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The Fate of the Collateral Source Rule After Healthcare Reform

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ABSTRACT

The passage of the Patient Protection and Affordable Care Act (PPACA) brought vast changes to the world of health insurance. Although much of the focus has been on the individual mandate provision's constitutionality, this Comment explores a less-mentioned but equally important implication of PPACA: a change to the rationales behind the common law collateral source rule. The collateral source rule allows an insured plaintiff to recover medical damages in the amount that the medical provider bills, regardless of the fact that the plaintiff's medical provider likely accepted a lesser amount from the plaintiff's insurance company as payment in full. This Comment argues that because PPACA provisions weaken, if not eliminate, at least two of the rationales behind the collateral source rule, courts should calculate medical damages by factoring in the amount the insurance company paid to the provider and a percentage of the health insurance premiums that the plaintiff paid, calculated based on the extent of the plaintiff's injury.

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INTRODUCTION

In 2005, David Swanson was injured in an auto accident in Minnesota. He incurred $62,259.30 in medical bills.[1] Swanson paid $1169.80 out of pocket in copayments for these bills, which left a $61,089.50 balance.[2] Swanson also paid $4570.64 in insurance premiums during the two-year period between the accident and the resultant lawsuit.[3] Because of a prenegotiated contractual arrangement between Swanson's hospital and his insurance company, Swanson's hospital wrote off $43,445.74[4] and his insurance company paid $17,643.76 to satisfy the remaining balance.[5] Swanson commenced a personal injury suit against both the driver and the owner of the vehicle in 2007 and ultimately recovered $5740.44 for his medical expenses.[6] This damage award was calculated based on the amount that Swanson paid out of pocket in insurance premiums and copayments.[7]

Rebecca Howell was injured in an auto accident in California.[8] She incurred $189,978.63 in medical bills.[9] Howell's insurance provider also enjoyed a contractual discount and paid only $59,691.73 to satisfy the $189,978.63 in medical costs.[10] In 2009, the California Court of Appeal held that Howell should recover the full $189,978.63—the amount her insurance company paid, $59,691.73, plus the amount written off, $130,286.90.[11] Unlike Swanson, Howell's recovery included payments made by her insurance company.

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1. Swanson v. Brewster, 784 N.W.2d 264, 266 (Minn. 2010).
2. *Id.* at 282.
3. *Id.*
4. A write-off is the difference between the billed and paid amounts that is due pursuant to a contract between the provider and insurance company. Amounts written off are neither paid nor owed by anyone. Generally, providers are incentivized to contract with insurance companies at such reduced rates because the lower cost of care motivates insured individuals to visit providers that accept their insurance instead of providers that do not. *See* Bryce Benjet, *A Review of State Law Modifying the Collateral Source Rule: Seeking Greater Fairness in Economic Damages Awards*, 76 DEF. COUNS. J. 210, 224 (2009) (noting that write-offs are discounts that providers give insurance companies in exchange for providing a volume of business).
5. *See Swanson*, 784 N.W.2d at 282.
6. *Id.*
7. *Id.* Swanson also recovered damages for other expenses, including past and future pain and suffering and lost wages. *Id.* at 267. Section 548.251 of the Minnesota Statutes requires medical damage awards to be reduced by the amount the plaintiff's collateral source pays, but offsets this amount by any insurance premium payments the plaintiff paid in the two-year period immediately prior to the suit. *See* MINN. STAT. ANN. § 548.251 (West 2010).
8. Howell v. Hamilton Meats & Provisions, Inc., 101 Cal. Rptr. 3d 805, 807 (Ct. App. 2009), *rev'd*, 257 P.3d 1130 (Cal. 2011).
9. *Id.*
10. *Id.*
11. *See supra* note 4.

The California Supreme Court recently reviewed Howell's case to examine the common law collateral source rule and to decide how to calculate medical damages. Prior to the California Supreme Court's decision in *Howell v. Hamilton Meats & Provisions, Inc.*,[12] California courts following the collateral source rule allowed plaintiffs like Howell to recover the full amount billed (in Howell's case, $189,978.63).[13] The court in *Howell* reinterpreted the collateral source rule, however, and held that the rule does not allow recovery of written-off expenses because "the injured plaintiff did not suffer any economic loss in that amount."[14] Howell's medical damages award was therefore limited to the amount her insurance company paid plus her out-of-pocket costs.[15]

Swanson's and Howell's cases illustrate the lack of consensus among courts regarding how to calculate medical damages in personal injury cases.[16] This analysis is complicated when a third party, such as a health insurer, has made payments that might mitigate the damages.[17] The role of third-party payments in damage calculations is governed by the collateral source rule: A tortfeasor-defendant cannot mitigate the damages he owes to a plaintiff by introducing evidence of collateral source payments.[18] This common law rule has been modified in various ways, however, by states attempting to calculate medical damages accurately.[19] A plaintiff like Howell could collect $189,978.63 in a state that has adopted the common law rule—or a sum well under $10,000 in a state employing a modified rule. Thus, the damages a defendant owes in a personal injury case depend on what version of the collateral source rule is used in the state where the injury occurred.

The collateral source rule developed during a time when having health insurance was considered rare and plaintiffs recovered medical damages to pay for medical expenses directly from defendants.[20] Thus, a rule that excluded health

12. 257 P.3d 1130.
13. California has adopted the common law collateral source rule with the exception of medical malpractice cases in which mitigation is allowed under CAL. CIV. CODE § 3333.1 (West 1997).
14. *Howell*, 257 P.3d at 1133.
15. *Id.*
16. *See* F. Patrick Hubbard, *The Nature and Impact of the "Tort Reform" Movement*, 35 HOFSTRA L. REV. 437, 486–88 (2006) (discussing the various modifications states have made to the collateral source rule). *See generally* Benjet, *supra* note 4.
17. See *infra* notes 99–111 for a discussion of states that mitigate medical damages by third-party payments.
18. RESTATEMENT (SECOND) OF TORTS § 920A (1979); *see also* John G. Fleming, *The Collateral Source Rule and Loss Allocation in Tort Law*, 54 CALIF. L. REV. 1478, 1478 (1966).
19. *See* sources cited *supra* note 16.
20. *See* Fleming, *supra* note 18, at 1478–80 (describing how the collateral source rule developed when maintaining insurance was rare and defendants were the main source of recovery and the shift to today when plaintiffs often have their medical bills paid by their third-party insurer); *see also* Benjet, *supra* note 4, at 211–12 ("As more Americans become privately insured or are covered by government

insurance payments when calculating medical damages did not generally overcompensate personal injury plaintiffs. As health insurance has become more common, however, some states have begun to question the practicality of the rule and to modify it. States that have modified the collateral source rule raise questions such as (1) whether the insurance company or the tortfeasor should pay for the harm a tortfeasor causes to an insured plaintiff, and (2) how much the tortfeasor should fairly be required to pay if he owes medical damages.[21] These factors are further complicated by the wide variation in medical costs, which depends on whether a plaintiff is insured or uninsured, and if plaintiff is insured, on what type of insurance plaintiff holds.[22]

Because of various state modifications to the collateral source rule, the amount of medical damages recoverable in personal injury suits can vary widely from jurisdiction to jurisdiction. Thus, states currently measure medical damages in one of three ways: (1) by allowing the plaintiff to recover for the full billed charge,[23] (2) by reducing the amount of medical damages by the amount paid by the plaintiff's insurance company, or (3) by reducing medical damages by the amount the plaintiff's insurance company paid but offsetting this amount by premium payments made by the plaintiff.[24]

Consider the *Howell* case in light of these issues. Assuming the defendant, Hamilton Meats & Provisions, Inc., is liable to Howell for her injuries, how much does it owe in medical damages? Under the common law collateral source rule, Howell would be able to recover the entire billed amount, since third-party insurance payments would not be considered. In states employing the traditional rule, the defendant would owe Howell $189,978.63. It is not clear that this is a

benefits, state legislatures will likely continue to address the problems of potential overcompensation resulting from the collateral source rule."); John Dewar Gleissner, *Proving Medical Expenses: Time for a Change*, 28 AM. J. TRIAL ADVOC. 649, 682–83 (2004) ("The original common law Collateral Source Rule only had to deal with two of six factors inherent in the payment of modern medical bills. Those two factors historically were simply (1) the amount of the stated bill or damages and (2) the admissibility or legal effect of the insurance payment. The following four additional and complicating evidentiary factors have been added or magnified since the creation of the Collateral Source Rule: (3) the lower reimbursement rate, (4) the full satisfaction of the higher bills without any balance billing, (5) the insured's duty to repay the carrier out of any award, and (6) the insured's cost of procuring the insurance.").

21. *See* Michael K. Beard, *The Impact of Changes in Health Care Provider Reimbursement Systems on the Recovery of Damages for Medical Expenses in Personal Injury Suits*, 21 AM. J. TRIAL ADVOC. 453, 457 (1998) (discussing questions that arise in determining medical damages in personal injury suits).
22. See *infra* note 60 and accompanying text for a discussion of different types of insurance.
23. States that apply the common law collateral source rule bar evidence of health insurance payments from being presented in court and also prohibit defendants from mitigating damages based on health insurance payments. *See infra* note 65.
24. *See* discussion *infra* Part II.D–E.

fair measure of damages, however, given that Howell's expenses were fully covered by her insurance company. Even if one accepts that Howell's medical recovery is necessary because she will have to reimburse her insurance company for its payments, she would owe them only the $59,691.73 that they paid.[25] On one hand, if she recovers the entire billed amount, she will receive a $130,286.90 windfall. On the other hand, it seems incongruous that a tortfeasor who injures an insured person whose costs are reimbursed will incur less liability (and therefore be better off) than one who injures an uninsured person. The above considerations and the striking discrepancies between the billed amount and the discounted amount paid by insurance companies illustrate why the formula for calculating medical damages varies widely among states.[26]

On March 23, 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act (PPACA).[27] PPACA drastically alters the initial motivation for the collateral source rule.[28] Although this Comment examines potential modifications to the collateral source rule in light of PPACA's individual mandate, the analysis set forth also provides guidance on how to revamp the

25. Some insurance contracts provide for subrogation, which requires a successful plaintiff to reimburse her health insurance company for medical expense payments it has made. Subrogation allows "the insurer to recover its claim expense either directly from the tortfeasors or from any judgment or settlement the insured recovers from the tortfeasor." Steven Flower, Note, *Toward Correcting the Misapplication of Subrogation Doctrine in California Healthcare*, 77 S. CAL. L. REV. 1039, 1041 (2004). See *infra* notes 54–57 and accompanying text for a brief discussion of subrogation.

26. *See* Benjet, *supra* note 4, at 211 (discussing ways that states have modified the collateral source rule to ensure that it is compensatory rather than punitive and noting the "clear national trend towards limiting the collateral source rule, especially in health care liability cases"). *But see* Kevin S. Marshall & Patrick W. Fitzgerald, *The Collateral Source Rule and Its Abolition: An Economic Perspective*, 15 KAN. J.L. & PUB. POL'Y 57, 61–62 (2005) (arguing that if the justification for changing or abolishing the collateral source rule were rational, states that have attempted to modify the rule would have all made the same modifications).

27. Pub. L. No. 111-148, 124 Stat. 119 (2010).

28. The importance of health insurance to the American public makes it likely that increased coverage will be prioritized as a future change to the insurance system. For example, Massachusetts enacted statewide healthcare reform in 2006, and the Clinton administration also attempted to reform health care. *See* DAVID A. BLUMENTHAL & JAMES MORONE, THE HEART OF POWER: HEALTH AND POLITICS IN THE OVAL OFFICE 1–20, 346–84 (2009) (illuminating how healthcare reform is contemplated in almost every president's agenda); Ezekiel J. Emanuel & Victor R. Fuchs, *Health Care Vouchers—A Proposal for Universal Coverage*, 352 NEW ENG. J. MED. 1255, 1255 (2005) (discussing the widespread "[d]issatisfaction with the financing of the U.S. health care" system and proposing a voucher system to achieve universal care); John F. Cogan et al., *A Better Way to Reform Health Care*, WALL ST. J., Feb. 24, 2010, http://online.wsj.com/article/SB10001424052748704804204575069133264585068.html (suggesting alternative ways to curb rising healthcare costs). *See generally* Timothy Stoltzfus Jost, *The Massachusetts Health Plan: Public Insurance for the Poor, Private Insurance for the Wealthy, Self-Insurance for the Rest?*, 55 U. KAN. L. REV. 1091 (2007) (discussing Massachusetts's healthcare reform and other potential healthcare reform plans, such as the Clinton Health Care Plan).

collateral source rule in light of any future healthcare reforms.[29] The need to reform the collateral source rule was apparent even before PPACA's enactment, as evidenced by the assortment of ways that states have attempted to define medical damages.[30] Therefore, courts reviewing the justifications for the collateral source rule under any future healthcare reform can draw on the reasoning in this Comment.

The collateral source rule, which developed at a time when having health insurance was rare, needs to be reexamined. Because of PPACA's individual mandate requirement (effective January 1, 2014), almost everyone will be insured.[31] Thus, defendants will rarely, if ever, encounter plaintiffs whose medical bills are paid in full at the billed rate rather than at the lower negotiated rate paid by insurance companies.[32] This also means that medical providers will usually receive a lower negotiated reimbursement rate rather than the higher billed charge[33] as full payment for services.[34] It is therefore necessary to ask whether courts following the collateral source rule should still use billed charges in calculating medical damages when medical providers themselves are accepting lower negotiated rates.

This Comment argues that PPACA will diminish the justification for the collateral source rule and change the way courts determine medical damages in personal injury suits. Part I lays out the collateral source rule and explains how the two parts of the rule result in medical damages being awarded at the billed amount. Part I also explores different ways that medical damages could be calculated for an insured plaintiff depending on how the reasonable cost of medical care is defined.

To understand how PPACA changes the rationales behind the collateral source rule, it is necessary to identify the main rationales set forth in support of the rule. Part II contributes to existing literature on the collateral source rule by classifying the various arguments courts have offered in support of the rule into four cat-

29. *See* Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566 (2012) (upholding the individual mandate provision of PPACA); Jonathan Gruber, *Covering the Uninsured in the United States*, 46 J. ECON. LITERATURE 571 (2008) (discussing health reform methods that can result in currently uninsured individuals becoming insured); Dodd Harris, *11th Circuit Strikes Down Individual Mandate*, OUTSIDETHEBELTWAY.COM (Aug. 12, 2011), http://www.outsidethebeltway.com/11th-circuit-strikes-down-individual-mandate (noting that if the mandate had been deemed unconstitutional, private insurance would have become "prohibitively unprofitable" and a single payer healthcare system could have taken the place of the PPACA-created system). *See generally* Gary T. Schwartz, *A National Health Care Program: What Its Effect Would Be on American Tort Law and Malpractice Law*, 79 CORNELL L. REV. 1339, 1341–49 (1994) (discussing how healthcare reform could lead to the repeal of the collateral source rule).

30. *See supra* notes 20–23 and accompanying text. See also *infra* note 143 and accompanying text for support for the claim that the uninsured are often unable to pay the billed charges.

31. *See infra* notes 140–143 and accompanying text.

32. *See infra* notes 140–143 and accompanying text.

33. *See infra* note 41 and accompanying text.

34. *See infra* Part III.C.

egories: deterrence, avoiding unjust enrichment, incentivizing risk mitigation, and restoration.

Part III of this Comment argues that under PPACA, the individual mandate and the provisions that standardize insurance contracts will cause courts to change how they calculate medical damages. Once almost everyone is insured, medical providers will rarely receive payment for the full amount they bill. This will require courts to reevaluate whether calculating medical damages at the billed amount is fair. Part III then examines how the four rationales for the collateral source rule change after PPACA. I conclude that after PPACA those rationales weaken, and it becomes more logical to calculate medical damages based on insurance reimbursement rates and insurance premium payments.

Although many states have modified or abrogated the collateral source rule, these solutions are inadequate in light of PPACA. Part IV of this Comment fills a void by proposing a new way to calculate medical damages while still factoring in rationales underpinning the collateral source rule. Part IV proposes that after PPACA, courts calculate medical damages using negotiated reimbursement rates and a percentage of premiums the plaintiff paid.

I. BACKGROUND

The common law collateral source rule states that a tortfeasor-defendant cannot mitigate the damages he owes to a plaintiff by introducing evidence of collateral source payments.[35] Collateral source payments are payments by third parties to a plaintiff or to a medical provider on the plaintiff's behalf as a result of injuries the defendant caused. These third parties are wholly unrelated to the suit and bear no relation to the defendant who allegedly caused the plaintiff harm. Under the rule, collateral source payments such as insurance payments, employment benefits, gratuities, and social legislation benefits may not be used to mitigate damages a defendant owes;[36] if a plaintiff receives compensation for injuries from a third party, the defendant will nonetheless be liable to the plaintiff for the total cost of the

35. RESTATEMENT (SECOND) OF TORTS § 920A (1979); *see also* Michael Flynn, *Private Medical Insurance and the Collateral Source Rule: A Good Bet?*, 22 U. TOL. L. REV. 39, 40–41, 42 (1990) ("The Collateral Source Rule is fundamentally a rule that prohibits the introduction of certain types of evidence in court. In the context of personal injury litigation, it allows an injured party to recover the value of medical treatment from a culpable party, irrespective of payment of actual medical expenses by the injured party's insurance carrier. . . . [T]he Collateral Source Rule requires the tortfeasor to compensate the injured party for all harmed caused and not merely the net loss suffered . . . ." (footnotes omitted)).

36. *See* Richard C. Maxwell, *The Collateral Source Rule in the American Law of Damages*, 46 MINN. L. REV. 669 (1962) (examining different types of collateral source benefits including insurance proceeds, employment benefits, gratuities, and social legislation benefits).

plaintiff's medical care. Although there are many types of collateral sources, this Comment's focus is on payments made by private health insurance companies.

Under common law, the collateral source rule has two parts: an evidentiary part and a damages part.[37] The evidentiary part of the rule prevents the jury from learning about any collateral source payments a plaintiff receives.[38] This means jurors are told only the amount billed for the plaintiff's medical services and not the lesser amount ultimately paid by the plaintiff's health insurance company. Since a jury will not be aware of insurance payments, a jury might award medical damages that are higher than the amount the plaintiff or insurer ultimately pays for medical care. The damages part of the rule prevents a trier of fact from mitigating the damages a defendant owes by amounts third parties already paid to the plaintiff.[39] Barring mitigation based on collateral source payments, however, also means that defendants are prevented from reducing the damages owed to the amount actually paid by insurance companies, even when medical providers accept this lesser amount as payment in full.[40] In the context of medical care, the amount a medical provider bills is rarely a true reflection of what they are actually paid or expect to be paid for rendering care.

A brief discussion of terminology is necessary to understand the complexity of the collateral source rule. For the purpose of this Comment, the full amount a medical provider bills a patient is the "billed charge."[41] It is now common practice, however, for medical providers to negotiate with health insurance companies and agree to provide care to insured individuals at a rate lower than the billed charge.[42] The lower rate that medical providers set with insurance companies is often referred to as a negotiated reimbursement rate.[43] Although a medical provider sets a billed charge amount for their medical services, if the patient is insured, the insurer will likely pay the provider the lower negotiated reimbursement rate.[44] The

37. *See* Larry D. Warren & Nathan L. Mechler, *Paid or Incurred and the Collateral Source Rule Across the Country*, 59 FED'N DEF. & CORP. COUNS. Q. 203–06 (2009).
38. *See id.*
39. *See id.*
40. *See* Tolan v. ERA Helicopters, Inc., 699 P.2d 1265, 1267 (Alaska 1985) ("The collateral source rule thus prohibits the reduction of a plaintiff's damages when he has received compensation from another source. It also has an evidentiary role, excluding evidence of other compensation on the theory that such evidence would affect the jury's judgment unfavorably to the plaintiff on the issues of liability and damages.").
41. *See* Christopher P. Tompkins et al., *The Precarious Pricing System for Hospital Services*, 25 HEALTH AFF. 45, 46 (2006); *see also* Uwe E. Reinhardt, *The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy*, 25 HEALTH AFF. 57, 59 (2006) (describing how hospitals set their charges).
42. *See* Tompkins et al., *supra* note 41, at 46.
43. *See* Beard, *supra* note 21, at 456–57; Tompkins et al., *supra* note 41, at 46.
44. For simplicity, it is assumed the medical services in question are covered under the patient's plan. Note that health insurance policies provide varying levels of care, so in some instances medical

difference between a billed charge and the lower negotiated reimbursement rate can be as much as 250 percent.[45] Currently, the only people subject to medical services at the billed charged rate are uninsured individuals. Uninsured individuals who seek medical care generally do not know they can negotiate billed charges.[46] The uninsured population consists mainly of wealthy individuals who opt not to have health insurance and people who cannot afford insurance.[47] People who cannot afford insurance likely also cannot afford to pay the billed charge.[48] Therefore, medical providers are rarely able to collect the billed charge amount.[49]

When determining medical damages, courts attempt to determine the economic harm the plaintiff suffered, which is measured by the cost of the medical services received. As the brief discussion above illustrates, however, the costs of medical services vary based on whether the billed charge or negotiated reimbursement rate is used and on the negotiated rate for particular insurers.

Consider the following two people, Matt and Lisa. Both are injured, and they each incur $100,000 in billed charges for treatment they received at a hospital:

(a) Matt has health insurance and pays a monthly premium of three hundred dollars to his health insurance company.[50] Because he is insured, his insurance company pays the hospital $30,000 for his medical expenses. This $30,000 is a negotiated reimbursement rate that the hospital accepts as payment in full for the original $100,000 billed charge. The difference between the billed charge and the negotiated reim-

procedures might not be covered. An insured patient whose insurance plan does not cover a medical procedure would be charged the billed charge rate for that procedure.

45. *See* Mark A. Hall & Carl E. Schneider, *Patients as Consumers: Courts, Contracts, and the New Medical Marketplace*, 106 MICH. L. REV. 643, 663 (2008) (describing how hospitals bill uninsured patients as much as 250 percent more than what insured patients pay).

46. Some uninsured individuals may try to negotiate the billed charge. For example, a patient may ask a medical provider if there is a discount if they pay in cash.

47. Those who cannot afford insurance are generally not poor enough to qualify for government-sponsored insurance yet also cannot afford private insurance. *See infra* note 144 and accompanying text.

48. *See* Reinhardt, *supra* note 41, at 62.

49. *See* Gleissner, *supra* note 20, at 660 ("Is it really an 'expense' if nobody ever pays that amount?").

50. Matt or his employer could pay these medical premiums. If the employer pays the premiums, the cost of the premiums are considered a benefit Matt receives in exchange for a slightly reduced salary. If Matt pays the premiums, his employer likely compensates him more since it is not providing the health insurance benefit. Regardless of the compensation method, the cost of Matt's premiums will come from his pocket either directly or indirectly. For simplicity's sake, this example assumes Matt pays his own premiums. *See* John K. Iglehart, *Changing Health Insurance Trends*, 347 NEW ENG. J. MED. 956, 960 (2002) (describing how, as the cost of insurance rises, employers have shifted from giving "employees a defined set of insurance benefits and instead offer them a fixed amount of money to pay for coverage").

bursement rate (in this case $70,000) is considered a written-off amount and is not paid or owed by anyone.

(b) Lisa does not have health insurance and thus has not incurred monthly premium costs. Therefore, she will be liable for the full billed charge for her medical services—$100,000.

Now imagine that John caused both Matt and Lisa's injuries and assume that the only question is how much John owes to each of them for the medical expenses they incurred.[51] Lisa's medical damages are straightforward: Since Lisa owes the entire billed charge of $100,000 to the hospital for her treatment, she will likely recover the entire amount from John. Matt was also billed $100,000, but the hospital accepted a lower negotiated rate, $30,000, as full satisfaction of the bill. Two issues further complicate how Matt's medical damages are calculated: (1) The $30,000 was not paid by Matt but by his insurance company; and (2) to get this insurance benefit, Matt had been paying monthly premiums of $300 per month. The first issue raises the question of whether Matt should be reimbursed for money he did not pay out of his own pocket. The second issue raises the question of whether premium payments should be included in medical damages calculations. This issue turns on whether $30,000 or $100,000 is considered the true measure of Matt's medical costs.[52]

A. Different Ways to Measure the Reasonable Cost of Medical Expenses

There are a few possible ways to calculate Matt's damages award:

(a) *The collateral source rule.* John could owe Matt $100,000 in medical damages since that is the amount originally billed. This approach assumes that the reasonable cost of medical expenses is the billed charge amount. This scenario reflects the common law collateral source rule.

(b) *The negotiated reimbursement rate.* John could owe Matt $30,000—the amount actually paid by the insurance company to satisfy the medical bill. This approach assumes that the reasonable cost of medical expenses is the negotiated reimbursement rate, but it ignores any premium payments Matt made.

51. For simplicity, assume that John is found liable for their injuries.

52. *See generally* Thomas R. Ireland, *The Concept of* Reasonable Value *in Recovery of Medical Expenses in Personal Injury Torts*, 14 J. LEGAL ECON. 87 (2008) (discussing and providing case examples of how the calculation of the reasonable value of medical services varies state by state).

(c) *The negotiated reimbursement rate plus premiums.* John could owe Matt the $30,000 his insurance company paid, plus a determined amount based on the monthly insurance premiums Matt paid to obtain the $30,000 rate. Suppose the court determines that John should reimburse Matt for five years' worth[53] of health insurance premiums, which is $18,000. In this situation, the total amount John would owe is $48,000. This approach assumes that the reasonable cost of medical expenses is the negotiated reimbursement rate and a portion of the health insurance premiums that were paid to make the discount possible.

(d) *Out-of-pocket costs including premiums.* A fourth approach would allow Matt to recover only insurance premium payments. This approach determines Matt's medical damages based on what he actually had to pay out of pocket (assuming his health insurance plan does not require any copayments). Thus, the only postinjury cost to him is the health insurance premiums he paid to get the benefit of his insurer paying his medical bills. In this case, assuming John is responsible for five years' worth of premiums, this comes to $18,000. Note that this scenario puts the responsibility of the medical costs on the health insurance company.

(e) *Out-of-pocket costs excluding premiums.* Lastly, John might owe Matt nothing in medical damages because Matt's insurance company already paid for his care. This approach assumes that the reasonable cost of medical expenses is the portion of the medical bills, if any, that Matt paid or owes, excluding insurance premium payments. This approach is similar to scenario (d) in that it factors in Matt's out-of-pocket costs, but it does not include premium payments. This is considered an abrogation of the collateral source rule.

Scenarios (c)–(e) demonstrate a practice known as subrogation.[54] Subrogation is a situation in which the insurance company seeks reimbursement from a tortfeasor for medical expenses paid on plaintiff's behalf.[55] Where subrogation is allowed, the insurance company can either seek reimbursement from a tortfeasor directly or assert a right to part of an award that the plaintiff recovers from a

53. The number of years of insurance payments that should be included in a damages award is a question of what amount will compensate Matt for his injury. This issue is discussed further in Part IV.

54. *See* TOM BAKER, INSURANCE LAW AND POLICY 331–32 (2d ed. 2008).

55. *Id.*

tortfeasor.[56] The health insurance company is given the right to subrogate under the insurance contract between plaintiff and the insurance company.[57] Scenario (c) likely reflects the situation in which the insurance company is reimbursed by the plaintiff, and scenarios (d) and (e) are situations in which the insurance company separately seeks recovery directly from a tortfeasor.

In the situations above, scenario (a) focuses on treating the defendant, John, consistently by ensuring he owes the same amount of damages regardless of whether the plaintiff is insured. Scenarios (b)–(e) focus on trying to treat injured plaintiffs fairly by compensating plaintiffs for the actual costs they incur. The differences between scenarios (b)–(e) depend on how the cost to the injured plaintiff, along with the reasonable cost of medical care, is conceptualized.

B. Barring of Evidence and Mitigation

The collateral source rule results in damage awards as in scenario (a) regardless of whether the plaintiff is insured. This is because the first part of the collateral source rule prevents evidence of any outside payments from being presented to a jury.[58] Courts fear that "the jury will misuse the evidence to diminish the damage award."[59] Thus, in calculating a medical damage award, billed charges is the only amount on which the jury has to base its award. Assuming that the jury wants to compensate the plaintiff for the full cost of her injury, the jury is likely to return a medical damages award of at least the billed charge, which is assumed to be the cost to the plaintiff. In the hypothetical situation above, a jury would be told that Matt's and Lisa's medical bills were $100,000 each, and it would likely award medical damages of $100,000 to each of them if a guilty verdict were returned.

The second part of the collateral source rule prevents a court's postverdict mitigation of a damage award. This damages aspect of the rule prevents results like scenarios (b)–(e), in which the damage award is reduced based on the negotiated rate paid by Matt's insurance company and sometimes offset by Matt's insurance

56. *See* Flower, *supra* note 25, at 1041.

57. *See* Spencer L. Kimball & Don A. Davis, *The Extension of Insurance Subrogation*, 60 MICH. L. REV. 841, 843 (1962). *See generally* Flower, *supra* note 25 (providing a more detailed discussion of the subrogation doctrine's evolution in the medical insurance context).

58. Evidence is barred because courts worried that "the jury may be inclined to . . . reduce a damage award, when it learns that plaintiff's loss is entirely or partially covered." Jurgensen v. Smith, 611 N.W.2d 439, 442 (S.D. 2000) (alteration in original) (quoting Moses v. Union Pac. R.R., 64 F.3d 413, 416 (8th Cir. 1995)) (internal quotation marks omitted).

59. Proctor v. Castelletti, 911 P.2d 853, 854 (Nev. 1996). The fear is that juries that learn of a plaintiff being insured will diminish the award to amounts less than insurance payments, or in the more extreme cases, award the plaintiff no damages.

premium payments. In practice, since evidence of insurance payments is barred, the jury is not given an option to mitigate damages based on this information.

C. Other Complicating Issues

The above scenarios are further complicated by the fact that health insurance plans operate differently.[60] Insured plaintiffs might have plans that vary remarkably from Matt's plan, which guarantees that the insurance company will pay Matt's medical bills in exchange for monthly premiums and does not require Matt to pay additional copayments. This plan resembles a type of health maintenance organization (HMO) insurance plan.[61] Different plans may carry different monthly premiums and may result in different negotiated rates with healthcare providers.[62]

For the purposes of this Comment, it is sufficient to note that determining the reasonable cost of medical damages a defendant owes can be further complicated by the type of insurance a plaintiff holds. Calculating the damages the defendant owes for injuring an insured plaintiff turns on a number of questions[63]: Has the plaintiff paid insurance premiums to obtain the health insurance benefits? How long has the plaintiff been paying insurance premiums? Did the plaintiff have to pay a portion of the medical bill in addition to the insurance premiums? What was the negotiated amount accepted as full payment and how much does this differ from the billed amount?

Applying scenario (a), the traditional collateral source rule, in all cases seems to avoid the complex questions presented above. But even though the collateral source rule avoids the complexity of scenarios (b)–(e), it also ignores the reality that a blanket rule leads to different results for plaintiffs who incur similar injuries. This range of differing results under the collateral source rule has led many states to

60. *See* Beard, *supra* note 21, at 461–70 (discussing the development of health insurance and the various types of reimbursements depending on an individual's type of health insurance); *see also* GARY CLAXTON & JANET LUNDY, HENRY J. KAISER FAMILY FOUND., HOW PRIVATE HEALTH COVERAGE WORKS: A PRIMER (2008) (explaining the various types of private healthcare coverage). The focus of this Comment is on private health insurance. Public health insurance plans, which are largely, if not completely, funded by the government, are beyond the scope of this Comment.

61. *See* CLAXTON & LUNDY, *supra* note 60, at 2. Note that some health maintenance organizations (HMOs) may require the insured to pay a small copayment before the health insurer will pay for the care. There are many HMO plans, however, for which HMO members' copayments are $0. *See About Health Plans*, CAL. DEP'T MANAGED HEALTH CARE, http://www.hmohelp.ca.gov/dmhc_consumer/hp/hp_default.aspx (last visited Dec. 26, 2012).

62. *See* Reinhardt, *supra* note 41, at 62 ("An individual hospital might be paid by a dozen or more distinct third-party payers, each with its own distinct set of rules for and levels of payment, which are negotiated separately with each private insurer once a year.").

63. Note that other issues such as plan deductibles and annual limits may complicate the damages calculation. These factors are beyond the scope of this Comment.

question whether the rule is the proper method of calculating medical damages. Several states have modified the rule because of such complexities.[64] These modifications are incomplete, however, given the nature of modern health insurance. Furthermore, the implementation of PPACA strengthens the need to define how medical damages are calculated, as it becomes even less justifiable for courts to use billed charges when almost everyone will have health insurance.

II. RATIONALES FOR THE COLLATERAL SOURCE RULE

It is necessary to examine the collateral source rule's underlying goals to understand why some states have maintained the common law rule while others have modified or abolished it.[65] The rule's goals can be separated into four categories: deterrence, unjust enrichment, risk mitigation incentive, and restoration. The deterrence theory seeks to impose a harsh enough punishment to deter the tortfeasor and possibly other potential tortfeasors from injuring future plaintiffs. Unjust enrichment rests on the belief that the defendant should not receive a benefit just because the injured plaintiff is insured. The risk mitigation theory seeks to encourage the purchase of health insurance. Lastly, the restoration theory seeks to make the plaintiff whole by placing the plaintiff in the position he would have been in had the injury not occurred.

A. Deterrence

One justification for the collateral source rule may be to create the greatest possible deterrence against harms. Courts believe the highest possible damages award will most deter a defendant from causing future harm to other potential

64. These modifications are discussed *infra* Part II.E. For modifications states have made, see Benjet, *supra* note 4, and Marshall & Fitzgerald, *supra* note 26.

65. Some states that follow the common law collateral source rule are California, Delaware, Georgia, Hawaii, Illinois, Kansas, Kentucky, Maine, Maryland, Massachusetts, Mississippi, and Missouri. For a more comprehensive list of how states have applied, modified, or abolished the collateral source rule, see Benjet, *supra* note 4, and Marshall & Fitzgerald, *supra* note 26. Indiana has modified the collateral source rule and now allows into evidence collateral source payments, any amounts the plaintiff would be required to repay, and any payments the plaintiff made to obtain collateral source benefits. *See* IND. CODE ANN. §§ 34-44-1-1 to -2 (LexisNexis 2008). Minnesota changed the common law collateral source statute so that a plaintiff cannot recover the same amount from the defendant and a collateral source. *See* MINN. STAT. ANN. § 548.251 (West 2010). Minnesota has also recently ruled that insurance write-offs are a collateral source payment that must be deducted from damages awards. *See* Swanson v. Brewster, 784 N.W.2d 264, 282 (Minn. 2010) (holding that the discount negotiated by the plaintiff's medical insurance company is a collateral source and that damages may be reduced by this amount).

plaintiffs.[66] Plaintiffs raise this argument in opposition to defendants' attempts to reduce their medical damages based on the amount plaintiffs' insurance companies paid.[67] Courts worry that "reducing the recovery by the monies paid by a third party would hamper the deterrent effect of the law."[68] Therefore, to most deter "a tortfeasor's negligent conduct . . . [the rule] makes the tortfeasor fully responsible for [medical billed charges] as a result of tortious conduct."[69]

To maximally deter while justifiably maintaining that the damages award is not punitive, some courts define billed charges as actual damages, which is generally defined as "an amount awarded to a complainant to compensate for a proven injury or loss" or as "damages that repay actual losses."[70] Defining billed amounts as actual damages allows courts to argue that compensating the plaintiff for the billed charge is not punitive (punitive damages are generally regarded to be "damages awarded in addition to actual damages").[71] Implicit in this reasoning is the assumption that using the billed amount is a fair measure of a plaintiff's actual loss.[72]

Consider the hypothetical from Part I: Under the common law rule, Matt and Lisa will both recover $100,000. Courts applying the collateral source rule are worried that if the rule were altered, John could reduce the damages he owes Matt to the amounts described in scenarios (b)–(e), thus resulting in less deterrence. If mitigation were allowed, John might only owe 20 to 50 percent of the medical damages he would owe if he injured an uninsured plaintiff like Lisa. Thus, allowing mitigation reduces the level of deterrence by decreasing the amount of damages for which defendants will potentially be liable. This lower deterrence might entice potential defendants to take more risks, which could lead to more injuries. Therefore, to create the highest possible deterrence for potential tortfeasors, the collateral source rule holds defendants liable for the full cost of harm—which is

66. *See* Hubbard, *supra* note 16, at 485 ("The reasons traditionally given in support of this rule are [that] . . . reducing a damage award by collateral benefits would reduce the deterrent effect of the award because the defendant would no longer be paying the full amount of the accident costs caused by the wrongdoing."); *see also* Beard, *supra* note 21, at 459 ("The most widely accepted argument [for the collateral source rule] is that a wrongdoer should pay the full amount of damages he causes.").

67. *Id.*

68. Bozeman v. State, 879 So. 2d 692, 700–01 (La. 2004) (quoting Suhor v. Lagasse, 770 So. 2d 422, 424 (La. Ct. App. 2000)) (internal quotation marks omitted).

69. Leitinger v. DBart, Inc., 736 N.W.2d 1, 10 (Wis. 2007).

70. BLACK'S LAW DICTIONARY 447 (9th ed. 2009).

71. *Id.*

72. *But see* Lopez v. Safeway Stores, Inc., 129 P.3d 487, 491–92 (Ariz. Ct. App. 2006) ("In many respects, the rule 'is punitive' because it 'allows a plaintiff to fully recover from a defendant for an injury even when the plaintiff has recovered from a source other than the defendant for the same injury.'" (quoting Norwest Bank (Minn.), N.A. v. Symington, 13 P.3d 1101, 1109 (Ariz. Ct. App. 2000))).

interpreted as the full amount of a medical provider's bills.[73] This blanket rule is an attempt by courts to set the deterrence cost at the highest level possible while maintaining that the rule is not punitive.[74]

B. Unjust Enrichment

Another justification for the collateral source rule is the desire to prevent defendants from receiving unearned windfalls.[75] This theory turns on the belief that a defendant who injures an insured plaintiff and is allowed to mitigate based on collateral source payments would be unjustly enriched because he would pay less in damages to that plaintiff than he would to an uninsured plaintiff.[76] In deciding whether the defendant should pay a different amount based on the plaintiff's insurance status, courts have considered whether there is anything that would allow the defendant to take advantage of the plaintiff's medical costs discount.[77] This has led courts to consider whether defendants are privy to plaintiffs' health insurance contracts.[78]

An insured plaintiff pays monthly premiums to her health insurance company and in return the insurance company will cover some part or all of the plaintiff's medical bills as they arise.[79] An insurance company is able to do this because it pools together premiums from other insured persons to create a pool of cash that it can use to pay the medical bills of the individuals who are harmed or become ill and need medical care. This sharing of losses is called risk pooling.[80] Risk pooling

73. *See* John G. Fleming, *The Collateral Source Rule and Contract Damages*, 71 CALIF. L. REV. 56, 57 (1983); RESTATEMENT (SECOND) OF TORTS § 920A (1979); *see also Lopez*, 129 P.3d at 495–96 (stating that a defendant cannot reduce the damages he owes by the amount of the plaintiff's medical insurance write-off because the collateral source rule's purpose is to prevent the defendant from escaping liability for the full value of his harm).

74. *See supra* note 66 and accompanying text. There is the possibility that the full amount billed for medical services will not deter potential defendants who do not mind paying that amount, but proponents of the rule believe that at least the majority of potential tortfeasors will be deterred.

75. *See* Hubbard, *supra* note 16, at 485 (noting that supporters of the collateral source rule believe that a defendant should not benefit from something that the plaintiff pays for or that gets donated on the plaintiff's behalf).

76. *See Lopez*, 129 P.3d at 492.

77. *See* Maxwell, *supra* note 36, at 673.

78. *Id.*

79. *See* Flynn, *supra* note 35, at 43 (arguing that if the defendant is allowed to benefit from the private insurance contract between the plaintiff and the insurance carrier, the private medical insurance company will be protecting the guilty party instead of the insurer); Marshall & Fitzgerald, *supra* note 26, at 58–60 (explaining that a plaintiff does not receive a windfall under the collateral source rule because the defendant is not privy to the insurance contract and such damages are not a gain but rather an "expected remittance purchased"); Maxwell, *supra* note 36, at 673.

80. *See infra* notes 146–147 and accompanying text.

is possible because not everyone uses the same amount of medical care. Thus, for a given year, individual A might pay more in premiums than she used in care, and this excess can be shifted to individual B, who used more in medical care than she paid in premiums. Basically, a plaintiff who purchases insurance is safeguarding against the possibility that she might incur higher medical costs in any given year than she would be able to pay on her own.

In the collateral source rule context, the medical costs discount that the defendant is trying to take advantage of is a product of the plaintiff's insurance contract. A medical provider gives an insurer, and thus the insured, a negotiated reduced rate in exchange for the potential volume of business from all the individuals that buy the insurer's health plan.[81] The defendant takes no part in securing the benefits under a plaintiff's insurance contract; he does not pay premiums, does not partake in negotiations, and does not provide the plaintiff anything in return for paying premiums to an insurance company.[82] Preventing the defendant from benefiting from this contract is one of the main principles of the collateral source rule[83]: "The collateral source doctrine is predicated upon the theory that a tortfeasor has no interest in, and therefore no right to benefit from, monies received by the injured person from sources unconnected with the defendant."[84] Thus, in calculating medical damages, courts following the collateral source rule justify calculating damages based on billed charges by arguing that a defendant cannot benefit from a contract to which he is not privy. Applying this reasoning to the hypothetical from Part I, scenarios (b)–(e) in which Matt would recover a lesser amount than Lisa because he is insured are undesirable because John is not privy to Matt's health insurance contract and should not benefit from it.

C. Creating an Incentive for Risk Mitigation

A third justification for the collateral source rule is that courts want to create an incentive for risk mitigation by rewarding injured plaintiffs who have voluntarily

81. *See* Benjet, *supra* note 4, at 223–24 (describing how hospitals accept lower negotiated rates from insurers in exchange for the insurers providing a volume of business).

82. *See* COLO. REV. STAT. ANN. § 13-21-111.6 (West 2011) (allowing personal injury damages to be reduced based on collateral source payments unless the collateral source payment was made because of a contract entered into and paid for by the plaintiff).

83. *See* Olariu v. Marrero, 549 S.E.2d 121, 123 (Ga. Ct. App. 2001) ("Georgia does not permit a tortfeasor to derive any benefit from a reduction in damages for medical expenses paid by others, whether insurance companies or beneficent boss or helpful relatives." (quoting Bennett v. Haley, 208 S.E.2d 302 (Ga. 1974)) (internal quotation marks omitted)).

84. State Farm Mut. Auto. Ins. Co. v. Nalbone, 569 A.2d 71, 73 (Del. 1989) (citing Yarrington v. Thornburg, 205 A.2d 1, 2 (Del. 1964)) (laying out the state's collateral source rule).

purchased insurance.[85] Although encouraging the purchase of insurance was not an original rationale for the collateral source rule, it has become a common justification.[86] This is because the policy of encouraging citizens to "purchase and maintain insurance for personal injuries and other eventualities" has become more prominent as health insurance becomes more commonplace and more costly.[87] Recognizing that purchasing insurance is a voluntary act,[88] courts use the collateral source rule to encourage such purchases.[89] Courts believe that "a person who has invested years of insurance premiums to assure his medical care should receive the benefits of his thrift."[90] Thus, the collateral source rule creates an incentive for individuals to purchase insurance by allowing insured plaintiffs to recover damages for the full amount billed,[91] regardless of the fact that a lesser amount was actually paid and accepted as payment in full.[92]

Applying this rationale to the hypothetical from Part I will help illustrate this incentive. Under the collateral source rule, both Matt and Lisa could recover $100,000 because evidence of Matt's health insurance payments and any discounted rate he received would be inadmissible. Matt paid $18,000 out of pocket in insurance premiums. Even if Matt had to reimburse his insurance company $30,000 for paying his medical bills at the negotiated rate, he would still have $52,000 leftover from the $100,000 damage award. Allowing Matt to collect this

85. RESTATEMENT (SECOND) OF TORTS § 920A cmt. b (1979) ("If the plaintiff was himself responsible for the benefit, as by maintaining his own insurance or by making advantageous employment arrangements, the law allows him to keep it for himself. If the benefit was a gift to the plaintiff from a third-party or established for him by law, he should not be deprived of the advantage that it confers.").

86. *See* Beard, *supra* note 21, at 460 ("The collateral source rule and its policy justifications were widely accepted before health insurance became prevalent."); Marshall & Fitzgerald, *supra* note 26, at 62 ("The existence of an insurance contract between an underwriter and insured is of no consequence in the determination of the loss caused by a negligent defendant.").

87. Helfend v. S. Cal. Rapid Transit Dist., 465 P.2d 61, 66 (Cal. 1970).

88. Insurance is seen as a voluntary "form of investment, the benefits of which become payable without respect to any other possible source of funds. If [courts] were to permit a tortfeasor to mitigate damages with payments from plaintiff's insurance, plaintiff would be in a position inferior to that of having bought no insurance, because his payment of premiums would have earned no benefit." *Id.*

89. *See* Leitinger v. DBart, Inc., 736 N.W.2d 1, 10 (Wis. 2007) ("The collateral source rule ensures that the liability of similarly situated defendants is not dependent on the relative fortuity of the manner in which each plaintiff's medical expenses are financed."); *see also* Flynn, *supra* note 35, at 66 (noting that buying insurance is seen as a gamble in which "[t]he insurer controls the cost of placing a medical insurance wager [and] an insured can choose to play or not play the insurance game").

90. *Helfend*, 465 P.2d at 66; *see also* Ellsworth v. Schelbrock, 611 N.W.2d, 767 (Wis. 2000) ("The tortfeasor who is legally responsible for causing injury is not relieved of his obligation to the victim simply because the victim had the foresight to arrange, or good fortune to receive, benefits from a collateral source for injuries and expenses.").

91. *See Ellsworth*, 611 N.W.2d at 767.

92. *See* Bozeman v. State, 879 So. 2d 692, 706 (La. 2004) (holding that a plaintiff is "entitled to the benefit of the bargain, and may recover the full value of his medical services, including the 'write-off' amount").

extra $52,000 is the incentive or benefit courts allow under the rule to encourage Matt to purchase and maintain health insurance.[93]

If Matt's recovery were reduced to the amount that his insurance company paid ($30,000), such as in scenario (b) above, and he had to reimburse his insurance for this amount, he might be seen as worse off than Lisa, who had no insurance. This is because although Matt recovers damages for his medical bills, he has still paid $18,000 out of pocket for his voluntary health insurance premiums while Lisa spent zero dollars on health insurance. In this situation, Matt has less of an incentive to maintain health insurance voluntarily when he could remain uninsured and still recover the full cost of his medical care.

A damages award like scenario (c), which reimburses Matt for the $30,000 his insurance company paid and the $18,000 in insurance premiums, appears to place Lisa and Matt in the same position since all their expenses are covered. Matt might be indirectly worse off,[94] however, since in the previous five years he spent $18,000 in insurance premiums, while Lisa had no such obligation and thus enjoyed greater spending power or investment returns from the $18,000 she saved by not paying premiums.[95] But this ignores the realities of why people purchase health insurance. Matt's decision to purchase health insurance likely benefitted him during those five years, as he was probably entitled to a reduced cost for other

93. *See* Benjet, *supra* note 4, at 223 (noting that Louisiana applies the collateral source rule and "to the extent that the write-offs were procured through the payment of the premiums, they cannot properly be considered a 'windfall' to the plaintiff" because the plaintiff had to pay premiums to secure the benefits). *But see Bozeman*, 879 So. 2d at 705 (holding that the plaintiff cannot recover Medicaid write-offs, since unlike in the case of private insurance, the plaintiff pays no consideration for Medicaid benefits).

94. Although the $18,000 Matt receives could just be considered a delayed increase in his spending power, he still might be worse off if the damages award did not factor in interest or inflation.

95. Allowing defendants to mitigate damages because of a plaintiff's insurance payments could be viewed as placing the plaintiff "in a *position inferior* to that of having bought no insurance, because his payments of premiums would have earned no benefit." *Helfend*, 465 P.2d at 66 (emphasis added); *see also* Flynn, *supra* note 35, at 66; Marshall & Fitzgerald, *supra* note 26, at 59 (noting that the plaintiff did not take the insurance policy out for the defendant's benefit (citing Harding v. Town of Townshend, 43 Vt. 536, 538 (1871)). Opponents of the rule argue we should not look at consideration paid, such as insurance premium payments, but at consideration given—such as why the plaintiff bought insurance. If it was because of a possibility of double recovery, then the evidence should be excluded under the collateral source rule because mitigation gives him less than he bargained for. It is more likely, however, that the plaintiff is "purchasing security—prompt and sure payments without the necessity of litigation and without regard to the liability and financial resources of prospective defendants." *See* Note, *Unreason in the Law of Damages: The Collateral Source Rule*, 77 HARV. L. REV. 741, 750 (1964).

See *infra* Part E.II for an example of how states have compensated plaintiffs for insurance premiums paid while allowing defendants to mitigate damages by collateral source payments to prevent double recovery to plaintiffs.

services, such as preventative care.[96] Thus, in fashioning the collateral source rule to allow plaintiffs like Matt an additional recovery (of $52,000 in this example), courts created an additional incentive to purchase insurance.

D. Restoration—What Does It Take to Make the Injured Party Whole?

Finally, courts justify the collateral source rule by arguing that it leads to the most accurate form of restoration. Restoration is the amount that a court determines will make a plaintiff financially whole again in light of the injuries suffered.[97] Applying the collateral source rule, courts stress that "'the injured party should be made whole *by the tortfeasor*, not by a combination of compensation from the tortfeasor and collateral sources.'"[98] Thus, courts following the collateral source rule believe that using billed charges is the best way to measure the harm caused to the plaintiff, and they choose not to factor in actions the plaintiff has voluntarily taken to mitigate his loss.[99] Under this reasoning, medical damages are calculated at the billed charge amount irrespective of lower insurance payments.

Under the five scenarios in Part I, only scenario (a), in which Matt receives $100,000 in damages, reimburses Matt and Lisa the same amount for medical damages. This reflects the philosophy that using billed charges best measures the harm the plaintiff incurs.

E. Modifications to the Collateral Source Rule—Redefining Restoration

Some states consider other factors in measuring the harm caused or suffered by the plaintiff and thus have moved toward abandoning the rule. These factors may include collateral source payments by the plaintiff's health insurance company, whether the plaintiff's insurance plan calls for subrogation, and whether the plaintiff paid premiums to secure the benefits. These states still believe that the tortfeasor owes a responsibility to the plaintiff, but they also believe that considering other relevant factors provides a better measure of the harm caused and therefore of what is needed to make the plaintiff whole again.[100]

96. *See* Note, *supra* note 95.
97. *See Bozeman*, 879 So. 2d at 702–04.
98. *Id.* at 704 (emphasis added) (quoting Acuar v. Letourneau, 531 S.E.2d 316, 323 (Va. 2000)).
99. See *supra* Part II.C for a discussion of plaintiffs voluntarily mitigating their damages by purchasing health insurance. *See also* Beard, *supra* note 21, at 458 ("Simply put, our tort law has placed the policy of punishing defendants above the principle of compensation for actual net losses.").
100. Beard, *supra* note 21, at 459 (arguing that the collateral source rule "misses the point" and that "[a] compensatory system should make the plaintiff whole, not punish the defendant").

This leads to two general alternative rules that states have used to measure personal injury damages accurately:

(a) Reducing billed charges by the amount the plaintiff's health insurance company paid, including amounts written off.

(b) Reducing billed charges by the amount the plaintiff's health insurance company paid but offsetting this by insurance premiums plaintiff paid. This also abolishes the collateral source rule, but it provides an additional recovery for premium payments.

1. Alternative #1: Abolishing the Rule

The first alternative reflects the view that medical expenses already paid or discounted by collateral sources do not constitute harm suffered by the plaintiff and should not be included in the damage award needed to make the plaintiff whole again. This approach abandons the collateral source rule.[101] States following this approach believe that allowing the plaintiff to recover amounts already paid or amounts that will never be owed goes beyond what is needed to make the plaintiff whole and results in a windfall.[102] For instance, Florida Statute Section 768.76 states that a "court shall reduce the amount of such award by the total of all amounts which have been paid for the benefit of the claimant, or which are otherwise available to the claimant, from all collateral sources."[103] Interpreting the statute, a Florida appellate court held that "[t]his alteration in the common law collateral source rule evinces the legislature's intent to prevent plaintiffs from receiving a windfall by being compensated *twice* for the same medical bills by both their insurance company and by the tortfeasor."[104] This view is further supported by the limitation that

101. Recently, the California Supreme Court in *Howell v. Hamilton Meats & Provisions, Inc.*, 257 P.3d 1130, 1145 (Cal. 2011), took this approach but simultaneously declared it was not abrogating the collateral source rule.

102. *See* Marshall & Fitzgerald, *supra* note 26, at 61 n.39 (noting that the argument that the plaintiff receives a windfall under the rule has driven state reform, with forty-four out of fifty states enacting legislation for the reconsideration of the collateral source rule); *see also* Gleissner, *supra* note 20, at 656 ("[To p]resent[] such charges to the jury is arguably against public policy because they represent illusory or illegal charges.").

103. FLA. STAT. ANN. § 768.76(1) (West 2011); *see also* Swanson v. Brewster, 784 N.W.2d 264, 282 (Minn. 2010) (requiring a postverdict reduction of damages by collateral source payments and categorizing insurance write-offs as a collateral source).

104. Cooperative Leasing, Inc. v. Johnson, 872 So. 2d 956, 959 (Fla. Dist. Ct. 2004) (emphasis added); *see also* Imlay v. City of Lake Crystal, 453 N.W.2d 326, 331 (Minn. 1990) (noting that the common law collateral source rule was abrogated by state statute to prevent double recoveries by plaintiffs).

"there shall be no reduction for collateral sources for which a subrogation or reimbursement right exists."[105] Thus, states such as Florida have effectively abrogated the common law collateral source rule by mandating that collateral source payments be subtracted from damage awards to restore plaintiff to a preinjury state.

Consider the abrogation alternative as applied to the medical damages scenarios from Part I involving Matt and Lisa. This is most closely reflected in scenario (e) in which Matt can only recover out-of-pocket costs excluding premium payments. Abrogation calls for Matt's damage award to be reduced by the negotiated reimbursement rate and insurance write-offs, but it does not compensate him for insurance premium payments. If Matt were injured in Florida, he would collect no damage award for his medical expenses since they are fully covered by his health insurance. In this situation, Matt might be considered undercompensated since his premium payments were not taken into account. If Matt were to sue, he could only collect an award for medical damages if subrogation were required. In that scenario, however, it makes more sense for Matt's insurance company to bring the claim on its own since Matt's recovery would be turned over to his insurance company.[106]

States that have abolished the collateral source rule believe third-party payments adequately restore a plaintiff. This might not make the plaintiff whole, however, in light of the insurance premiums the plaintiff paid to secure the third-party payments. Thus, if insurance premiums are considered necessary to make the plaintiff whole, the collateral source rule may compensate Matt better than an alternative that abolishes the rule, even if it results in overcompensation.

2. Alternative #2: Factoring in Premium Payments

The second alternative to the collateral source rule reflects the view that even if the plaintiff's insurance covers her medical expenses, she should be compensated for medical premiums paid. For instance, Connecticut, Minnesota, and Michigan have all enacted statutes that allow damage awards to be reduced by payments made by collateral sources, but offset that reduction by insurance premiums plaintiff paid.[107] These statutes reflect the belief that the collateral source payment requires

105. FLA. STAT. ANN. § 768.76(1).

106. If Matt were suing for noneconomic medical damages, however, like pain and suffering, he might still bring suit and reimburse the insurance company for any medical damages award he receives.

107. *See* CONN. GEN. STAT. ANN. § 52.225a(a)–(c) (West Supp. 2012) (reducing damages awards by collateral source payments if no subrogation exists but offsetting it by the amount of premiums paid "as of the date the court enters judgment"); MICH. COMP. LAWS ANN. § 600.6303(1)–(2), (4)–(5) (West 2000) (stating that a court must reduce the damages award by the amount paid or payable by a collateral source, but the reduction is offset by any insurance premiums the plaintiff paid that secured the negotiated reimbursement rate benefit); MINN. STAT. ANN. § 548.251 (West 2010) (requiring a court to reduce a damages award by the amount collateral sources paid, except where subrogation

the premiums the plaintiff paid to secure it.[108] Similar to the Florida rule, this reduction for collateral source payments is limited to situations in which subrogation does not exist.

States employing this alternative, however, must still resolve how many years' worth of premium payments plaintiffs should receive and there is currently no clear consensus on how to make that determination. For example, under the Connecticut statute the plaintiff can collect the amount paid "as of the date the court enters judgment."[109] Connecticut courts interpret this as the amount the plaintiff paid in premiums during the years in which the plaintiff received care related to the injury.[110] In contrast, the Minnesota statute requires a premium offset for the premiums paid in the two years before the lawsuit at issue.[111] The proposal in Part IV of this Comment attempts to provide a solution to this problem.

An alternative way to factor premium payments into the plaintiff's damages award is reflected in scenario (d), in which Matt, because he is insured, only recovers $18,000 worth of insurance premiums. Scenario (d) illustrates the belief that when the plaintiff's insurance plan covers all the medical expenses and no subrogation exists, insurance premium reimbursements are needed to make the plaintiff whole.[112] Under scenario (d), both Matt and Lisa have their medical expenses covered in full and neither has to pay extra to secure such payments; Lisa pays no insurance premiums and is compensated at the billed rate, and Matt has his insurance premiums reimbursed. If subrogation exists, then scenario (c), in which Matt recovers the negotiated reimbursement amount and insurance premiums, also reflects Alternative #2. In a subrogation situation, the damages award necessary to restore a plaintiff is presumed to be the amount the plaintiff paid in premiums, plus the amount the insurance company paid for the plaintiff's medical expenses, because the plaintiff will have to reimburse the insurance company for its payments.

rights exist, but offsetting this by insurance premiums paid in the two year period "immediately before the accrual of the action"); *see also* Benjet, *supra* note 4, at 216; Hubbard, *supra* note 16, at 488 (noting the considerable variations in how courts factor in plaintiffs' insurance premiums).

108. Pikulski v. Waterbury Hosp. Health Ctr., 848 A.2d 373, 378 (Conn. 2004) (explaining that for a plaintiff to receive an offset for premium payments, the plaintiff must show that the jury award of damages reimburses the plaintiff for amounts paid by a collateral source to which the plaintiff paid premiums to obtain such payment).

109. *See* CONN. GEN. STAT. ANN. § 52.225a(c).

110. *See Pikulski*, 848 A.2d at 377.

111. MINN. STAT. ANN. § 548.251.

112. Scenario (d) could also reflect a situation in which subrogation does exist but the insurance company has brought a separate action against the tortfeasor.

III. PPACA AND THE COLLATERAL SOURCE RULE

This Part outlines how provisions in PPACA will uproot the justifications for the collateral source rule and standardize the calculation of damages in jurisdictions that have abrogated the rule as discussed above. This Part begins by outlining PPACA's individual mandate requirement and some of the new requirements that make health insurance more standardized.[113] I then argue that courts will have to reexamine how they calculate medical damages under the collateral source rule because of the mandate and other provisions in PPACA.[114] Finally, I contend that PPACA provisions will erode most of the justifications for the collateral source rule set forth in Part II.

A. The Individual Mandate

The individual mandate requirement of PPACA will result in almost all Americans being insured.[115] Section 1501, the individual mandate, requires that most Americans maintain "qualified" health insurance coverage.[116]

> Exemptions will be granted for financial hardship, religious objections, American Indians, those without coverage for less than three months, undocumented immigrants, incarcerated individuals, those for whom the lowest cost plan option exceeds 8% of the individual's income, and those with incomes below the tax filing threshold . . . .[117]

Nonexempt individuals who do not comply with the mandate are subject to a "penalty of the greater of $695 per year up to a maximum of three times that amount ($2085) per family or 2.5% of household income."[118]

113. *But see* Sheryl Gay Stolberg & Kevin Sack, *Obama Backs Easing State Health Law Mandates*, N.Y. TIMES, Feb. 28, 2011, http://www.nytimes.com/2011/03/01/us/politics/01health.html?_r=2&ref=health (discussing President Obama's support for granting insurance mandate waivers to states as long as they find other ways to expand coverage without driving up costs).

114. *See generally* HEALTH CARE & YOU, http://www.healthcareandyou.org (last visited Dec. 27, 2012) (allowing people to see what parts of PPACA apply to them based on their individual characteristics).

115. *See infra* notes 140–142 and accompanying text.

116. *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1501, 124 Stat. 119, 244 (2010) (codified at 42 U.S.C. § 18091 (Supp. V 2011)). *But see* Julie Rovner, *Alternatives to Mandating Insurance? Maybe*, NPR (Feb. 8, 2011), http://www.npr.org/2011/02/07/133503755/alternatives-to-mandating-insurance-maybe (discussing alternatives offered in place of the individual mandate).

117. *Summary of New Health Reform Law*, KAISER FAM. FOUND., http://www.kff.org/healthreform/upload/8061.pdf (last modified Apr. 15, 2011); *see* 26 U.S.C. § 5000A(d)–(e) (Supp. V 2011).

118. *See Summary of New Health Reform Law*, *supra* note 117, at 6.

As outlined in the law, the individual mandate (which includes the restrictions described above) "will minimize adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums."[119] Healthy individuals joining risk pools will allow insurers to guarantee coverage for those previously denied because of their preexisting conditions.[120]

B. More Standardized Insurance Contracts

Several provisions of PPACA seek to standardize insurance contracts.[121] Some of the provisions apply only to newly created plans, while others apply to all health insurance plans.[122] For instance, to meet the individual mandate requirements a plan must include, at a minimum, what PPACA calls "essential health benefits."[123] Essential health benefits must include "ambulatory patient services, emergency room services, hospitalization, maternity and newborn care, mental

119. Patient Protection and Affordable Care Act § 1501(a)(2)(G), 124 Stat. at 243 (codified at 42 U.S.C. § 18091).

120. *Id.* (stating that the individual mandate "is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of preexisting conditions can be sold"). Note, however, that the requirements for these plans will not apply to currently existing health insurance plans that are grandfathered, nor will it cover employer-funded insurance plans. *Fact Sheet: Keeping the Health Plan You Have: The Affordable Care Act and "Grandfathered" Health Plans*, HEALTHREFORM.GOV, http://www.healthreform.gov/newsroom/keeping_the_health_plan_you_have.html (last visited Dec. 27, 2012). *But see* David Nather, *Experts: Individual Mandate Might Fail*, POLITICO (Mar. 1, 2011, 4:25 AM), http://www.politico.com/news/stories/0211/50355.html (describing how premiums might still not be affordable under the health care law if healthy people opt out of the mandate because they are willing to pay the low penalty, which would defeat the cost-saving goal of including healthy individuals in insurance pools).

121. *See* Patient Protection and Affordable Care Act §§ 1001, 1302(b), 1402, 124 Stat. at 130–38, 163–65, 220–24 (codified in scattered sections of 42 U.S.C.).

122. *See infra* notes 123–126 and accompanying text. *But see* Robert Pear, *Four States Get Waivers to Carry Out Health Law*, N.Y. TIMES, Feb. 16, 2011, http://www.nytimes.com/2011/02/17/health/policy/17health.html (describing how four states were given temporary waivers from certain healthcare law requirements, which allowed them to offer "less generous benefits than they would otherwise be required to provide . . . under the new federal health care law").

123. The requirement that qualified health plans offer at minimum an essential health benefits package goes into effect January 1, 2014. *Summary of New Health Reform Law*, *supra* note 117, at 6; *see also* 26 U.S.C. § 5000A(f) (Supp. V 2011). *But see* Geri Aston, *Defining Essential Benefits: How Much Is Too Much?*, AM. MED. NEWS (Apr. 4, 2011), http://www.ama-assn.org/amednews/2011/04/04/gvsa0404.htm (describing some of the difficulties that arise in defining what specific medical benefits are covered under the ten essential health benefits categories); Avery Johnson, *Defining 'Essential' Care*, WALL ST. J., Feb. 28, 2011, http://online.wsj.com/article/SB10001424052748703905404576164904171231570.html (noting that although the health law mandates that insurance companies provide coverage for ten essential health benefits categories, the regulators must define what services are covered within each essential category).

health and substance abuse, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services."[124]

PPACA further limits the amount a patient pays out of pocket for care to the current Health Savings Account (HSA) limits.[125] Other PPACA provisions that limit the variability between insurance plans include prohibiting lifetime limits on coverage,[126] prohibiting insurers from rescinding coverage except in fraud cases,[127] prohibiting preexisting-condition exclusions,[128] requiring guarantee issue and renewability of health insurance plans,[129] and limiting rating variations based only on age, premium rating area, family composition, and tobacco use.[130] These limitations will create insurance contracts that are more standardized from patient to patient regardless of which insurance plan a patient holds.

PPACA also limits insurance contract negotiation by requiring that new health insurance exchanges comply with one of four benefit categories, classified as bronze, silver, gold, and platinum.[131] A bronze plan is the minimum level of coverage that will be considered a qualified plan. Under a bronze plan, the insurance company will cover 60 percent of the plan's benefit costs.[132] Silver plans will cover 70 percent of the plans benefit costs, and gold and platinum plans will respectively cover 80 and 90 percent of the plan's benefit costs.[133] All four types of plans must

124. *Health Reform & the Individual Insurance Market*, HEALTHAMERICA (Apr. 2010), http://healthamerica.coventryhealthcare.com/web/groups/public/@cvty_regional_chcpa/documents/webcontent/c050095.pdf; *see* Patient Protection and Affordable Care Act § 1302(b), 124 Stat. at 163–65 (codified at 42 U.S.C. § 18022 (Supp. V 2011)).

125. *Summary of New Health Reform Law*, *supra* note 117, at 6 (showing that 2010 HSA limits are $5950 for an individual and $11,900 for a family).

126. Patient Protection and Affordable Care Act § 1001, 124 Stat. at 130–37.

127. *Id.*

128. *Id.* § 1201, 124 Stat. at 154–61.

129. *Id.* § 1001, 124 Stat. at 130–37.

130. *Id.* § 1201, 124 Stat. at 154–61. The effective dates of these limits vary; some started six months after the Act was signed into law, and others will not take effect until January 1, 2014. *Summary of New Health Reform Law*, *supra* note 117, at 6.

131. Health insurance exchanges are insurance markets that individuals in the open market can use to shop for insurance. *See Summary of New Health Reform Law*, *supra* note 117, at 4. Employer-sponsored insurance plans do not have to meet the outlined benefit categories. *Id.* at 6; *see* Patient Protection and Affordable Care Act § 1302(d), 124 Stat. at 167 (codified at 42 U.S.C. § 18022 (Supp. V 2011)).

132. *Summary of New Health Reform Law*, *supra* note 117, at 5; *see* Patient Protection and Affordable Care Act § 1302(d)(1)(A), 124 Stat. at 167.

133. Patient Protection and Affordable Care Act § 1302(d)(1)(B)–(D), 124 Stat. at 167; *see also Summary of New Health Reform Law*, *supra* note 117, at 5 (summarizing the relevant benefit percentages covered by the plan).

provide essential health benefits, and the out-of-pocket limits must be equal to the HSA limits.[134]

Lastly, PPACA will require a medical loss ratio of 80 percent for the individual and small group markets and 85 percent for the large group insurance plans.[135] This medical loss ratio requires that the designated percentage of an insured's premium payments will go toward medical costs rather than administrative costs.[136] All the new requirements or limits under PPACA will reduce the variability among insurance plans, resulting in greater standardization among health plans regardless of insurer.

C. How PPACA Affects Rationales for the Collateral Source Rule

The individual mandate and PPACA provisions that limit insurance contract negotiation will make it less rational to use billed charges in calculating medical damages. It is important to examine briefly the impact of these provisions on how we view the cost of medical services before discussing the impact of these provisions on the four rationales articulated in Part II.[137] Recall that under the collateral source rule, medical damages are calculated using billed charges, regardless of whether the medical provider accepts a lower negotiated rate from the plaintiff's insurance company as payment in full. After the mandate, almost everyone will now carry some form of health insurance, and although a medical provider's billed charge might not change, the amount ultimately received as payment will almost always be a reduced negotiated rate.[138]

134. *Summary of New Health Reform Law*, *supra* note 117, at 5.

135. *See* Patient Protection and Affordable Care Act § 10101(f), 124 Stat. at 886 (codified at 42 U.S.C. § 300gg-18); *cf.* James C. Robinson, *Use and Abuse of the Medical Loss Ratio to Measure Health Plan Performance*, 16 HEALTH AFF. 176 (1997) (arguing that the medical loss ratio is not a good measure of quality or efficiency).

136. *But see* Drew Armstrong, *Maine Gets Waiver From Health Premium Rules*, WASH. POST, Mar. 9, 2011, http://www.washingtonpost.com/wp-dyn/content/article/2011/03/08/AR2011030805908.html (noting that Maine received a three-year waiver on the medical loss ratio requirement).

137. *See generally* Schwartz, *supra* note 29. *Cf.* Rebecca Levenson, Comment, *Allocating the Costs of Harm to Whom They Are Due: Modifying the Collateral Source Rule After Health Care Reform*, 160 U. PA. L. REV. 921, 936 (2012) (analyzing factors to consider in modifying the collateral source rule, such as political benefits, the purpose of tort law, the rule as a rule of damages and evidence, subrogation, and ramifications for those exempted from the mandate requirement).

138. *See* Beard, *supra* note 21, at 489–90 ("If your stated fee for a procedure is $5000, but no insurer is paying more than $2500, . . . [and] you're willing to take $2500, then that's your [true] fee." (quoting Mark Crane, *Getting Peanuts*, MED. ECON., Sept. 22, 1997, at 144, 146) (internal quotation marks omitted)); Hall & Schneider, *supra* note 45, at 663 (discussing the difference between "what hospitals nominally charge and what insured patients pay" and noting that "[i]nsurers pay about forty cents per dollar of listed charges").

Further, the new limitations set on health insurance plans, such as limits on patients' out-of-pocket costs, minimum benefits the plan must cover, and the percentage of premiums that must go toward care, will cause health insurance plans to be less variable. These new provisions will require courts to reexamine how they calculate medical damages.[139]

A possible counterargument to the claim that courts should revise their medical damages calculation is the fact that there are still many individuals who will remain uninsured after PPACA comes into effect.[140] This uninsured population will mainly consist of those who choose to opt out and pay the penalty, undocumented immigrants, and individuals who are too poor to purchase insurance but not poor enough to qualify for government sponsored insurance.[141]

After PPACA comes into effect, however, the uninsured population will be greatly reduced. This is because some previously uninsured individuals will choose to purchase insurance to avoid the penalty,[142] while others will now be guaranteed because of the elimination of preexisting-conditions exclusions and the other provisions in PPACA discussed in Part III.B. This assumes that those that purchase insurance after PPACA previously may not have been able to afford billed charges but could at least afford to pay insurance premiums and previously did not because they either (1) believed they were healthy and did not need insurance or (2) were

139. *See also* Reinhardt, *supra* note 41, at 63 ("Invoices at chargemaster prices, however, are insincere, in the sense that they would yield truly enormous profits if those prices were actually paid. The reality is that hospitals accept different payments from different payers for identical services, and that can properly be called price discrimination.").

140. *See* Ezra Klein, *Who Is Left Uninsured by the Health-Care Reform Bill?*, WASH. POST EZRA KLEIN BLOG (Mar. 22, 2010, 3:29 PM), http://voices.washingtonpost.com/ezra-klein/2010/03/who_is_left_uninsured_by_the_h.html (depicting a graph showing the uninsured category as the smallest portion after healthcare reform); *see also* Levenson, *supra* note 137, at 948–49 (proposing a statutory modification to the collateral source rule focusing on the willfully uninsured plaintiff).

141. *See* Klein, *supra* note 140.

142. There could also be the other extreme: an individual who is healthy and wealthy enough to purchase insurance yet chooses to pay the low penalty amount imposed for not maintaining insurance. The billed charge is a realistic measure of the cost of care for this individual. It is likely that these scenarios are outliers, however, and should not prevent courts from reexamining how they calculate medical damages. *See Summary of New Health Reform Law*, *supra* note 117; *see also* Matthew Buettgens & Mark A. Hall, *Who Will Be Uninsured After Health Insurance Reform?*, ROBERT WOOD JOHNSON FOUND. (Mar. 10, 2011), http://www.rwjf.org/content/rwjf/en/research-publications/find-rwjf-research/2011/03/who-will-be-uninsured-after-health-insurance-reform-.html (predicting that after PPACA comes into effect, 15 percent of uninsured adults will be able to afford insurance but will choose not to purchase it); Merrill Matthews, *Why Obama Should Drop the Insurance Mandate*, WALL ST. J. (Jan. 24, 2011), http://online.wsj.com/article/SB10001424052748704754304576096313336919534.html (discussing how eliminating the mandate would create adverse selection problems but arguing that the penalty is so small that people who do not want to buy insurance will just pay the penalty until they need insurance).

denied coverage because of preexisting conditions. With the exception of the wealthy, those that do remain uninsured after PPACA will likely still be unable to pay billed charge rates.[143] Because the uninsured and the newly insured will not be paying billed charge rates,[144] using such billed charges to calculate the cost of medical services becomes less reasonable. If billed charges are a less plausible measure of the cost of medical services, then the collateral source rule, which calculates medical damages based on the billed amount, must be reexamined.

1. Deterrence After PPACA

After PPACA comes into effect, the deterrence rationale for calculating damages at billed charges might no longer be justifiable. Although the common law collateral source rule aims to set damages at the highest amount possible to create the greatest deterrence, this aim should not result in unfairly high damage awards. Thus, this rationale should be reexamined in light of the mandate to see if using billed charges is a fair measure of medical damages. Prior to the mandate, using billed charges to calculate damages was generally considered to be fair because plaintiffs who do not have insurance might have owed the full billed charge for their medical care. Once most people are required to have insurance, however, almost no one will be paying billed charges.[145] Although there is value in deterring potential tortfeasors from causing harm, the level of damages used to deter under the rule should be adjusted to reflect the reality of reimbursed rates fairly and to avoid unfairly measuring damages based on a rate that is rarely paid.

143. *See supra* notes 48–49 and accompanying text; see also David U. Himmelstein et al., *Medical Bankruptcy in the United States, 2007: Results of a National Study*, 122 AM. J. MED. 741, 743 (2009) for a study showing how even those that *are* insured have trouble paying their medical bills (noting that about 62 percent of all bankruptcies in 2007 were due to medical bills and 92 percent of those bankruptcies due to medical bills were in part caused by *high* medical bills); Melissa B. Jacoby & Elizabeth Warren, *Beyond Hospital Misbehavior: An Alternative Account of Medical-Related Financial Distress*, 100 NW. U. L. REV. 535, 581 (2006) (analyzing hospital collection practices and contending that hospitals do not collect billed charges from self-pay patients); Cathy Schoen et al., *How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007*, 27 HEALTH AFF. w298, w305 (2008), http://content.healthaffairs.org/content/early/2008/06/10/hlthaff.27.4.w298.full.pdf+html (discussing how the uninsured have "high rates of financial stress related to medical bills," which translates to "difficulty paying bills").

144. This uninsured group would be people who are not considered poor enough to qualify for government-sponsored insurance yet are still not wealthy enough to purchase private insurance. *See generally* Katherine Swartz, *Uninsured in America: New Realities, New Risks*, *in* HEALTH AT RISK: AMERICA'S AILING HEALTH SYSTEM AND HOW TO HEAL IT 32, 32–45 (Jacob S. Hacker ed., 2008).

145. *See id.*

2. Rethinking Unjust Enrichment

There are two main reasons why the changes to insurance contracts under PPACA, coupled with the mandate, might change the way we view the unjust enrichment justification for the collateral source rule. First, the goal of universal participation under PPACA might justify a defendant paying the lower negotiated rate in medical damages. Like plaintiffs, defendants in post-PPACA personal injury cases are also more likely to be insured and thus to participate in cost sharing. If this purchase is seen as helping to achieve PPACA's universal participation goals, reducing damages to negotiated reimbursement rates might not be unjust enrichment. Rather, reducing medical damages to negotiated rates may be justified because the defendant is participating in a project of risk sharing.[146] Given the mandate, although the defendant will not be paying the plaintiff's insurance premiums, presumably he will be contributing premiums to an insurance group's cost-sharing pool.[147] Thus, under PPACA, whether or not a defendant who pays the negotiated rate is unjustly enriched might depend on whether the defendant himself has purchased insurance.

If the insurance market was a single-payer system, the reduced rate the plaintiff's insurance company pays, the so-called discount given to the plaintiff, would be made possible by other individuals, like the defendant, who would elect to participate in the insurance pool.[148] Although PPACA does not create a single-payer system, there are certain mechanisms in place that will enable greater cost sharing—the individual mandate foremost among them.[149] In addition, PPACA increases risk pooling in insurance markets by regulating and restructuring these markets.[150] For example, under PPACA the small group and individual insur-

146. For example, under PPACA, state health insurance exchanges aim to pool health insurance premiums from the individual market into one insurance pool. These exchanges create a larger market, which facilitates a reduction in insurance plan costs. For the exchanges to be effective there needs to be widespread participation. *See* Noam M. Levey, *7 States Get Grants to Develop Online Shopping Systems for Health Insurance*, L.A. TIMES, Feb. 17, 2011, http://articles.latimes.com/2011/feb/17/business/la-fi-insurance-shopping-20110217.

147. For a robust discussion of risk pooling, see Allison K. Hoffman, *Oil and Water: Mixing Individual Mandates, Fragmented Markets, and Health Reform*, 36 AM. J.L. & MED. 7, 12, 32–33, 48–53 (2010) (describing how insurers place purchasers of insurance into risk pools to "manage risk and profit").

148. See Helen A. Halpin & Peter Harbage, *The Origins and Demise of the Public Option*, 29 HEALTH AFF. 1117 (2010), for an overview of the public option.

149. *See supra* Part III.A.

150. *See* Timothy Stoltzfus Jost, *Health Insurance Exchanges in Health Care Reform: Legal and Policy Issues* 27 (Commonwealth Fund Pub. No. 1364, 2009), *available at* http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2009/Dec/1364_Jost_hlt_ins_exchanges.pdf (discussing ways that health insurance exchanges can be structured to increase risk pooling and to avoid current adverse selection problems in which some insurance pools comprise only "high-risk individuals and groups [leading to] high prices"); *see also* Julie Appleby, *A Primer on Health-Care 'Exchanges*,' WASH.

ance markets within a state will merge into one cost-sharing pool.[151] Although the defendant might not contribute directly to the plaintiff's insurance pool, if he holds insurance, he is at least contributing to the universal participation goal of PPACA.[152]

Secondly, although the defendant might not be privy to the plaintiff's insurance contract, PPACA's standardized changes and limits will make that insurance contract less important and therefore reduce the need for courts to safeguard the benefits of the contract. This is because when PPACA comes into effect the contractual relationship between a plaintiff and his insurance company will be more regulated. Even if the defendant is not privy to the plaintiff's contract with his insurance company, the stricter PPACA guidelines will standardize insurance benefits that currently have to be bargained for and will ensure that all plans have at least the same baseline coverage and pricing rates.[153] Thus, in analyzing unjust enrichment, the focus might shift from whether the defendant is privy to the insurance contract to whether the defendant is contributing insurance premium payments to an insurance contract and thereby sharing costs with others in a risk pool.[154]

Therefore, the universal participation goal and standardized insurance contracts diminish the unjust enrichment theory of the collateral source rule and open up the possibility that a defendant should pay less than the billed charge when he harms an insured plaintiff.[155]

POST, Mar. 29, 2011, http://www.washingtonpost.com/politics/a-primer-on-health-care-exchanges/2011/03/29/AF7uC7wB_story.html (providing a brief overview of the details of exchanges).

151. *But see* Hoffman, *supra* note 147, at 17 (noting that even under the individual mandate there might still be "fragmented markets" that would "divide people and groups on the basis of risk" and not allow for cost sharing among groups).

152. *See supra* notes 119–120 and accompanying text.

153. *See supra* notes 75–84 and accompanying text; *see also* Jennifer Haberkorn, *Medical Loss Ratios*, HEALTH AFF. HEALTH POL'Y BRIEF, Nov. 12, 2010, http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_30.pdf (describing the medical loss ratio requirement under PPACA, which will require health insurance companies to spend a specified percentage of insurance premiums on health services). The medical loss ratio will ensure that all insurance plans use the same percentage of premiums to cover health services rather than administrative costs. *Id.* To achieve parity among insurance plans, the Act also created the National Association of Insurance Commissioners (NAIC) "to create the formula for calculating medical loss ratios." *Id.* at 2.

154. *See* CLAXTON & LUNDY, *supra* note 60, at 1, 5–8 (explaining the rationales behind risk pooling); *see also* Jost, *supra* note 28, at 1100 (arguing that cost sharing is necessary for universal coverage since 10 percent of the population can be responsible for 70 percent of health care costs).

155. *See* Hoffman, *supra* note 147, at 32. Hoffman defines financiers as low-risk individuals (those who do not use a lot of medical services) whose payment of insurance premiums goes into a cost-sharing pool and helps pay medical costs for insurance purchasers who use more medical care. *Id.*; *see also id.* at 20 (noting that the individual mandate will not only make more people purchase insurance but will also make some people "financiers of health care"); *id.* at 21 ("When this occurs, some part of their premium payment will pay for someone else's medical expenses.").

3. Eliminating the Need to Incentivize Risk Mitigation

The third justification for the collateral source rule—incentivizing the purchase of insurance—will likely no longer be necessary after the individual mandate comes into effect. However, the elimination of this rationale is dependent on the mandate's success. As noted in Part III.C, there could be individuals who choose to pay the penalty rather than to purchase insurance; for these individuals, the incentives under the collateral source rule still hold.[156] Because PPACA intends to make insurance available and more affordable to people who currently want insurance but are being denied it or cannot afford it, however, the number of individuals who opt out for financial reasons is likely to be low.[157]

There is a possibility that critics might see PPACA and the changes this Comment proposes as discouraging individuals from buying insurance since, at least in some states, the amount one could potentially recover in a personal injury suit would be higher if one was uninsured. It is unlikely, however, that modifying the collateral source rule will discourage people from purchasing insurance. This is because, as discussed in Part III.C, most people who are uninsured are so because (1) they are wealthy and choose to pay for their own care rather than to purchase insurance, or (2) they cannot afford insurance.[158] People in the former category presumably would be wealthy enough not to be motivated by the possibility of collecting a large personal injury judgment, and people in the latter category presumably want insurance for many things other than protection from accidental injuries caused by third parties. Since peoples' decisions to purchase insurance are only partially motivated by a desire to safeguard against accidents caused by others, it is unlikely that individuals in the latter category will be discouraged from buying insurance once it is more affordable in hopes of obtaining large judgments.[159] Ultimately, PPACA will not discourage those who were previously unmotivated by the risk mitigation incentive to purchase insurance from doing so after PPACA because their original motivation was already lacking. For these individuals, PPACA has no impact on their decision to forgo purchasing insurance.

Thus, the individual mandate eliminates the need for the collateral source rule to incentivize the purchase of insurance. After the mandate, those who still choose not to purchase insurance despite the mandate and penalty would also not have

156. *See* CONG. BUDGET OFFICE, PAYMENT OF PENALTIES FOR BEING UNINSURED UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (2010), *available at* http://cbo.gov/sites/default/files/cbofiles/ftpdocs/113xx/doc11355/individual_mandate_penalties-04-22.pdf (predicting the number of people who will remain uninsured and be subject to the penalty).

157. *See supra* notes 117–119 and accompanying text.

158. *See supra* notes 48–49 and accompanying text.

159. *See supra* notes 95–97 and accompanying text.

been compelled by the collateral source rule incentive courts created. As a result, the risk mitigation rationale for the collateral source rule, without more, will no longer be a compelling justification for upholding the rule.

4. Redefining What It Takes to Restore a Plaintiff

After the mandate comes into effect, calculating medical damages based on the common law collateral source rule might result in overcompensating plaintiffs for their losses.[160] Recall that under the restoration justification, courts do not factor in plaintiffs' attempts to mitigate damages in compensatory damages calculations. This reasoning was predicated on the assumption that purchasing insurance was voluntary, however, and therefore that many people would not be insured.[161] Under the mandate, when almost everyone is insured and medical providers will rarely, if ever, receive billed rates as payment, this amount might be less plausible as a measure of the plaintiffs' harm.[162] Thus, courts will need to reexamine how much it takes to make a plaintiff whole.

If medical providers mainly accept the lower rates they have negotiated with insurance companies, it is plausible to conclude that the cost of medical care is less than the billed amount. This assumes that medical providers will adjust their reimbursement rates to reflect their costs accurately in order to continue operating.

There will still be differences in negotiated reimbursement rates between different insurance plans plaintiffs hold, however, based on factors such as the region and actuarial value of the plaintiffs' various plans.[163] For example, premium rates in different regions may vary, which in turn may result in differing negotiated reimbursement rates.[164] Also, under PPACA, the actuarial value for individual

160. *See supra* Part II.D.

161. *See* Swartz, *supra* note 144, at 35–41; *see also* Gruber, *supra* note 29, at 571 (noting that as of 2008, forty-seven million persons in the United States were uninsured).

162. *See supra* Part III.C.

163. Negotiated reimbursement rates can vary based on the actuarial value of the plan, which is "the percentage of expected health care costs a health plan will cover." *See* CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, ACTUARIAL VALUE AND COST-SHARING REDUCTIONS BULLETIN 2 (n.d.), *available at* http://cciio.cms.gov/resources/files/Files2/02242012/Av-csr-bulletin.pdf; *see also* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1201(4), 124 Stat. 119, 155–56 (2010) (codified at 42 U.S.C. § 300gg (Supp. V 2011)) (allowing premium rates charged by a health insurer to vary based on the region in which the individual resides); Ryan Lore et al., *Choosing the "Best" Plan in a Health Insurance Exchange: Actuarial Value Tells Only Part of the Story* 1–2 (Commonwealth Fund Issue Brief, Pub. No. 1626, 2012), *available at* http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2012/Aug/1626_Lore_choosing_best_plan_HIE_actuarial_ib_v2.pdf (discussing how actuarial values will still vary under PPACA).

164. *See* ANDREW COBURN ET AL., THE RURAL IMPLICATIONS OF GEOGRAPHIC RATING OF HEALTH INSURANCE PREMIUMS 1, 4 (2012), *available at* http://www.shadac.org/files/shadac/publications/RuralImplicationsofGeographicRating.pdf (noting that the common justification for

market plans can vary from 60 to 90 percent, corresponding with the bronze-to-platinum plan classifications.[165]

Even with the assumption that using billed charges will likely overcompensate plaintiffs, it is still unclear how to best calculate medical damages. Based on the foregoing analysis, it is clear that two of the justifications for the collateral source rule—the desire to incentivize individuals to purchase insurance and the worry that a defendant might be unjustly enriched—are eliminated or strongly mitigated if the defendant himself is insured. The deterrence and restoration justifications are still relevant after PPACA. The provisions of PPACA, however, may render billed charges an inappropriate measure of medical damages and require an adjustment to how medical damages are calculated.

IV. THE NEW WAY OF CALCULATING MEDICAL DAMAGES IN THE POST-PPACA WORLD

This Part explores how medical damages should be calculated in personal injury suits after PPACA. As discussed in Part III, some of the principles behind the collateral source rule are still important after PPACA. Fairness and accuracy, however, require changes in how courts calculate medical damages: A new way to calculate medical damages should fairly allocate responsibility and accurately measure the amount of medical damages a defendant should owe in personal injury suits.

A. Proposed Method to Calculate Medical Damages in Light of PPACA

This proposal serves as a guideline for courts in calculating medical damages. After PPACA, courts should calculate medical damages using (1) the negotiated reimbursement rate and (2) a portion of premium payments that the plaintiff has paid.[166] While some courts have already moved in this direction, as discussed in Part II.E, this Comment provides new support for altering the collateral source rule and expands on how courts should include premium payments in damage awards.

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variations in premiums between regions is that "[t]he cost of delivering care varies dramatically from one area to another," but that comparisons between different insurance plans in the same regions revealed no patterns for premium ratings, which "suggests that health plans may use geographic rating for business purposes other than adjusting for underlying cost/price differences").

165. *See* Patient Protection and Affordable Care Act § 1302(d)(1), 124 Stat. at 167 (codified at 42 U.S.C. § 18022).

166. *Cf.* Levenson, *supra* note 137, at 949–50 (proposing that insured plaintiffs' damage awards be reduced by the negotiated reimbursement rate except in cases of subrogation, thereby allowing recovery of the written-off amounts).

1. Negotiated Reimbursement Rates

Courts should use the negotiated reimbursement rate when calculating medical damages since after the mandate medical providers will rarely receive billed charges as payment for services.[167] Using negotiated rates will achieve the goals of holding the defendant responsible for the harm caused (deterrence) and ensuring that he pays an accurate amount (restoration).[168] This method more accurately calculates the cost of medical care, but it still overcompensates the plaintiff if he is not obligated to reimburse his insurance company for the payments made on his behalf. In addition, if there is a concern about creating parity in recovery between plaintiffs, using negotiated rates will still lead to different recoveries because different insurance plans may not provide the same negotiated reimbursement rates. However, this method will more accurately assess a defendant's responsibility than the current collateral source rule.[169] Thus, to uphold the principles of the collateral source rule that survive after PPACA—deterrence and restoration—and to ensure defendants are held liable for injuries they cause, courts should use negotiated reimbursement rates in calculating medical damage awards to reflect the cost of harm a defendant inflicted more accurately.

2. Premium Payments

After PPACA, premium payments should be included in medical damage awards because negotiated rates are predicated on a plaintiff paying them. As discussed in Part II.E, some states allow plaintiffs to collect premiums paid from the moment of injury until the end of the suit.[170] Although such a method provides a simple formula for calculating the amount of premium payments to award a plaintiff, it is arbitrary. Since the amount and length of time that premiums are paid vary between plaintiffs, this Part offers a more equitable standard to guide

167. *See* Hall & Schneider, *supra* note 45, at 687 ("As health economist Gerard Anderson told Congress, for 'a price list to be reasonable it needs to reflect what is actually being charged in the market place.' And since 'virtually no public or private insurer actually pays full charges, charges are an unrealistic standard for comparison. A more realistic standard is what insurers actually pay and what the hospitals have been willing to accept.'" (quoting *What's the Cost?: Proposals to Provide Consumers With Better Information About Healthcare Service Costs: Hearing Before the Subcomm. on Health of the H. Comm. on Energy and Commerce*, 109th Cong. 103, 106, 109 (2006) (testimony of Gerard F. Anderson, Dir., Johns Hopkins Ctr. for Hosp. Fin. & Mgmt.))).

168. *See* Beard, *supra* note 21, at 489–90 (arguing that medical damages should be limited to amounts actually paid).

169. *See id.* (noting that if a provider is "willing to accept the discounted amount," this more accurately reflects the real value of medical services).

170. *See, e.g.*, Swanson v. Brewster, 784 N.W.2d 264, 266 (Minn. 2010).

courts in calculating the amount of premium payments that should be included in medical damage awards based on the extent of the injury caused.

Courts should allow plaintiffs to be reimbursed for a percentage of premiums paid during the months they received care for the injury at issue. This percentage should be based on the extent of a plaintiff's injuries because this directly correlates with the payment amount an insurance company will make on the plaintiff's behalf. Basing the recoverable percentage on the extent of the injury aligns the damages award with the value a plaintiff places on the premiums paid.[171] Thus, a plaintiff might attribute anywhere from 50 percent of his premiums paid during the length of his medical treatment as providing for accidental care if he has multiple hospitalizations, to less than 10 percent if he has have one doctor's visit as a result of an accident. Since the majority of plaintiffs will be maintaining health insurance after PPACA, if a plaintiff is injured in an accident, he will consider a percentage of his monthly health insurance premiums to be effectively covering him for the resulting accident.

To identify this reimbursable amount, courts should first determine which category the extent of injury falls into based on the length of care received. These categories are (1) care spanning less than three months, (2) care spanning at least three months but less than six months, (3) care spanning at least six months but less than one year, and (4) care spanning over one year. This will correlate directly with the extent of the injury because more extensive injuries usually require longer medical care.

After determining the extent of the injury, courts should then apply a reimbursement percentage that corresponds to the severity. For example, for injuries resulting in less than three months of care, the percentage of the premiums paid and recoverable during this time should be less than 25 percent. For injuries spanning in care over three months but less than six months, the percentage of premiums paid and recoverable during that time should be between 25 and 50 percent. For care over six months and under one year, the percentage recoverable should be between 50 percent and 75 percent. For care spanning over one year, the recovery should be between 75 percent and 90 percent.[172] A court should not allow a 100 percent recovery of premiums because, as noted above, plaintiffs also maintain

171. This proposal would not apply to those enrolled in publicly funded healthcare plans as those individuals do not pay insurance premiums. The recovery for those individuals under this proposal would be zero because those plaintiffs pay no consideration for the publicly funded plan. *See* Bozeman v. State, 879 So. 2d 692, 705–06 (La. 2004).

172. For accidents that result in lifetime care a plaintiff would be able to recover 90 percent of his premium payments for all the months of care leading up to the end of the lawsuit. Future medical expenses will not fall under the medical damages calculation but rather would be accounted for in the future damages remedy.

health insurance for other reasons such as preventative care. This method is illustrated in Table 1 below.

TABLE 1. Recoverable Percentage of Premiums Paid

Extent of the Injury	Medical care spanning less than three months	Medical care spanning at least three months but less than six months	Medical care spanning at least six months but less than one year	Medical care spanning at least one year
Recoverable Percentage of Premiums Paid During the Length of Care	Less than 25 percent	Between 25 percent and 50 percent	Between 50 percent and 75 percent	Between 75 percent and 90 percent

Therefore, after PPACA comes into effect, the collateral source rule should be replaced with a new way for courts to calculate medical damages that still maintains some of the principles of the old rule, specifically the emphasis on deterrence and restoration. Under the new method, courts should calculate medical damages by combining the negotiated reimbursement rate paid for medical services and a court-determined fair percentage of the premiums paid during the length of care based on the extent of the injury.

B. Application

Applying the proposed medical damage calculations to Matt and Lisa illustrates how the proposal more accurately calculates medical damages. After PPACA, assume that the previously uninsured Lisa becomes insured. As in the hypothetical presented in Part I, both are injured in auto accidents. This time, Matt incurs $25,000 in medical expenses and Lisa incurs $100,000. Matt's insurer has a total negotiated reimbursement rate with his health care provider of $9000, while Lisa's insurer negotiated a total reimbursement rate of $55,000. Matt pays $105 per month in insurance premiums, and Lisa pays $115 per month.[173] Howev-

173. The difference in premium payments that Matt and Lisa pay could be attributed to the difference in coverage between their plans.

er, Lisa's injuries from the car accident required her to receive medical care for two years, while Matt required care for eight months.

Matt and Lisa both commence suit against the tortfeasor. This scenario is summarized below in Table 2.

TABLE 2. Summary of Proposal Applied to Hypothetical

	Matt	Lisa
Billed Charges	$25,000	$100,000
Negotiated Reimbursement Rate	$9000	$55,000
Amount Written Off	$16,000	$45,000
Insurance Premium Payments Per Month	$105	$115
Extent of Injury	Hospitalization, provider visits, and follow-up care spanning eight months.	Hospitalization, multiple provider visits, and follow-up care spanning two years.

Under the medical damages calculation method outlined above, Matt's recovery for payments made by his insurance company is $9000, while Lisa's is $55,000—these amounts reflect the negotiated reimbursement rates of their respective insurance plans. The more complicated part of the damages calculation is the amount of premium payments each plaintiff should recover.

Under my proposed method, Matt received care for eight months, thus a court may allow Matt to recover 50 to 75 percent of his premiums paid during that eight-month period. Lisa received care for two years; thus, the court may allow her to recover between 75 and 90 percent of premiums paid during that time. In this situation, a court might allow Lisa to recover 80 percent of her premium payments over the two-year span, while Matt recovers 60 percent of his premiums for the eight-month period. This is because while both Matt's and Lisa's injuries resulted in hospitalization, Lisa's injuries were more extensive, evidenced by the fact that her care spanned three times as long. Matt's premium payments during the eight months in which he received care equaled $840, and Lisa's premium payments during the two year span equaled $2760. Thus, if Matt is allowed to recover 60

percent of the $840 he paid, he recovers $504 in insurance premium payments. If the court determines Lisa is entitled to an 80 percent reimbursement, she would recover $2208 of her premium payments during the past two years. Matt's full medical damages would then be $9504, and Lisa's would be $57,208.

The above example provides a guide for how courts would determine the percentage of premium payments to award plaintiffs. After first determining which category the extent of injury falls into based on the length of care required, the court must then decide what percentage in the given range it should apply. For example, consider a plaintiff that is involved in an accident and requires medical care. Because the plaintiff's injuries are not extensive, the required care consists only of two provider visits in less than three months. In that situation, a court might set the premium reimbursement rate between 10 and 15 percent of the premiums paid during the length of care rather than at the maximum 25 percent. Each case presented to a court will be unique and such a method allows the court to correlate the damages recovery with factors relating to the extent of the injury.

This proposed method allows for a more accurate calculation of the medical costs of an accident, which includes the medical premiums invested to provide for such care. This method also eliminates damage awards based on billed charges, which no one pays, and factors in the cost of maintaining health insurance to reduce the out-of-pocket cost of an injury.

CONCLUSION

The rationale for the collateral source rule is shifting as PPACA 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 that we calculate medical damages should likewise change.

Thus, courts should calculate post-PPACA medical damages using negotiated reimbursement rates plus a percentage of a plaintiff's insurance premium payments. The premium payments percentage should correlate with the extent of the harm caused, with a higher percentage reimbursed for injuries that require long-term medical treatment and a lower percentage for injuries requiring less medical care.

Further efforts to determine how courts can calculate medical damages more accurately should continue to take into account negotiated reimbursement rates and the premium payments that make such rates possible. The above proposal attempts to provide a more equitable standard in light of the new healthcare law.

However, the two elements in the proposal will serve as a useful guide to courts calculating medical damages under any future healthcare reform, such as a move toward a single-payer health insurance regime.

Future research in this area may expand on how health insurers allocate premium payments toward different types of care. For example, if there is a formulaic method that insurers use to correlate premium payments to accidental care, then courts can integrate that formula into the proposed method for calculating medical damages outlined in this Comment. Also, this Comment does not address calculating the percentage of premium reimbursements based on the amount of billed charges, but research in this area may reveal a correlation between the billed charge amount and the extent of the injury. More research would be needed on how providers set billed charges to see if such a method would lead to an even more accurate measure of premium reimbursements.

Furthermore, this Comment does not attempt to lay out all the factors that courts should consider when determining the percentage of reimbursement under the four extent-of-injury categories. Future empirical research may reveal specific factors that courts should consider when setting the premium reimbursement percentage. As the American healthcare system is reformed, it is necessary to revise medical damages calculation rules based on the old system. This Comment provides a more equitable framework for calculating medical damages after the implementation of PPACA.