Evolution of the collateral source rule and its effect on life-care planning

Understand this 1988 ruling and be skeptical of the data and methodologies relied upon by defense life-care planners that would ignore it

By Eustace de Saint Phalle and Sarah Madan

The collateral source rule was established to prevent tortfeasors from reducing an adverse judgment by the amount of collateral benefits plaintiff had received. There are two principles which are foundational to the collateral source rule. First, where there is a choice between a windfall to the defendant, or full compensation to the plaintiff, it should be resolved in the favor of the non-liable party. Second, Plaintiff should be fully compensated for all the detriment proximately caused by the defendant's tort. (Civ. Code, §§ 3281, 3333.) Simply put, an issue of fairness should be resolved in favor of the person who was injured due to the negligence of another.

In the late '80s, California caselaw began the characterization of Plaintiff's foresight to maintain insurance policies through their employment or other vulnerable status, as a source of double recovery. We would assert this is a false characterization.

Original intent and construction of the collateral source rule

Under the collateral source rule, if an injured party receives compensation for his or her injuries from a source wholly independent of the tortfeasor, that amount of compensation *should not be deducted from the damages that the plaintiff would otherwise collect* from the tortfeasor. Therefore, an injured plaintiff may recover from the tortfeasor money an insurer has paid to medical providers on his or her behalf. (6 Witkin Sum. Cal. Law Torts § 1847.) This principle has been applied to payments received through medical insurance, gratuitous medical care, disability income insurance, employment leave, unemployment compensation, and disability retirement benefits.

Before *Hanif v. Housing Authority* (1988) 200 Cal.App.3d 635 was decided, a plaintiff, relying on the collateral source rule, could recover the full amount of a health provider's charges despite the fact that an insurer or governmental agency had pre-negotiated a discounted rate for the services and the plaintiff was not liable for the full amount. (*Helfend v. Southern Cal. Rapid Transit Dist*. (1970) 2 Cal.3d 1, 6.) At trial, this rule limited what the jury was told if plaintiff had received collateral source compensation. Defendants and insurance companies had always criticized the collateral source rule, asserting that plaintiffs were being compensated in amounts above what they had incurred as an expense. This criticism was in furtherance of a coordinated effort by defendants to narrow plaintiff's damages and limit their liability exposure.

Evolution of the collateral source rule in the California courts

The impetus for the evolution of the collateral source rule came down in a decision from the Court of Appeal in *Hanif v. Housing Authority* (1988) 200 Cal.App.3d 635. The Court in *Hanif*, crucially drew a line in the sand by holding that plaintiffs could not recover medical damages beyond what had been actually paid for medical services, despite the pre-negotiated reduced cost. In holding this limitation, the court in *Hanif* implicitly endorsed the calculation of the "reasonable value" of medical treatment to be based on what insurance providers had actually paid for them. Unfortunately for plaintiffs, the court in *Hanif* failed to consider the many factors that make up the value of medical services.

The *Hanif* ruling does not acknowledge realities like artificially discounted Medicare and Medicaid rates or bonus compensation to doctors for new patients or other subsidies government-funded and private plans have in place with providers. The decision also ignores that the prices paid by insurance companies are not what an individual consumer would be expected to pay if they were to seek the same service on their own in the private marketplace. For example, just because Medicare paid $40 for an X-ray, does not mean that X-rays reasonably cost $40. If an uninsured individual were to pay out of pocket for an X-ray, the value of the X-ray is several times higher than what an insurance plan would pay as a negotiated reduced rate. Life care planners and economists can elaborate further on the various forms of compen-

sation and value that are not reflected in hospital bills. Consequently, this decision was the catalyst for further cases to narrow the collateral source rule.

The California Supreme Court continued to move further from the purpose of the collateral source rule by preventing plaintiffs from introducing evidence of the full-billed amounts of medical expenses at trial in *Howell v. Hamilton Meats* (2011) 52 Cal.4th 541. The issue with preventing a jury from seeing the full-billed amounts is that they are unable to appreciate what the market rate of medical services are without pre-negotiated discounts with major insurance providers and government entities. This holding was reinforced in *Corenbaum v. Lampkin* (2013) 215 Cal.App.4th 1308, where the court again held that evidence of full amount billed for medical services was irrelevant and could not support past or future medical or noneconomic damages. The decision in *Corenbaum* significantly limited plaintiff's experts in their calculations of future life care plans. *Corenbaum* added further to the degradation of the original intent of the collateral source rule as was made clear with plaintiffs ending up with judgments that were insufficient to pay for their future medical care expenses. If the court permits Defendants to use Medicare or Medi-Cal rates to determine future care, and a plaintiff is subsequently not eligible for these government-funded plans, the future care award will then be insufficient to cover the future care costs as determined by the jury. Many in the medical field believe that Medicare or Medi-Cal rates for many items do not reflect the true costs of providing the services and if that was the only source of payment, many medical institutions would go bankrupt.

Efforts to maintain plaintiffs' access to treatment

Fortunately, in the last decade, plaintiffs have seen the courts preserve plaintiffs' right to seek necessary treatment, regardless if they are insured. The appellate court's decision in *Pebley v. Santa Clara Organics, LLC* (2018) 22 Cal.App.5th 1266 held when a plaintiff is not insured, medical bills are relevant and admissible to prove both the amount incurred and the reasonable value of medical services provided. The caveat in *Pebley*, was that the uninsured plaintiff must also present additional evidence, typically in the form of expert opinion testimony, to establish that the amount billed is a reasonable value for the services rendered.

The expectation for plaintiff to retain a qualified expert life care planner to provide credible and substantial evidence to support future economic damages was established in *Markow v. Rosner* (2016) 3 Cal.App.5th 1027 just two years prior. In *Markow,* plaintiff's life care planner, an RN with a master's degree in business administration and specialty in health care management with seven years of life care planning experience, estimated that plaintiff's future medical care costs based on her research, knowledge, and experience would be 50 to 75% of the total amount billed. This conclusion was reached through extensive analysis and supported by reflective data. The court held the life care planner's testimony sufficiently credible to support the estimated future life care costs.

Markow and *Pebley* are critical holdings for plaintiffs' attorneys to ensure their clients are able to seek and receive specialized treatment without worrying if the care they need falls within their insurance plan. Insurance coverage is an unknown factor, plaintiffs may lose insurance or their insurance may not cover the treatment they need to rehabilitate from permanent injuries. Despite these cases, plaintiffs' attorneys continue to see future medical awards underfunded due to oversimplified interpretations of the reasonable value of medical services.

Improper foundations for a life-care plan

Not surprisingly, defendants and insurance companies alike have uniformly criticized and called for reform of the collateral source rule for years, asserting primarily that the rule facilitates over-compensation of plaintiffs and leads to increased insurance costs. Plaintiffs' attorneys have attempted to address the concerns of *Howell* and *Hanif*, but defendants still attempt to assert improper foundations for opinions and misinterpret the holdings to justify improper arguments on damages for medical care costs. It remains to be seen if the state legislature will address these issues or if such matters will continue to evolve through the courts.

You may see defense experts attempt to use Medicare and Medi-Cal rates as the standard rate to determine reasonable value of medical services. Beware of defense-oriented experts and life-care planning organizations that may argue that the lowest rate, or the average rate or the median rate is the proper rate to use. These are not scientifically based calculations or calculations that have a foundation to show that they represent the "reasonable value for the services," which is the standard that must be articulated.

Be aware that there are defense-oriented life care planners attempting to publish articles that would lay a foundation for these methodologies as being accepted in the field of life care planning. These methodologies for calculating a reasonable rate often reflect a fundamental lack of understanding of what the data in these datasets represent and how little those numbers reflect the actual reasonable value of medical services. Do not be surprised to see defense experts using averages of averages to come up with their future care estimates. These are improper foundations and, if relied on, will leave plaintiff with an inability to afford future medical care. Not only have these methods been criticized, but they have been thrown out. One appellate case out of Illinois threw out a defense expert's testimony because (1) the data came from an unknown number of insurance companies, not health care providers, (2) the data base that was used was meant

to determine reimbursement rates, not the reasonableness of provider charges, and (3) the data contained in the database was incomplete. (*Verci v. Highi*, (2019) IL.App (3d) 190106, 6.)

In *Cuevas v. Contra Costa County* (2017) 11 Cal.App.5th 163, the court scrutinized the methodologies and rationales of the proposed life-care plans using testimony of the life-care planners. *Cuevas* was a birth injury medical malpractice action. During discovery, plaintiff disclosed a life-care plan prepared by Jan Roughan, RN, in which she provided her opinion as to the kind of medical and rehabilitative care plaintiff would need for the rest of his life. The projected costs of said items were included. Her plan was based upon her independent knowledge, expertise and experience working as a rehabilitation, case management and nurse life care planning specialist with a similar patient population, as well as the recommendations of medical experts who testified on plaintiff's behalf.

Roughan determined the current prevailing charges for the services recommended. The plan did not account for service discounts associated with Medi-Cal, even though plaintiff was currently receiving Medi-Cal benefits. Nor did it reflect negotiated discounts that would potentially be available under insurance procured through the ACA.

Instead, Roughan determined future costs for plaintiff's medical care by utilizing her own knowledge, expertise and experience as a medical billing specialist, additionally referencing a national database that reflects the prevailing charge billed for each type of service. The court admitted Roughan's life-care plan into evidence and commended her expertise in articulating her thorough rationale which included a breakdown of the rates and ranges she used. *Cuevas* is salient because it highlights the importance of a life care planner's ability to establish their credibility and that there be substantial evidence to support their proposed future economic damages.

When cross-examining life-care planners and filing motions in limine, plaintiffs' attorneys need to be aware of and deal with issues that commonly arise such as a relying on the 50th percentile, averaging percentiles, whether Medicare or private local data is being used, and assumptions about future insurance coverage. Be skeptical of the data and methodologies relied upon by defense life-care planners and ensure your own retained life-care planner is not naïve to these pitfalls.

Conclusion

Life-care planers are often medical professionals, nurses and doctors. The very idea of proposing an underfunded life care plan goes against the Hippocratic Oath. Just as a doctor is required to do no harm, a life care planner should rely on proper methodologies to prepare a life care plan that will allow a plaintiff to afford future necessary treatment. As plaintiffs' attorneys, we must be diligent in ensuring our verdicts and settlements protect the future care needs of our clients.


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