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Will the *Affordable Care Act* and Tort Reform Render the Collateral Source Doctrine Obsolete in Resolving the Issue of Damages in Cases Involving Personal Injury and Life Care Planning?

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With the passage of the *Affordable Care Act* and the legal and legislative activity on tort reform on state-by-state collateral source rules, the professional specialty area of life care planning has been and will continue to be impacted by these developments. It remain to be seen how both state and federal courts (depending of individual state rules) will allow or disallow collateral source issues to be discussed before, during, or after court proceedings. Issues are discussed related to the implications for the life care planner including a discussion and summary of selected legal cases that already have been adjudicated in the courts. Life care planners need to take notice of these developments of tort reform on the rules on collateral sources and the various differences which exist by geographical jurisdictions.

In cases of civil action where liability against a tortfeasor has been clearly established, the focus shifts to issues related to the awarding of financial damages for the plaintiff. For decades, the collateral source doctrine has prevailed in civil cases with respect to damage awards (Matlock, 2013, see Apendix B). Namely, damage awards established through a pre-trial settlement, as a result of jury deliberations, or post-trial negotiations have precluded a tortfeasor from being relieved of a part of the damage award by shifting financial responsibility from the company (or entity) which was found liable to another source such as health insurance (see Appendix C). However, over the last decade, there have been three significant developments that have challenged, with growing success, the traditional rationale of the collateral source doctrine. The three developments (tort reform within states, more aggressive strategies by the defense to reduce awards, and the emergence of the *Affordable Care Act*) are discussed in succession with a further analysis of implications for life care planners within the forensic rehabilitation profession.

The Collateral Source Doctrine

As discussed by Field, Johnson, Choppa, and Fountaine (in press), the collateral source doctrine (rules) are designed to assure that the tortfeasor does not benefit by being able to reduce an award because an insurance company (or any other benefit source) paid, or is paying, some of the costs associated with an injury. More specifically,

> *As a rule of evidence, the collateral source rule bars the admission of evidence that the plaintiff received benefits from a third party as compensation for the loss. As a rule of damages, this doctrine prevents the trier of fact from reducing the plaintiff's damage amount by the amount of collateral benefits received from a third party (Warren & Mechler, 2009, p. 206).*

Any reduction of an award from any source (including private insurance, Medicaid or Medicare) would result in a benefit to the tortfeasor since they would be relieved of some degree of punishment for their liability in the case. On the other hand, a plaintiff would be benefitting (double-dipping) if a private insurance policy covered most of the medical expenses (espe-

cially pre-trial expenses) and they still received a damage award for all medical expenses – past and future. The collateral source rule emphasizing a full damage award to the plaintiff is also a prudent reminder that an employer, for example, needs to take specific action to reduce or eliminate any sources of liability within the workplace; any relief of damages would result in a less diligent effort by the employer to correct potential sources of hazard and danger to workers. However, in some venues like workers' compensation or Medicare, subrogation to these insurance sources is often a common occurrence.

The *Affordable Care Act*

The *Affordable Care Act* (ACA) was established by the U.S. Congress in 2010 and took effect on January 1, 2014. In spite of many legal challenges and objections from various quarters, the U.S. Supreme Court affirmed that the law was constitutional *(Thomas More Law Center, et al., v. Barack H. Obama, et al., Petition of Writ of Certiorari*, June 28, 2012). A second challenge *(King v. Burwell, US Ct Appl for the Fourth Cir. 14-1158, 2014)* to the ACA was decided before the U.S. Supreme Court which raised the issue of state verses federal exchanges. The central issue is whether the federal exchanges for insurance programs under ACA (available if the states refused to provide their own exchanges) will be allowed to continue as a means of providing tax credits for lower income people. If the tax credits (or subsidies) were disallowed with the federal exchanges, the ACA program would have been threatened in the 34 states that opted to not have their own state exchanges (in reference to the presence of four words which are at the center of the dispute – "established by the state"). Insurance companies providing insurance programs in the 34 states would probably would have raised premiums, and coupled with the loss of tax credits, many people would not have been able to afford to purchase the insurance policies in those states. The issue "[was] whether the Act's tax credits are available in states that have a Federal Exchange rather than a State Exchange" (*King v. Burwell*, 2015, p. 2).

Concurrently, and independent of the ruling by the U.S. Supreme Court in *King v. Burwell* (2015), the ACA seems to be on a collision course with the collateral source doctrine with regard to economic damages in personal injury and life care planning cases. Along with other collateral sources, i.e., Medicare, Medicaid, Veterans' benefits, private insurance, and so forth, ACA is a recent development that may effect the collateral source issue. While it may seem that the ACA is the foundation for securing health insurance, several have argued that the inception of the ACA in the mix of potential benefits may have some serious implications in terms of future damage settlements in cases of liability. For example, Moye and Moye (2013), both attorneys, suggest that ACA will become a new approach to loss allocation by citing the numerous differences in how individual states allow for damages in light of what is paid, or billed, or discounted, and the "reasonable expenses" to be established. Rather than relying on a "billing expert to establish reasonable expenses," the authors suggest that either the plaintiff or defense attorneys will "call upon life care planners to assist in this task – given the skills and expertise of such professionals" (pp. 69-70). Several others have also viewed the role of the life care planner within the coming of the *Affordable Care Act* era as a changing environment. Green and Neathery (2014) suggest that

> *Expert reports supporting life care plans are not yet taking into account the savings available under the ACA. The omission is substantial in terms of the actual value of any future medical expense needs and makes the reports unreliable under the standards set forth by the Federal Rules of Evidence 401, 402, and Daubert v. Merrill Dow Pharmaceuticals, Inc. (509 US 579, 1993) (p. 2).*

Green and Neathery (2014), both attorneys, further suggest that the ACA is not a collateral source with the strong suggestion that the ACA be utilized to mitigate damages in cases of personal injury. "States are increasingly abolishing the collateral source rule and limiting the introduction of evidence of incurred medical expense amounts . . . . the respondent has the right to expect that the injured person will take steps legally available (and indeed required) to mitigate his/her expenses" (p. 2). Within the context of the ACA, which currently is the law, pre-existing conditions do not prevent a person from obtaining insurance, and that would be insurance to mitigate the expenses of further medical expenses due to the injury as a result of the individual mandate.

Hindert (2014), a journalist in the field of structured settlements, examines the affect of ACA on the work product of the nurse life care planner. Noting that the position of the American Association of Nurse Life Care Planning is that the "*Affordable Care Act* is still being challenged and its full effect remains to be seen" (p. 37); never-the-less, Hindert suggests that the "ACA is expected to reduce health care costs and will likely require changes to traditional personal injury life care plans to account for the expanded availability of health insurance resulting from the individual mandate and the elimination of pre-existing restrictions (p. 740) (see also Note 1). A tentative conclusion presented by Hindert is that understanding how the ACA will affect the mitigation of damages will take time in terms of the calculation of medical damages, and will be complicated by the "state-specific changes [which are] unlikely to be uniform without additional federal legislation" (p. 740). While the future of life care planning consulting will be impacted by the ACA,

"new opportunities will almost certainly create new business – including previews of previous life care plans as well as life care plans for new cases" (p. 741).

Congdon-Hohman and Matheson (2013) suggest that as a result of the ACA, there will be a "new role or task of the life care planner"

> *Under the old health insurance laws, the task of the life care planner was to identify any medical and living expenses that are necessary for the victim but would not otherwise have been required in the absence of the accident. If governments legislate or courts hold that medical damages under the ACA can be capped as described, the life care planner also needs to specifically address which health care and living expenses would normally be covered by the minimum insurance requirements mandated by the ACA and which health expenditures would result in out-of-pocket costs to the plaintiff necessitating their inclusion in a damage award. (p. 157).*

Of course, the above comment is made by two economists who may not have an accurate reading on the changing role (if any) of the life care planner. It will be interesting to observe if their prediction comes true, especially in view of their quotation by Niels Bohr that "prediction is very difficult, especially about the future" (as cited in Congdon-Hohman & Matheson, p. 159).

The main tenants of the ACA include the national goal of all Americans having access to health insurance, preventing insurance companies from denying health coverage for a person based on a pre-existing condition, requiring large businesses to provide health insurance for employees, providing tax breaks to small businesses, allowing young adults to remain on their parent's plan through age 26, stopping insurance companies from dropping a person from health insurance when a person becomes sick or disabled, and expanding Medicaid coverage to millions in various states that choose to expand the Medicaid program. To date, over 16 million Americans now receive coverage under the ACA program. While the threat of the *King v. Burwell* case was real, the ACA, following an uncertain beginning of the program, appears to have become part of the government's repertoire of providing needed safety-net programs for U.S. citizens (along with Social Security, workers' compensation programs, Medicare and Medicaid, to name a few).

The collateral source doctrine, and the collateral source rules which vary from state-to-state, was established during a time when questions of damage allocation was not at issue. Beginning in the 1980s, tort reform within states persistently began to examine the assumptions related to the collateral source doctrine (Matlock, 2013). According to Hindert (2014), to date, 39 states have modified the collateral source rule for their respective state. Hipp and Lilling (n.d.) identified the major justifications for the common law rule as

> *(a) a means to promote deterrence by the tortfeasor,*
>
> *(b) by an enforcement of the fundamental collateral rule, the tortfeasor should pay for the consequences of the actions,*
>
> *(c) that the defendant should not receive a windfall resulting from a lesser degree of damages or no damages because of benefits being paid by a third party, and*
>
> *(d) because plaintiffs can be viewed unfavorably by a jury if the jury was aware of medical expenses and costs already being covered by a collateral source – in effect, double dipping (p. 1-2).*

Translated, Hipp and Lilling argue that:

> *The defendant then would only be responsible to reimburse the plaintiff for the premiums to maintain the policy (i.e., an insurance plan mandated by the ACA), annual increases in those premiums, and any other out-of-pocket expenses such as co-pays, deductibles or other expenses not covered by the insurance. (p. 3) (See also Daily & Huber for an summary of the rationale for the collateral source doctrine, 2014).*

However, Daily and Huber observe that:

> *ACA necessitates reconsideration of each of the rationales. The collateral source rule came about during a time when insurance was a rare luxury, not a necessity it is now. With the universal mandate and the standardization of insurance contracts, benefits and risk pools, the cost of a given medical service has and will become standardized. Thus, it cannot be said that the billed charge is the true cost of a medical service. By contrast, accounting for the amounts an insurance company actually paid is more equitable to both parties in a personal injury action and conforms to the status quo post-ACA. (p. 2-3).*

The ACA and Tort Reform on the Collateral Source Doctrine

The changing landscape relative to collateral source rules, as a result of both developing tort reform within states and the emergence of the ACA, is succinctly articulated by Hipp & Lilling (n.d.):

> *The enactment of the ACA arguably undermines some of the main arguments made in support of the common law collateral source rule. First, the ACA undermines the rationale that the common law collateral source rule was designed to hide from the jury whether the plaintiff has insurance. Now, given the individual mandate, most jurors will assume that the plaintiff has insurance. Thus, the ACA essentially eliminates the evidentiary*

purpose of the common law rule. And second, the common law collateral source rule was intended to serve as a deterrent and to prevent a windfall to the defendant. As such, defendants were required to pay the full amount billed by the medical provider for the plaintiff's care. Now, however, most people will have insurance and their insurance company will be billed at a reduced rate. (p. 2).

With the enactment of the ACA one obvious consequence by defense firms is to include the ACA as a collateral resource as a means of reducing future medical care awards (Fagel, 2014). Insurance companies will take an active part, along with the defense, to reduce medical costs to discounted rates based on actual costs for services and goods. The damage awards will be further reduced by three critical factors in establishing economic damage awards for the plaintiff:

(a) Pre-trial medical expenses. This factor is essentially a continuation of what currently exists. Pre-injury expenses, based on actual costs, are common place in damage awards.

(b) Health insurance premiums. Since the goal of the ACA is to provide insurance for all citizens of the United States, services and medical cost items would be covered by the plaintiff's individual insurance program (the individual mandate of the ACA). As noted by Fagel (2014) in two California cases, the *Howell v. Hamilton* Meats (2011) case "limits the plaintiff's recovery to the actual amount paid by their health insurance for their health insurance for past medical care costs" and *Carenbaum v. Lampkin* (2013) "appears to extend this limitation to future damages" (p. 1). According to Hipp and Lilling (n.d.), "defendants can argue that the plaintiff can reduce the amount of damages by purchasing an insurance policy. The defendant would only be responsible to reimburse the plaintiff for the premiums to maintain the policy, annual increases in those premiums and any other out-of-pocket expenses such as co-pays, deductibles, and other expenses not covered by insurance" (p. 3). Levin (2013) suggests that the damage award would include an estimate of a percentage of the premiums covered by a damage award based on the extent of the individual's disabling condition (or the extent to which the defendant is liable).

(c) Medicare reimbursement. Private insurance plans under ACA most probably will have the right to receive reimbursement for monies paid for goods and services once a settlement is reached. According to Fagel (2014), "Medicare's right to recover for future medical care costs paid now requires that a plaintiff establish a Medicare Set Aside Trust, specifically to protect Medicare's interest" (p. 3), and further argues that "the ACA effectively minimizes any damages for future medical care costs in all medical-malpractice cases" (p. 4). In fact, the *Bloomberg Business* blog (2015) recently reports about "the lawyer who invented a way to take cash from accident victims" by going after plaintiffs who received large damage awards and yet, were required, under the law, to return part of that award through subrogation to the appropriate collateral source. A staff of hundreds of professionals "scan billions of claims from insurers" resulting in a 20% profit of any funds subrogated to the insurer.

In an extensive analysis of the fate of the collateral source rule under the ACA health reform movement, Levin (2013) argues that the ACA weakens, if not eliminates, the traditional approach of reliance on the collateral source doctrine. Namely,

the rationale for collateral source rule is shifting as ACA comes into effect. What was a practical rule for calculating medical damages at a time when health insurance was rare is now neither logical nor workable in a world in which health insurance is mandatory. As the health insurance industry under goes massive changes, the way medical damages are calculated should likewise change. (p. 775).

The future of the collateral source doctrine is uncertain although significant changes are developing on a state-by-state basis (Matlock, 2013, see Appendix B). It is undeniable that tort reform is in the works as over 30 states have already moved from the strict application of the traditional doctrine. As Hindert suggests (2014), the future effect of the ACA is uncertain, although it is the view of many that the ACA will clearly have an impact on collateral adjustments to damage awards.

Future Medical Expenses

One of the major problems associated with a damage settlement under a revised ACA environment is that a current or future insurance policy may not be sufficient to cover all unforeseen future expenses. Yagerman and Bookman (2012) list a few of these limitations:

(a) A wide variety of policies are available with a wide range of premiums. It may be nearly impossible to predict what level of insurance will be needed and the ACA will only assure that "some" coverage will be available.

(b) One would need to account for policy changes year to year.

(c) Expensive permanent confinement issues are not covered (like long term care, nursing, home care, etc.) – the ACA is the legal foundation for health insurance, not disability insurance.

(d) Services like PT, OT, SLT are capped by most insurance companies.

(e) Out of pocket expenses. On occasion, and out of necessity, a plaintiff may spend money for medical goods and/or services out of pocket. Expenses of this nature are usually not covered by any settlement for future medical damages.

As often is the case with people with severe disabilities, future medical care complications will occur. In reaching a settlement post-trial on economic damages, relying solely on an insurance policy for future medical care and out-of-pocket expenses will surely not be sufficient. In addition to probable future medical complications, such as medical equipment, home modifications, and so forth, is the difficult task of estimating a person's life expectancy – especially a person with a significant disability. A situation such as this can be remedied by establishing an interest-bearing trust from a lump sum settlement (part of the damage award) which would cover probable and inevitable future expenses. Within the context of the ACA and tort reform, Yagerman and Bookman (n.d.) suggest that the "question that will be litigated in the coming months and years is whether it remains fair to continue to force the fiction upon the jury that future medical expenses projected by the plaintiff's life care plan will be paid 100% out-of-pocket, when in the post-ACA world, that will be the case for almost no one" (p. 2). Levin (2013) reinforces this possibility and concludes as follows:

The rationale for the collateral source rule is shifting as ACA comes into effect. What was a practical rule for calculating medical damages at a time when health insurance was rare is now neither logical nor workable in a world in which health insurance will soon be mandatory. As the health insurance industry undergoes massive changes, the way we calculate medical damages should likewise adapt (p. 775).

Subrogation, Mediation and Related Issues

The passage of the ACA, especially following the clarification of the tax credit issue in *King v. Burwell*, seems to have ignited a flurry of discussion and debate in the life care planning community on the implications of the role of the life care planner. Many of the questions that are being addressed include:

- Will the writing a traditional life care plan based on billed/charged rates continue as usual?
- Will the different possible rates (billed or charged, most reasonable, discounted, Medicare, etc.) become more central to the damage issue.
- Will there be an occasional second or third scenario (alternative life care plans) as a defense strategy to assist in establishing a reduction in damages?
- Will subrogation be more activity required with Medicare, workers' compensation programs, and possibly the ACA (nothing appears in the ACA's language of the law that suggests this could happen)?
- Will life care planners be expected to delineate what health or disability insurance policies (under the ACA umbrella) will cover, and then identify medical services or procedures that will become part of the damage award?
- In identifying medical services for the future in the plaintiff's award, will there be new expectations of what the life care planner will present to the economist for calculating the value of a damage award (and adjusting to present value)?
- Will mediation between attorneys and relevant experts become more of the court's attempt to resolve the damage issue (possibly including life care planners and insurance specialists)?
- How will the continuing movement of tort reform (state-by-state rules) on the collateral source doctrine impact the role of life care planners?

The above are but a few of the questions and issues which will be addressed over time. To a significant degree, the variables of court settings, state rules, the strategies employed by the defense, and tort reform on collateral sources, will all impact how individual cases will be adjudicated. With respect to the life care planner and the role that one plays in the process, exercising due diligence is imperative. The suggestions which are offered in the conclusion section, along with the checklist, may serve useful for the life care planner in the near term – especially as greater clarification of these issues become better understood.

Conclusions

The effect of the ACA on the collateral source doctrine is a very complex and challenging issue and the development, or lack thereof, will be interesting to follow. To propose that the ACA and tort reform will render the collateral source doctrine obsolete would be over-reaching. The ACA will *not* render the collateral source rules obsolete, however, a failure to acknowledge that the ACA and tort reform represent both a significant change in the legal environment, or that there will be little impact by either is merely an attempt to ignore the obvious. In the meantime, this issue needs to be analyzed at both the macro (legal/public policy perspective) and the micro (individual cases) levels to better understand the implications for the life care planner in practical terms.

Macro

Collateral sources are becoming an issue for a few reasons. First, it is part and parcel of the legal process. Civil litigation is an adversarial contest between two opposing fiduciary advocates. Simply stated, the plaintiff wants to obtain as much money as possible and the defense wants to pay as little as possible. This is not to say that attorneys are not interested in fairness and justice, but the system is established to reward advocacy for their side. Thus one side or the other is always trying to change the rules or the process to their benefit. Collateral sources, including the ACA, in some way is the next logical step for the defense. The defense is attempting to limit the damage award through tort reform and caps. The plaintiff counters by establishing a life care plan and showing that special medical needs exist into the future which require a greater financial award. The defense now counters to move the costs to someone other than their client by the use of a collateral source strategy. A State of Michigan case (*Donaldson v. Advantage Health Physicians* (2011), the court found "that health insurance under the ACA is reasonably likely to continue into the future and that its discussion before the jury is not precluded by MCLA 600.6303(1). Accordingly, what medical care and therapies would be provided by insurance through the ACA can be discussed/argued at trial" (p. 3). In *Christy v. Humility of Mary Health Partners* (2015), the court ruled that "it cannot restrict reference to the ACA as it is the law of the land" (p. 2). And in a similar case, the court in *Jones v. Metrohealth Medical Center* (2015) allowed a defendant's motion to include set-off on collateral benefits, but "only to the extent that such benefits are actually included in the jury's award, and [are] entitled to an off-set for future benefits only to the extent that they can be determined with a reasonable degree of certainty" (p. 4). The ruling included a discussion of the ACA.

Assuming liability, catastrophic injuries result in high numbers and potentially large awards, especially in child cases. The role of a dynamic court is to promote fairness and prevent abuse on either side (plaintiff or defense). The vehicle for justifying these large numbers has become the life care plan. In an attempt for a balance of financial damages between what is reasonable award and given the very high cost of some plans, the courts are concerned with two issues. First, are these numbers legitimate (i.e. reasonable) or secondly, are they necessary? The legitimacy issue has occurred because of concerns about the scientific foundations in the life care planning process. There is agreement in the LCP community about the process and methodology which has developed over the last twenty-five years or more (see Weed & Berens, 2010). Besides, the "necessary" factors that come into play provides the plaintiff with other options such as collateral sources and the courts are provided another option in attempting to balance unreasonable demands against the necessary requirements for future medical care. An example of "collateral sources which provide the courts another option" (noted above) is Section 3333.1 of the *Medical Injury Compensation Reform Act (MICA) of 1975*, State of California. Section 3333.1 provides:

> *(a) In the event the defendant so elects, he may introduce evidence of any amount payable as a benefit to the plaintiff as a result of the personal injury pursuant to the U.S. Social Security Act, any state or federal income or disability or workers' compensation act, any health, sickness or income-disability insurance, accident insurance that provides health benefits or income-disability coverage, and any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, reimburse the cost of, medical, hospital, dental, or other health care services.*

In Leung v. Verdugo Hills Hospital (2013), the Appeals Court in the State of California reviewed the issue of insurance benefits covering the future medical expenses of the plaintiff. Relying primary on Section 3333.1 of the *MJCA of 1975*, the court determined that the traditional collateral source rule was modified by Section 333.1 "in professional negligence actions against a health care provider" and that "the Legislature apparently assumed that in most cases the jury would set plaintiff's damages at a lower level because of its awareness of plaintiff's 'net' collateral source benefits" (p. 2). Furthermore, the court concluded that "the statute permits a defendant to introduce evidence of future insurance benefits that the plaintiff is reasonably certain to receive" (p. 3). However, following a review of the life care plans presented by two life care planners, the court considered the law's intent (Sec. 3333.1) with respect to insurance benefits for future medical expenses. Noting the many negative possibilities of insurance coverage for the future, the court "excluded evidence of future insurance because it's too speculative" (p. 7). The discussion included such observations as:

> *You don't know what the insurance company is going to allow . . . .The insurance company could go out of business. The father could not have his job anymore and . . . lose the policy . . . . The insurance company retains the right to cancel the policy at any time (Note: the ACA would no longer permit this to happen) . . . . The benefits payable under the policy change every year. Who knows what is going to be allowed (p. 6).*

Life care plans are shaped and developed to reflect an acceptance and admissibility with the policies and legal rulings in the geographical area or specific court in which the case will be adjudicated. Various players in the process, including the life care planner, are subject

to these policies and rules – factors that are beyond an individual's control. (See also the Author's Note 2; *Personal communication from Kent Jayne*, 07/05/2015).

Micro

Many issues, such as discussed above, take on a different meaning when they are applied to a specific situation or person. Moving from the macro considerations of public policy and the law, individual characteristics and considerations come into play. Some of the concerns and complexities of a case come to light for both the LCPer and the courts when trying to apply collateral sources to a specific (albeit hypothetical) case such as the following:

> Mary is a 29 yr old female with three children. Dave is a driver for *ACME Trucking*. Dave's company, along with many others, pay millions of dollars each year in premiums to Lloyds of London (LOL – a foreign company in London). Dave, while texting, runs a red light and hits Mary's vehicle. She is rendered quadriplegic. The plaintiff's expert presents a LCP worth XX million. The defense expert uses collateral sources, including insurance policies as mandated by the ACA, resulting in a total approximately one-tenth of the plan developed by the plaintiff's expert. The judge (a bench trial) finds 100% liability on *ACME Trucking* but makes an award based upon the defense plan of collateral sources. Three issues become apparent:
>
> 1: Absolution of responsibility: It appears that LOL will get to keep the premium monies and have limited exposure or loss. Does this mean that Mary' future care will be covered or subsidized by an third party, such as the taxpayers? This is a departure of the courts historical position of "if you break it you pay for it." It is also a benefit for the defendant having to be fully responsible for the damages resulting from a liability.
>
> 2: Mary's future care: The current method of awarding real dollars insures that Mary has both the resources and freedom to direct her own care. If we place Mary in programs which are subsidized by the ACA or other collateral programs, Mary's own care will more than likely be regulated to some degree by those programs that are funding her care.
>
> 3: Life care planner exposure: The real concern for the LCPer is the potential confusion as to which collateral source would cover what expense. Clearly, this would require the life care planner to be aware of the rules and stipulations of various collateral sources as they may exist within a given state. Knowing what would or would not be covered by a collateral source is critical to a court's final determination of damage award covered by the defendant. For example, a life care planner in *Reed v. City of Modesto*, was asked to amend her life care plan for the plaintiff based on Medicare and insurance "payment rates" – not billed rates. The life care planner was asked once again to provide costs based on Medicare rates and customary rates for medical services [which] Medicare does not cover" (p. 2). The defendant asked for yet another amended report based on "non-Medicare rates." To be sure, the defendant's strategy was to reduce the damage award as much as possible, but it also illustrated the additional concerns related to the exposure of the life care planner's skills at being able to provide such information on various challenges to the life care plan. Basically, this is nothing more than providing different scenarios by the LCPer with different assumptions requested by an attorney or the court. It is one thing to view the damage issue in light of public policy and state and/or federal benefit programs; it is quite another situation when decisions have to be made for an individual plaintiff within a judicial proceeding.

The *Affordable Care Act* is a major piece of legislation, enacted by the U.S. Congress, affirmed by the U.S. Supreme Court (in *Thomas More Law v. Barack Obama*, 2012), and a technicality clarified (in *King v. Burwell*, 2015). The ACA will likely continue to have a major impact on the health care industry in the United States, and in the lives of people who are in a litigated process, i.e. the subject of a life care plan and who will pay. ACA will significantly influence the debate involving the long standing tradition of the collateral source doctrine and the funding of the life care plan. One such observation is presented by a representative (Hindert, 2014) of the life care planning practice:

> *The ACA is expected to reduce health care costs and will likely require changes to traditional personal injury life care plans to account for the expanded availability of health insurance resulting from the individual mandate and elimination of pre-existing conditions. Many such changes will likely result from state specific litigation (or new legislation) to determine whether and how the ACA affects existing collateral source rules and, therefore, the calculation of future medical damages. (p. 740).*

To illustrate what changes may occur with regard to the role of the life care planner, the following case illustrates a few of the issues that may arise.

In *Stanley v. Walker* (2009), the defendant attempted to confuse the issue of past and future expenses by invoking the *Indiana Rules of Evidence* (401, 402, & 403) showing that the plaintiff's expert presented "evidence irrelevant, inadmissible because its probative value is substantially outweighted by the danger of unfair prejudice, confusion of the issues, and mislead-

ing the jury. A second defense strategy would be to utilize the services of a qualified expert to present evidence on costs, discounts, and potential collateral sources to offset a damage award (Schroder, 2012). A life care planner with expertise in the area of such issues as costs and off-sets could possible serve as either a consulting or testifying expert to defense attorneys.

Finally, the collateral source doctrine (and rules), tort reform within states, and the *Affordable Care Act* are issues that need to be addressed and discussed by the rehabilitation and life care planning community to a greater degree than is presently evident. Future development in areas of tort reform, and how the ACA and related collateral sources will be employed in the future as set-asides and adjustments, remains to be seen. To be sure, changes and new strategies will continue to emerge, and the rehabilitation consultant and the life care planner must be part of this evolving future.

In the meantime, and to be specific, the following are a few suggestions that the life care planner might consider as more attention is given to such issues as collateral sources, tort reform, and the ACA:

1. Be familiar with the rules on collateral resources as they differ from state-to-state (Matlock, 2013, see Appendix B).

2. Study the rules and regulations on the *Affordable Care Act*.

3. Be familiar with the terminology of payment strategies for damages issue such as paid, billed, customary charges, reasonable charges, Medicare rates, and how they would apply to your case within your state (or the state in which the case is being adjudicated). Identify and develop information and data on each of the potentially needed resources.

4. Be familiar with the strategy of a "special needs trust" that can be generated to utilize government resources with a supplement from the trust. However, at death, the remaining trust funds, if any, are transferred back to the government to reimburse costs to the extent that funds are available.

5. Be very familiar with your professional guidelines for ethics, standards, and scope of practice and use these resources as guides in developing your life care plan.

6. Until these issues are better defined and clarified over time, continue your casework practice as usual, but rely on the advice and direction of the retaining attorney for guidance on how to develop a response to challenges to the conclusions of your life care plan. As in the case of *Reed v. City of Modesto* (2015), be prepared to provide additional information based on a different scenario, if requested.

7. And finally, carefully consider important factors in developing your life care plan in light of the collateral source rules, tort reform (if any) in the state in which the legal case resides, and the ACA. The "check list" (see Appendix A) may offer useful suggestions in developing a life care plan.

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#1: McGrory (2015), writing for the *Tampa Bay Times,* suggests that rates by major insurance companies (Aetna, Cigna, Coventry, and United Health) "have already proposed double-digit rate increases for individual health insurance plans. There's no denying that health care costs are rising, particularly when it comes to prescription medication. And as costs rise, premiums rise." The author offered no firm data on the amount of premium costs under the ACA umbrella for year 2016, but by way of illustration did indicate that one person who "had been paying $79.00 per month . . . was recently told that a new ACA-compliant plan would cost between $400 and $700 a month."

#2: Comments by Kent Jayne (*personal communication*, 7/5/2015). "Health care costs don't disappear because of a collateral source payment. They are simply shifted. Case law seems to be going the direction of ignoring this economic fact, and indeed may succeed in shifting costs from the tortfeasor to a multitude of other payment sources. We might consider what could be referred to as the "dependent origination" theory of collateral source payment liability. If an offset is allowed for the tortfeasor, the carrier (public or private) pays the offset. This increases the liability of the carrier, who then shifts the costs to the insured in the form of higher premiums for lower benefits (benefits per dollar), while also shifting part of the costs to the public in a partially publicly funded program. The tortfeasor then profits from the offset, and the net cost of negligence goes down for him. But it is shared by those who may be further harmed by his reduced cost/benefit. This reduction in cost/benefit could result in either lower taxes, if passed on by the government, in higher profits to stockholders if passed on by a private carrier, or in more benefits per dollar. In the case of the ACA, a collateral source offset benefits the defendant immediately, and may or may not further harm the plaintiff, depending on the net impact on premiums, taxes or benefit coverage. The overall net effect going forward is greater uncertainty for the plaintiff, which according to risk analysis, means he pays more for uncertainty than the net cost of the change in taxes or insurance premiums, whichever direction they go. Plaintiffs (victims of the tortfeasor) are more greatly harmed by the increased uncertainty at a macro level by the defendants' (plural) cost shifting to the taxpayers and the carriers, than the defendants in the long run, who have shifted the uncertainty costs to the plaintiffs. If the defendant is a carrier, they may be actually shooting themselves in the foot by not recognizing TNSTAAFL (*There is no such thing as a free lunch*). But of course, if premiums or taxes are inelastic or negative to demand for benefits, they will be shifted again by the carrier. Cost shifting never dies, it is just reincarnated."

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Appendix A

Affordable Care Act Related Checklist for Forensic Litigation: What A Life Care Planner Needs to Know

1. Is the case medical malpractice, personal injury or other federal or state tort related? (Excludes workers compensation type cases, vaccine injury, wrongful adoption, et al. which will also have varying rules relating to subrogation and collateral sources.)
2. Are there jurisdiction rules currently in place where the introduction of collateral sources is not allowed? If so, what restrictions? (e.g., prohibited from using the word "insurance.")
3. If this is a state case, does the state have provision for admission of collateral source information such as if the lawsuit is against a "political subdivision" (e.g., Ohio) or is a medical negligence action? (Collateral source rules are venue specific!)
4. Is there a provision for a post-trial hearing of a successful civil litigation case to determine collateral source set-offs based in part on trial testimony? If so, what the life care planner opines at trial can be very important.
5. Did the retaining or opposing attorney obtain the services of an insurance expert?
6. If a pediatric case, are you thoroughly familiar with the potential collateral source expectations? (e.g., the child is receiving Medicaid services and the father is receiving Social Security disability and Medicare resulting in the child's access to Medicare at age 20.)
7. Does the case for which you are retained expect to be settled prior to trial and negotiations include discussion of sources of additional support such as school based therapies to enhance education for pediatric cases (not including "medical" or maintenance therapies) or ACA?
8. Are you familiar with ACA expected premium, co-pay, co-insurance, deductible level, out-of-network, and out-of-pocket expenses? (Some critical resources may be out of network.)
9. Do you know what is NOT supported by the ACA? Examples (for discussion):
   - long term care
   - custodial care
   - housing
   - ramps
   - home modifications
   - transportation
   - maintenance therapies or therapies required beyond insurance caps
10. Are you prepared to offer alternative plans (without ACA or with ACA) if necessary?
11. Is your malpractice insurance current?

Appendix B

50-State Survey: Collateral Source Rule & Write-Offs

(States: [1] Paid Evidence Only; [2] Billed Evidence Only; [3] Hybrid)

	Private Insurance		Medicare/Medicaid		
State	**Maximum Recovery**	**Evidence Accepted**	**Maximum Recovery**	**Evidence Accepted**	**Authority + Notes**
ALABAMA[3]	Billed	Billed, paid & premiums	Billed	Billed, paid & premiums	Ala. Code §12-21-45, 6-5-22: essentially circumventing the need for a "billed v paid" distinction. *also admissible*: Plaintiff's obligation to repay Collateral Source
ALASKA[3]	Billed + post-verdict reduction	Billed (implied)	Billed + post-verdict reduction	Billed	Alaska Stat. § 9.17.070., Alaska Stat. § 9.55.548: limits damages to amounts exceeding that already paid by a collateral source in MedMal cases (except for CS in the form of death benefits and fed programs where subrogation is required by law). *Reid v. Williams*, 964 P.2d 453, 456 (Alaska 1998). *Jones v. Bowie Industries, Inc.*, 282 P.3d 316 (Alaska 2012).
ARIZONA[3]	Billed	MedMal: Billed, paid, & premiums Other: Billed	Billed	MedMal: Billed, paid, & premiums Other: Billed	*Lopez v. Safeway Stores, Inc.*, 129 P.3d 487, 496 (Ariz. 2006). A write-off is considered a collateral source.
ARKANSAS[1]	Paid	Paid	Paid	Paid	**Ark. Code** § 16-55-212(b).
CALIFORNIA[1]	Paid	Paid	Paid	Paid	**Insurance:** *Howell v. Hamilton Meats & Provisions, Inc.*, 52 Cal. 4th 541, 550, 257 P.3d 1130, 1134 (2011), reh'g denied (Nov. 2, 2011). **Medicare/caid:** *Hanif v. Hous.* Auth., 200 Cal. App. 3d 635, 639, 246 Cal. Rptr. 192, 194 (Ct. App. 1988).
COLORADO[2]	Billed	Billed	Billed	Billed	Colo. Rev. Stat § 13-21-111.6 (2008) allows a reduction of the verdict by the amount paid by the CS EXCEPT where the payments arose from contractual obligations intended to benefit the injured party. *Barnett v. American Family Mut. Ins. Co.*, 843 P.2d 1302, 1309 (Colo. 1993). *Crossgrove v. Wal-Mart Stores, Inc.*, 280 P.3d 29 (Colo. Ct. App. 2010) aff'd, 2012 CO 31, 276 P.3d 562 (Colo. 2012).
CONNECTICUT[3]	Billed + post-verdict reduction	Billed	Billed + post-verdict reduction	Billed	*Hernandez v. Marquez*, 377482, 2004 WL 113616 (Conn. Super. Ct. Jan. 5, 2004). Conn. Gen. Stat. Ann. § 52-225 (West) recovery is reduced post-verdict by the total amount of collateral sources paid minus premiums paid for the benefit.
DELAWARE[3]	Billed	Billed	MedMal: Post-verdict reduction Other: Billed	Billed	*Mitchell v. Haldar*, 883 A.2d 32 (Del. 2005). Del. Code Ann. tit. § 18 6862.
FLORIDA[3]	Billed + post-verdict reduction	Billed	Billed	Billed	Under Fla. Stat. § 768.76(1) (2008): the write-off is a collateral source. REDUCTION: by the amount contributed by the CS less the cost of consideration for that benefit. Note: no reduction for Medicare/Medicaid/ Workers' Comp/gov programs because the Federal government has a right to subrogation claims.
GEORGIA[2]	Billed	Billed	Billed	Billed	Ga. Code Ann., 51-12-1 CSR is applicable in tort cases, **but not applicable in breach of contract** cases: *Amalgamated Transit Union Local 1324 v. Roberts*, 263 Ga. 405, 434 S.E.2d 450 (1993). *Olariu v. Marrero*, 549 S.E.2d 121 (Ga. 2001) A write-off is a collateral source (adhering to the traditional CSR).

State	Private Insurance: Maximum Recovery	Private Insurance: Evidence Accepted	Medicare/Medicaid: Maximum Recovery	Medicare/Medicaid: Evidence Accepted	Authority + Notes
HAWAII[2]	Billed	Billed	Billed	Billed	Traditional CSR: *Bynum v. Magno*, 101 P.3d 1149 (Hawaii 2004).
IDAHO[3]	Billed + post-verdict reduction	Billed	Billed + post-verdict reduction	Billed	Idaho Code Ann § 6-1606 (2008). *Dyet v. McKinley*, 81 P.3d 1236 (Idaho 2003).
ILLINOIS[3]	MedMal: Billed + post-verdict reduction Other: Billed	Billed	MedMal: Billed + post-verdict reduction Other: Billed	Billed	*Wilson v. Hoffman Group, Inc.*, 546 N.E.2d 524, 530-31 (Ill. 1989). "reasonable value" of medical services is the amount billed the provider. **MedMal cases**: 735 Ill. Comp. Stat. § 5/2-1005 (2008). Reduction post-verdict – 50% of the benefits provided for lost wages by private or governmental disability programs, 100% of the benefits provided for medical/hospital/ nursing or caretaking charges (BUT NOT for benefits where there is a right of subrogation, or where the reduction would exceed 50% of the award). Done by Application for Reduction w/in 30 days of the judgment
INDIANA[3]	Billed	Billed & paid	Billed	Billed & paid	*Shirley v. Russell*, 663 N.E.2d 532 (Ind. 1996); *Stanley v. Walker*, 906 N.E.2d 852 (Ind. 2009); Ind. Code § 34-44-1-1 (2008). The CSR does not bar evidence that a lesser amount was accepted by a medical provider, but evidence that payment came from a third-party is INADMISSIBLE. The CSR does NOT apply to write-offs because they are not payments. Inadmissible evidence for Personal Injury/Wrongful death actions: payments of life insurance or death benefits, insurance benefits for which plaintiff or his family paid for directly, and *payments made* by the state/US or its agencies.
IOWA[3]	Billed	Billed, paid & premiums	Billed	Billed, paid & premiums	Plaintiff is entitled to reasonable value of services and can show this through billed and paid amounts, and expert witness testimony as to reasonableness. *Pexa v. Auto Owners Ins. Co.*, 686 N.W.2d 150 (Iowa 2004) Iowa Code § 668.14. Iowa Code § 147.136: MED MAL Cases prohibits an award that includes any losses replaced or indemnified by insurance or gov/employment benefit programs.
KANSAS[3]	Billed	Billed & paid	Billed	Billed & paid	Follows common law CSR: Rst. 2d Torts § 920A(2). State statute ruled unconstitutional (60-3802) *Martinez v. Milburn Enterprises, Inc.*, 290 Kan. 572, 233 P.3d 205 (2010). The source of the CS payment is inadmissible, but the billed & paid amounts may be used to establish reasonableness of medical services because the Write-off is not a CS.
KENTUCKY[2]	Billed	Billed	Billed	Billed	*Baptist Healthcare Sys., Inc. v. Miller*, 177 S.W.3d 676 (Ky. 2005). (no mention of write-offs specifically).
LOUISIANA[3]	Billed	Billed	Medicaid: paid, Medicare: billed	Medicaid: paid, Medicare: billed	*Griffin v. Louisiana Sheriff's Auto Risk Ass'n*, 802 So. 2d 691 (La.App. 1 Cir. 2001) writ denied, 801 So. 2d 376 (La.App. 1 Cir. 2001). **Medicaid/care**: because Medicaid is free for its recipients, they cannot recover the write-off, but Medicare recipients can recover it since they pay consideration for it. *Bozeman v. State*, 879 So.2d 692 (La. 2004).
MAINE[3]	MedMal: post-verdict reduction if coll. Source *doesn't* subrogate w/in 30 days Other: Billed	Billed	MedMal: post-verdict reductions for Medicare/caid and Soc. Sec. if Def makes Pf whole for any subrogation claims Other: Billed	Billed	Professional negligence case: post-verdict reduction by the amount paid by a CS if the source has NOT exercised its subrogation rights w/in 30 days after notice of the verdict. Reductions are taken for Medicare/Medicaid, Social Security (provided that the Def. makes the plaintiff whole for any related subrogation claims.) Me. Rev. Stat. Ann. tit. 24,§ 2906(2) (2008). *Barday v. Donnelly*, CV-04-508, 2006 WL 381876 (Me. Super. Jan. 27, 2006).

State	Private Insurance: Maximum Recovery	Private Insurance: Evidence Accepted	Medicare/Medicaid: Maximum Recovery	Medicare/Medicaid: Evidence Accepted	Authority + Notes
MARYLAND[3]	MedMal: Billed+ post-verdict reduction motion Other: Billed	Billed+ evidence of reasonableness	MedMal: Billed+ post-verdict reduction motion Other: Billed	Billed+ evidence of reasonableness	Evidence of CS payments admissible to show malingering or an exaggeration of an injury, if alleged. Plaintiffs are entitled to the "reasonable value" of medical services, and the court hasn't said which amount that is, but it has said that neither amount properly establishes the value. The plaintiff must offer some evidence that the amount charged was fair and reasonable." See, e.g., *Simco Sales Service v. Schweigman*, 205 A.2d 245, 249 (Md. 1964) (plaintiff satisfied burden where hospital's director of admissions and accounts testified that the hospital charges were fair and reasonable and were the customary charges made by the hospital for such services). Md. Code Ann., Cts. & Jud. Proc. § 10-104(e)(1) (West 2008). (Damages claims under $25,000 do not need supporting evidence of reasonableness.) *Brethren Mut. Ins. Co. v. Suchoza*, 212 Md. App. 43, 66 A.3d 1073, 1076 (2013)
MASSACHUSETTS[3]	MedMal: mandatory post-verdict reduction Other: Billed	Billed	MedMal: mandatory post-verdict reduction Other: Billed	Billed	Healthcare liability claims: mandatory post-verdict reduction by the amount paid by a CS, off-set by amount of premiums/consideration paid. Mass. Gen. Laws ch. 231, § 60G(a) (2008). **Medicaid Write-offs ARE payments.** and are "not a proper element of damages in a malpractice action." *Sylvestre v. Martin*, SUCV2003-05988, 2008 WL 82631 (Mass. Super. Jan. 4, 2008).
MICHIGAN[3]	Billed + Mandatory post-verdict reduction less premiums paid	Billed	Medicaid: billed Medicare: billed + post-verdict reduction	Billed	Mich. Comp. Laws § 600.6303 (2008). **Medicaid payments are not a collateral source.** See *Shinholster v. Annapolis Hosp.*, 660 N.W.2d 361, 372-73 (Mich App. 2003), *aff'd in part rev'd in part* 671 N.W.2d 539 (Mich 2004). A write-off "has not been paid, nor is it payable, such that it is not a collateral source." *Detary v. Advantage Health Physicians, PC*, 308179, 2012 WL 6035024 (Mich. Ct. App. Nov. 29, 2012) appeal denied, 493 Mich. 970, 829 N.W.2d 862 (2013).
MINNESOTA[3]	Billed + post-verdict reduction	Billed	Billed + post-verdict reduction	Billed	*Swanson v. Brewster*, 784 N.W.2d 264. **Write-offs are collateral sources** and must be deducted by trial court from a jury award. Minn. Stat. Ann. § 548.251 (West). CSR still applies, but amount paid by CS is reduced from verdict.
MISSISSIPPI[2]	Billed	Billed	Billed	Billed	**Medicare/caid**: *Robinson Property Group, L.P. v. Mitchell*, 7 So.3d 240 (Miss. 2009). *Wal-Mart Stores, Inc. v. Frierson*, 818 So. 2d 1135, 1139 (Miss. 2002). (paid amount admissible for impeachment purposes only)
MISSOURI[2]	Billed	Billed	Billed	Billed	*Washington by Washington v. Barnes Hosp.*, 897 S.W.2d 611, 619 (Mo. 1995), *Smith v. Shaw*, 159 S.W.3d 830, 832 (Mo. 2005). CS payments admissible when plaintiff makes financial condition an issue.
MONTANA[3]	Personal Injury: post-verdict reduction Other: Billed	Billed	Billed	Billed, but not yet specifically addressed	Mont. Code Ann. 27-1-308, when award >$50,000 and Plaintiff is fully compensated for damages, recovery is reduced by CS payments that are not subject to subrogation (less premiums Plaintiff paid for 5 previous years). *Fretts v. GT Advanced Technologies Corp.*, CV 11-160-M-CWM, 2013 WL 816684 (D. Mont. Mar. 5, 2013). Medicare/caid remains unaddressed. *Elliott v. Goulet*, 2012 WL 8530906 (Mont.Dist.) (Trial Order).
NEBRASKA[3]	Billed + post-verdict reduction	Billed	Billed	Billed	Neb. Rev. Stat. 44-2819 (2008), bodily injury or wrongful death cases: evidence of medical reimbursement insurance is inadmissible. reduction by amt of nonrefundable medical reimbursement insurance minus premiums paid. **Medicare/caid** payments: excluded from the statute and covered by traditional CSR.
NEVADA[2]	Billed	Billed (but worker's comp benefits may be admissible)	Billed	Billed	Write-offs are collateral sources. *Tri County Equip. & Leasing v. Klinke*, 286 P.3d 593 (Nev.2012) (Gibbons, J. concurring). *Alexander v. Wal-Mart Stoes, Inc.*, 2:11-CV-752 JCM PAL, 2013 WL 427132 (D. Nev. Feb. 1, 2013).

State	Private Insurance: Maximum Recovery	Private Insurance: Evidence Accepted	Medicare/Medicaid: Maximum Recovery	Medicare/Medicaid: Evidence Accepted	Authority + Notes
NEW HAMPSHIRE[2]	Billed	Billed	Billed	Billed	*Carson v. Maurer*, 424 A.2d 825 (N.H. 1980), overruled by *Community Resources for Justice, Inc. v. City of Manchester*, 154 N.H. 748 (2007) on other grounds.
NEW JERSEY[3]	Billed + post-verdict reduction	Billed	Billed	Billed	N.J. Stat § 2A: 15-97 – **Verdict reduced by amount of CS payment (other than workers' comp and life insurance) less premiums paid.** *Perreira v. Rediger*, 778 A.2d 429 (N.J. 2001). *Cockerline v. Menendez*, 411 N.J. Super. 596, 988 A.2d 575, (App. Div. 2010).
NEW MEXICO[2]	Billed	Billed	Billed	Billed	*Summit Properties, Inc. v. Pub. Serv. Co. of New Mexico*, 2005-NMCA-090, 138 N.M. 208, 118 P.3d 716.
NEW YORK[3]	Billed + post-verdict reduction	Billed	Billed + post-verdict reduction	Billed	N.Y. C.P.L.R. LAW § 4545 (McKinney 2008). 4545(a): MedMal: evidence admissible of indemnification from a CS, verdict reduced accordingly (minus amount of premiums paid for past 2 years). 4545(b): actions against a public employer for PI/wrongful death evidence admissible of CS payment, but not CSes that are entitled to liens against recovery, to reduce verdict accordingly (minus premiums). 4545(c): PI/ injury to property/ wrongful death – evidence admissible of CS payment, but not CSes that are entitled to liens against recovery, to reduce verdict accordingly (minus 2 yrs of premiums + amt of maintaining such benefits). 4545(d): charitable contributions – are not considered collateral sources, inadmissible to reduce award.
NORTH CAROLINA[2]	Billed	Billed	Billed	Billed	*Fallis v. Watauga Med. Ctr., Inc.*, 132 N.C. App. 43, 510 S.E.2d 199 (1999). *Young v. Baltimore & O. R. Co.*, 266 N.C. 458, 463, 146 S.E.2d 441, 444 (1966).
NORTH DAKOTA[3]	Billed + post-verdict reduction	Billed	Billed + post-verdict reduction	Billed	*N.D. Cent. Code Ann.* § 32-03.2-06 (West).
OHIO[3]	Billed	Billed & paid (if no subrogation right) + premiums paid	Billed	Billed & paid (if no subrogation right) + premiums paid	*Ohio Rev. Code Ann.* § 2315.20 (West 2008). *Robinson v. Bates*, 112 Ohio St. 3d 17, 857 N.E.2d 1195 (2006).
OKLAHOMA[1]	Paid	Paid	Paid	Paid	12 O.S. § 3009.1 (2011). Cases filed pre-Nov 1., 2011: no precedent, *Brown v. USA Truck, Inc.*, 2013. WL 653195 (W.D. Okla. 2013).
OREGON[3]	Billed + post-verdict reduction MOTION	Billed	Billed + post-verdict reduction MOTION	Billed	**Write-offs are collateral source payments.** Or. Rev. Stat. Ann. § 31.580 (West). *White v. Jubitz Corp.*, 219 Or. App. 62, 182 P.3d 215 (2008) aff'd, 347 Or. 212, 219 P.3d 566 (2009). *Cohens v. McGee*, 219 Or. App. 78, 180 P.3d 1240, 1241 (2008).
PENNSYLVANIA[3]	MedMal: paid, Other: billed	MedMal: paid, Other: billed	MedMal: paid, Other: billed	MedMal: paid, Other: billed	*Nigra v. Walsh*, 2002 PA Super 113, 797 A.2d 353 (2002). CSR does not apply to Write-Offs in **MedMal**: *Moorhead v. Crozer Chester Medical Center*, 564 Pa. 156, 765 A.2d 786 (2001) (abrogated on other grounds). 40 P.S. § 1303.508: Subrogation right eliminated in certain instances.
RHODE ISLAND[3]	MedMal: Billed Other: billed	MedMal: Billed & paid & premiums Other: billed	Billed	Billed	Trial courts split. Some have found R.I. *Gen. Laws Ann.* § 9-19-34.1 (West) unconstitutional. *Maguire v. Licht*, C.A. PC1999-3391, 2001 WL 1006060 (R.I. Super. Aug. 16, 2001); *Esposito v. O'Hair*, 886 A.2d 1197 (R.I. 2005). **Medicare/caid**: Jacqueline G. Kelley, Esq., Stephen P. Sheehan, Esq., *Collateral Source Rule Applies to Medicaid Without Exception for Medical Malpractice Cases*, R.I. B.J., November/ December 2006, at 17. In trial, jury instructed to reduce award by any sum equal to the difference be- tween what plaintiff contributed and what it received from collateral source (if CS evidence is introduced).

State	Private Insurance: Maximum Recovery	Private Insurance: Evidence Accepted	Medicare/Medicaid: Maximum Recovery	Medicare/Medicaid: Evidence Accepted	Authority + Notes
SOUTH CAROLINA[2]	Billed	Billed	Billed	Billed	*Covington v. George*, 597 S.E.2d 142, 144 (S.C. 2004).
SOUTH DAKOTA[2]	Billed	Billed	Billed	Billed	*Cruz v. Goth*, 2009 S.D. 19, 763 N.W.2d 810. *Papke v. Harbert*, 2007 S.D. 87, 738 N.W.2d 510, 530. **Evidence of Write-offs is not permissable: Plaintiff is entitled to recover the *reasonable value* of medical services which is a question for the jury. Ruling that either amount is the reasonable value makes the other value inherently *unreasonable*.** SDCL § 21-3-12. MedMal exception: evidence that special damages were paid for or are payable by insurance (not subject to subrogation or that was purchased privately) or state/fed gov't programs (not subject to subrogation).
TENNESSEE[3]	MedMal: paid Other: billed	MedMal: paid Other: billed	MedMal: paid Other: billed	MedMal: paid Other: billed	*Tenn. Code Ann.* § 29-26-119 (2008). A Plaintiff may recover unsubrogated moneys. *Cassie Nalawagan v. Hai v. Dang*, No. 06 2745 STA dkv, 2010 WL 4340797, at *2–*3 (W.D.Tenn. Oct.27, 2010). *Calaway ex rel. Calaway v. Schucker*, 2:02-CV-02715-STA, 2013 WL 960495 (W.D. Tenn. Mar. 12, 2013).
TEXAS[1]	Paid	Paid	Paid	Paid	*Tex. Civ. Prac. & Rem. Code Ann.* § 41.0105 (West). *Haygood v. De Escabedo*, 356 S.W.3d 390 (Tex. 2011), reh'g denied (Jan. 27, 2012).
UTAH[3]	MedMal: Billed + post-verdict reduction for unsobrogated moneys Other: billed	Evidence to establish reasonableness	MedMal: Billed + post-verdict reduction for unsobrogated moneys Other: billed	Evidence to establish reasonableness	Requested damages need only be "reasonable and necessary." *Gorostieta v. Parkinson*, 17 P.3d 1110 (Utah 2000); *Hansen v. Mountain Fuel Supply Co.*, 858 P.2d 970, 981 (Utah 1993). *Utah Code Ann.* § 78B-3-405 (West). What evidence is admissible to establish "reasonable and necessary" has yet to be determined, but a district court held in 2012 that only the billed amount is permitted. *Sanchez v. Cache Valley Specialty Hosp., LLC*, 2012 WL 6057104 (Utah Dist. Ct.) (Trial Order).
VERMONT[2]	Billed	Billed	Billed	Billed	*Windsor School Dist. v. State*, 956 A.2d 528 (Vt. 2008).
VIRGINIA[2]	Billed	Billed	Billed PAID in federal court	Billed PAID in federal court	*Acuar v. Letourneau*, 531 S.E.2d 316, 320 (Va. 2000); *Va. Code Ann.* § 8.01-35 (2008). Write-offs are akin to payments. FEDERAL COURT: **The collateral source rule does not apply to the illusory "charge"** of $96,500.91 since that amount was not paid by any collateral source. See *McAmis v. Wallace*, 980 F. Supp. 181 (W.D. Va. 1997).
WASHINGTON[2]	Billed	Billed	Billed	Billed	*Diaz v. State*, 175 Wash. 2d 457, 285 P.3d 873 (2012) preempting RCWA 7.70.080 (2006).
WEST VIRGINIA[2]	Billed	Billed	Billed	Billed	*Keesee v. General Refuse, Inc.*, 604 S.E.2d 449, 452 (W.Va. 2004). Case law does not indicate that the court has evaluated the specific issue of writeoffs and their implication under the CSR. *State Farm Mut. Auto. Ins. Co. v. Schatken*, 230 W. Va. 201, 737 S.E.2d 229, 237 (2012).
WISCONSIN[2]	Billed	Billed	Billed	Billed	*Leitinger v. DBart, Inc.*, 736 N.W.2d 1 (Wis. 2007).
WYOMING[2]	Billed	Billed	Billed	Billed	*Garnick v. Teton County School Dist. No. 1*, 39 P.3d 1034, 1041 (Wyo. 2002).
WASHINGTON D.C.[2]	Billed	Billed	Billed	Billed	*Hardi v. Mezzanotte*, 818 A.2d 974, 984 (D.C. 2003); *Calva-Cerqueira v. United States*, 281 F.Supp.2d 279, 295 (D.D.C. 2003) dismissed, 04-5005, 2004 WL 2915332 (D.C. Cir. Dec. 16, 2004).

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Appendix C

Collateral Sources

Collateral sources are any source of income that can potentially be deducted from a damage award following the determination of defendant's liability. The following are examples of collateral sources:

- Automobile or Travel Insurance payment(s)
- Life Insurance proceeds
- Medical Malpractice Insurance payment(s)
- Medicare/Medicaid payments
- Private Health Insurance
- Private Pension Plans (which may include disability benefits)
- Property Insurance (which may include disability benefits)
- Social Security Disability Income (SSDI) payments
- Social Security Survivor's (SSS) benefits
- Supplemental Security Income (SSI) payments
- Veterans' benefits
- Wage Continuation Plan benefits
- Worker Compensation payments (either federal or state, i.e., FELA, Jones Act)