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Specialty Law Columns
Tort and Insurance Law Reporter
Recovery of Medical Expenses by Insured Medical Malpractice Victims
by Anthony Viorst

This column provides information concerning current tort law issues and insurance issues addressed by practitioners representing either plaintiffs or defendants in tort cases. In addition, it addresses issues of insurance coverage, regulation, and bad faith.

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This month's article was written by Anthony Viorst, Denver, an associate with Lapin and Associates, P.C.—(303) 320-4162, viorst@lawlapin.com.

This article discusses whether a medical malpractice victim is entitled to be compensated by a defendant doctor for causally-related medical expenses that were paid by an insurance company or government program, such as Medicare.

Medical expenses in medical malpractice cases often can reach six or seven figures. Thus, an important issue is whether an insured victim of medical malpractice may recover medical expenses paid by a third party. Such recovery may depend on whether the third party has filed notice of its subrogated claim. Further, in situations where medical expenses are paid by a government program, such as Medicare, recovery may depend on whether the insured has paid "premiums" to the government in the form of taxes or labor. However, Colorado law is not definitive as to these issues.

This article examines the statutory collateral source rule and statutory right of subrogation in medical malpractice cases. It addresses conflicts between the statutes and reviews relevant case law. It also discusses the issues in the context of private insurance and Medicare and addresses additional related arguments, including "real party in interest" and "actual damages." Finally, it provides guidance regarding the admissibility of evidence of third-party payments, as well as practice pointers for lawyers who handle medical malpractice cases.

Statutory Collateral Source Rule

Prior to 1986, Colorado applied the common law collateral source rule.

[1] Under this rule, compensation that a tort victim receives from a source unrelated to the tortfeasor will not reduce the damages recoverable from the tortfeasor.[2] The purpose of the

common law collateral source rule was to prevent the wrongdoer from receiving reduced liability merely because the injured party had been indemnified by an outside, independent source.[3] It was considered fairer that any windfall should be realized by the plaintiff in the form of double recovery rather than by the tortfeasor in the form of reduced liability.[4]

In 1986, the Colorado General Assembly enacted CRS § 13-21-111.6,

[5] which served to limit application of the common law collateral source rule. This statute applies to medical malpractice actions, as well as other types of personal injury cases, in which a plaintiff is successful. Pursuant to CRS § 13-21-111.6, for a tort that results in death or injury, the court must reduce the amount of the verdict by the amount for which such person is "wholly or partially indemnified or compensated . . . in relation to the injury, damage, or death sustained." However, there is an important exception:

> [T]he verdict shall not be reduced by the amount by which such person . . . has been or will be wholly or partially indemnified or compensated by a benefit paid *as a result of a contract entered into and paid for by or on behalf of such person.*
>
> [6] (*Emphasis added.*)

Thus, CRS § 13-21-111.6 significantly narrows the scope of the common-law collateral source rule, so that it applies only to payments made under the terms of a "contract" entered into by or on behalf of the injured victim. Other statutes were later enacted to address a third party's right of subrogation.

Statutory Right of Subrogation

In 1988, the Colorado General Assembly enacted the Health Care Availability Act ("HCAA").

[7] According to the legislative declaration, the purpose of the HCAA is to ensure the continued availability of health care in Colorado by containing costs of malpractice insurance for medical care institutions and licensed medical care professionals.[8]

The HCAA, at CRS § 13-64-402, requires that within sixty days of filing a complaint, a plaintiff in a medical malpractice action must provide written notice of the action to any third party that has paid any portion of the plaintiff's medical bills.

[9] A sample notice to the third party is provided in the Appendix to this article.

CRS § 13-64-402 also states that any third party receiving such notice from a medical-malpractice plaintiff then has ninety days to file with the court a formal notice of its subrogated claim. Otherwise, the third party will waive its "right of subrogation as to such action."

[10] By the explicit statutory language of CRS § 13-64-402, a third-party payor that fails to file a written notice of its subrogated claim within ninety days loses its right of subrogation for that action.[11] The breadth of this statute, and its interplay with the collateral source rule, is a matter of ongoing debate within the medical malpractice bar.

Conflicts Between Collateral Source Rule And Right of Subrogation

The debate among medical-malpractice attorneys focuses on whether the provisions of the statutory collateral source rule, CRS § 13-21-111.6, conflict with the provisions of the HCAA's subrogation rule, CRS § 13-64-402. If so, the issue is which of the two rules should prevail. The answer to these questions may depend, in part, on whether the third-party payor is a private insurance company or a government program, such as Medicare. Each of these scenarios is discussed below.

Private Health Insurance Policies

The collateral source rule contained in CRS § 13-21-111.6 exempts those benefits paid "as a result of a contract entered into and paid for by or on behalf" of the injured party. This rule clearly exempts from setoff any "benefits that result from private insurance contracts for which someone pays monetary premiums."

[12] However, it is unclear whether the HCAA's subrogation statute, CRS § 13-64-402, effectively "trumps" the statutory collateral source rule. If this is the situation, a medical malpractice victim is precluded from recovering his or her past health care expenses unless the insurance company files a timely notice of its subrogated claim.

Arguments Against Recovery:

The argument supporting the position that a medical malpractice victim loses the right to recover past health care expenses relies on the language of CRS § 13-64-402, which provides that a third-party payor that fails to file a written notice of its subrogated claim loses its "right of subrogation as to such action." By this language, it is argued, if a third-party payor fails to file timely notice of its subrogated claim for medical expenses, it thereby waives its right to seek reimbursement from the tortfeasor, as well as from its own insured. Further, if the third-party payor has no right of reimbursement for medical expenses it has paid, the insured likewise must be denied the right to seek compensation for those expenses.

Such position is buoyed by the 1989 case of *United States Fidelity & Guaranty Co. v. Salida Gas Service Co.*

[13] ("*Fidelity*"). In *Fidelity*, the Colorado Court of Appeals stated that the only payments that fall within the collateral source exception to CRS § 13-21-111.6 are "those payments received from persons or entities who have subrogation rights against the tortfeasor."[14] Citing *Fidelity*, medical-malpractice defendants have asserted that where a health insurance company fails to file a timely notice of its subrogated claim, pursuant to CRS § 13-64-402, a medical-malpractice victim is precluded from recovering any past health care expenses paid by that company, because the company lacks any "subrogation rights against the tortfeasor."[15]

Arguments in Favor of Recovery:

Proponents of recovery of payments of past health care expenses paid by a health insurance company point to several perceived flaws in the opposing argument. First, the oft-cited *Fidelity* case, which was decided by the Colorado Court of Appeals in 1989, appears to conflict with a 1992 Colorado Supreme Court case, *Van Waters & Rogers, Inc. v. Keelan*.

[16] The *Keelan* Court was asked to determine whether disability payments payable under a pension plan were covered under the statutory collateral source exception found at CRS § 13-21-111.6. After reviewing the relevant legislative history, the Court concluded that the statutory collateral source rule reflects

> an intent not to deny a plaintiff compensation to which he is entitled by virtue of a contract that either he, or someone on his behalf, entered into and paid for with the expectation of receiving the consequent benefits at some point in the future.
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The *Keelan* Court found that, within the context of the statutory collateral source rule, employment services are analogous to the payment of insurance premiums. Therefore, the Court construed the clause excluding certain types of benefits from setoff as

> broad enough to cover contracts for which a plaintiff gives some form of consideration, whether it be in the form of money or employment services, with the expectation of receiving future benefits in the event they become payable under the contract. . . .
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The *Keelan* Court did not expressly overrule the holding in *Fidelity*.

[19] However, the Court appeared to implicitly reject the view espoused in *Fidelity* that only those payments received from persons or entities with subrogation rights against the tortfeasor are covered by the statutory collateral source rule. A post-*Keelan* Court of Appeals ruling recognized the potential effect of that decision on the *Fidelity* case, stating that the *Keelan* Court's broad interpretation of the term "contract" leaves "the continuing vitality" of *Fidelity* in doubt.[20]

Second, the opposing argument is at odds with the "plain meaning rule" of statutory construction, which provides that statutory language that is clear and unambiguous should be construed as written.

21 Applying the plain meaning rule to CRS § 13-64-402, that statutory provision clearly states that a subrogor that does not comply with written notice requirements loses its right of recovery "*as to such action*."22 (*Emphasis added.*)

Although CRS § 13-64-402 limits the subrogor's right to seek reimbursement directly from the tortfeasor, it does not preclude a subrogor from enforcing its contractual right to seek a refund of benefits from its insured following a tort recovery. In fact, almost all health insurance policies provide that the insured must refund to the carrier any tort recovery for medical expenses that the carrier has paid.

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Regardless of whether a health insurance company chooses to become involved in a medical malpractice case filed by its insured, it retains its contractual right to a refund of any subrogated benefits that the insured recovers. Thus, in situations where the insurance company fails to intervene directly in the insured's case against the tortfeasor, the insured nonetheless should be permitted to recover those medical expenses covered by insurance, inasmuch as the denial of those expenses could result in an inequitable reduction of the insured's recovery.

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Finally, in those rare instances where the insurance company waives its right to reimbursement, it is more appropriate for the insured plaintiff to receive a windfall, in the form of a double recovery, than for the defendant to receive a windfall in the form of reduced liability merely because the plaintiff received indemnification from an insurance carrier. In contrast with collateral payments that are made gratuitously, benefits paid by an insurance carrier have been paid for by the insured, who has made regular premium payments. The *Keelan* Court noted that in these situations "the concern of double recovery for a loss is lessened by the fact that the benefits were previously paid for. . . ."

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Medical Expenses Paid
By Medicare

There is some disagreement regarding whether a plaintiff has the right to recover expenses paid by Medicare. Arguably, Medicare payments are conceptually different from payments made by private health insurance companies, because the beneficiary of Medicare payments does not pay "premiums" or contribute services in exchange for Medicare coverage. Nevertheless, a 1993 opinion by the Colorado Supreme Court, *Barnett v. American Family Mutual Insurance Co*,

26 would suggest that Medicare payments are not subject to offset.

The *Barnett* Court explicitly held that Social Security Disability Insurance ("SSDI") benefits are excluded from the setoff requirement contained in CRS § 13-21-111.6. In reaching this conclusion, the Court found that an eligible taxpayer pays "premiums" to the Social Security system in the form of employment taxes. In support of its holding regarding SSDI benefits, the Court cited *Schmiedigen v. Celebrezze*:

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> . . . [T]he law created a contributory insurance system, under which what in effect constitute premiums are shared by employees and employers. Consequently, in spirit at least, if not strictly and technically, the employee, who throughout his working life has contributed part of the premiums in the form of deductions from his wages or salary, should be deemed to have a vested right to the payments prescribed by the statutory scheme, which in effect comprises the terms of his insurance policy. He has earned the benefits; he is not receiving a gift. . . .
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Medicare benefits, like SSDI benefits, are provided to taxpayers who have paid into the federal Social Security system. Thus, pursuant to the holding in *Barnett*, it appears they also come within the ambit of those expenses excluded from setoff under the statutory collateral source rule.

29 In addition, CRS § 13-64-402 does not appear to impact the right of recovery even if Medicare does not file formal notice of its subrogated claim. This is because Medicare maintains a statutory right of subrogation regardless of whether it chooses to become directly involved in a lawsuit filed by its beneficiary.30

Finally, it is worth noting that the foregoing Medicare analysis would probably not be applicable to *Medicaid* payments. Unlike Medicare, eligibility for Medicaid is determined on the basis of the recipient's income, and prior payment of Social Security taxes is not required.

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"Real Party in Interest" and "Actual Damages" Arguments

Defendants in medical malpractice cases also have argued that, with regard to the recovery of medical expenses that have been paid by insurance, the plaintiff-patient is not the "real party in interest," as required by C.R.C.P. 17(a).

32 Ironically, this argument appears to have been put to rest in a recent case concerning a physician-defendant's right to seek an award of costs following a verdict in his favor, notwithstanding the fact that his liability insurer actually paid the costs. In *Mullins v. Kessler*,33 the Colorado Court of Appeals held that the defendant,

> . . . as the named party in this action and the party on whose behalf costs were incurred, has the substantive right to receive reimbursement for such costs. The arrangement between defendant and his liability issurer for disbursement and repayment of those costs is of no consequence.
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It also has been suggested that a plaintiff who fails to pay his or her own medical expenses has not suffered "actual" economic damages, so that the recovery of those is precluded. However, in 2001, in *Hale v. Erickson*,

35 the Court of Appeals explicitly rejected the argument that the "defendant had not actually incurred the requested costs because they had been paid by defendant's insurer."36

Admissibility of Evidence
Of Third-Party Payments

If a medical malpractice plaintiff is entitled to recover health care expenses paid by private insurance or Medicare, evidence of such benefits is likely inadmissible at trial on the ground that it is irrelevant.

37 To determine the reasonable value of the medical services provided to the plaintiff, the jury needs to review only the medical bills issued by the provider.38

It is possible that the defendant will maintain that the reasonable value of health care services received by the plaintiff is reflected in the amount paid by insurance or Medicare, rather than the amount billed by the medical provider. In this event, the trial court should weigh the probative value of the insurance or Medicare payments against potential prejudice the plaintiff may suffer when the jury learns that some or all of the medical expenses were paid by a third party.

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Practice Pointers

In light of the foregoing discussion, a number of practice pointers should be considered. First, plaintiff's counsel in a medical malpractice case should be sure to comply with the statutory requirement to provide notice to any third-party payor within sixty days of filing the complaint. The likelihood that the trial court will permit recovery of medical expenses is higher in cases in which the third-party payor has declined to become involved in the plaintiff's case than it is in those situations where the third-party payor has never been notified that the case exists.

Second, plaintiff's counsel may want to include in the C.R.C.P. 26(a)(1) initial disclosures a copy of the health insurance agreement, providing for a refund of benefits to the insurance carrier in the event of a tort recovery. C.R.C.P. 26(a)(1)(B) requires each side to turn over documents "relevant to the disputed facts"; therefore, disclosure of the health insurance agreement probably is not mandatory. However, the timely disclosure of this document to the defense

should increase the likelihood that the trial court will permit the plaintiff to recover those medical expenses paid by the carrier.

Third, until an appellate court decision definitively resolves the circumstances under which an insured plaintiff may recover medical expenses in a medical malpractice case, the parties may want to ask the trial court to make a pretrial ruling on this issue, so as to facilitate trial preparation. Such a request may be made pursuant to C.R.C.P. 56(h), which authorizes a motion for a determination of a question of law, or by means of a motion *in limine*.

Conclusion

Colorado statutes and case law generally suggest that an insured victim of medical malpractice may recover medical expenses paid by a third party, even when the third party has declined to file notice of its subrogated claim in the court where the action is pending. However, this issue has not been definitively resolved by the state appellate courts.

Until this issue is resolved, practitioners should seek a pretrial ruling by the trial court, so that they can adequately prepare for trial. In addition, a pretrial ruling will enable counsel to knowledgeably assess the value of the case, so that they can advise their clients accordingly.

NOTES

1. *Van Waters & Rogers, Inc. v. Keelan*, 840 P.2d 1070, 1074 (Colo. 1992).

2. *Id.* at 1074 ("compensation or indemnity received by an injured party for a collateral source, wholly independent of the wrongdoer and to which he has not contributed, will not diminish the damages otherwise recoverable from the wrongdoer," *citing Kistler v. Halsey*, 481 P.2d 722, 724 (Colo. 1971)).

3. *Id.; see also Smith v. Zufelt*, 880 P.2d 1178, 1184 n.10 (Colo. 1994).

4. *Id.*

5. S.B. 86-67, codified at CRS § 13-21-111.6.

6. CRS § 13-21-111.6.

7. S.B. 143, codified at CRS §§ 13-64-101 *et seq.*

8. CRS § 13-64-102.

9. CRS § 13-64-402(1).

10. CRS § 13-64-402(2).

11. *Id.*

12. *Keelan, supra*, note 1 at 1078.

13. *Fidelity*, 793 P.2d 602, 604 (Colo.App. 1989).

14. *Id.* at 604.

15. *Id.*

16. *Keelan, supra*, note 1.

17. *Id.* at 1078.

18. *Id.* at 1079.

19. *Fidelity, supra*, note 13.

20. *Simon v. Coppolla*, 876 P.2d 10, 18 (Colo. App. 1995).

21. *Jones v. Cox*, 828 P.2d 218, 221 (Colo. 1992); *Talley v. Diesslin*, 908 P.2d 1171, 1175 (Colo.App. 1996).

22. CRS § 13-64-402(2).

23. *See Keelan, supra*, note 1 at 1080-81.

24. *Id.* at 1080 (plaintiff's recovery of insurance funds "will not ordinarily result in a windfall recovery for plaintiffs," because insurance company will enforce contractual right of subrogation).

25. *Id.* at 1078.

26. *Barnett*, 843 P.2d 1302, 1310 (Colo. 1993).

27. *Schmiedigen*, 245 F.Supp. 825 (D.D.C. 1965).

28. *Barnett, supra*, note 26 at 1310, *citing Schmiedigen, supra*, note 27 at 827.

29. *See also Witherspoon v. St. Paul Fire & Marine Ins. Co.*, 548 P.2d 302, 306 (Wash. 1976) ("Inasmuch as the beneficiaries of Medicare pay for this coverage through Social Security taxes and Part B premiums, Medicare cannot be classified as 'welfare' as that term is understood in modern usage."); *Black v. Am. Bankers Ins. Co.*, 478 S.W.2d 434, 439 (Tex. 1972) ("Medicare is not a free or charitable program under which a governmental agency provides hospitalization services or expenses 'without cost' to aged citizens.").

30. *See* 42 U.S.C. § 1395y(b)(2). Medicare regulations extend the subrogation right to any judgments or settlements related to injuries for which Medicare paid medical costs. 42 C.F.R. § 411.37 (2002).

31. Liens covered under Medicaid are addressed in CRS § 26-4-403.

32. C.R.C.P. 17(a) states that "[e]very action shall be prosecuted in the name of the real party in interest."

33. *Mullins*, 33 Colo.Law. 149 (Feb. 2004) (App. No. 02CA2564, *annc'd* 12/18/03).

34. *Id.* at 150.

35. *Hale*, 23 P.3d 1255 (Colo.App. 2001).

36. *Id.* at 1257 (party "is entitled to recover costs even if those costs were actually paid by an insurance company").

37. *See Myers v. Beem*, 712 P.2d 1092, 1093 (Colo.App. 1986) ("evidence of compensation from a collateral source is inadmissible, because it is irrelevant"); *see also Carr v. Boyd*, 229 P.2d 659, 662-63 (Colo. 1951) (trial court committed reversible error in admitting evidence that plaintiff received insurance proceeds); *Technical Computer Servs., Inc. v. Buckley*, 844 P.2d 1249, 1253-55 (Colo.App. 1992) (trial court erred in denying plaintiff's motion *in limine* to preclude evidence of unemployment compensation).

38. *See Pyles-Knutzen v. Bd. of Cty. Comm'rs*, 781 P.2d 164, 169 (Colo.App. 1989) (plaintiff's testimony that he "had incurred over $7,000 in medical bills" admissible as evidence of reasonable value of medical services rendered).

39. *See* C.R.E. 403 ("[a]lthough relevant, evidence may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice. . ."). If the plaintiff is entitled to recover past medical expenses paid by a third party, the admission of such evidence could be unfairly prejudicial, because a jury hearing such evidence might be more inclined to deny the plaintiff his or her rightful recovery.

[*date*]

Dear Sir or Madam:

This law firm has been retained by [*client name*] to investigate a claim of medical negligence. This case was filed with the [*court name*] in Colorado on [*date filed*].

Pursuant to CRS § 13-64-402(1), plaintiff is required to give written notice to any third-party payor or provider of any medical benefits. Our records indicate your company may have paid medical benefits on behalf of [*name of insured*].

Pursuant to CRS § 13-64-402(2), if any third-party payor or provider of medical benefits has a right of subrogation for such payments, such payor shall file with the court written notice of such subrogated claim within ninety days after receipt of notice. A copy of the notice of right of subrogation should be transmitted to the party plaintiff as well.

If you are claiming a subrogation lien, please provide us with the following: (1) name and address of Plan Administrator; (2) Plan documents; (3) Summary Plan Description; (4) IRS Form 550; and (5) listing of claimed charges with accompanying invoices.

I have enclosed the appropriate release so that you can provide us with insurance information regarding [*name of insured*]. Please call me at any time with questions or concerns.

Sincerely,

[*attorney name*]

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