in the country and states that are well-known to be on the opposite ends of the political spectrum, have each determined that evidence of medical expenses actually paid or incurred does not offend or abrogate the traditional collateral source rule.

. . . shall be admissible as evidence of the fair and reasonable charge for such services or the necessity of such services or treatments. . . ." Mass. Gen. Laws ch. 233, § 79G.

In light of the statute, the Supreme Judicial Court of Massachusetts recently rejected a defendant's argument that its rebuttal evidence of the amounts actually accepted by plaintiff's providers was also admissible:

> We must decide whether the defendant's proffered evidence of the amounts paid to the plaintiff's medical providers was admissible as well—that is, in addition to her medical bills rather than in lieu of them. The answer to this question requires consideration of § 79G as well as our common-law collateral source rule. . . . We conclude that evidence of amounts actually paid to the plaintiff's medical providers is not admissible, but evidence may be introduced concerning the range of payments that the providers accept for the types of medical services that the plaintiff received.

Law v. Griffith, 930 N.E.2d 126, 131 (Mass. 2010).

As to the "range of payments" language, Massachusetts handles this by permitting the defendant to "call a representative of the particular medical provider whose bill the defendant wishes to challenge, and to elicit evidence concerning the provider's stated charges and the range of payments that that provider accepts for the particular type or types of services the plaintiff received." *Id.* at 135. The court provided that the witness may acknowledge that the range of payments being testified to reflects "amounts paid by both individual, self-paying patients and third-party payors." But "the witness would be limited to testimony solely about the amounts in the range that the provider accepted for the services at issue, with no information relating to what was paid by or on behalf of the plaintiff herself." *Id.*

How Massachusetts' version of the collateral source rule plays with Massachusetts juries remains to be seen. In light of the near-universal knowledge that health insurance is mandatory in Massachusetts, it will be interesting to have an insurance adjuster on the stand testifying about a range of accepted payments, but not about actual payments.

III. Conclusion

Many states have created some exception to the collateral source rule when confronted with an insured plaintiff's economic damages. One extreme, represented by Texas, provides courts and litigants with a great deal of certainty, but at the expense of any legitimate evidentiary uses of medical expenses that are not actually paid or incurred. Other states permit varying degrees of evidence to come in, with the trade-off coming in the form of decreased certainty for litigants as to the amounts ultimately at stake. Understanding where your state falls along this jurisdictional spectrum may help you the next time you are evaluating your client's exposure, weighing an insured plaintiff's settlement demand, or arguing a motion in limine.

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