

COLLATERAL SOURCE RULE - TODAY AND TOMORROW

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I. History of Collateral Source Rule

In the United States, the Collateral Source Rule has been in effect in state and federal courts for decades. In recent years, it has been the subject of attacks through tort reform.

A. Common law adoption

The Collateral Source Rule is a common law rule adopted in the 19th Century that prohibits the reduction of damages that a personal injury claimant or plaintiff is awarded from a tortfeasor when being compensated for reasonable medical expenditures when the claimant or plaintiff is covered by insurance or other benefits.

The Restatement (Second) of Torts, §920A provides a description of the common law Collateral Source Rule and is titled “Effect of Payments Made to Injured Party,” as follows:

- (1) A payment made by a tortfeasor or by a person acting for him to a person whom he has injured is credited against his tort liability, as are payments made by another who is, or believes he is, subject to the same tort liability.
- (2) Payments made to or benefits conferred on the injured party from other sources are not credited against the tortfeasor’s liability, although they cover all or a part of the harm for which the tortfeasor is liable.

1. Rule of evidence

On one side of the equation, the Collateral Source Rule is a rule of evidence. The Federal Rules of Evidence, Rule 411 for federal matters defines the evidentiary rule as follows:

Evidence that a person was or was not insured against liability is not admissible upon the issue whether the person acted negligently or otherwise wrongfully. This rule does not require the exclusion of evidence of insurance against liability when offered for another purpose, such as proof of agency, ownership, or control, or bias or prejudice of a witness.

From an evidentiary perspective at trial, collateral benefits are most often addressed prior to trial with a motion in limine to secure a pretrial ruling that it will be impermissible for the defendant to introduce evidence of collateral source

payments, such as medical insurance. If no limine order is entered, then it is incumbent upon the plaintiff to object to the introduction of such collateral source payments during the trial.

2. Substantive rule of damages

The Collateral Source Rule is also a substantive rule. Some jurisdictions either allow or disallow the recovery of damages on behalf of an injured party for medical expenses or income losses covered by insurance or other collateral source. In some states, once the jury returns a verdict, then the law permits the reduction of the award for the amount received by the injured party or paid on his or her account from a collateral source.

3. Rule varies from state to state, and federal

The definition of the Collateral Source Rule does vary from jurisdiction to jurisdiction. The general concept is that the injured person has a collateral benefit in some form of payment from someone or some entity other than the tortfeasor. These sources of collateral benefit can include health insurance, automobile medical payments insurance, disability payments, workman's compensation, and other third-party collateral source payments.

In virtually every jurisdiction, there is some form of the Collateral Source Doctrine.¹

B. Arguments for Collateral Source Rule

The arguments in favor of the Collateral Source Rule were most formidable during the 19th Century when there were fewer individuals covered by medical insurance.

The grounds upon which the proponents of the Collateral Source Rule defend the rule are multiple.

- First, proponents contend that the rule is consistent with fundamental tort principles that a tortfeasor should pay the full costs of recovery for a party injured, and in addition it acts as a deterrent effect on tortious conduct. This deterrent effect is contended by proponents to be undermined absent this rule's application to prevent the introduction into evidence of insurance payments.

¹ 50 State Statutory Surveys: Civil Laws: Torts, Tort Reform, (Thomson Reuters, April 2013)

- Second, it is argued that a tortfeasor should not be entitled to a windfall just because the injured person spent money to secure insurance coverage.
- Third, since personal injury lawyers recover their fees on a contingent basis and this is not a factor presented to the jury, proponents contend that the practical effect of the collateral source rule is to create additional damages to cover the contingent fees of lawyers, in addition to the cost of the insurance and any applicable deductible that was applied.
- Fourth, proponents note that medical insurers that provided collateral benefits often have subrogation rights against the tortfeasor and they can lien the recovery awarded to the plaintiff. Such enforcement of subrogation rights, some through statutory liens like workers' compensation, negates any double recovery.
- Finally, some contend that when a jury gets to look at insurance payments and write-offs, there is less empathy for the plaintiff and more of a likelihood of a defense verdict in close liability cases.

C. Arguments against Collateral Source Rule

There has always been opposition to the Collateral Source Rule, and some states have abrogated the rule. The opponents of the rule have numerous arguments, as follows:

- First, opponents contend that the purpose of tort law is not deterrence, but compensation for losses. The purpose is compensatory, not punitive and punitive damages serve as deterrence.
- The most often cited objection to the rule is that it constitutes a double recovery for the plaintiff
- Opponents also contend that most of the time insurers don't pursue subrogation.
- It is argued that by not taking into consideration medical write-offs, commonplace in today's medical insurance world, jury awards are unduly inflated.
- The medical write-offs concept that has come about in the healthcare industry poses an interesting question of what is the "reasonable" cost of the medical services provided, the inflated charge by the doctor or the amount the doctor agreed with the

insurer to be paid. [Because some states now allow for this type of medical write-off evidence to be presented to the jury, plaintiff lawyers circumvent this by having their clients go to doctors who will provide care and treatment on a lien basis so that they don't submit to their insurance carrier and get lower rates. The question then becomes whether the doctor is really getting paid this sum or whether there is a backdoor agreement with the lawyer or consultant to reduce the fees in the end analysis. In Nevada, numerous lawyers, consultants and physicians were deemed to be part of the Medical Mafia in engaging in dishonest practices of this nature and criminally prosecuted.]

- Double payments increase the cost of insurance.
- Inflated awards encourage more tort litigation.

II. Statutory Abrogation of Collateral Source Rule

The debate over the propriety of the Collateral Source Rule has led state and federal courts to maintain or limit the rule. In recent years, state legislatures through the pressure of tort reform have passed laws to modify or abrogate the rule. The tort reform measures not only modify or abrogate the Collateral Source Rule, but limit recovery of noneconomic damages and punitive damages, limit awards of attorney's fees, reform class action recoveries, mandate periodic payments for future damages, and substantively change joint and several liability laws.

A. Impact of Healthcare Tort Reform Laws

Due in large part to the never-ending spiraling out-of-control health care costs in this country, tort reform measures have been instituted in many states that have led to the potential extinction of the Collateral Source Rule. Specifically due to a perception that we had a medical malpractice crisis in this country, in the medical malpractice arena, in order to protect physicians and hospitals, laws have been passed in many states modifying or eliminating the Collateral Source Rule in these professional liability cases.²

Currently, only a minority of states has kept the rule intact. Most states have substantially overhauled the rule and more states have abrogated it entirely.

Medicare and Medicaid have complicated the issue with write-downs of medical bills for services rendered for past medical services.

² See ft.nt. 1

B. Cases Upholding Constitutionality

In *State ex rel. Ohio Academy of Trial Lawyers v. Sheward*, 86 Ohio St.3d 451, 715 N.E.2d 1062 (Ohio, 1999), a statute which sought to abrogate common law collateral source rule, and which authorized pre-verdict setoff for collateral payments and allowed reduction of amount of compensatory damages by amount of collateral payments, violated due process clause. Const. Art. 1, § 16; R.C. § 2317.45 (1997).

C. Cases Holding Unconstitutional

Although, the court in *Arbino v. Johnson & Johnson*, 880 N.E.2d 420 (Ohio 2007), did not reach the issue of the constitutionality of abrogating the collateral source rule, prior measures have been struck down by the Ohio Supreme Court multiple times. See, e.g., *State ex rel. Ohio Acad. of Trial Lawyers v. Sherward*, 715 N.E.2d 1062, 1102-03 (Ohio 1999) (striking down the repeal of the collateral source rule for violating separation of powers); *Sorrell v. Thevenir*, 633 N.E.2d 504, 510 (Ohio 1994) (striking down the repeal of the collateral source rule for violating the right to trial by jury), superseded by statute, 2002 Ohio Laws File 250.

Other state courts declaring such laws constitutional, include, e.g., *Marsh v. Green*, 782 So.2d 223 (Ala.2000); *Barme v. Wood*, 37 Cal.3d 174, 207 Cal.Rptr. 816, 689 P.2d 446 (1984). For state courts declaring such laws unconstitutional, see, e.g., *O'Bryan v. Hedgespeth*, 892 S.W.2d 571, 576-78 (Ky.1995) (violation of separation of powers); *Carson v. Maurer*, 120 N.H. 925, 424 A.2d 825, 835-36 (N.H.1980) (violation of equal protection); *State ex rel. Ohio Academy of Trial Lawyers v. Sheward*, 86 Ohio St.3d 451, 715 N.E.2d 1062, 1088-90 (1999) (violation of due process).

Statutes have been struck down on constitutional grounds in Kansas, Kentucky, New Hampshire, North Dakota, Ohio, Pennsylvania and Rhode Island. In *O'Bryan v. Hedgespeth*, 892 S.W.2d 571 (Ky. 1995), a statute allowing admission of evidence of collateral source payments was deemed an unconstitutional legislative infringement on judicial power to make rules governing practice and procedure in courts and would not be adopted under principles of comity. See *The Unconstitutionality of Medical Malpractice Limitations*, ATLA Press Release, January 2003.

III. Insurance Write-Offs and The Collateral Source Rule

In our modern healthcare/insurance industry, healthcare providers enter into contracts with insurance companies, wherein they agree to fee schedules. Under these fee schedules, the healthcare provider agrees to accept less than the actual amount billed to the patient. The provider writes off the difference. This practice raised the question of whether the injured plaintiff should be able to

recover the actual amount paid by the plaintiff (co-pays and deductible), the amount paid by the insurer or the amount of the total bill. The answer to this question varies from jurisdiction to jurisdiction, depending on the extent to which the collateral source rule has been modified or abrogated.

These issues are exemplified by the Wisconsin case of *Koffman v. Leichfuss*.³ Plaintiff was billed \$187,932 for medical services provided by several healthcare providers treating a severe spine injury. His employer provided a self-funded health insurance plan. The employer had contracted rates for these providers and was able to satisfy the medical bills for the sum of \$62,324. Plaintiff also had Farmers automobile insurance that provided medical payments coverage to the extent of \$1,869. This sum of \$1,869 was the amount of co-pays and deductibles that the plaintiff had to come out of pocket to pay. The lawsuit by plaintiff named the employer and the automobile insurer as defendants and they countersued for subrogation. These defendants stipulated that the amounts billed by the physicians and hospitals were “reasonable.” The court at first sided with the insurers and did not allow the plaintiff to introduce evidence of the amount billed, only the amount paid. But the judge reconsidered before the trial ended and allowed the billed amount, thus allowing the jury to come back with a verdict in the sum of \$98,664. The trial court reduced this award to \$66,063, the amount actually paid by plaintiff and the insurers.

On appeal, the Wisconsin Supreme Court looked at three issues, to wit: valuation of medical expense damages, collateral source rule and subrogation. The court noted the plaintiff was under Wisconsin law allowed to recover the reasonable value of medical services, not the amount actually paid. Further, the court applied the Collateral Source Rule and disallowed the evidence of write-offs or actual amounts paid, noting that otherwise the windfall goes to the tortfeasor that caused the injury. The court approved of the subrogation to disallow a double recovery, but still place the full responsibility on the tortfeasor who caused the harm.

On the other hand, many states statutorily permit the write-off evidence. In Nevada, for example, NRS 42.021 provides in full as follows:

NRS 42.021 Actions based on professional negligence of providers of health care: Introduction of certain evidence relating to collateral benefits; restrictions on source of collateral benefits; payment of future damages by periodic payments.

1. In an action for injury or death against a provider of health care based upon professional negligence, if the defendant so elects, the defendant may introduce evidence of any amount payable as a benefit to the plaintiff as a result of the injury or death pursuant

³ 630 N.W.2d 201 (Wis. 2001).

to the United States Social Security Act, any state or federal income disability or worker's compensation act, any health, sickness or income-disability insurance, accident insurance that provides health benefits or income-disability coverage, and any contract or agreement of any group, organization, partnership or corporation to provide, pay for or reimburse the cost of medical, hospital, dental or other health care services. If the defendant elects to introduce such evidence, the plaintiff may introduce evidence of any amount that the plaintiff has paid or contributed to secure the plaintiff's right to any insurance benefits concerning which the defendant has introduced evidence.

2. A source of collateral benefits introduced pursuant to subsection 1 may not:

- (a) Recover any amount against the plaintiff; or
- (b) Be subrogated to the rights of the plaintiff against a defendant.

3. In an action for injury or death against a provider of health care based upon professional negligence, a district court shall, at the request of either party, enter a judgment ordering that money damages or its equivalent for future damages of the judgment creditor be paid in whole or in part by periodic payments rather than by a lump-sum payment if the award equals or exceeds \$50,000 in future damages.

4. In entering a judgment ordering the payment of future damages by periodic payments pursuant to subsection 3, the court shall make a specific finding as to the dollar amount of periodic payments that will compensate the judgment creditor for such future damages. As a condition to authorizing periodic payments of future damages, the court shall require a judgment debtor who is not adequately insured to post security adequate to assure full payment of such damages awarded by the judgment. Upon termination of periodic payments of future damages, the court shall order the return of this security, or so much as remains, to the judgment debtor.

5. A judgment ordering the payment of future damages by periodic payments entered pursuant to subsection 3 must specify the recipient or recipients of the payments, the dollar amount of the payments, the interval between payments, and the number of payments or the period of time over which payments will be made.

Such payments must only be subject to modification in the event of the death of the judgment creditor. Money damages awarded for loss of future earnings must not be reduced or payments terminated by reason of the death of the judgment creditor, but must be paid to persons to whom the judgment creditor owed a duty of support, as provided by law, immediately before the judgment creditor's death. In such cases, the court that rendered the original judgment may, upon petition of any party in interest, modify the judgment to award and apportion the unpaid future damages in accordance with this subsection.

6. If the court finds that the judgment debtor has exhibited a continuing pattern of failing to make the periodic payments as specified pursuant to subsection 5, the court shall find the judgment debtor in contempt of court and, in addition to the required periodic payments, shall order the judgment debtor to pay the judgment creditor all damages caused by the failure to make such periodic payments, including, but not limited to, court costs and attorney's fees.

7. Following the occurrence or expiration of all obligations specified in the periodic payment judgment, any obligation of the judgment debtor to make further payments ceases and any security given pursuant to subsection 4 reverts to the judgment debtor.

8. As used in this section:

(a) "Future damages" includes damages for future medical treatment, care or custody, loss of future earnings, loss of bodily function, or future pain and suffering of the judgment creditor.

(b) "Periodic payments" means the payment of money or delivery of other property to the judgment creditor at regular intervals.

(c) "Professional negligence" means a negligent act or omission to act by a provider of health care in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death. The term does not include services that are outside the scope of services for which the provider of health care is licensed or services for which any restriction has been imposed by the

applicable regulatory board or health care facility.

(d) “Provider of health care” means a physician licensed under [chapter 630](#) or [633](#) of NRS, dentist, licensed nurse, dispensing optician, optometrist, registered physical therapist, podiatric physician, licensed psychologist, chiropractor, doctor of Oriental medicine, medical laboratory director or technician, licensed dietitian or a licensed hospital and its employees.

(Added to NRS by 2004 initiative petition, Ballot Question No. 3; A [2011, 1511](#))

IV. Impact of Affordable Care Act and Individual Mandate

The Affordable Care Act mandates that most Americans acquire insurance coverage. The impact of this is to undercut one of the principal arguments in favor of the Collateral Source Rule.

One concept that the jury will now be aware of is that essentially everyone is insured. There is no longer any need to hide the fact the plaintiff has health insurance, since by federal law it is mandated.

On the other side of the coin, those who fail in their obligations to secure the mandated insurance and are uninsured will be able to recover full damages for their losses despite their lack of coverage and legal noncompliance. The purpose of the Affordable Care Act is to reduce health care costs in this country and a conscious effort to spread costs among individuals in order to reduce health insurance premiums and health care costs in general.

Now we are confronted with the issue of the Collateral Source Rule allowing willfully uninsured plaintiffs to conversely hide their lack of insurance during trial and at the time the jury calculates damages. Now the maintenance of this common law rule, already close to extinction, is much less justifiable.

V. Changing the Rule in Light of the Affordable Care Act

How might a state legislature change the rule in light of the Affordable Care Act?

In order for legislative bodies to fully address this question, they will obviously look to pleasing big business, the healthcare industry, citizens who have purchased the mandated insurance, and others interested in reducing premium costs. By limiting the rule, these folks will be accommodated in part. Prior tort reform measures were viewed as potentially reducing the cost of health care costs. For example, in 2002 the Department of Health and Human Services

asserted that tort reform could reduce healthcare costs by 5%-9%, while the Congressional Budget Office concluded reforms would have little impact. One study assessed the aggregate impact of reforms, using a database of employer-sponsored health plans covering over 10 million nonelderly Americans each year. The study found evidence that caps on non-economic damages, collateral source reform, and joint and several liability reform reduce self-insured premiums by 1 to 2 percent each.⁴

Attempting to address the issues created by the ACA would likely involve looking at the rule from both its evidentiary perspective and substantive damage perspective. If evidence is introduced showing the existence or lack of existence of mandated insurance, the effect might be that jurors who spent their hard earned money to buy mandated insurance will be prejudiced against the willfully uninsured who is in violation of the federal law. This could transition into the jury not awarding equal amounts of damages to the uninsured plaintiff. Thus, in changing the rule, a legislative body might want not to deny all damages to the willfully uninsured, but to still adhere to the idea of spreading the costs of injury and illness and at the same time not compensate the willfully uninsured for medical coverage he or she refused to obtain.

One way legislators could address this is to keep the evidentiary rule, but shift the timing of the introduction of the evidence of insurance or lack of insurance to after the jury verdict and charge the judge with the task of considering the evidence and reducing the verdict, if necessary, accordingly. This eliminates the prejudice against the willfully uninsured claimant.

By deferring the consideration of insurance evidence to the post verdict stage of trial, not only allows the more dispassionate judge to view the lack of mandated insurance relative to the uninsured claimant's damage claim and make an appropriate reduction, it allows the judge to also more fairly examine this evidence in light of the insured claimant that has a real subrogation claim intact and the exempt uninsured claimant. In this later category, the Affordable Care Act exempts certain individuals who can't afford health coverage.⁵

Consequently, as we enter into this phase of the implementation of the Affordable Care Act, we may see statutory modification efforts to take into consideration the above factors and political motivations, dealing with reducing

⁴ The Impact of Tort Reform on Employer-Sponsored Health Insurance Premiums, Ronen Avraham, Leemore S. Dafny, and Max M. Schanzenbach (September 2009)

⁵ Affordable Care Act, 26 U.S.C.A. §§ 1501(b), 5000A(d) and (e)[these sections additionally exempt for religious conscience, health care sharing ministry, individuals lawfully not a citizen or national of the U.S., and those incarcerated].

health care costs, reducing the cost of insurance and addressing those who subvert the objectives of the new health care law. It has been recommended by one commentator that the following would be a potential model statute for the introduction of evidence pertaining to collateral sources:

- 1) In all tort actions for which economic damages for personal injury are claimed and are legally recoverable, information pertaining to whether the claimant has been or will be paid or reimbursed by a third party is not admissible, except that information relating to the payment of collateral benefits or the lack thereof may be introduced by the claimant if:
 - a) The court determines that the claimant has an obligation to repay the expenses which have been or will be paid or reimbursed or
 - b) The court determines that the claimant is exempt from obtaining insurance under 26 U.S.C. §5000A(d) or (e).
- 2) The trial judge shall deduct from the verdict the amount of nonsubrogated collateral benefit paid to the claimant by a third party, less the total amount determined to be paid, contributed, or forfeited by the claimant to obtain reimbursement or payment of medical or hospital expenses.
- 3) After the finder of fact has returned its verdict, the defendant may produce evidence that the claimant failed to obtain minimum essential insurance coverage under 26 U.S.C. §5000A(b), but was not exempt from purchasing insurance under 26 U.S.C. §5000A(d) or (e). If the court so finds, it shall reduce the damages to be awarded by the amount that would have been reimbursed to him by the lowest level of minimum essential coverage accepted under 42 U.S.C. §18022(d)(1), “the bronze plan,” except that:
 - a) This amount may be deducted only to the extent that the verdict exceeds the amount of the claimant’s damages that would not be covered by the bronze plan; and
 - b) The claimant is not entitled to the costs of any penalty paid under 26 U.S.C. §5000A(b) for failure to obtain insurance coverage.⁶

⁶ Allocating the Costs of Harm to Whom they are Due Modifying the Collateral Source Rule after Health Care Reform, 160 U. Pa. L. Rev. 921, 950-51 (2012).