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**FEDERAL HEALTH INSURANCE MANDATES  
AND THE IMPENDING UPHEAVAL OF  
THE COLLATERAL SOURCE RULE**

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# TABLE OF CONTENTS

|  |     |
|--|-----|
| ABOUT WLF’S LEGAL STUDIES DIVISION.....  | ii  |
| ABOUT THE AUTHORS.....   | iii |
| INTRODUCTION.....  | 1   |
| I. THE COLLATERAL SOURCE RULE: COMMON LAW AND (SOMETIMES) STATUTORY .....  | 2   |
| A. The Substantive Rationale for the Rule .....  | 2   |
| B. The Evidentiary Component of the Rule .....   | 4   |
| II. THE IMPACT OF THE ACA ON THE RULE AND THE SUBROGATION RIGHTS<br>OF COLLATERAL SOURCES.....   | 5   |
| A. Overview of the ACA.....  | 5   |
| B. The ACA Undermines the Rule’s Traditional Justifications.....   | 6   |
| C. The ACA Undermines Current Law Governing Subrogation Claims .....   | 7   |
| 1. Subrogation and reimbursement rights and those who may assert<br>them .....   | 7   |
| 2. The impact of abolishing the collateral source rule on subrogation<br>claims.....   | 10  |
| III. THE ACA’S LIKELY IMPACT ON THE AMOUNT OF RECOVERABLE TORT DAMAGES.....  | 12  |
| A. The <i>Howell</i> Decision: Recovery for Past Medical Expenses Cannot Exceed<br>the Amount Accepted as Full Payment by a Service Provider ..... | 12  |
| B. The <i>Corenbaum</i> Decision: Applying <i>Howell</i> ’s Rationale to Future<br>Medical-expense Recovery .....                                  | 16  |
| C. Medical-expense Recovery under the ACA .....  | 16  |
| IV. PRACTICE POINTERS .....  | 18  |
| CONCLUSION.....  | 19  |

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# FEDERAL HEALTH INSURANCE MANDATES AND THE IMPENDING UPHEAVAL OF THE COLLATERAL SOURCE RULE

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## INTRODUCTION

The Patient Protection and Affordable Care Act (ACA) has caused a national upheaval in the way healthcare services are provided and paid for in America. It also may cause the upheaval of a long-standing legal principle—the collateral source rule. This CONTEMPORARY LEGAL NOTE explores how the ACA may impact the collateral source rule, subrogation rights, and the recovery of medical-expense damages by a plaintiff.

As explained herein, the ACA undermines traditional justifications for the collateral source rule and requires reevaluation of that rule, at least in cases involving medical-expense damages. To account for these changes under the ACA, federal legislation may be required to curtail or eliminate subrogation claims based on collateral source payments for health services. Such legislation would be consistent with ACA's goal of spreading the cost of health care as widely and evenly as possible, and the sound public policy of minimizing the cost of liability insurance supports it.

The ACA bolsters recent appellate decisions from California limiting tort damages for past and future medical-expense damages. These decisions, the ACA, and the doctrine of avoidable consequences can be used in harmony to ensure that tort damages for past and future medical-expense damages do not exceed the cost of medical care.

# I. THE COLLATERAL SOURCE RULE: COMMON LAW AND (SOMETIMES) STATUTORY

## A. The Substantive Rationale for the Rule

Under the collateral source rule, benefits that the injured party receives from a source independent of the tortfeasor do not diminish the recovery of damages against that tortfeasor.<sup>1</sup> It is the “prevailing rule” in the United States and is recognized by the “vast majority of courts.”<sup>2</sup>

However, the rule has also been “one of the more controversial . . . in the law of damages.”<sup>3</sup> Many legal commentators have criticized the rule and “called for its early demise,”<sup>4</sup> because it is “at odds with the compensatory purpose of tort liability.”<sup>5</sup> It is an “exception” to the ordinary “rule of universal application in a tort action, that the measure of damages is [limited to] that which will compensate and make the plaintiff whole.”<sup>6</sup>

As a result, legislatures in a number of states have abrogated or limited the rule, particularly in medical malpractice actions. But courts have divided on the constitutionality of these reform efforts.<sup>7</sup>

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<sup>1</sup> *E.g.*, *Arthur v. Catour*, 833 N.E.2d 847, 851 (Ill. 2005); *Helfend v. S. Cal. Rapid Transit Dist.*, 465 P.2d 61, 63 (Cal. 1970); RESTATEMENT (SECOND) OF TORTS § 920A(2) (1979).

<sup>2</sup> *Standard Oil Co. v. United States*, 153 F.2d 958, 963 (9th Cir. 1946), *aff'd*, 332 U.S. 301 (1947); *Mitchell v. Haldar*, 883 A.2d 32, 38 (Del. 2005).

<sup>3</sup> LELAND M. JOHNS, CALIFORNIA DAMAGES: LAW AND PROOF § 1.60 at 1-82.5 (5th ed. 2014).

<sup>4</sup> *Helfend*, 465 P.2d at 63-64.

<sup>5</sup> *Sweep v. Lear Jet Corp.*, 412 F.2d 457, 459 (5th Cir. 1969).

<sup>6</sup> *Pryor v. Webber*, 263 N.E.2d 235, 238 (Ohio 1970).

<sup>7</sup> *See Lagerstrom v. Myrtle Werth Hosp.-Mayo Health Sys.*, 700 N.W.2d 201, 208 n.8 (Wis. 2005); *Marsh v. Green*, 782 So. 2d 223, 230-31 (Ala. 2000) (constitutional); *Barme v. Wood*, 689 P.2d 446, 447, 449 n.5 (Cal. 1984) (“The purpose of [the legislative enactment] has generally been viewed as an attempt to eliminate the so-called ‘double recovery’ obtained by plaintiffs who have their medical expenses paid by their own health insurance and still obtain damages for such expenses from defendant tortfeasors.”); *Pinillos v. Cedars of Lebanon Hosp. Corp.*, 403 So. 2d 365, 368 (Fla. 1981) (constitutional); *Rudolph v. Iowa Methodist Med. Ctr.*, 293 N.W.2d 550, 559 (Iowa 1980) (same); *Eastin v. Broomfield*, 570 P.2d 744, 752 (Ariz. 1977) (same); *O’Bryan v. Hedgespeth*, 892

Courts have posited three major rationales for the collateral source rule. First, the rule purportedly avoids a windfall to the tortfeasor. One court explained, “[i]f 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.”<sup>8</sup>

Second, courts reason that “a person who has invested years of insurance premiums to assure his medical care should receive the benefits of his thrift. The tortfeasor should not garner the benefits of his victim’s providence.”<sup>9</sup> This rationale is sometimes restated as promoting investment in insurance.<sup>10</sup>

Third, courts consider the interplay between the jury’s evaluation of general damages and evidence of the collateral source benefit. Under this rationale, courts

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S.W.2d 571, 578 (Ky. 1995) (unconstitutional) (“Those plaintiffs receiving collateral source payments cannot have their tort remedy denied as punishment for their prudence in obtaining insurance coverage.”); *Denton v. Con-Way S. Exp., Inc.*, 402 S.E.2d 269, 272 (Ga. 1991) (unconstitutional), disapproved on other grounds by *Grissom v. Gleason*, 418 S.E.2d 27 (Ga. 1992); *Farley v. Engelken*, 740 P.2d 1058, 1068 (Kan. 1987) (same); *Carson v. Maurer*, 424 A.2d 825, 836 (N.H. 1980) (same), overruled on other grounds by *Cnty. Res. for Justice, Inc. v. City of Manchester*, 917 A.2d 707 (N.H. 2007).

<sup>8</sup> *McConal Aviation, Inc. v. Commercial Aviation Ins. Co.*, 799 P.2d 133, 139 (N.M. 1990) (quoting *Grayson v. Williams*, 256 F.2d 61, 65 (10th Cir. 1958)); see also, e.g., *Kenney v. Liston*, 760 S.E.2d 434, 445 (W. Va. 2014) (“Because the law must sanction one windfall and deny the other, it favors the victim of the wrong rather than the wrongdoer.” (emphasis omitted)); *Papke v. Harbert*, 738 N.W.2d 510, 531 (S.D. 2007); *Bynum v. Magno*, 101 P.3d 1149, 1154 (Haw. 2004); *Acuar v. Letourneau*, 531 S.E.2d 316, 323 (Va. 2000); *Montgomery Ward & Co. v. Anderson*, 976 S.W.2d 382, 384 (Ark. 1998); *O’Bryan*, 892 S.W.2d at 576; RESTATEMENT (SECOND) OF TORTS § 920A(2) & com. b.

<sup>9</sup> *Helfend*, 465 P.2d at 66; accord *Johnson v. Cenac Towing, Inc.*, 544 F.3d 296, 305 (5th Cir. 2008); *Kenney*, 760 S.E.2d at 441; *Haygood v. De Escabedo*, 356 S.W.3d 390, 395 (Tex. 2012); *Wills v. Foster*, 892 N.E.2d 1018, 1021 (Ill. 2008); *Windsor Sch. Dist. v. State*, 956 A.2d 528, 542 (Vt. 2008); *Bozeman v. State*, 879 So. 2d 692, 698 (La. 2004); *In re W.B. Easton Constr. Co.*, 463 S.E.2d 317, 318 (S.C. 1995) (Plaintiff’s “foresight in obtaining the ‘insurance’ of a guaranty agreement should not benefit [defendants].”).

<sup>10</sup> *Bozeman*, 879 So. 2d at 704 (“The collateral source rule expresses a policy judgment in favor of encouraging citizens to purchase and maintain insurance.”); accord *Helfend*, 465 P.2d at 66; *Campbell v. Sutliff*, 214 N.W. 374, 376 (Wis. 1927) (“The sums paid for such insurance are in the nature of an investment, which, like other investments made by the plaintiff, ought not to inure to the benefit of the defendant.”), overruled on other grounds by *Powers v. Allstate Ins. Co.*, 102 N.W.2d 393, 400 (Wis. 1960).

exclude evidence of collateral source benefits because it could lead the jury to discount the plaintiff's pain and suffering. "[T]he cost of medical care often provides both attorneys and juries in tort cases with an important measure for assessing the plaintiff's general damages."<sup>11</sup>

Two additional rationales are worth noting, if only for the purpose of quickly discounting them. Some courts have justified the collateral source rule on the ground that its tendency to overcompensate the plaintiff counterbalances the plaintiff's inability to recover attorneys' fees.<sup>12</sup> But this is more a critique of the American rule, which requires that each party bear its own attorneys' fees, than a justification for the collateral source rule.<sup>13</sup> Also this rationale is circular. The truism that a tortfeasor should bear the cost of its own conduct sheds no light on the calculation of that cost.

## **B. The Evidentiary Component of the Rule**

The collateral source rule also has an evidentiary component. To prevent the jury from reducing the injured party's damages by the amount of the collateral source payments, courts generally exclude evidence of those payments.<sup>14</sup>

However, a number of courts acknowledge that evidence of collateral source payments can be admitted under appropriate circumstances.<sup>15</sup> For example, the

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<sup>11</sup> *Helfend*, 465 P.2d at 68; accord *John Munic Enters., Inc. v. Laos*, 326 P.3d 279, 284 (Ariz. Ct. App. 2014) ("[T]he collateral source rule . . . aid[s] the jury in the computation of damages.").

<sup>12</sup> *Helfend*, 465 P.2d at 68-69; accord *John Munic Enters.*, 326 P.3d at 284 ("[T]he collateral source rule . . . better approximat[es] full compensation to victims by allowing victims a larger pool of funds from which to pay their attorneys.").

<sup>13</sup> *Cf. Trope v. Katz*, 902 P.2d 259, 262-63 (Cal. 1995). Other courts have mentioned the benefit of ensuring that "tortfeasors bear the costs of their own conduct." *Johnson*, 544 F.3d at 304-05; see *Leitinger v. DBart, Inc.*, 736 N.W.2d 1, 10 (Wis. 2007).

<sup>14</sup> *Eichel v. N.Y. Cent. R.R.*, 375 U.S. 253, 255 (1963) ("[T]he likelihood of misuse by the jury clearly outweighs the value of this evidence."); *Tri-County Equip. & Leasing, LLC v. Klinke*, 286 P.3d 593, 595 (Nev. 2012) ("[T]his court has adopted 'a *per se* rule barring the admission of a collateral source of payment for an injury into evidence for any purpose.'").

<sup>15</sup> *E.g., Corsetti v. Stone Co.*, 483 N.E.2d 793, 802 (Mass. 1985); *Evans v. Wilson*, 650 S.W.2d 569, 570 (Ark. 1983); *Hrnjak v. Graymar, Inc.*, 484 P.2d 599, 602 (Cal. 1971); *Kainer v. Walker*, 377

California Supreme Court has held that evidence of the plaintiff's receipt of collateral insurance benefits is admissible upon a "persuasive showing" that it "is of substantial probative value" on an issue such as malingering.<sup>16</sup> In Massachusetts, such evidence is admissible, at the discretion of the trial judge, "as probative of a relevant proposition, say "control" or credibility of a particular witness."<sup>17</sup>

## **II. THE IMPACT OF THE ACA ON THE RULE AND THE SUBROGATION RIGHTS OF COLLATERAL SOURCES**

### **A. Overview of the ACA**

Congress enacted the ACA in 2010. The ACA seeks to ensure that everyone in the United States has health insurance regardless of their health condition or financial situation. It attempts to accomplish this by: (1) imposing an individual mandate that requires every applicable individual to obtain minimum essential coverage or pay a penalty; (2) creating the guaranteed-issue and community-rating requirements that prohibit insurance companies from denying coverage to individuals with preexisting health conditions or charging higher rates to individuals based on their medical history; (3) providing for the creation of state-operated health benefit exchanges where individuals can obtain coverage; (4) setting minimal essential coverage standards and establishing four levels of coverage for plans sold on the state exchanges (bronze, silver, gold, and platinum); and (5) limiting the annual out-of-pocket medical expenses that can be incurred by insured patients to \$5,950 per individual and \$11,900 per family.<sup>18</sup>

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S.W.2d 613, 617 (Tex. 1964), overruled on other grounds by *Burk Royalty Co. v. Walls*, 616 S.W.2d 911 (Tex. 1981).

<sup>16</sup> *Hrnjak*, 484 P.2d at 733.

<sup>17</sup> *Corsetti*, 483 N.E.2d at 802 (emphasis omitted).

<sup>18</sup> See 26 U.S.C. § 5000A; 42 U.S.C. §§ 300gg, 300gg-1, 300gg-3, 300gg-4, 18022, 18031, 18041.

As explained below, several of these key provisions of the ACA undermine traditional justifications for both the substantive and evidentiary aspects of the collateral source rule.

## **B. The ACA Undermines the Rule’s Traditional Justifications**

As a result of the ACA, procuring health insurance for the care of an injured plaintiff is no longer a matter of a plaintiff’s foresight, investment, or prudence. It is instead mandated by federal law.<sup>19</sup>

Moreover, the ACA seeks to control healthcare costs, in part, by spreading the cost as widely as possible through the mandate that everyone either purchase at least a “minimum essential coverage” plan or pay a penalty. Thus, under the ACA, *everyone* (including the young and the healthy) is supposed to purchase insurance, which will help to subsidize the cost of providing healthcare services to those who have the greatest need for those services—and who are not paying larger premiums to cover the higher cost associated with treating their preexisting conditions. In light of these circumstances, the justification for the collateral source rule of preventing a “windfall” to tortfeasors no longer holds up because tortfeasors, like everyone else, have been and will continue paying premiums that contribute to subsidizing the cost of caring for tort victims.

The ACA’s role in spreading healthcare cost may also mean that liability insurance should not be used for the same purpose. In general, the only tortfeasors who are in a position to pay large damages awards are those who had the foresight and prudence to purchase liability insurance. Requiring tortfeasors to pay for a plaintiff’s medical expenses even if they are covered by plaintiff’s health insurer shifts healthcare expenses from medical to liability insurers. But if the goal is to spread the cost of health care as widely and evenly as possible, the ACA already accomplishes that goal. Shifting part of that cost to tortfeasors does not make that cost go away; it

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<sup>19</sup> 26 U.S.C. § 5000A; see generally H. Thomas Watson, *PPAC and Its Possible Effects on Medical Expense Tort Damages*, MED. MALPRACTICE L. & STRATEGY, Oct. 2011, at 1-2.

simply makes a particular subsection of society (those who purchase liability insurance) responsible for a greater portion of that cost. Although that might reduce the cost of healthcare a little for everyone else, it increases the cost of liability insurance, which covers the defendant's liability for all of tort victims' losses, including property damage, lost income, lost earnings capacity, and other expenses. Shifting the cost of health care to liability insurers thus seems at odds with the ACA and potentially undermines the public policy goal of keeping liability insurance affordable so as to maximize the opportunity for tort victims to be completely compensated for all of their losses—especially since their medical expenses are already covered by health insurance.

For these reasons, courts should consider abolishing or modifying the collateral source rule in states where it exists under common law, and legislatures should consider doing the same in jurisdictions that have enacted statutory versions of the rule. To accomplish such a change, the law regarding subrogation will likewise need to be modified, as explained below.

### **C. The ACA Also Undermines Current Law Governing Subrogation Claims**

#### **1. Subrogation and reimbursement rights and those who may assert them**

As the Wisconsin Supreme Court explained in *Weborg v. Jenny*,<sup>20</sup> “[t]he collateral source rule ordinarily works in tandem with the legal principle of subrogation. . . . In either case, the policy goals are the same: subrogation helps to ensure that the loss is ultimately placed upon the tortfeasor and prevents the injured party from being unjustly enriched through a double recovery, *i.e.*, recovery from both the subrogated party and the tortfeasor.” But, with the enactment of the ACA, these policy goals are in flux—both for the collateral source rule *and* for subrogation. Shifting the cost of health care to tortfeasors may no longer be sound public policy.

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<sup>20</sup> 816 N.W.2d 191, 201-02 (Wis. 2012).

Collateral sources generally have a right of subrogation or reimbursement in connection with claims against a tortfeasor.<sup>21</sup> That right to seek subrogation or reimbursement from the plaintiff's tort recovery has a checkered history.<sup>22</sup> At common law, the "made whole" doctrine prohibited equitable subrogation unless the victim's loss was completely indemnified.<sup>23</sup> Courts later accepted and enforced express contractual subrogation and reimbursement rights, but continued to apply the "made whole" doctrine, together with the "common fund" doctrine that ensured the party seeking subrogation and/or reimbursement paid a fair share of the plaintiff's attorneys' fees.<sup>24</sup> Insurers then attempted to work around the equitable "made whole" and "common fund" doctrines by contracting for "first dollar" subrogation rights, which purported to create in them a senior claim on any portion of the plaintiff's recovery. The extent to which these first dollar provisions are enforced varies from jurisdiction to jurisdiction.<sup>25</sup>

In addition to contractual subrogation, equitable subrogation claims are also significant. Professors Maher and Pathak assert that the ERISA (Employment Retirement Income Security Act) subrogation law is of primary importance in this context because "ERISA regulates all private employer-provided health plans in America, and the majority of Americans with private health insurance receive it pursuant to an employer-provided plan. . . . ERISA imposes substantive rights and obligations on all those involved with employer-provided health care [and] . . . addresses the remedies, such as subrogation, that insurers (plan fiduciaries) may

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<sup>21</sup> *Weborg*, 816 N.W.2d at 201-02; *Helfend*, 465 P.2d at 67.

<sup>22</sup> See Brendan S. Maher & Radha A. Pathak, *Understanding and Problematizing Contractual Tort Subrogation*, 40 LOY. U. CHI. L. J. 49, 59-83 (2008).

<sup>23</sup> *Id.* at 63-65.

<sup>24</sup> *Id.* at 74-75.

<sup>25</sup> *E.g.*, *Blue Cross & Blue Shield of Neb., Inc. v. Dailey*, 687 N.W.2d 689, 699-700 (Neb. 2004) (majority opinion refusing to enforce first dollar subrogation clause); *id.* at 703-04 (Stephan, J., dissenting) (dissent citing jurisdictions enforcing first dollar subrogation rights).

assert against insureds (participants and beneficiaries). Thus, for the millions of working Americans who receive health coverage through their employers, the question of tort subrogation necessarily implicates ERISA.”<sup>26</sup>

Under ERISA, a fiduciary, such as a health insurer, may bring a civil action “to obtain . . . appropriate equitable relief . . . to enforce . . . the terms of the plan.”<sup>27</sup> This provision authorizes only “those categories of relief that were *typically* available in equity;” it does not authorize claims that seek “nothing other than compensatory *damages*.”<sup>28</sup> Recently, the Supreme Court held that the terms of the ERISA insurance plan, not unjust enrichment or other equitable principles, govern a plan administrator’s action to enforce an equitable lien and that the common fund doctrine informs the court’s interpretation of a plan’s reimbursement provision and provides the appropriate default rule where a plan is silent on the allocation of attorneys’ fees.<sup>29</sup>

Health insurers are not the only entities who may assert subrogation and reimbursement claims. Some healthcare providers may render services on a lien basis and seek recovery of their fees from the plaintiff’s tort recovery. However, because health insurance is now available to everyone as a matter of federal law, and because (as we explain below) the plaintiff’s duty to mitigate damages should limit recovery of damages to the amount accepted by healthcare providers under negotiated health services agreements, lien claims by providers are expected to diminish greatly over time.

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<sup>26</sup> Maher & Pathak, *supra* note 23, at 77-78.

<sup>27</sup> 29 U.S.C. § 1132(a)(3).

<sup>28</sup> *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 255, 256 (1983) (emphasis in original).

<sup>29</sup> *US Airways, Inc. v. McCutchen*, 133 S. Ct. 1537, 1542-43, 1547-51 & n.8 (2013).

Finally, government agencies that provide healthcare services likewise may seek reimbursement from the plaintiff's tort recovery, with their right to do so being governed by a host of statutes and regulations.<sup>30</sup>

## **2. The impact on abolishing the collateral source rule on subrogation claims**

The collateral source rule could be abolished in whole or just as to its evidentiary aspect. If the rule were abolished entirely, a plaintiff would not be able to recover from a tortfeasor expenses paid by a collateral source. If only the evidentiary component of the rule were eliminated, a plaintiff could still potentially recover damages that have already been paid by a collateral source, but the jury would be informed of that collateral source payment and might not award damages previously paid by a collateral source.

There are two possible means for handling subrogation, depending on how much of the collateral source rule is abolished. If the collateral source rule is completely abolished, then subrogation and reimbursement claims by collateral sources should be barred as well. This would prevent a plaintiff from having to reimburse collateral sources from funds that were intended to pay for damages other than those paid by the collateral source. In this circumstance, the cost of health care would be spread among all consumers of health care and their healthcare insurers, rather than shifting some of those costs to tortfeasors' liability insurers.

For example, § 3333.1(b) of the California Civil Code eliminates the right of subrogation for any collateral source benefits introduced into evidence during a medical malpractice trial, on the theory that the jury will not award plaintiff medical expenses which have been paid by a collateral source. Currently, however, this state law is preempted by contrary federal laws that provide subrogation rights for

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<sup>30</sup> See Deborah Tussey, *Personal Injury Recovery as Affecting Eligibility for, or Duty to Reimburse, Public Welfare Assistance*, 80 A.L.R.3d 772, Parts III & IV (1977).

Medicare, Medi-Cal, and other federal benefits (and, as a result, California courts exclude evidence of such collateral source benefits).<sup>31</sup>

Accordingly, a federal law similar to § 3333.1 of the California Civil Code would need to be enacted. Indeed, because the ACA has greatly expanded the reach of Medicare, and may result in many employers canceling group insurance plans covered by ERISA in favor of employee-selected plans purchased from the exchanges that are not covered by ERISA, such federal legislation may be critical. This is because these federal benefits carry with them a right to seek subrogation under federal law, and no state law can affect that federal subrogation right. The current version of the ACA does not directly address this issue (as enacted, the ACA has nearly half a million words but fails to mention “subrogation” at all), but that may change.

If only the evidentiary aspect of the collateral source rule is abolished and juries are accordingly informed that some of the damages the plaintiff is seeking have already been paid by a collateral source, then subrogation could be permitted provided the court instructs the jury regarding plaintiff’s reimbursement obligation. This instruction would ensure that the plaintiff does not suffer a double deduction (*i.e.*, no award for medical expenses paid by a collateral source, yet an obligation to reimburse the collateral source for those expenses). In addition, both parties should be allowed to present evidence regarding the extent to which a tort recovery might affect future eligibility for public welfare benefits.

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<sup>31</sup> See *Barme v. Wood*, 689 P.2d 446, 449 n.6 (Cal. 1984); *Brown v. Stewart*, 181 Cal. Rptr. 112, 119-20 (Cal. Ct. App. 1982).

### III. THE ACA'S LIKELY IMPACT ON THE AMOUNT OF RECOVERABLE TORT DAMAGES

#### A. The *Howell* Decision: Recovery for Past Medical Expenses Cannot Exceed the Amount Accepted as Full Payment by a Service Provider

Plaintiffs who prevail in personal injury actions are generally allowed to recover the reasonable value of their necessary medical treatments as special damages.<sup>32</sup> Several California appellate decisions inform how the ACA may affect the calculation of the “reasonable value” of medical expenses.<sup>33</sup>

In *Howell v. Hamilton Meats & Provisions, Inc.*,<sup>34</sup> the California Supreme Court addressed the issue of *past* medical-expense damages, holding that “bills” issued by medical service providers (*e.g.*, based on “chargemaster” schedules) do *not* reflect “reasonable value” because they grossly exceed what providers actually accept as full payment.<sup>35</sup> The court then held that “a [California] personal injury plaintiff may recover *the lesser* of (a) the amount actually paid or incurred for medical services, and (b) the reasonable value of the services.”<sup>36</sup> The amount actually incurred serves as a cap on a plaintiff’s recovery; “‘reasonable value’ is a term of limitation, not of aggrandizement.”<sup>37</sup>

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<sup>32</sup> See RESTATEMENT (SECOND) OF TORTS §§ 904, 924(c) & cmt. *f* (1979).

<sup>33</sup> See generally Robert H. Wright & Steven S. Fleischman, *The Effect of Howell on Personal Injury Medical Cost Recovery*, L.A. LAW., Oct. 2014, at 16-19.

<sup>34</sup> 257 P.3d 1130 (Cal. 2011).

<sup>35</sup> *Id.* at 1141-42 (“Hospital bills have been called ‘insincere, in the sense that they would yield truly enormous profits if those prices were actually paid.’”); see, *e.g.*, *Luttrell v. Island Pac. Supermarkets, Inc.*, 155 Cal. Rptr. 3d 273, 275 (Cal. Ct. App. 2013) (\$690,548 billed, but an amount five times lower (\$138,082) accepted as full payment); *Nishihama v. City & Cnty. of S.F.*, 112 Cal. Rptr. 2d 861, 866-68 (Cal. Ct. App. 2001) (\$17,168 in damages at billed rate reduced to an amount five times lower (\$3,600) and accepted as full payment).

<sup>36</sup> *Howell*, 257 P.3d at 1138.

<sup>37</sup> *Hanif v. Hous. Auth.*, 246 Cal. Rptr. 192, 195 (Cal. Ct. App. 1998).

“Reasonable market value, or fair market value, is the price that “a willing buyer would pay to a willing seller, neither being under compulsion to buy or sell, and both having full knowledge of all pertinent facts.”<sup>38</sup> “The scope of the rates accepted by or paid to [a medical service provider] by other payors indicates the value of the services in the marketplace. From that evidence, along with evidence of any other factors that are relevant to the situation, the trier of fact can determine the reasonable value of the particular services that were provided, *i.e.*, the price that a willing buyer will pay and a willing seller will accept in an arm’s length transaction.”<sup>39</sup> “[R]elevant evidence of the reasonable/market value of the services provided includes the full range of fees that [a provider] both charges and accepts as payment.”<sup>40</sup> “All rates that are the result of contract or negotiation, including rates paid by government payors, are relevant to the determination of reasonable value. In other words, . . . rates are relevant if they reflect a willing buyer and a willing seller negotiating at arm’s length.”<sup>41</sup>

The *Howell* court explained why its holding did not implicate the collateral source rule. The court explained that “[m]edical providers that agree to accept discounted payments by managed care organizations or other health insurers as full payment for a patient’s care do so not as a gift to the patient or insurer, but for commercial reasons and as a result of negotiations.”<sup>42</sup> Moreover, the fact “[t]hat plaintiffs are not permitted to recover undiscounted amounts from those who have injured them creates no danger these negotiations and agreements will disappear; the medical provider has no financial reason to care whether the tortfeasor is

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<sup>38</sup> *Children’s Hosp. Cent. Cal. v. Blue Cross of Cal.*, 172 Cal. Rptr. 3d 861, 872 (Cal. Ct. App. 2014); *accord Howell*, 257 P.3d at 1142 (“How a market value other than that produced by negotiation between the insurer and the provider could be identified is unclear.”).

<sup>39</sup> *Children’s Hosp.*, 172 Cal. Rptr. 3d at 873.

<sup>40</sup> *Id.* at 873-74.

<sup>41</sup> *Id.* at 875.

<sup>42</sup> *Howell*, 257 P.3d at 1139.

charged with or the plaintiff recovers the negotiated rate differential. Having agreed to accept the negotiated amount as full payment, a provider may not recover any difference between that and the billed amount through a lien on the tort recovery.”<sup>43</sup>

The *Howell* court further explained that the amount of the write-off does not constitute a gratuitous benefit the plaintiff is entitled to recover under the collateral source rule. When the medical provider has agreed, in advance of treating the plaintiff, to accept a certain amount as payment for its services, “[t]hat amount constitutes the provider’s price, which the plaintiff and health insurer are obligated to pay without any write-off. There is no need to determine a reasonable value of the services, as there is in the case of services gratuitously provided. ‘[W]here, as here, the exact amount of expenses has been established by contract and those expenses have been satisfied, there is no longer any issue as to the amount of expenses for which the plaintiff will be liable. In the latter case, the injured party should be limited to recovering the amount paid for the medical services.’”<sup>44</sup>

Finally, the *Howell* court held that a plaintiff is not entitled to recover as a collateral source benefit the “negotiated rate differential” between the amount billed and the amount accepted as payment in full for healthcare services.<sup>45</sup> As the court explained, “[t]he [collateral source] rule does not speak to losses or liabilities the plaintiff did not incur and would not otherwise be entitled to recover.”<sup>46</sup> “Certainly, the collateral source rule should not extend so far as to permit recovery for sums neither the plaintiff nor any collateral source will ever be obligated to pay.”<sup>47</sup>

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<sup>43</sup> *Id.* at 1140.

<sup>44</sup> *Id.* at 1140-41.

<sup>45</sup> *Id.* at 1143 (“Having never incurred the full bill, plaintiff could not recover it in damages for economic loss. For this reason alone, the collateral source rule would be inapplicable.”).

<sup>46</sup> *Id.*

<sup>47</sup> *Id.* (citation omitted).

The *Howell* court held that the amount of the negotiated discount was not itself a collateral source benefit that the plaintiff could recover because that discount “is not primarily a benefit to the plaintiff and, to the extent it does benefit the plaintiff, it is not provided as ‘compensation for [the plaintiff’s] injuries.’”<sup>48</sup> The court explained that “[i]nsurers and medical providers negotiate rates in pursuit of their *own* business interests . . . . [S]ellers in almost any industry may, for a variety of reasons, discount their prices for particular buyers, ‘[b]ut a *discounted price is not a payment*. . . . Nor has the value of damages the plaintiff *avoided* ever been the measure of tort recovery.’ And even when the overall savings a health insurance organization negotiates for itself can be said to benefit an insured indirectly—through lower premiums or copayments, for example—it would be rare that these indirect benefits would coincidentally equal the negotiated rate differential for the medical services rendered the plaintiff.”<sup>49</sup>

For these (and other) reasons, the *Howell* court concluded that “the negotiated rate differential is not a collateral payment or benefit subject to the collateral source rule.”<sup>50</sup> However, the court also recognized that some courts in other jurisdictions had reached a different conclusion.<sup>51</sup> Those jurisdictions ought to reconsider the application of the collateral source rule to medical-expense damages, in light of both the ACA (which undermines the traditional justification for the collateral source rule) and *Howell* (because the logic of the *Howell* decision is forceful and persuasive).<sup>52</sup>

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<sup>48</sup> *Id.*

<sup>49</sup> *Id.* at 1143-44 (first and second emphasis added).

<sup>50</sup> *Id.* at 1144.

<sup>51</sup> *Id.* at 1145 n.10.

<sup>52</sup> See also *Haygood v. De Escabedo*, 356 S.W.3d 390, 391, 392-96, 399-400 (Tx. 2012).

## **B. The *Corenbaum* Decision: Applying *Howell*'s Rationale to Future Medical-expense Recovery**

In *Corenbaum v. Lampkin*,<sup>53</sup> an intermediate California Court of Appeal extended the Supreme Court's holding in *Howell* to the recovery of *future* medical-expense damages. The court held that, because "the full amount billed is not an accurate measure of the value of medical services," the "full amount billed for past medical services is not relevant to a determination of the reasonable value of future medical services."<sup>54</sup> For the same reasons, *Corenbaum* precludes expert witnesses from relying on the inflated "full amount billed" to support opinions regarding future medical expenses. Evidence of "billed" amounts "*cannot support an expert opinion on the reasonable value of future medical services.*"<sup>55</sup> *Corenbaum* summarized the applicable rule in no uncertain terms: "[W]e conclude that *evidence of the full amounts billed for [the plaintiffs'] medical care was not relevant to the amount of [the plaintiffs'] damages for past medical expenses, future medical expenses or noneconomic damages . . . .*"<sup>56</sup>

## **C. Medical-expense Recovery under the ACA**

Under the ACA, health insurance is available to everyone, regardless of any preexisting condition (such as an injury caused by the tort of another),<sup>57</sup> and most people are required to maintain health insurance for all essential services or pay a penalty if they elect not to do so.<sup>58</sup> Moreover, pursuant to the doctrine of avoidable consequences (*i.e.*, mitigation of damages), defendants should not be required to pay medical-expense damages that a plaintiff reasonably could have avoided. Under that

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<sup>53</sup> 156 Cal. Rptr. 3d 347 (Cal. Ct. App. 2013).

<sup>54</sup> *Id.* at 363.

<sup>55</sup> *Id.* (emphasis added).

<sup>56</sup> *Id.* at 365 (emphasis added).

<sup>57</sup> 42 U.S.C. § 300gg-3.

<sup>58</sup> 26 U.S.C. § 5000A.

doctrine, plaintiffs may not recover damages that could have been avoided had they taken reasonable steps to minimize the loss caused by a defendant's actions.<sup>59</sup>

It follows that the reasonable value of a plaintiff's medical-expense damages should be the rate that would be accepted as full payment pursuant to a negotiated health services agreement (including Medicare). And it should be the *plaintiff's* burden to prove the reasonable value of his or her medical-expense damages, like every other element of the tort cause of action. In the event a plaintiff seeks to recover some inflated amount for medical-expense damages (such as the amount stated on a hospital bill that neither the plaintiff nor any collateral source will ever pay), the defense should be allowed to present evidence regarding the actual reasonable value of the medical care, and the court should instruct the jury that the plaintiff may not recover damages in excess of the lower reasonable value. In addition, the ACA's removal of pre-existing conditions as a bar to health-insurance coverage must be factored into future medical-expense damages. An injured, uninsured plaintiff, pursuant to the ACA, will be able to purchase and receive medical-expense payments from a health-insurance plan, and those payments must be taken into account for future damage estimates.

The ACA has drawn political criticism and legal challenges, and it may be modified by future legislation. Legislative decisions regarding changes to the collateral source rule and subrogation should be considered along with legislation making other potential changes to the ACA. But that does not affect how individual cases ought to be decided under existing law. Indeed, arguments that the continued existence of the ACA is in doubt should be disregarded. Courts must accept the law

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<sup>59</sup> RESTATEMENT (SECOND) TORTS § 918 (1979) ("One injured by the tort of another is not entitled to recover damages for any harm that he could have avoided by the use of reasonable effort or expenditure after the commission of the tort."); *Placer Cnty. Water Agency v. Hofman*, 211 Cal. Rptr. 894, 898 (Cal. Ct. App. 1985).

as it currently exists, and may not speculate about how existing law might change in the future when deciding litigation.<sup>60</sup>

#### IV. PRACTICE POINTERS

Defense attorneys handling personal injury cases must be prepared to assert and perfect arguments that the ACA has altered the justifications for the collateral source rule, especially in jurisdictions where the rule exists as a matter of common law. A few practical ways to do this are:

- File motions *in limine* asking the court to admit only evidence of medical care costs based on the amounts paid to healthcare providers pursuant to negotiated agreements with health insurers, Medicare, or other government agencies.
- Depose the plaintiff's life care plan expert, and other experts providing testimony regarding the cost of medical damages, to ascertain whether they are basing their opinions on amounts "billed" by healthcare providers, or the lower amounts "accepted" as payment in full by these providers pursuant to health services agreements with government agencies and/or health insurers.
- Retain defense experts who can testify, or prepare a declaration needed for an offer of proof, regarding likely future negotiated rates for the healthcare services the plaintiff claims to need.
- Propose jury instructions limiting the plaintiff's damages recovery to the amounts accepted as payment in full (and likely to be accepted as full payment in the future) rather than the higher amounts billed by healthcare providers.
- Object at trial to impermissible testimony regarding the amounts billed by healthcare providers or to ambiguous testimony that blurs the distinction between amounts billed and accepted as payment in full.
- To the extent a court rules adversely to the defense on issues related to medical-expense recovery, include questions on a special verdict form to facilitate showing prejudice from that ruling on appeal (for example, by asking questions which reveal the bases of the jury's calculations).

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<sup>60</sup> *Dist. of Columbia Court of Appeals v. Feldman*, 460 U.S. 462, 477 (1983); *Weldon v. Weldon*, 968 S.W.2d 515, 518 (Tex. App. 1998) ("A trial judge rules on a statute that is *in effect at the time of the case* and is not in the position of predicting future changes by the legislature." (emphasis added)).

## CONCLUSION

It is unlikely that Congress contemplated the collateral source rule when considering the Affordable Care Act. The law, and its requirement that all Americans purchase healthcare insurance, severely undermines traditional justifications for the rule, at least in cases involving medical-expense damages. The rule is in fact contrary to the ACA's policy goal of keeping liability insurance affordable. If a tortfeasor's insurer must provide windfall payments for an injured plaintiff's medical expenses, then the cost of insurance will increase. State courts and legislatures will have to address this unintended consequence of the ACA by abolishing or modifying the collateral source rule.

Such alteration or abolition of the rule will in turn impact the legal principle of subrogation. In the context of medical-expense damages, those entities that provide collateral sources of payment generally have a right of subrogation against a tortfeasor. If the collateral source rule is abolished, then subrogation claims should be barred as well. State legislatures would be unable to do this until Congress acts, because a federal law preempts state laws that do not provide subrogation to beneficiaries of government health plans, such as Medicare. If only the evidentiary aspect of the rule is abolished, courts will need to adjust what information is communicated to the jury prior to deciding on subrogation.

Even prior to the ACA's passage, courts in some states, such as California, were recalibrating the rules for future medical-expense damages. The upheaval caused by the ACA requires that this reassessment continues. Questions about the law's continued existence should not affect courts' rulings, nor should it deter tortfeasors from adjusting their arguments in personal injury cases where the collateral source rule is in effect.