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Leadership Note

Letter from the Chair

By J. Richard Moore

On the threshold of summer, our committee is hard at work without much thought of vacation. As reported in our last update, we have recently completed our 2019 Medical Liability and Health Care Law seminar in Nashville, Tennessee. By every measure the seminar was a wild success. Our attendees enjoyed our seminar's first visit to Nashville, and took every advantage of the entertainments of the Music City. We had a near record-setting attendance of over 500. But, as confirmed by the attendee feedback we received, the highest measure of success was the quality of educational offerings afforded by our sterling roster of speakers. Congratulations to our 2019 Program Chair Erika Amarante and our Program Vice Chair Andrew DeSimone for their hard work. It certainly paid off.

Not content to sit on his laurels, Andrew is already hard at work on the 2020 Medical Liability and Health Care Law seminar. Assisted by Program Vice Chair Meg Yanacek, Andrew accepted promotion to Program Chair for 2020. Assisted by our seminar steering committee, Meg and Andrew already have planning for 2020 well under way. We will again be visiting a new city, Austin, Texas. I encourage you to reserve March 26–27, 2020, and to make plans to attend the seminar. Moreover, we are in the process of developing our seminar agenda, and welcome suggestions for topics and speakers.

In addition, we are less than 90 days from our committee's other mainline seminar, the 2019 Nursing Home/ALF Litigation seminar. Program Chair Caroline Berdzick and Program Vice Chair Drew Graham have developed an extremely sophisticated program including litigation instruction from experienced trial lawyers, issue analyses by in-house counsel and representatives, a view industry trends from the insurance perspective, and clinical presentations involving wound care issues, Legionnaire's disease and failure to thrive. In addition, a number of long-term care providers and insurers will be holding panel counsel meetings in connection with the seminar. The seminar will be held on September 19–20, 2019, in Chicago.

Alongside the above, our publications team of Chair Justin Hardin and Vice Chair Jacob Malatesta have been shepherding our committee's robust publication schedule. That includes this quarterly publication, as well as our committee's dedicated issue of *For The Defense*. This year our committee was featured in four cutting-edge articles in the May 2019 issue. We also hope to publish substantive articles in this newsletter, in *The Voice*, and in the *In-House Defense Quarterly*. If you are looking for an opportunity to publish, please do not hesitate to reach out to Justin or Jacob.

In addition to these ongoing activities, we are persistently looking for opportunities to provide additional substantive content authored or curated by our committee members. We are in the process of developing webinars and other on-line content that we hope to promulgate throughout the year, and to enhance our mainline seminars with trial technique add-ons. We welcome any suggestions from our committee members about ways we can increase the educational offerings we provide.

Thanks to all of those mentioned in this letter for the time and effort you put into your roles. Thanks as well to our committee Vice Chair Barclay Wong. Thanks in particular to those who are not identified by name here, but who invest their time and mental resources into assisting with seminar planning and presentation, recruiting authors and writing articles, and donating the benefit of your experience to our committee's work. We cannot do that work without you.

J. Richard Moore is a shareholder with BleekeDillonCrandall in Indianapolis. His practice focuses on the defense of professional liability claims against physicians, nurses, long-term care providers, architects, engineers, and attorneys; advising businesses and insurers regarding large property losses, catastrophic casualty claims, complex insurance coverage questions, fraud and bad faith; and assistance in the resolution of a variety of business and commercial disputes before litigation where possible, and through trial where necessary. Richard is licensed in Indiana, Alabama and Tennessee, and has also assisted in the assessment and handling of matters in Arkansas, Illinois, Ohio, West Virginia, Missouri, Mississippi and Georgia. Richard is an active member of DRI, having served as program chair for the 2011 and 2012 DRI Nursing Home/ALF Litigation Seminars, and as program chair for the DRI Sexual Torts Seminar. He currently serves as chair of the DRI Medical Liability and Health Care Law Committee.

No One Pays Sticker Price for Healthcare Anymore

A Multistate Analysis of Recoverable Medical Special Damages in Medical Malpractice Litigation

By Karen McElhinny, Emily L. Lilly, and Caleb David



Historically, medical malpractice defendants in most states were precluded by the collateral source rule from introducing evidence that insurance or some other collateral source paid plaintiff's medical bills and were precluded from reducing the total damages by the insurance payments or the negotiated discounts of those bills (sometimes referred to as "written-off amounts"). However, recent changes in insurance coverage trends and tort reform have resulted in modifications to the collateral source rule in many states, especially in the context of medical malpractice litigation. In this article, we will review the history of the traditional collateral source rule; we will discuss the factors that have produced changes to the traditional rule; we will discuss the four approaches states have taken to address insurance payments and write-offs in medical malpractice litigation; and we will provide practice pointers for medical malpractice defense attorneys.

History of the Collateral Source Rule

The traditional collateral source rule states that, while a payment made by a tortfeasor to a person whom he has injured is credited against his tort liability, payments made to or benefits conferred on the injured party from other sources are not credited against the tortfeasor's liability even though they may cover all or a part of the harm for which the tortfeasor is liable. *See Restatement (Second) of Torts* §920A (1977) (entitled "Effect of Payments Made to Injured Party). Accordingly, under the traditional collateral source rule, payments from other sources to plaintiffs are prohibited from being used to reduce damages awards imposed upon culpable defendants. *Kenney v. Liston*, 760 S.E.2d 434, 440 (W.Va. 2014).

The collateral source rule dates back to England in 1823 and was adopted in this country in 1854 in the United States Supreme Court decision, *The Propeller Monticello v. Mollison*, 58 U.S. 152 (1854). *See* Dag Ytreberg, Annotation, *Collateral Source Rule: Injured Person's Hospitalization or Medical Insurance as Affecting Damages Recoverable*, 77 A.LR.3d 415, §2a (1977). However, the term "collateral source" originated from language used in a decision drafted by the Supreme Court of Vermont in 1871, *Harding v. Town of Townshend*, 43 Vt. 536 (1871). In the years that followed, the collateral source rule became "a staple of American tort law." Michael I. Krauss & Jeremy Kidd, *Collateral Source and Tort's Soul*, 48 U. Louisville L. Rev. 1, 4 (2009).

The collateral source rule is both a rule of evidence and a rule of damages. *Kenney v. Liston*, 760 S.E.2d at 441. It has been understood to have substantive and evidentiary components with the substantive component barring a defendant from reducing the plaintiff's compensatory award by the amount received from the collateral source(s) and the evidentiary component barring the introduction of evidence of the existence of the collateral source or the receipt of the benefits. *Arthur v. Catour*, 216 Ill. 2d 72, 79–80, 833 N.E.2d 847, 852 (2005).

The justification behind the collateral source rule is likewise twofold. With regard to the substantive component, the theory is that the wrongdoer should not benefit from the expenditures made by the injured party or take advantage of contracts or other relations that may exist between the injured party and third persons. *Arthur*, 216 Ill. 2d at 79, 833 N.E.2d at 852. With regard to the evidentiary component, the concern is that the trier of fact may use evidence of the collateral source or the benefit provided therefrom to improperly deny the plaintiff the full recovery to which he or she is entitled. *Id.*, 216 Ill. 2d at 80, 833 N.E.2d at 852.

Changes Leading Many States to Modify the Collateral Source Rule

The collateral source rule has been met with growing criticism, and recent changes involving tort reform and health care reform have fueled a push to move away from the collateral source rule. At the time the collateral source rule took root in America, individuals rarely had insurance. John

G. Fleming, *The Collateral Source Rule and Loss Allocation in Tort Law*, 54 Calif. L. Rev. 1478–79 (1966).

That is no longer the case today. The most dramatic change in recent years to the health care system in the United States was the enactment of Patient Protection and Affordable Care Act ("ACA") in 2010. Pub. L. No. 111-148, 124 Stat. 119. The ACA includes various provisions that have expanded insurance coverage. *See, e.g.*, *id.* §1001, 124 Stat. at 130–137 (guaranteed issue and renewability provision, prevents denial of coverage based on pre-existing conditions); *Id.*, §1201, 124 Stat. at 154–161 (prevention of premium increases based on pre-existing conditions, annual or lifetime limits on coverage). Current estimates indicate that over 91 percent of American citizens now carry health insurance. Edward R. Berchick, Emily Hood, and Jessica C. Barnett, United States Census Bureau, Health Insurance Coverage in the United States: 2017; Robin A. Cohen, Ph.D., Michael E. Martinez, M.P.H., M.H.S.A., and Emily P. Zammitti, M.P.H., Division of Health Interview Services, National Center for Health Statistics, Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey January–March 2018.

As a result of health insurance companies' negotiated discounts, virtually no one in today's society pays the full amount billed by any medical care provider for any medical service or medical product. In fact, even the rare uninsured self-pay patient is typically afforded an initial discount on their medical bills. *Seaberg v. Steak N' Shake Operations, Inc.*, 2016 U.S. Dist. LEXIS 185548 (M.D. Fla. 2016).

Four Approaches to the Collateral Source Rule

Legislatures and courts are increasingly limiting the application of the collateral source rule. In this changing area of law, approaches to the collateral source rule and written-off amounts fall into four main categories. First, the "Traditional Collateral Source Rule" refers to the evidentiary rule that a defendant may not introduce evidence of collateral source payments at trial and the substantive rule that a defendant may not receive a post-verdict reduction from the court. The "Amount Paid Rule" refers to the evidentiary standard that a defendant may introduce evidence of collateral source payments or evidence that only a certain dollar figure was paid for medical services, and, in some states, the plaintiff may then introduce evidence of payments, typically premium payments, that the plaintiff has incurred to secure collateral source payments. The "Post-verdict Reductions Rule" refers to the rule that a defendant may introduce evidence of collateral source payments to the court for reduction of the compensatory damages awarded after a verdict has been rendered in favor of the plaintiff. Finally, the "Hybrid Rule" refers to evidentiary standards that combine any of the aforementioned rules.

COLLATERAL SOURCE RULES IN MEDICAL NEGLIGENCE CASES

Rule followed regarding written-off amounts	*States following this rule*
Traditional Collateral Source Rule	Arkansas, D.C., Georgia, Hawaii, Kentucky, Mississippi, Nevada, New Hampshire, New Mexico, North Dakota*, Oregon*, South Carolina, South Dakota, Vermont, Virginia, Wyoming
Amount Paid Rule	Alabama, Arizona, California, Idaho, Iowa, Michigan, Missouri, North Carolina, Ohio, Oklahoma, Pennsylvania, Rhode Island, Texas, Washington, Wisconsin
Post-verdict Reductions Rule	Alaska, Colorado, Connecticut, Illinois, Maine, Maryland, Massachusetts, Minnesota, Montana, Nebraska, New Jersey, New York, Tennessee, Utah
Hybrid Rule	Delaware, Florida, Indiana, Kansas, Louisiana, West Virginia

States Following the Traditional Collateral Source Rule

Currently, fifteen states and the District of Columbia follow the Traditional Collateral Source Rule. The Supreme Court of South Dakota has articulated the rationale that is generally proffered for adherence to the Traditional Collateral Source Rule: "[n]o reason in law, equity or good conscience can be advanced why a wrongdoer should benefit from part payment from a collateral source of damages caused by his wrongful act. If there must be a windfall certainly it is more just that the injured person shall profit therefrom, rather than the wrongdoer shall be relieved of his full responsibility for his wrongdoing." *Papke v. Harbert*, 738 N.W.2d 510, 531 (S.D. 2007) (internal citations omitted).

Some states with statutes that appear to permit post-verdict reductions still fall under the Traditional Collateral Source Rule approach because of the exceptions contained within their statutes, as interpreted by the courts. Oregon, for example, has been classified as a state falling under the Traditional Collateral Source Rule, despite Oregon having a statute providing for post-verdict reductions. Oregon's statute provides that, when a plaintiff is awarded damages for bodily injury or death and the plaintiff received benefits for the injury or death other than from the defendant, "the court may deduct from the amount of damages awarded, before the entry of a judgment, the total amount of those collateral benefits other than": (1) benefits the plaintiff or plaintiff's estate is obligated to repay, (2) life insurance or other death benefits, (3) insurance benefits for which the plaintiff or plaintiff's family paid premiums, and (4) retirement, disability and pension plan benefits, and federal Social Security benefits. O.R.S. §31.580(1). The Oregon Court of Appeals has held that Medicare write-offs are "federal Social Security benefits" that preclude the trial court from reducing a plaintiff's award. *White v. Jubitz Corp.*, 182 P.3d 215, 221, 219 Ore. App. 62, 74 (2008). Likewise, the Oregon Court of Appeals has held that Medicaid write-offs are also "federal Social Security benefits" that are precluded from reduction post-verdict. *Cohens v. McGee*, 180 P.3d 1240, 1242, 219 Ore. App. 78, 81 (2008). Thus, the only conceivable post-verdict reductions permitted in Oregon are reductions for payments made by the defendant or on the defendant's behalf. Presumably, if a defendant health-care provider wrote off the bills incurred for his or her own medical services, then the verdict may be reduced by that written-off amount. Otherwise, despite its statute, Oregon follows the Traditional Collateral Source Rule.

Similarly, North Dakota law provides for post-verdict reductions for collateral source payments "from any other source paid or to be paid to cover an economic loss which need not be repaid by the party recovering economic damages, but does not include life insurance, other death or retirement benefits, or any insurance or benefit purchased by the party recovering economic damages." N.D. Cent. Code, §32-03.2-06. Neither the North Dakota legislature nor North Dakota courts have addressed whether amounts written off by healthcare providers may be reduced post-verdict. Therefore, like in Oregon, defendants in North Dakota medical negligence cases can only conceivably seek post-verdict reductions of their own written-off bills.

While Georgia lacks a statute addressing this issue, the Court of Appeals of Georgia has held that, "[w]here damages are special and ascertainable and the defendant or its privies, indemnitor, or insurers have paid the medical expenses prior to judgment, in whole or in part, a set-off against such special damages, specifically identified and awarded in the verdict, is mandated to prevent a double recovery." *Candler Hosp. v. Dent*, 228 Ga. App. 421, 422, 491 S.E.2d 868, 869 (1997). Thus, Georgia's intermediate appellate court has held the same principle espoused in Oregon's and North Dakota's collateral source statutes and has provided for post-verdict reductions of only medical expenses paid by the defendant or on the defendant's behalf.

States Following the Amount Paid Rule

The Amount Paid Rule addresses the collateral source rule as an evidentiary standard, permitting introduction of collateral source payments at trial. Ohio, which has the most robust statute addressing the Amount Paid Rule, has expressly stated its rationale for the Rule: "[d]ue to the realities of today's insurance and reimbursement system, in any given case, that determination is not necessarily the amount of the original bill or the amount paid. Instead, the reasonable value of medical services is a matter for the jury to determine from all relevant evidence." *Robinson v. Bates*, 112 Ohio St. 3d 17, 23, 857 N.E.2d 1195, 1200 (2006). To that end, 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." *Id.* Ohio's medical negligence collateral source statute spells out the exact evidentiary rules to be followed. First, the defendant may elect to "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, except if the source of collateral benefits has a mandatory self-effectuating federal right of subrogation, a contractual right of subrogation, or a statutory right of subrogation." ORC Ann. 2323.41(A). 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 receive the benefits of which the defendant has introduced evidence." ORC Ann. 2323.41(B). Additionally, Ohio law permits the introduction of evidence of write-offs from healthcare providers. "Because no one pays the negotiated reduction, admitting evidence of write-offs does not violate the purpose behind the collateral-source rule." *Robinson*, 112 Ohio St. 3d at 23, 857 N.E.2d at 1200. Therefore, in Ohio, parties are permitted to introduce evidence of most collateral sources, and it is the jury's job to determine

the reasonable value of the medical care received by the plaintiff.

Like Ohio, California has enacted a statute permitting a medical negligence defendant to introduce to the jury evidence of "any amount payable as a benefit to the plaintiff as a result of the personal injury pursuant to the United States Social Security Act, any state or federal income disability or worker's compensation act, any health, sickness or income … disability coverage, and any contract or agreement of any … organization … to provide, pay for, or reimburse the cost of … health care services." Cal. Civ. Code §3333.1(a). If the defendant elects to introduce this evidence, "the plaintiff may introduce evidence of any amount which the plaintiff has paid or contributed to secure his right to any insurance benefits concerning which the defendant has introduced evidence." Cal. Civ. Code §3333.1(a).

Texas and Pennsylvania have streamlined the Amount Paid Rule. In Texas, by statute, the amount of medical expenses introduced to the jury is the amount actually paid by the plaintiff. The Texas statute states, "[i]n addition to any other limitation under law, recovery of medical or health care 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. The Supreme Court of Texas has interpreted this statute to limit "recovery, and consequently the evidence at trial, to expenses that the provider has a legal right to be paid." *Haygood v. De Escabedo*, 356 S.W.3d 390, 391, 54 Tex. Sup. J. 1377 (Tex. 2011). Thus, while not expressly stated, the Supreme Court of Texas appears to have excluded written-off amounts from the amounts that may be introduced to the jury at trial.

Pennsylvania does not have a statute governing the evidentiary rules regarding the introduction of medical damages at trial; however, the Supreme Court of Pennsylvania in *Moorhead v. Crozer Chester Med. Ctr.*, 564 Pa. 156, 162, 765 A.2d 786, 789 (2001), held "that the amount paid and accepted by [the tortfeasor] as payment in full for the medical services is the amount [the plaintiff] is entitled to recover as compensatory damages." *Id.* Thus, the Supreme Court of Pennsylvania found that the reasonable value of medical care is the amount that was actually paid and streamlined the Amount Paid Rule by only permitting introduction of the amounts paid as special damages.

States Following the Post-verdict Reductions Rule

States following the Post-verdict Reductions Rule have addressed the collateral source rule as a damages standard, permitting introduction of collateral source payments to the court post-verdict. For example, in New York, in medical negligence cases, "evidence shall be admissible for consideration by the court to establish that any such past or future cost or expense was or will, with reasonable certainty, be replaced or indemnified, in whole or in part, from any collateral source, except for life insurance and those payments as to which there is a statutory right of reimbursement." NY CLS CPLR §4545(a). If the court finds that any medical cost or expense will be replaced or indemnified from a collateral source, the court "shall reduce the amount of the award by such finding, minus an amount equal to the premiums paid by the plaintiff for such benefits for the two-year period immediately preceding the accrual of such action and minus an amount equal to the projected future cost to the plaintiff of maintaining such benefits." NY CLS CPLR §4545(a). The statute specifically provides that these reductions "shall be made by the trial court after the rendering of the jury's verdict." NY CLS CPLR §4545(a). Thus, New York has taken the approach of permitting the plaintiff to introduce all of his or her medical expenses as damages and then, post-verdict, permitting the court to reduce the damages award by the amounts paid by collateral sources, less two years of premiums the plaintiff paid to secure those collateral source payments. Therefore, the plaintiff does not receive a double recovery both from the benefits of payments made by collateral sources and from the damages awarded by the jury against the tortfeasor. The plaintiff does, however, still receive the benefit of his or her bargain with his or her own health insurance provider because any post-verdict reduction will be itself reduced by two-years-worth of the plaintiff's insurance premium payments.

In Massachusetts, after a verdict has been reduced by the trial court, no entity that is a source of a collateral benefits that have been reduced by the court may "recover any amount against the plaintiff, nor shall it be subrogated to the rights of the plaintiff against the defendant, nor shall it have a lien against the plaintiff's judgment, on account of its payment of the benefits by which the court has reduced the amount of the plaintiff's judgment …." M.G.L.A. 231 §60G(c). If, however, "the plaintiff has received compensation or indemnification from any collateral source whose right of subrogation is based in any federal law, the court shall not reduce the award by the amounts received prior

to judgment from such collateral source and such amounts may be recovered in accordance with such federal law." M.G.L.A. 231 §60G(c). Thus, in Massachusetts, after a court has reduced a verdict by non-Federal collateral source payments, the collateral source's right to subrogation is extinguished.

States Following a Hybrid Rule

Some states have combined parts of the above approaches to the collateral source rule. In West Virginia, the Medical Professional Liability Act provides for a post-verdict reduction of a jury's compensatory damages award by amounts paid by collateral sources. In West Virginia medical negligence cases, "a defendant who has been found liable to the plaintiff for damages for medical care, rehabilitation services, lost earnings or other economic losses may present to the court, after the trier of fact has rendered a verdict, but before entry of judgment, evidence of payments the plaintiff has received for the same injury from collateral sources." W.Va. Code §55-7B-9a(a). After a defendant presents evidence of collateral source payments, "the plaintiff may present evidence of the value of payments or contributions he or she has made to secure the right to the benefits paid by the collateral source." W.Va. Code §55-7B-9a(c).

While this appears to be a straightforward application of the Post-verdict Reductions Rule, the statutory definition of "collateral source" makes West Virginia a Hybrid Rule state. In West Virginia, "collateral source" is defined in part as "a source of benefits or advantages for economic loss that the claimant has received from … Any federal or state act, public program or insurance which provides payments for medical expenses, disability benefits, including workers' compensation benefits or other similar benefits. *Benefits payable under the Social Security Act and Medicare are not considered payments from collateral sources except for Social Security disability benefits directly attributable to the medical injury in question*." W. Va. Code §55-7B-2(b)(1) (emphasis added). Thus, Medicare and Social Security disability benefits *not* attributable to the injury in question are *not* considered collateral sources and, by implication, arguably may be introduced at trial. Other governmental benefits such as Medicaid payments or workers' compensation are collateral sources and are subject to a post-verdict reduction. The West Virginia definition of "collateral source" also includes "[a]ny contract or agreement of any group, organization, partnership or corporation to provide, pay for or reimburse the cost of … health care services or provide similar benefits, *but excluding any amount that a group, organization, partnership, corporation or health care provider agrees to reduce, discount or write off of a medical bill.*" W.Va. Code §55-7B-2(b)(2) (emphasis added). Thus, payments made by an insurance carrier for health care services are collateral sources subject to post-verdict reduction but written-off amounts are *not* considered collateral sources. This implies that a defendant may introduce written-off amounts at trial to permit the jury to determine the reasonable value of medical services.

In Delaware medical negligence cases, evidence may be introduced to the jury of "[a]ny and all facts available as to any public collateral source of compensation or benefits payable to the person seeking such damages (including all sums which will probably be paid payable to such person in the future) on account of such property damage or bodily injury." 18 Del. C. §6862(1). Additionally, evidence may be introduced of "any and all changes, including prospective changes, in the marital, financial or other status of any persons seeking or benefiting from such damages known to the parties at the time of trial …." 18 Del. C. §6862(2). This statute, however, is not applicable to "life insurance or private collateral sources of compensation or benefits." 18 Del. C. §6862. Thus, only public collateral source payments may be introduced to the jury for the determination of the reasonable value of medical care. Plaintiffs who purchased their own health insurance benefits receive the full benefit of their bargain with their health insurers. However, in Delaware, the collateral source rule does not apply to written-off amounts where a plaintiff's medical bills were paid by Medicare because the write-offs are not benefits conferred on the plaintiff and instead were conferred on federal taxpayers. *Stayton v. Del. Health Corp.*, 117 A.3d 521, 530 (Del. 2015). The Delaware court also found that, in cases where the plaintiff's medical bills were paid by Medicare, it is best "to treat the amount paid by Medicare as dispositive of the reasonable value of healthcare provider services." *Stayton*, 117 A.3d at 533.

Practice Tips

In light of the abrogation of the collateral source rule in most states, it may be helpful to consider the following when defending a medical negligence case. First, when conducting discovery, make sure you obtain complete medical billing information so that you have an accurate calculation of the written-off amount to present to the jury or to the court. In some cases, it may be necessary to depose healthcare providers' billing staff to obtain accurate written-off amounts.

Second, consider these issues in your pre-trial motion practice, even if your jurisdiction has not modified the collateral source rule at this time. To limit plaintiff's recoverable future damages in a situation in which a plaintiff has elected to not purchase insurance or has not sought payment for his or her medical treatment from insurance, you may want to argue failure to mitigate based upon the ACA's requirement that most Americans maintain minimum essential health insurance coverage. ACA, Pub. L. 111-148, §1501, 124 Stat. 119, 244 (codified as 42 U.S.C. §18091); *See, Brewington v. United States,* 2015 U.S. Dist. LEXIS 97720 (C.D. Cal. 2015); *Cephus v. CSX Transp., Inc.*, 2016 U.S. Dist. LEXIS 194016 (N. D. Ga. 2016); *Jones v. MetroHealth Med. Ctr.*, 2015 Ohio Misc. LEXIS 21152 (2015) (affirmed in part and reversed in part by *Jones v. MetroHealth Med. Ctr.*, 2017 Ohio 7329, 89 N.E. 633 (Ohio App. 2017)). It should be noted, however, that although the individual mandate was upheld by the Supreme Court in *National Federation of Independent Business v. Sebilius*, 567 U.S. 519 (2012), the penalty that gave the individual mandate its teeth was reduced to zero as of 2019 by the Tax Cuts and Jobs Act of 2017. Pub. L. 115-97, §11081. Nevertheless, the individual mandate itself persists, as does the longstanding rule that tort victims must mitigate their damages. See Restatement (Second) of Torts §928 (1979).

Third, consider developing some of these issues through damages experts. Now that the definition of the "reasonable value" of medical services is changing, you may need to retain damages experts to provide opinion testimony about whether the billed amounts are the reasonable value of the medical services. Be prepared when you depose and/or cross-examine plaintiffs' damages experts to ask whether they analyzed the billed amounts to determine if they are the reasonable value of the services provided.

Karen Tracy McElhinny is a member and owner of Shuman, McCuskey & Slicer, PLLC. She defends and advises health care providers and other professionals in professional negligence actions in state and federal court and before administrative agencies. She is a member of DRI and the Defense Trial Counsel of West Virginia.

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Caleb B. David is an associate at Shuman, McCuskey & Slicer, PLLC. He practices civil defense litigation in the areas of medical malpractice, construction defects, and governmental liability. He represents clients in state and federal courts in West Virginia, in state courts in Kentucky, and before administrative agencies. He is a member of DRI and Defense Trial Counsel of West Virginia.

What Defense Counsel Should Know About Electronic Health Records

By Jason Winslow

Electronic Health Records (EHRs) help improve patient care, increase patient participation, enhance coordination of care, and reduce costs, among other benefits. In the medico-legal context, some believe EHRs can also "facilitate streamlined and effective dispute resolution, holding certain healthcare providers accountable for mistakes while shielding others from illegitimate claims." DeAngelis, Joseph, "Who Guards the Guardians—Simplifying the Discovery of EHR," 90 U. Colo. L. Rev. 319, 320 (2019). However, various facets of EHR technology have in reality been used to complicate the discovery process and to challenge the veracity of health care providers and institutions, for reasons often completely external to patient care. The primary focus of this article is to promote a better understanding among defense attorneys—particularly those producing EHR in written discovery, or presenting a witness for deposition—about how EHRs operate and how they differ from the paper charts we grew accustomed to using in prior medical malpractice cases.

Legal Discovery of EHR and "Export Distortion"

Obtaining a copy of the patient chart is one of the first tasks attorneys will initiate after a medical malpractice lawsuit has been filed. Before EHRs existed, this process simply entailed creating a photocopy of the paper chart and its various sections. However, production of a patient's chart stored within an EHR system is a much more complicated process. Because EHR software vendors create their systems with the

intention that the stored information will remain electronic, facilitating a printout for patients, physicians, or lawyers, is often an afterthought. Brouillard, Esq., Chad P., "EHR and Audit Trails Might Reveal More than You Think," Inside Medical Liability, a publication for the Medical Professional Liability Community (Q3 2015).

The process of creating a printout of the patient chart involves someone with access to the EHR requesting a report, which the EHR system compiles from its underlying metadata and exports back to the requesting user (hereinafter referred to as an "export report"). The underlying metadata in an EHR system is created by the users of the system (*i.e.*, physicians and nurses checking boxes, clicking buttons, selecting options on drop-down menus, free text entry, etc.), by the system itself (*i.e.*, dates, times, patient ID numbers and demographic information), and by other means. Some EHR systems record metadata down to the level of a singular keystroke, but in general the captured metadata is information about the "Who? What? When? and Where?" relating to the provision of patient care. The exported report, typically in a PDF format, is the EHR system's best effort at taking the underlying metadata and reconstructing an electronic version of what we typically associate with the patient's paper chart.

Any attorney who has prepared health care providers for depositions in medical malpractice lawsuits involving EHRs has likely encountered a witness or two expressing a sense of frustration over how starkly different the exported report appears from the electronic display which was available to them at the point of care. Without access to the proprietary viewing software through which clinicians view metadata at bedside, the exported report often appears unwieldy, disorganized, and cluttered by comparison, even when the underlying data is the same. This phenomenon, known as "export distortion," can take many forms, but at its root is the result of changes to the configuration of how underlying metadata is displayed even though the underlying metadata has not been altered in any way. Artigliere, Hon. Ralph, *et al.*, "Diagnosing and Treating Legal Ailments of the Electronic Medical Records," 18 Sedona Conf. J. 209 (2017).

Sometimes successive export reports contain new data, altered data, or missing data from prior versions, which can arouse distrust and suspicion among litigants. These data disparities can and do occur, however, because EHR systems are dynamic, which leads to distortions in how underlying metadata is displayed in reports exported at different times. For example, two separate exported reports may display different data when:

- The export requests are made by persons with different role-based levels of EHR access. Someone in Health Information Management may have a greater or lesser degree of access to export metadata than a physician consult who prints a copy of his or her note at bedside.
- The export requests are made at different stages in the healthcare life cycle. An export report generated at bedside before the chart has been finalized or before patient is discharged from the hospital may appear different from an export report generated after a lawsuit has been filed.
- The export requests are made at different stages in the EHR life cycle. Even two export reports generated after a lawsuit has been filed may result in data distortion if the EHR system has been upgraded, security patches have been applied, the metadata has been migrated to a different EHR software vendor, or the underlying metadata has been corrupted in the interim.
- The export requests are made at different locations within the EHR system. From some points of access to the EHR system, data can be collected automatically, whereas other data must be accessed manually.

EHR Audit Trails

When discovery disputes arise relating to the authenticity or reliability of a record purporting to contain the patient's medical information, the audit trail sometimes proves helpful in explaining the underlying cause of data distortion. An audit trial is one form of export report which can be requested from an EHR system and typically documents "who has accessed a computer system, when it was accessed, and what operations were performed." Because EHR software developers often design audit trails, however, they can be idiosyncratic by their very nature. Until regulation forces EHR software developers to "define and implement an audit trail adhering to given specifications, the reliability, comprehensiveness, and level of detail captured in audit trails will vary in form and effectiveness for any given EHR." *Id.*, 90 U.Colo.L.Rev. 319.

Some courts have determined that a reasonable starting point for exploration of why data distortion might exist is the audit trail, as opposed to a more searching inquiry into the underlying metadata at the outset. *Gilbert v. Highland Hosp.*, 31 N.Y.S.3d 397 (N.Y. Supp.Ct. 2016). In *Peterson v. Matlock*, 2014 U.S. Dist. LEXIS 152994, 2014 WL 5475236 (D.N.J. Oct. 29, 2014), the Court denied Plaintiff's request to obtain the medical record in its innate format with a software viewer and instead ordered the production of an audit log.

While the presence of data distortion alone in most cases should not justify converting the in-house legal team into a forensics department, or require the creation and production of custom built audit reports that would never otherwise be used by a clinician for purposes of medical care and treatment, in some cases courts have authorized more intrusive forms of discovery. In one recent case, *Miller vs. Sauberman*, 2018 N.Y. Misc. LEXIS 5954 (N.Y. Dec. 4, 2018), a trial court ordered the production of underlying metadata where there was no explanation for conflicting versions of the EHR, an audit trial did not resolve the conflict, and that resolution of the conflict was material to Plaintiff's malpractice claim, despite an estimated cost of $250,000.00 to produce the metadata.

Audit logs can also be used to corroborate a healthcare provider's assertion that he or she accessed (or did not access) certain records, lab results, or studies, an area of common inquiry during depositions in medical malpractice lawsuits. Generally audit trails reliably capture information relating to the identity of the EHR system user who logs in, which records he or she viewed, the duration of the review, and any actions taken in that time period. However, the presence or absence of EHR user's metadata on an audit log can be misleading in some circumstances. Sometimes physicians and nurses inadvertently fail to log out of the EHR, which can result in that provider's credentials beings used to access other portions of the chart and potential misattribution of identity in an audit log. In other cases, providers review records together during periods of collaboration without each being independently logged into the EHR system contemporaneously. This "over-the-shoulder" review of data and information in a patient's chart would not generate the EHR user tag metadata that one would otherwise expect to see in an audit trail. While the question of whether a provider accessed a record in the paper chart era was one primarily of credibility, defense counsel should be aware that EHR technology has now given litigants the potential to answer this question on the basis of electronically verifiable data.

EHR Alterations

The specter of fraudulent medical record alteration is perhaps one of the more concerning aspects of medical malpractice litigation. Since the advent of EHR technology, audit trails and metadata make it more difficult for healthcare providers to intentionally alter the medical record to cover-up negligence, or otherwise falsely alter the factual circumstances in given case, without detection. Nevertheless, some studies estimate that approximately one-half of all records in medical negligence cases have been altered, and approximately one-tenth of records have been fraudulently altered. *Id.*, 90 U.Colo.L.Rev. 319.

There exists a critical distinction between correcting a medical record and fraudulently altering one. Typically, corrections to a medical record occur before the record has been finalized and electronically signed by the provider, in the normal course of treatment, and before a claim or lawsuit arises. Corrections made without an addendum, without attribution for date/time, without an explanation for why the correction was made, and which do not strikethrough old text, but instead delete it, can call into question the legitimacy of an otherwise benign "correction."

But evidence of a data distortion alone is likely insufficient, in and of itself, to give rise to an inference of deliberate falsification. For example, in *Desclos v. Southern New Hampshire Medical Center*, 2006 N.H. LEXIS 101 (July 11, 2006) the Court prohibited plaintiff from presenting evidence to the jury that the EMR had been altered, despite the presence of suggested after-the-fact changes, and reasoned that "[w]hether a medical record can be and has been altered on a computer, or on an electronic medical record system after having been transcribed is an issue requiring expert testimony." In *Green v. Pa. Hosp.*, 2013 Phila. Ct. Com. Pl. LEXIS 108 (Pa. C.P. 2013), the Court concluded similarly that proper expert testimony is required to prove an EMR alteration. In that case, Plaintiff presented an informatics expert who had never worked with the specific EMR system either as a nurse or as an informatics consultant, who had never seen the audit logs generated by this EMR system prior to this case, and who according to the Court was completely unfamiliar with the complex EMR. These cases suggest that the severity of leveling an allegation against a healthcare provider—that its record was deliberately falsified—requires not only an expert, but one who is qualified by experience and familiarity with the specific type of EHR system and audit trail and/or metadata at issue in the case.

Conclusion

Because EHR systems collect and maintain much more data than the paper charts of the past, litigants should in theory be better equipped to both prosecute and defend claims of medical negligence. With the advent of this technology, however, new medico-legal disputes centered on data export distortion and corrections to medical records have emerged and continue to evolve. Attorneys retained to fend

health care practitioners in these lawsuits should remain abreast of these rapidly changing circumstances.

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