# IS UNIVERSAL HEALTHCARE REALLY THE DEATH OF MEDICAL EXPENSE AWARDS? THE CURRENT AND FUTURE STATE OF THE COLLATERAL SOURCE RULE

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*The collateral source rule is a common law evidentiary rule that prevents a tortfeasor from introducing evidence regarding another source compensating the injured party before judgment against the tortfeasor. It also operates as a rule of damages by precluding reductions in the ultimate judgment due to the other source's compensation. It has long been an essential protection for plaintiffs who have medical insurance in cases involving medical expenses. Yet, despite its long-standing application, the collateral source rule has been under fire during the expansion of Medicare and Medicaid. With a universal healthcare system gaining momentum in the United States, both courts and legislatures must not overlook the importance of this obscure litigation rule. This Comment aims to address how courts and legislatures should address the collateral source rule if the United States adopts a universal healthcare policy.*

## INTRODUCTION

Assume that a tortfeasor causes some injury to you that results in a large medical bill. Rather than paying the entire bill, you were a prudent victim that had secured insurance before the incident. Your medical bills amount to $300,000 initially, but your insurance "writes-off" $125,000 of the invoice with your provider, and your provider accepts the $175,000 as satisfaction for the services. After filing suit to recover the entirety of the medical expenses from the tortfeasor—after all, their conduct does have a causal connection to the damages—what are you able to recover? Can you recover the entire cost, the negotiated, "written off" price, or nothing at all? What if,

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rather than having private medical insurance, you are a Medicare or Medicaid enrollee, and one of these public programs paid or negotiated your medical services? What if, in the future, the United States has a single-payer, universal system? Can anyone recover medical expenses if there are no actual costs? Should the United States be able to recover from the tortfeasor? Some of these questions have already been addressed by courts, but the fundamental problem that this comment strives to address is how courts will and should respond to the unanswered questions. Additionally, this comment will provide recommendations for legislatures and courts to prevent ambiguities regarding these questions in the future.

The 2020 United States election had far-reaching policy implications that will impact the political and social landscape of the United States for countless years to come. At the forefront of this discussion, especially amongst Democratic candidates, was the role of healthcare in American society.[1] The election resulting in a Democratic President and a Democratic-run Congress—in both houses—brings the potential for legislation that can dramatically affect the United States' healthcare system.[2] While sweeping legislation resulting in an entirely "Universal" healthcare system in the United States is still doubtful because of Congress's unique voting requirements, incremental change will likely have similar effects.[3] The thought of reforming the healthcare system excites many Americans, but it is safe to say most Americans were not thinking about how healthcare reform would affect a common law damages and evidentiary rule that could be wholly eliminated with legislation ignorant of its existence. This rule is known as the "collateral source rule."

The collateral source rule is considered to be an "oddity" of American accident law.[4] Injured plaintiffs cannot always be expected to pay expenses

[1] *See* Danielle Kurtzleben, *Democratic Debate Exposes Deep Divides Among Candidates Over Health Care*, NPR (Sept. 13, 2019, 12:37 AM), https://www.npr.org/2019/09/13/760364830/democratic-debate-exposes-deep-divides-among-candidates-over-health-care.

[2] *See* Sarah Kliff & Margot Sanger-Katz, *With New Majority, Here's What Democrats Can (and Can't) Do on Health Care*, N.Y. TIMES: THEUPSHOT (Jan. 7, 2021), https://www.nytimes.com/2021/01/07/upshot/biden-democrats-heath-plans.html.

[3] *Id.*

[4] John G. Fleming, *The Collateral Source Rule and Loss Allocation in Tort Law*, 54 CAL. L. REV. 1478, 1478 (1966).

resulting from a tort entirely by themselves.[5] If a plaintiff has their expenses, damages, or injuries covered by a third party, defendants are quick to argue that the plaintiff has not technically "incurred" any recoverable damage.[6] This scenario is precisely where the collateral source rule steps in—it prevents a defendant from introducing evidence to show that a plaintiff received outside or third-party benefits to cover the loss caused by the tort.[7] Courts have additionally treated the collateral source rule as a rule of damages, either permitting full recovery or limiting recovery to a "discounted" amount.[8]

The early implementation of the collateral source rule covered all third-party benefits; while courts still permit the rule in this context, its primary application has been narrowed to the effect insurance should have on the plaintiff's ability to recover damages covered by insurance.[9] This application is especially true in the realm of medical insurance.[10] With private medical insurance gaining popularity in American society over the last century and public options supplementing insurance for individuals without private insurance, insurance has become necessary to have adequate healthcare in the United States.[11] The rapid approach of medical insurance also brought along attacks to the collateral source rule because defendants warned of double

[5] *See id.* Throughout this comment, I will use "plaintiff" and "victim," and "defendant" and "tortfeasor," interchangeably.

[6] *See* Stephen L. Olson & Pat Wasson, *Is the Collateral Source Rule Applicable to Medicare and Medicaid Write-offs?*, 71 DEF. COUNS. J. 172, 172 (2004).

[7] *See* Fleming, *supra* note 4, at 1478.

[8] Gary L. Wickert, *Medical Expenses, Insurance Write-Offs, and the Collateral Source Rule*, MATTHIESEN, WICKERT & LEHRER, S.C. at 5–6 (May 19, 2021), https://www.mwl-law.com/wp-content/uploads/2018/02/MEDICAL-EXPENSES-INSURANCE-WRITE-OFFS-COLLATERAL-SOURCE-RULE.pdf.

[9] Richard C. Maxwell, *The Collateral Source Rule in the American Law of Damages*, 46 MINN. L. REV. 669, 671–72 (1962).

[10] Fleming, *supra* note 4, at 1501.

[11] *See* Katherine Keisler-Starkey & Lisa N. Bunch, *Health Insurance Coverage in the United States: 2019*, U.S. DEPT. OF COM., at 3–4 (Sept. 2020), https://www.census.gov/content/dam/Census/library/publications/2020/demo/p60-271.pdf (showing that in the United States 2019 population, individuals with private insurance reached a 68% peak in comparison with a 34.1% peak for public insurance options); *see also* Robin A. Cohen, et. al, *Health Insurance Coverage Trends, 1959–2007: Estimates from the National Health Interview Survey*, 17 NAT'L HEALTH STATS. REPS. 8, 9 (July 1, 2009), https://www.cdc.gov/nchs/data/nhsr/nhsr017.pdf (showing that public coverage has grown nearly every year since 1972).

recovery for plaintiffs and punishing tortfeasors, among other things.[12] This has left courts grappling with whether to treat plaintiffs differently based on their insurance coverage.[13] With the potential to expand public coverage in the coming years via legislation, Congress must be conscious of how courts currently apply the collateral source rule.

This comment strives to provide practical solutions regarding medical recovery for the emergence of a primarily public form of healthcare in the United States. First, this comment will provide an overarching review of the collateral source rule's origins and justifications. Second, this comment will briefly review the private and public healthcare systems in the United States. Third, this comment will reconcile the collateral source rule's various applications among jurisdictions with the rationale for each application, including its application for individuals with Medicare, Medicaid, and the Affordable Care Act. Finally, this comment will set forth proposed solutions regarding the applicability of the collateral source rule should public healthcare coverage be expanded in the forthcoming years.

## I. ORIGIN AND JUSTIFICATIONS OF THE COLLATERAL SOURCE RULE

Before discussing the collateral source rule's historical context, it is vital to establish its general effect and purpose. In general, an "absolute" collateral source rule (i.e., a collateral source rule without modifications or exceptions) serves to allow plaintiffs to recover damages from a tortfeasor despite being compensated from another source prior to judgment.[14] In practical effect, if a jurisdiction has a collateral source rule, it prevents a defendant from either: (1) introducing evidence of payment to the plaintiff from a collateral source; or (2) reducing the plaintiff's damages.[15] The distinction between these two

[12] *See generally* Olson & Wasson, *supra* note 6, at 172.

[13] *Compare* Kastick v. U-Haul Co., 740 N.Y.S.2d 167, 169 (App. Div. 2002) (holding that plaintiffs cannot recover medical expense write-offs for private insurance), *with* Cyr v. J.I. Case Co., 652 A.2d 685, 688 (N.H. 1994) (holding that damages are not reduced and evidence of a collateral source is inadmissible), *and* Wal-Mart Stores, Inc. v. Frierson, 818 So.2d 1135, 1139 (Miss. 2002) (holding that Medicare and Medicaid payments are subject to collateral source rule protections), *and* Simpson v. Saks Fifth Ave., Inc., No. 07-CV-0157-CVE-PJC, 2008 WL 3388739, at *2 (N.D. Okla. Aug. 8, 2008) (denying extension of the collateral source rule to Medicaid payments).

[14] Fleming, *supra* note 4 (noting that, specifically, the term "collateral source" was derived from *Harding v. Town of Townshend* and is considered to be a source wholly independent of the defendant. *See* 43 Vt. 536, 538 (1871)).

[15] William Schwartz, *The Collateral-Source Rule*, 41 B.U.L. REV. 348, 348–49 (1961).

functions is determined by whether the jurisdiction recognizes the collateral source rule as a rule of damages or an evidentiary barrier to defendants.[16]

The collateral source rule's origin plays a vital role in understanding the modern-day policy justifications for standing up to scrutiny that tort reform has brought over the past half-century. The consensus is that the collateral source rule originated as early as 1823 from English common law.[17] A mere thirty-one years later, the Supreme Court was quick to adopt the rule in American common law in *Propeller Monticello v. Mollison*.[18]

*Propeller Monticello* involved a shipwreck in which the owners of the sunken ship (the "Schooner") filed suit against the owners of the negligent ship (the "steamship").[19] The Schooner was insured and had its losses secured before filing suit against the steamship.[20] Being aware of the Schooner's insurance and without having any American common law to rely upon, the steamship argued that the satisfaction of the plaintiff's losses released its liability.[21] Ultimately, the Court held that "[t]he [defendant] is not presumed to know, or bound to inquire, as to the relative equities of parties claiming the damages. *He is bound to make satisfaction for the injury he has done*."[22] These two sentences set forth the groundwork for the underlying modern-day justifications for the collateral source rule.

### *A. Plaintiff's Perspective*

Generally, plaintiffs have been successful in convincing courts to adopt the collateral source rule for three central policy concerns, all of which stem from the concise yet foundational holding in *Propeller Monticello*: (1) fairness; (2) deterrence; and (3) protection.[23] The Louisiana Supreme Court succinctly summarized these concerns as follows:

[16] Christian D. Saine, *Preserving the Collateral Source Rule: Modern Theories of Tort Law and a Proposal for Practical Application*, 47 CASE W. RES. L. REV. 1075, 1076 (1997) (distinguishing between the evidentiary and damage aspects of the rule).

[17] Dag E. Ytreberg, Annotation, *Collateral Source Rule: Injured Person's Hospitalization or Medical Insurance as Affecting Damages Recoverable*, 77 A.L.R.3d 415 (1977).

[18] 58 U.S. 152 (1854).

[19] *Id.* at 153–54.

[20] *Id.* at 155.

[21] *Id.*

[22] *Id.* (emphasis added).

[23] *See generally* La. Dep't of Transp. & Dev. v. Kan. City S. Ry. Co., 846 So. 2d 734 (La. 2003).

> Several public policy concerns support the collateral source rule generally. The reason most often stated is that the defendant should not gain an advantage from outside benefits provided to the plaintiff independently of any act of the defendant. It is also clear that the collateral source rule promotes tort deterrence and accident prevention. Moreover, absent the collateral source rule, victims would be dissuaded from purchasing insurance or pursuing other forms of reimbursement available to them.[24]

Fairness—the balance of individual and societal interests—serves as the anchoring tenant of the policy concerns from the plaintiff's perspective.[25] Defendants have a different idea of what is inherently fair or unfair. They argue that because an insurance payout may have mitigated a plaintiff's injury, courts should not award the plaintiff extra compensatory damages out of fear of "double recovery."[26] However, plaintiffs retort that courts should not tie a defendant's liability to its victim's socioeconomic status (i.e., the ability to procure insurance).[27]

Moreover, plaintiffs often present two methods to combat the "double recovery" argument: subrogation and inadequacy of collateral sources.[28] Insurance as a collateral source is a contractual obligation, which means that the payment is not out of "mercy."[29] The payment comes with an implied right for the insurance company to recover damages from the tortfeasor, not relieving the obligation to pay.[30] Further, collateral sources often do not cover

[24] *Id.* at 739 (citations omitted).

[25] *See* Hudson v. Lazarus, 217 F.2d 344, 346 (D.C. Cir. 1954).

[26] *See* Michael I. Krauss & Jeremy Kidd, *Collateral Source and Tort's Soul*, 48 U. LOUISVILLE L. REV. 3, 32 (2009).

[27] *See* Brandon HMA, Inc. v. Bradshaw, 809 So. 2d 611, 618–19 (Miss. 2001), *abrogated by* Univ. of Miss. Med. Ctr. v. Lanier, 97 So. 3d 1197, 1203 (Miss. 2012).

[28] *See* Krauss & Kidd, *supra* note 26, at 32; James P. Moceri & John L. Messina, *The Collateral Source Rule in Personal Injury Litigation*, 7 GONZ. L. REV. 310, 312 (1972).

[29] Krauss & Kidd, *supra* note 26, at 31–32 (explaining the difference between mercy payments, which only impose moral obligations on the victim to repay, and implied loan payments (usually in the form of subrogation), which impose a legal obligation on the victim to repay); William C. Harvin, *The Case against the Collateral Source Rule*, 4 INTL. SOC'Y BARRISTERS Q. 54, 62 (1969) (explaining that even gratuities (i.e., mercy payments) are treated as classic cases for the application of the collateral source rule).

[30] Krauss & Kidd, *supra* note 26, at 31–32.

the total compensatory harm done to the plaintiff—attorneys' fees, premiums paid to the insurance for the coverage, pain and suffering, etc.[31]

In addition to the arguments that plaintiffs make to combat "double recovery," courts also must make a judgment call using public policy rationales.[32] This is sometimes referred to as the "windfall" argument because, in theory, one of the parties will benefit from the court's conclusion of whether or not evidence of a collateral source is introduced.[33] Most courts balancing these considerations have conceded public policy favors placing the windfall with the plaintiff.[34] Critics of this rationale argue that abrogating or abolishing the collateral source rule does not create a windfall for tortfeasors because there is no actual economic harm to the victim.[35]

Deterrence—the attempt to reduce future harm—serves to teach tortfeasors a lesson, even though courts maintain that it is not punitive in nature.[36] Deterrence is a unique justification because it effectively allows civil courts to become an enforcement mechanism.[37] Society-at-large does not want to create incentives for defendants to act with more recklessness.[38] Critics of deterrence argue that it undercuts innovation and efficiency.[39] While this may be true in some contexts, this argument completely undervalues the obvious observation that sanctions change behavior, one of the most central themes of the tort system.[40]

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[31] Moceri & Messina, *supra* note 28, at 312; *see* Hudson v. Lazarus, 217 F.2d 344, 346 (D.C. Cir. 1954) (explaining that "[n]ot many people would sell an arm for the average or even the maximum amount that juries award for loss of an arm").

[32] *See* Motor Vehicle Admin. v. Seidel Chevrolet, Inc., 604 A.2d 473, 479 (Md. App. 1992) (citing RESTATEMENT (SECOND) OF TORTS, § 920A(2), cmt. b (1979)).

[33] Guillermo Gabriel Zorogastua, *Improperly Divorced from Its Roots: The Rationales of the Collateral Source Rule and Their Implications for Medicare and Medicaid Write-Offs*, 55 U. KAN. L. REV. 463, 476 (2007).

[34] *See, e.g.*, Green v. Denver & Rio Grande W. R.R. Co., 59 F.3d 1029, 1032 (10th Cir. 1995).

[35] *See* Paul W. Pretzel, *Do We Need the Collateral Source Rule?*, 529 INS. L.J. 69, 72 (1967) (arguing that double recovery for the same harm makes a mockery of the basic concepts of the justice system).

[36] Ann S. Levin, *The Fate of the Collateral Source Rule After Healthcare Reform*, 60 UCLA L. REV. 736, 750 (2013).

[37] *See generally* Andrew F. Popper, *In Defense of Deterrence*, 75 ALB. L. REV. 181 (2011) (providing the rationale for and against the civil justice system using deterrence as a justification for rules and damages).

[38] *See* Bozeman v. State, 879 So. 2d 692, 700–01 (La. 2004).

[39] Popper, *supra* note 37, at 197.

[40] *Id.* at 195–96.

Protection works inversely to deterrence—it serves to encourage victims to maintain private insurance.[41] The practice of encouraging plaintiffs by rewarding good behavior has been referred to as the "foresight theory."[42] The foresight theory rewards victims that protect themselves by allowing them to reap the benefits of a "double recovery" because, as a society, we do not want to punish individuals who engage in responsible practices.[43] Along the same lines as the fairness argument above, courts are reluctant to allow defendants to avoid full payment merely because the victim had the foresight to protect himself.[44]

Each primary policy concern has ancillary arguments that further bolster the victim's perspective. Victims have made arguments that tie fairness to deterrence—a fair process includes preventing tragedy from repeating.[45] Additionally, they argue that other forms of deterrence, such as a moral obligation or personal safety, are insufficient to deter individual behavior alone.[46] Lastly, the incentive to protect oneself has benefits beyond the courtroom; victims are more likely to settle when the collateral benefits have provided the security necessary to avoid a lengthy litigation process.[47]

### *B. Defendant's Perspective*

However, it has not been all sunshine and roses for plaintiffs regarding the collateral source rule's history.[48] Whether by statute or common law, tortfeasors have successfully persuaded courts or legislatures to abrogate or make qualifications for applying the collateral source rule.[49] Tortfeasors have

[41] *See* Lee R. West, *The Collateral Source Rule Sans Subrogation: A Plaintiff's Windfall*, 16 OKLA. L. REV. 395, 413 (1963).

[42] *Id.*

[43] *See id.*

[44] Helfend v. S. Cal. Rapid Transit Dist., 465 P.2d 61, 66–67 (Cal. 1970); EDWARD P. RICHARDS & KATHARINE C. RATHBUN, LAW AND THE PHYSICIAN: A PRACTICAL GUIDE (1993) (setting forth victims' arguments that tortfeasors should not be placed in a more advantageous situation merely because they stumbled upon a better protected victim).

[45] Popper, *supra* note 37, at 182.

[46] Saine, *supra* note 16, at 1090–91.

[47] Moceri & Messina, *supra* note 28, at 312.

[48] *See* Richard C. Witzel, Jr., *The Collateral Source Rule and State-Provided Special Education and Therapy*, 75 WASH. U.L.Q. 697, 705–11 (1997) (explaining the recent attacks of the collateral source rule through tort reform).

[49] *See, e.g.*, CONN. GEN. STAT. § 52-225a (2014); ALA. CODE § 12-21-45 (2013); ALASKA STAT. § 09.17.070 (providing examples of statutes that have modified either how much damages

particularly seen success in reducing damages or introducing evidence in cases involving medical expenses and health insurance.[50] This success greatly impacts the rule's modern application, which will be discussed more in Section III. Regardless, the policy concerns raised by tortfeasors play an essential role in the history and justifications for the rule. In particular, the arguments challenging the need for the collateral source rule because of the socioeconomic changes since the time of the adoption of the collateral source rule have benefitted tortfeasors the most in achieving abrogation or qualifications.[51]

For example, at least one commentator points out that the leading case from English common law, *Clark v. Inhabitants of the Hundred of Blything*,[52] does not justify applying the collateral source rule outside its original intended context.[53] The court held that the owner of haystacks destroyed by unknown arsonists could recover from the city, although insurance had previously covered the entirety of his losses.[54] However, the Second Statute of Winchester,[55] under which the suit was brought, mandated explicitly that the inhabitants of the hundred, town, or city remain "vigilant for their own sakes, by making it their interest to prevent the commission of [arson and riots]."[56] Thus, argues the commentator, double recovery was acceptable because it, quite literally, served the Act's purpose to create communal responsibility.[57] The argument stemming from the *Blything* holding resonates throughout other contexts—the social and economic landscape and tort law,

are awarded or whether evidence of collateral benefits exist); Jojola v. Baldridge Lumber Co., 635 P.2d 316, 320 (N.M. App. 1981) (showing an example of a common law collateral source rule only preventing a reduction in damages, not introducing evidence of collateral benefits); *see also* James L. Branton, *The Collateral Source Rule*, 18 ST. MARY'S L.J. 883, 887 (1987) (demonstrating that many states have abolished the rule in medical malpractice cases).

[50] *See generally* Wickert, *supra* note 8, at 3–4 (explaining the three basic approaches to how much medical expenses can be introduced into evidence and recovered, which are discussed *infra* Section II).

[51] Harvin, *supra* note 29, at 55–58; William A. Olson, Comment, *The Collateral Source Rule: Double Recovery and Indifference to Societal Interests in the Law of Tort Damages*, 2 U. PUGET SOUND L. REV. 197, 199–200 (1978); Pretzel, *supra* note 35, at 74–76.

[52] (1823) 107 Eng. Rep. 378, 378 (KB).

[53] Pretzel, *supra* note 35, at 75–76.

[54] Regan v. N.Y. & N.E.R. Co., 22 A. 503, 507 (Conn. 1891) (citing *Blything*).

[55] Statute of Winchester 1285, 13 Edw. c. 2 (Eng.).

[56] Pretzel, *supra* note 35, at 76 (quoting *Blything*).

[57] *Id.*

in general, has changed since the collateral source rule's beginnings; thus, tortfeasors believe that the rule should adapt to modern-day tort law.[58]

First, the social and economic landscape has changed because of the need for and prevalence of insurance in the United States.[59] At the time of the adoption and spread of the collateral source rule in the late nineteenth century, the lack of protection against personal injury losses justified the need to incentivize plaintiffs to protect themselves.[60] Are these justifications still present today? Tortfeasors argue no. Collateral sources are no longer scarce in our society and have become essential to protecting oneself.[61]

Second, and perhaps more critical to tortfeasors' arguments, is the drastic change in how our civil justice system views and applies tort law since the adoption of the collateral source rule.[62] Early in the civil justice system, tort law served as a supplement to the criminal system, where it made sense to have punitive rules.[63] Tortfeasors argue that, by focusing too heavily on punishing the defendant's causal conduct, it completely ignores the windfall that comes to the victim.[64] Additionally, many concepts important to our modern understanding of the tort system were non-existent or in their early stages in the nineteenth century: comparative negligence, strict liability, and compensation-based recovery over punishment.[65] Just as victims are quick to argue that the collateral source rule's punitive nature deters individuals from committing torts, tortfeasors point out that it is difficult to deter ordinary negligent behavior—especially with how prevalent inadvertent harm exists in modern, fast-paced societies.[66]

Third, the social expense does not always fall on the tortfeasor; instead, it falls onto the general population in the tortfeasor's risk pool.[67] While the collateral source rule focuses heavily on the defendant's conduct, it is not mindful of whether the defendant is in an insured position. Many defendants will have some form of liability insurance, which will bear the ultimate

[58] *See* Harvin, *supra* note 29, at 55–59.

[59] *Id.* at 59.

[60] *See* Olson, *supra* note 51, at 200.

[61] *See id.* at 199.

[62] *See id.* at 200–01.

[63] *See* Harvin, *supra* note 29, at 55.

[64] *See id.* at 56–57 (arguing that tort law does not recognize windfalls, only losses to the extent that it is a loss).

[65] *See* Olson, *supra* note 51, at 200.

[66] *See id.* at 201.

[67] *See id.* at 201–02.

financial responsibility.[68] The ultimate financial responsibility then falls on faultless individuals who will pay a higher premium cost because the risk associated with the pool continues to increase.[69] By indirectly assessing punitive damages through the collateral source rule, insurance companies are obligated under the terms of the policy to pay for the compensatory damages, causing this phenomenon.[70]

Overall, the victim's position has been the driving force behind the collateral source rule's adoption and application. Traditionally, the notions of fairness, deterrence, and incentivizing protection have overcome the tortfeasors' economic arguments. However, this does not mean that the tortfeasors have been entirely unsuccessful—as we have seen and will see in Section II, courts have been more willing to create exceptions or abrogate the rule in some manner in recent years.

## II. A BRIEF OVERVIEW OF HEALTHCARE IN THE UNITED STATES

This Section will provide a general overview of the complex landscape of healthcare in the United States. Healthcare is a behemoth of a topic to cover succinctly, so this Section will primarily focus on the general background, effects, and justifications for private and public healthcare.[71] Understanding the distinction between the public and private systems will help explain why courts struggle to determine whether to apply the collateral source rule in each situation. Additionally, this Section will address medical billing, as it has been a driving force in applying the collateral source rule for medical expenses.

### *A. Health Insurance Generally & Private Healthcare*

Before providing an overview of the public healthcare sphere of the United States, I will briefly explain how private health insurance generally works. Put simply, health insurance works the same way other insurance works; it shifts the risk from individuals to a collective group of individuals held together by an insurer. It reduces the out-of-pocket costs the insured

[68] *Id.* at 202.

[69] *See id.* (The author additionally discusses how the risk transfer can fall onto taxpayers when the tortfeasor is a public entity.).

[70] *Id.*

[71] This comment will address Private Healthcare, Medicare/Medicaid, the Affordable Care Act, and a "true" Universal System.

individual bears should an unforeseen event occur.[72] Consumers pay an up-front premium to share the risk with others in the same risk pool.[73] If someone in the risk pool falls ill or is injured, the collective premiums cover the (hopefully) few injured or ill individuals.[74] Based on the type of coverage bargained for, the insurer (insurance company) can and will place restrictions on the types of services or providers available to insureds.[75] Depending on the policy issued, the out-of-pocket expenses, annual deductible, copayment, coinsurance, and covered benefits can vary from person to person.[76]

The traditional forms of private insurance take the form of self-funded employee health benefit plans or state-licensed health insurance organizations, which an employer or individual-purchaser can provide.[77] Self-funded employee health benefit plans operate under federal law and have a plan sponsor that retains the responsibility to pay directly for healthcare services (i.e., the premium payment falls on the sponsor).[78] State-licensed health insurance organizations are organized under state law.[79] They may be subject to federal standards, such as commercial health insurers, Blue Cross and Blue Shield Plans, and Health Maintenance Organizations (HMOs).[80] These plans have one thing in common: they each require the insured to pay premiums to maintain coverage.[81]

### *B. Public Healthcare*

Public healthcare threw a wrench into the middle of personal injury litigation by providing more grounding for defendants to stand on to combat the collateral source rule. In general, the United States has traditionally been hesitant to implement the idea of publicly funded health insurance or social

[72] *How U.S. Health Insurance Works*, STANFORD UNIV., https://vaden.stanford.edu/insurance/health-insurance-overview/how-us-health-insurance-works (last visited Oct. 28, 2021).

[73] *Id.*

[74] *Id.*

[75] *Id.*

[76] *Id.*

[77] Gary Claxton, *How Private Insurance Works: A Primer*, KAISER FAM. FOUND., at 1–2 (Apr. 2002), https://www.kff.org/wp-content/uploads/2013/01/how-private-insurance-works-a-primer-report.pdf.

[78] *Id.* at 3.

[79] *Id.* at 2.

[80] *Id.*

[81] *Id.* at 1.

medicine.[82] Prior to the 1960s, the only form of public health seen in the United States was the Freedmen's Bureau, established by Abraham Lincoln in the post-war South to provide many necessary forms of assistance to former slaves.[83] The first half of the twentieth century brought many failed or abandoned efforts to create a form of public healthcare. In the early twentieth century, progressivists hoping to develop a public healthcare system in the face of multiple health crises faced an uphill battle against coordinated forces to prevent national reform.[84] The blockades halting the early twentieth progressive movements also plagued reformers during the New Deal-era.[85] Ultimately, from the New Deal-era to the heights of the Cold War in the 1950s, a lack of grassroots momentum and attacks against a "Soviet"-style federal health program prevented any major legislation from progressing.[86]

In the 1960s, the civil rights movement helped many groups spearheading earlier campaigns to finally conjure enough grassroots support to endorse Medicare legislation.[87] In 1965, John F. Kennedy's successor, Lyndon B. Johnson, enacted legislation that created the Medicare program found within

[82] There are hundreds of issues that contribute to the greater healthcare "crisis" in the United States. *See generally* Miriam F. Weismann & Irving Jorge, *The Regulatory Vision of Universal Healthcare in the United States: Strategic, Economic, and Moral Decision-Making*, 21 U. PA. J. BUS. L. 647 (2019) (suggesting that these issues largely derive from a lack of synergy between the economics of healthcare delivery and the national public health policy that limits access to medical treatment (i.e., free market principles, profit-based motives, the lack of constitutional protections for healthcare, etc.)).

[83] *Freedmen's Bureau Field Office Records*, NAT'L ARCHIVES, https://www.archives.gov/files/research/african-americans/freedmens-bureau/brochure.pdf (last visited Oct. 28, 2021).

[84] *See* Joseph S. Ross, *The Committee on the Costs of Medical Care and the History of Health Insurance in the United States*, 19(3) EINSTEIN Q. J. BIOLOGY MED., 129, 129 (2002) (explaining that a number of forces, such as WWI, the election of President Woodrow Wilson, and physician opinions, removed national health insurance from the federal agenda); *see also* Beatrix Hoffman, *Health Care Reform and Social Movements in the United States*, 93 AM. J. PUB. HEALTH 75, 76 (2003) (illustrating how the united force of insurance companies, physicians, and legislators branding public health insurance as "Bolshevism" squashed the movement).

[85] *See* Hoffman, *supra* note 84, at 76–77 (outlining how proposals of health insurance to the Social Security Act ultimately failed due to large societal and political pressures from the American Medical Association against President Franklin D. Roosevelt).

[86] *See id.* at 77 (singling out the failure of the Wagner–Murray–Dingell bill during Truman's presidency despite the overwhelming support of unions and the president himself).

[87] *Id.*

the Social Security Amendments.[88] The practical purpose was to serve as an economic safety net by providing lower premiums for older individuals that saw their health and income declining while their health costs continued to rise.[89] It did so by taking the form of a federally-funded insurance program for retirees and disabled workers.[90]

Medicare's two primary objectives were to provide hospital insurance for persons over sixty-five and create a supplementary medical insurance plan to cover areas not included in the hospital insurance plan.[91] The hospital insurance plan provided protection for inpatient hospital stays for formal admission into the hospital where individuals would only have to pay the deductible rather than the total cost of medical service.[92] Medicare's supplemental medical insurance portion covers mainly outpatient services, including up to seventy-five percent of the cost of services being placed on the government.[93] Both parts of the program are funded by general federal revenues, payroll taxes, and beneficiary premiums.[94]

Along with the two original Medicare programs—Part A, the hospital insurance, and Part B, the supplementary medical insurance—Part C and Part D have expanded Medicare over the years.[95] These expansions have had the objectives of expanding choices for beneficiaries and saving Medicare money.[96] The Part C expansion had been informally in existence for decades but was formally created in 1997[97] and 2003.[98] Part C is commonly called "Medicare Advantage," which includes plans offered by private companies

[88] *History of SSA During the Johnson Administration 1963-1968*, SOCIAL SECURITY ADMIN., https://www.ssa.gov/history/ssa/lbjmedicare1.html (last visited Oct. 28, 2021).

[89] *Id.*

[90] *See id.*

[91] *Id.*

[92] *Id.*

[93] Anna Schwamlein Howard, *Dewonkify – Medicare Part B*, NAT'L L. REV. (Nov. 5, 2013), https://www.natlawreview.com/article/dewonkify-medicare-part-b.

[94] Juliette Cubanski et al., *The Facts on Medicare Spending and Financing*, KAISER FAM. FOUND., at 6 (Aug. 20, 2019), https://files.kff.org/attachment/Issue-Brief-Facts-on-Medicaid-Spending-and-Financing.

[95] *See generally* Thomas G. McGuire et al., *An Economic History of Medicare Part C*, 89 MILBANK Q. 289 (2011).

[96] *Id.* at 290.

[97] Balanced Budget Act of 1997, Pub. L. No. 105-33, Title IV, § 4001, 111 Stat. 270.

[98] Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108-173, Title II, § 201, 117 Stat. 2176.

approved by Medicare to provide extra coverage (i.e., dental, vision, etc.).[99] Rather than directly paying health providers, Medicare will pay the company offering the plan a fixed amount, and the beneficiary will cover the difference.[100] This allows the companies within the program to have different sets of rules for the beneficiaries to follow to keep costs down (primarily on the company side).[101] Medicare Part D works similarly to Part C as it is a voluntary program through approved private plans.[102] Part D, enacted in 2003 but effective in 2006, allows individuals who participate in Medicare to obtain outpatient prescription drug benefit plans at a reduced rate.[103]

The Social Security Amendments of 1965 not only created Medicare but also set Medicaid into effect.[104] Although each program represents many individuals, Medicaid makes Medicare seem infinitesimal because of its intricacies.[105] In general, Medicaid is a joint federal-state program that provides health insurance to low-income adults and their families along with long-term services for older persons and persons with disabilities.[106] This gives low-income individuals in the United States access to "mainstream" health services at little to no cost.[107]

The program's dual nature requires the federal government to provide financial aid to states that participate.[108] States that participate in the program must allocate the funds under federal standards to provide essential health

[99] *What is Medicare Part C?*, U.S. DEPT. HEALTH & HUM. SERVS., https://www.hhs.gov/answers/medicare-and-medicaid/what-is-medicare-part-c/index.html (last updated Aug. 3, 2021).

[100] *Id.*

[101] *Id.* (explaining the types of consumer-experiences that Medicare Advantage plans can change, like out-of-pocket costs, referrals, and choice of doctors).

[102] *See An Overview of the Medicare Part D Prescription Drug Benefit*, KAISER FAM. FOUND. (Oct. 14, 2020), https://www.kff.org/medicare/fact-sheet/an-overview-of-the-medicare-part-d-prescription-drug-benefit/.

[103] *See generally id.* (providing an in-depth overview of Part D and explaining the success of the Part D program with forty-six million Medicare participants opting into the program).

[104] Gary Smith et al., *Using Medicaid to Support Working Age Adults with Serious Mental Illnesses in the Community: A Handbook*, U.S. DEP'T HEALTH & HUM. SERVS., at 19 (Jan. 23, 2005), https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//41461/handbook.pdf.

[105] *See generally id.* (Multiple chapters of the handbook are dedicated to explaining the complexities of Medicaid.).

[106] *Id.* at 19.

[107] *Id.*

[108] *Id.*

services to Medicaid recipients.[109] This financing structure guarantees states matching federal funds based on the actual expenditures of the state.[110] Although there have been various changes to Medicaid since its adoption, the most significant change has been states' ability to design and administer their Medicaid programs, subject to federal approval through Section 1115 waivers.[111] States' flexibility is vital to understanding Medicaid because it impacts who receives services and what services are offered to the public.[112]

Before the expansion of Medicaid under the Affordable Care Act ("ACA"), individuals were only eligible for Medicaid if their income bracket was below the federal poverty level ("FPL") and they fit into a "covered" group.[113] Individuals that fell into these categories would receive medical coverage at a limited out-of-pocket cost, capping it at five percent of the total household income.[114] Similar to Medicare Advantage plans seen in the expansion of Part C of Medicare, most Medicaid beneficiaries receive their coverage through private programs that contract with the states to provide the services.[115]

In 2010, with the passage of the ACA[116], many of the categorical eligibility barriers were eliminated.[117] This expanded coverage to nearly all individuals living up to 138% above the FPL, increasing the enrollment by

[109] *Id.*

[110] Laura Snyder & Robin Rudowitz, *Medicaid Financing: How Does it Work and What are the Implications?*, KAISER FAM. FOUND., at 1 (May 20, 2015), https://files.kff.org/attachment/issue-brief-medicaid-financing-how-does-it-work-and-what-are-the-implications.

[111] *See* Smith, *supra* note 104, at 26; *see also* Robin Rudowitz et al., *10 Things to Know about Medicaid: Setting the Facts Straight*, KAISER FAM. FOUND., at 2 (Mar. 6, 2019), https://files.kff.org/attachment/Issue-Brief-10-Things-to-Know-about-Medicaid-Setting-the-Facts-Straight.

[112] *See* Rudowitz, *supra* note 111, at 2.

[113] Rachel Garfield & Robin Rudowitz, *Eliminating the ACA: What Could It Mean for Medicaid Expansion?*, KAISER FAM. FOUND. (Oct. 1, 2020), https://www.kff.org/policy-watch/eliminating-the-aca-what-could-it-mean-for-medicaid-expansion/ (explaining that "covered" groups are children, some of their parents, pregnant women, adults with disabilities, and some older adults).

[114] Tricia Brooks et al., *Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost Sharing Policies as of January 2018: Findings from a 50-State Survey*, KAISER FAM. FOUND., at 2, 8 (Mar. 21, 2018), https://files.kff.org/attachment/Report-Medicaid-and-CHIP-Eligibility-Enrollment-Renewal-and-Cost-Sharing-Policies-as-of-January-2018.

[115] Rudowitz, *supra* note 111, at 6.

[116] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

[117] 111Rudowitz, *supra* note 111, at 3.

fourteen million since the expansion became effective.[118] Not including Missouri and Oklahoma that expand in 2021, thirty-seven states have chosen to expand Medicaid coverage under the ACA.[119] Increasing coverage to more Americans helped provide financial security and access to care for groups that slip through the cracks because their income initially prevented them from receiving coverage.[120]

Along with its benefits, the ACA created many legal and political controversies, most notably the conditioning of funds on mandatory expansion and the individual mandate to have health insurance.[121] These controversies led to the end of both of these aspects of the ACA.[122] Although the ACA created many constitutional challenges, it also created opportunities and barriers for personal injury litigation. With more victims having a form of medical insurance, the natural outcome is that people are more likely to seek medical care for their injuries, thus creating more opportunities for damages.[123] Inversely, however, this expansion has created some issues regarding the recoverability of damages with the collateral source rule, highlighted in Section III & IV.

Medicare and Medicaid have become the preeminent forms of public healthcare in the United States, and President Joseph Biden plans to expand on that. During his campaign, he outlined a four-step plan to build on the ACA's expansion while he was Vice President under President Barack Obama.[124] While most of the plan involves big-picture political talking

[118] *Id.*; *Medicaid Enrollment Changes Following the ACA*, MEDICAID AND CHIP PAYMENT AND ACCESS COMM'N, https://www.macpac.gov/subtopic/medicaid-enrollment-changes-following-the-aca/ (last visited Oct. 28, 2021).

[119] *The Far-Reaching Benefits of the Affordable Care Act's Medicaid Expansion*, CTR. ON BUDGET AND POLICY PRIORITIES (Oct. 21, 2020), https://www.cbpp.org/research/health/chart-book-the-far-reaching-benefits-of-the-affordable-care-acts-medicaid-expansion.

[120] *See id.*

[121] *See* Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 575 (2012) (upholding the individual mandate under Congress's taxing powers but declaring the mandatory expansion by states unconstitutional coercion by Congress).

[122] *See id.* at 588. The Tax Cuts and Jobs Act effectively ended the individual mandate by removing the penalty for failing to maintain health insurance beginning on January 1, 2019. *See* Tax Cuts and Jobs Act of 2017, Pub. L. No. 115-97, 131 Stat. 2092.

[123] Cory Bilton, *Effects of the ACA on Personal Injury Actions*, BILTON LAW FIRM (Oct. 5, 2013), https://www.biltonlaw.com/effects-of-the-aca-on-personal-injury-actions/.

[124] *Health Care*, JOE BIDEN (July 14, 2019), https://joebiden.com/healthcare/ (explaining the four steps as follows: (1) give every American access to affordable health insurance; (2) provide the peace of mind of affordable, quality health care and a less complex health care system; (3) stand up

points, the plan's portion with the most significant impact is his plan to give every American access to affordable insurance. President Biden aims to implement a plan akin to Medicare to lower costs whereby individuals could choose to "purchase" a public option regardless of their financial status.[125] He also hopes to provide tax credits for individuals and families living 100–400% above the FPL to ensure that health insurance is capped at 8.5% of their annual income.[126] Lastly, President Biden hopes to expand premium-free ACA protections automatically to all low-income Americans regardless of whether their state has opted into the ACA expansion.[127] Under President Biden's proposed changes to our healthcare system, significant threats to the collateral source rule need to be addressed.[128] In particular, if the Biden administration and Congress attempt to target public healthcare through reinstating an individual mandate, it reverses the presumption that the collateral source rule seeks to protect.

President Biden's hope to expand the ACA has not diminished the hopes of progressives for a "true" universal system. Proponents of a universal system argue that budgeting for healthcare should work akin to other publicly funded services, like police and fire departments.[129] They argue that individual medical billing creates warped incentives for healthcare providers and overcomplicates a system that is integral to the daily lives of millions of Americans, which a streamlined state-funded system could resolve.[130] Although, as discussed later, this system would outright abolish the collateral source rule absent a significant overhaul of the personal injury litigation industry.

to abuse of power by prescription drug corporations; and (4) ensure health care is a right for all, not a privilege for just a few).

[125] *Id.*

[126] *Id.*; *Distribution of the Total Population by Federal Poverty Level (above and below 400% FPL)*, KAISER FAM. FOUND. (2019), https://www.kff.org/other/state-indicator/population-up-to-400-fpl/ (providing data that 58.5% of the population would qualify for the tax credits under this plan).

[127] *Health Care*, *supra* note 124.

[128] *See* discussion, *supra* Section I.

[129] Adam Gaffney et al., *Moving Forward from the Affordable Care Act to a Single-Payer System*, 106 AM. J. PUB. HEALTH 987, 988 (2016).

[130] *See id.*

### *C. Medical Billing*

Understanding how the different types of health insurance impact the collateral source rule is fundamental to recognizing the difference between traditional and modern medical billing. Medical billing can significantly impact the amount of damages awarded in a trial because, more often than not, the full cost of the medical service is not paid by the plaintiff. Because of the modern healthcare system's complex structure, the amount expensed to the consumers is simply not what it once was—especially in the outpatient and pharmaceutical industries.[131]

In general, consumers traditionally paid a "fair" or "reasonable" value of the services rendered directly to the provider.[132] Present-day, patients are "rarely billed or pay a hospital's nominal charges."[133] This is because healthcare providers and health insurance companies will have contracts in which providers will agree to a fee less than the patient's bill.[134] The difference between the amount initially billed and paid is considered the "discount" or "write-off."[135] Gary Wickert, an insurance trial lawyer who is regarded as one of the world's leading experts on insurance subrogation, explains the process as follows:

> While the insured patient may only have direct interaction with one person or health care provider, it is really part of a three-party system – the patient, the health care provider, and the payer or entity which ultimately pays the bill – usually an insurance company or the government. . . . [T]he final bill

[131] *See* Jon Gabel & Karen Fitzner, *New Evidence to Explain Rising Healthcare Costs*, 9 AM. J. OF MANAGED CARE, at 1 (June 2003) (The authors explain the phenomenon from an early 2000s perspective, raising concerns over the 12.1% annual increase throughout the late 1990s in outpatient costs. The authors give credit to technological advances, workforce shortages, marketing structures, and legislative regulations.).

[132] *See* Wickert, *supra* note 8, at 28 (noting that because providers are accepting a discounted rate, there are additional incentives to inflate the price of care).

[133] Rich Daly, *CMS Data Show Wide Variation in Hospital Billing*, MOD. HEALTHCARE (May 8, 2013), https://www.modernhealthcare.com/article/20130508/NEWS/305089960/cms-data-show-wide-variation-in-hospital-billing (explaining that customers do not even understand what they are being billed for because of the complexities and that similar procedures can have extremely different prices (i.e., an undiscounted joint-replacement procedure varying from $5,300 to $223,000 at hospitals less than two hours apart in California)).

[134] Douglas Rallo, *Insurance Write-Offs and the Collateral Source Rule*, TRIAL, Sept. 2002, at 42.

[135] *Id.*

> is created by a medical biller who looks at the balance (if any) the patient has, adds the cost of the procedure or service to that balance, deducts the amount covered by insurance, and factors in a patient's co-pay or deductible.[136]

Thus, because these write-offs vary greatly depending on the insurer's contractual arrangement with the provider, tortfeasors and victims lack reasonable certainty about what damages could be included in the final award depending on the jurisdiction's interpretation of the collateral source rule.[137]

## III. CURRENT APPLICATION OF THE COLLATERAL SOURCE RULE REGARDING MEDICAL EXPENSES

The three main approaches courts have applied regarding the collateral source rule are the Amount Billed, Amount Paid, and Reasonable Value approaches.[138] This Section provides an overview and illustrations of the three approaches based on the rationales used by the jurisdictions applying each approach. Additionally, this Section will reconcile these approaches with the application of the cases using Medicare, Medicaid, and the ACA.

### *A. Amount Billed*

The Amount Billed approach allows plaintiffs to recover the full amount billed to the plaintiff from the provider.[139] This principle holds true regardless of whether a collateral source covered the amount or whether the collateral source (insurer) reduced the amount billed through a write-off.[140] This has also been referred to as the "benefit-of-the-bargain" approach because it rewards a prudent, insured plaintiff for obtaining coverage—one of the primary justifications that has formed the modern application of the collateral source rule.[141]

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[136] Wickert, *supra* note 8, at 2.8

[137] *See id.* at 2–3.

[138] Zorogastua, *supra* note 33, at 472–75; Wickert, *supra* note 8, at 3–4, 7–378 (providing an in-depth review of all fifty states' collateral source rule with respect to medical expense write-offs).

[139] Wickert, *supra* note 8, at 4.

[140] *See id.*

[141] *Id.* at 5.

The thirteen jurisdictions[142] that have explicitly adopted a version of the Amount Billed approach typically follow one of two trial-court procedures : (1) any evidence of a collateral source is inadmissible[143]; or (2) although evidence of collateral sources may be introduced, damages will not be reduced due to the collateral source or the write-off.[144] Jurisdictions lacking a statute or common law that abrogates the collateral source rule infer an adoption of the Amount Billed approach because it looks the most similar to the traditional application of the collateral source rule.[145]

For insight on the policy arguments in favor of the Amount Billed approach, we can look to the recent Tennessee Supreme Court holding in *Dedmon v. Steelman*.[146] This court favored the fairness and administrative rationales of the amount billed approach over the hybrid Reasonable Value and Amount Paid approaches.[147] The court first noted that it would be impermissible for jurisdictions that steadfastly adhere to a common-law collateral source rule to adopt any approach other than the Amount Billed approach.[148] In negating the arguments in favor of the Reasonable Value approach, the court admits that even with a complete understanding of the medical services industry, determining the reasonable value of medical services is not nearly as possible as determining the reasonable value of other

[142] *E.g.*, Lopez v. Safeway Stores, Inc., 129 P.3d 487, 495–96 (Ariz. Ct. App. 2006); Scholle v. Delta Air Lines, Inc., 486 P.3d 325, 332 (Colo. App. 2019); McInnis v. Hosp. of St. Raphael, No. CV030480767, 2008 WL 4150056, at *1 (Conn. Super. Ct. Aug. 15, 2008) (distinguishing between voluntary and involuntary write-offs); Mitchell v. Haldar, 883 A.2d 32, 39–40 (Del. 2005); Hardi v. Mezzanotte, 818 A.2d 974, 985 (D.C. 2003); Olariu v. Marrero, 549 S.E.2d 121, 123 (Ga. Ct. App. 2001); Baptist Healthcare Sys., Inc. v. Miller, 177 S.W.3d 676, 684 (Ky. 2005); Barday v. Donnelly, No. CV-04-508, 2006 WL 381876, at *3 (Me. Super. Jan. 27, 2006); Knox v. Ferrer, No. 5:07-cv-6(DCB)(JMR), 2008 WL 4446534, at *1 (S.D. Miss. Sept. 15, 2008); Papke v. Harbert, 738 N.W.2d 510, 536 (S.D. 2007); Dedmon v. Steelman, 535 S.W.3d 431, 467 (Tenn. 2017); Acuar v. Letourneau, 531 S.E.2d 316, 317 (Va. 2000); Leitinger v. DBart, Inc., 736 N.W.2d 1, 4 (Wis. 2007).

[143] *See, e.g.*, *Haldar*, 883 A.2d at 40.

[144] *See, e.g.*, *McInnis*, 2008 WL 4150056, at *3–4 (allowing evidence to determine whether the write-off is voluntary or involuntary (i.e., pursuant to a contract) because involuntary write-offs are not permitted for recovery).

[145] *See, e.g.*, Narayen v. Bailey, 747 A.2d 195, 199–200 (Md. Ct. Spec. App. 2000); Bynum v. Magno, 101 P.3d 1149, 1162 (Haw. 2004); Weatherly v. Flournoy, 929 P.2d 296, 299 (Okla. Civ. App. 1996).

[146] 535 S.W.3d at 467.

[147] *Id.* at 433; 463–64; 466–67 (declining to extend the Reasonable Value approach adopted in West v. Shelby Cnty. Healthcare Corp., 459 S.W.3d 33 (Tenn. 2014) to personal injury cases).

[148] *Id.* at 464.

goods such as a car or home.[149] Further, it states that "[a]t best [the Reasonable Value approach] would cause confusion by inserting into the evidence discounted payments with no explanation; at worst it would lead the jury to infer the existence of insurance."[150] In defending the fairness of an Amount Billed approach, the court reiterates the two of the policy rationales mentioned in Section I—rewarding prudent plaintiffs and placing a tortfeasor's responsibility for the plaintiff's loss.[151]

The Amount Billed approach is not without its faults or criticisms. Primarily, the plaintiff is not truly suffering an economic loss because of the write-off beyond the amount they actually pay, and this approach disregards putting the plaintiff in its rightful position.[152] This also begs the question: why should we compensate plaintiffs for a fictional and arbitrary number set by medical providers that is never actually paid or even expected to be paid? There is an overwhelming amount of evidence demonstrating that the price of procedures not only varies from provider to provider but is wildly inflated.[153] If the provider *knows* that it will ultimately accept less than the amount that it is billing the victim, why should we expect defendants to pay a judgment that entirely ignores the principles of compensatory damages?

Additionally, two other criticisms of the Amount Billed approach bear some merit. Before widespread public healthcare, a major criticism of the Amount Billed approach was that it "protects the rich" because only those who could afford insurance may recover more than the negotiated rate.[154] The other major problem with the Amount Billed approach is that courts that follow it consistently place individuals with private and public insurance in different categories, which is one of the fundamental reasons for following

[149] *Id.* at 462.

[150] *Id.* at 464 (describing how the discounted rate does not reflect a fair value, but the third-party's negotiating power).

[151] *Id.* at 465.

[152] *See* McConnell v. Wal-Mart Stores, Inc., 995 F. Supp. 2d 1164, 1171–72 (D. Nev. 2014); Malinda S. Matlock, *The Collateral Source Rule & Write-Offs: What is the True Value of Medical Services?*, US LAW (Fall/Winter 2013), available at https://web.uslaw.org/wp-content/uploads/2013/10/Malinda-S.-Matlock-USLAW-mag-article.pdf (explaining that the debt is non-existent, thus there is not a windfall for either the plaintiff or the defendant).

[153] *See* Daly, *supra* note 133; s*ee also Medicare Physician & Other Practitioners - by Geography and Service* (2019), https://data.cms.gov/provider-summary-by-type-of-service/medicare-physician-other-practitioners/medicare-physician-other-practitioners-by-provider-and-service/data/2019 (explaining the profit margin that medical providers make on procedures absent a negotiated rate).

[154] Wickert, *supra* note 8, at 48.

an "absolute" collateral source rule.[155] Many of the justifications supporting the rule begin to fall apart when applied to individuals with public insurance.[156]

### *B. Amount Paid*

The most criticized and least followed approach is the Amount Paid approach. Regardless of whether there is a write-off, gratuitous payment, or otherwise, plaintiffs in an Amount Paid jurisdiction may only recover the actual amount paid for the medical services.[157] Jurisdictions following this approach have generally had widespread tort reform and emphasize compensation, rather than punishment, as the leading theory behind tort recovery. However, this does not always hold true. For example, the leading case regarding the Amount Paid approach, discussed below, comes from California.[158] Procedurally, the six jurisdictions[159] explicitly following this approach either (1) only allow evidence of the amount actually paid (by the individual and insurer) to the provider,[160] or (2) allow a post-verdict reduction of the amount written-off by the collateral source and the provider.[161]

There are two main arguments grounding the Amount Paid approach—the first being that the collateral source rule is not implicated when determining whether a write-off should reduce the plaintiff's damage award.[162] For example, the Pennsylvania Supreme Court in *Moorhead v.*

[155] *Compare* Griffin v. La. Sheriff's Auto Risk Ass'n, 802 So. 2d 691, 715 (La. Ct. App. 2001) (permitting an amount billed recovery), *with* Bozeman v. State, 879 So. 2d 692, 705 (La. 2004) (declining to allow Medicaid recipients to recover the full amount billed because it is "free").

[156] *See* discussion, *infra* Section III.D.

[157] Wickert, *supra* note 8, at 38.

[158] *See* Howell v. Hamilton Meats & Provisions, Inc., 257 P.3d 1130, 1133–35; 1145–47 (Cal. 2011); *see also* Lawrence J. McQuillan & Hovannes Abramyan, *U.S. Tort Liability Index: 2010 Report*, PAC. RSCH. INST. (June 2010), available at https://www.commonwealthfoundation.org/docLib/201009211_pritort.pdf (explaining that California has sixteen of the top one hundred jury awards for tort cases and is the ninth highest victim-friendly tort jurisdiction).

[159] *See, e.g.*, MO. REV. STAT. § 490.715 (2017); *Howell*, 257 P.3d at 1143; Goble v. Frohman, 901 So. 2d 830, 835 (Fla. 2005); MINN. STAT. § 548.251 (2008); Moorhead v. Crozer Chester Med. Ctr., 765 A.2d 786, 788 (Pa. 2001); Haygood v. De Escabedo, 356 S.W.3d 390, 391 (Tex. 2011), reh'g denied (Jan. 27, 2012).

[160] *See, e.g.*, *Howell*, 257 P.3d at 1143.

[161] *See, e.g.*, Kastick v. U-Haul Co. of W. Mich., 740 N.Y.S.2d 167, 169 (N.Y. App. Div. 4th Dept. 2002).

[162] *See* Matlock, *supra* note 152.

*Crozer Chester Medical Center* held that the plaintiff was free to recover payments from the collateral sources (Medicare and Blue Cross), but not from the write-off.[163] The court reasoned that the collateral source rule did not apply to illusory charges such as a write-off because no one actually paid for the services and because the collateral source rule only covers "payments."[164]

The other argument grounding the Amount Paid approach is what is considered to be the "market-value of services" argument.[165] The California Supreme Court articulated this argument in *Howell v. Hamilton Meats & Provisions, Inc.*[166] It argues that, contrary to the Reasonable Value crowd's believing that its approach accurately depicts the market value of the services, the Amount Paid approach more efficiently and accurately determines market value.[167] This reasoning is persuasive because, given the complexities of medical economics, determining market value by looking at the provider's willingness to accept is a viable strategy.[168]

Opponents argue that prohibiting the plaintiff from recovering more than the negotiated rate thwarts the rule's purpose because it shifts the benefit from the prudent victim to the tortfeasor.[169] However, this leads us back to the first rationale for the Amount Paid approach: who is actually receiving the benefit of the negotiated rate? The biggest benefit comes to the insurer for having negotiated a rate well below the amount billed by the provider, not the victim.[170] The best criticism against this approach is that the write-off agreements are a form of compensation that is not seen on a balance sheet; thus, these agreements are part of the consideration bargained for by the insured and the insurer.[171] Under this rationale, because write-off is

[163] 765 A.2d at 791.

[164] *Id.*

[165] Matlock, *supra* note 152.

[166] *See* 257 P.3d 1130, 1142 (Cal. 2011).

[167] *Id.*

[168] *See id.* (explaining that determining market value other than this negotiated price is unclear because of the state of medical billing); Matlock, *supra* note 152, at 3 (further explaining that what hospitals charge could hardly be considered market-value and gives the example of $15 for a single aspirin).

[169] Acuar v. Letourneau, 531 S.E.2d 316, 322 (Va. 2000).

[170] *Howell*, 257 P.3d at 1143–44 (explaining that the insurer does not negotiate a discounted payment as compensation for the plaintiff's injuries and that the amount avoided is not a proper representation of "compensation" for tort recovery).

[171] *See Acuar*, 531 S.E.2d at 321.

compensation, it is "incurred" and a collateral source; thus, it should not be subject to a reduction.[172]

### *C. Reasonable Value*

The most complex approach, but perhaps the most effective, is the Reasonable Value approach. This approach allows a plaintiff to recover the "reasonable value" of their medical expenses.[173] Although this may effectively compensate a plaintiff, the lack of uniformity amongst jurisdictions defining "reasonable value" makes it difficult to estimate how much one can recover.[174] Most states' statutes provide that plaintiffs can recover the "reasonable value" of their medical expenses. Still, there are only thirteen jurisdictions that have explicitly applied a formulation of the Reasonable Value approach.[175] The most common formulations of the Reasonable Value approach are: (1) allowing the trier of fact to consider the amount billed, amount paid, and the write-off in determining what the reasonable value was,[176] or (2) merely placing the burden on the plaintiff to show the reasonable value.[177]

The Kansas Supreme Court opined in *Martinez v. Milburn Enterprises, Inc.* that "neither the amount billed, nor the amount actually accepted after a write-off conclusively establishes the 'reasonable value' of medical services."[178] This is the driving force behind the Reasonable Value approach—medical services do not have a "cut and dry" price tag. The variance of hospital procedure prices and insurance companies' bargaining power to negotiate lower discounts creates a market value that cannot be

[172] *See id.*

[173] Wickert, *supra* note 8, at 48.

[174] *See id.*

[175] *See, e.g.*, ALA. CODE § 12-21-45 (1987); ALASKA STAT. § 9.17.070 (1986); S.D. CODIFIED LAWS § 21-3-12 (1977); Arthur v. Catour, 833 N.E.2d 847, 853–54 (Ill. 2005); Stanley v. Walker, 906 N.E.2d 852, 855 (Ind. 2009); Pexa v. Auto Owners Ins. Co., 686 N.W.2d 150, 156 (Iowa 2004); Martinez v. Milburn Enters., Inc., 233 P.3d 205, 229 (Kan. 2010); Robinson v. Bates, 857 N.E.2d 1195, 1197 (Ohio 2006); Gorostieta v. Parkinson, 17 P.3d 1110, 1117–18 (Utah 2000) (stating medical expenses must be "reasonable" and "necessary" but failing to establish a strict rule); Torgeson v. Hanford, 139 P. 648, 649 (Wash. 1914); Long v. City of Weirton, 214 S.E.2d 832, 860 (W. Va. 1975); Lurus v. Rissler & McMurry Co., No. 02-CV-174-J, 2004 U.S. Dist. LEXIS 32626, at *13 (D. Wyo. Aug. 19, 2004).

[176] *See, e.g.*, *Martinez*, 233 P.3d at 222–23 (cleaned up).

[177] *See, e.g.*, *Torgeson*, 139 P. at 649.

[178] 233 P.3d at 222.

determined by looking only at the amount billed or paid.[179] Another benefit to the Reasonable Value approach is that it appropriately preserves the fundamental purpose of the collateral source rule. In particular, it allows the collateral source rule to bar evidence that the payments were made by insurance but enables the factfinder to make the ultimate determination of whether the amount billed or the amount paid is the true satisfaction of the services rendered.[180]

As stated above, the Reasonable Value approach is the most complex approach, which is its most considerable criticism. Unlike the Amount Billed and Paid approaches, the Reasonable Value approach does not present a clean number for juries.[181] This criticism of the Reasonable Value approach is outdated and prejudicial—our civil justice system entrusts the jury with many weighty and challenging damage calculations, especially those dealing with market value and reasonableness.[182] What makes medical expense damages any different?

Indeed, the Illinois Supreme Court set forth a simple and effective measure of determining reasonableness in adopting the Reasonable Value approach in *Arthur v. Catour*.[183] The process follows a typical method of admitting evidence. It begins with a presumption that if a bill has been paid, it is prima facie reasonable, regardless of whether it has been written down.[184] If the bill is unpaid, either party may establish its reasonableness by

[179] *See* Daly, *supra* note 133; Matlock, *supra* note 152, at 3.

[180] *Martinez*, 233 P.3d at 222–23.

[181] *See* Wickert, *supra* note 8, at 4.

[182] *See generally, e.g.*, Louisville, E. & St. L. Consol. R. Co. v. Berry, 36 N.E. 646, 650 (Ind. App. 1894) (The court explains that negligence, a pure question of reasonableness and ordinary prudence, is best left to juries. "Within the whole range of judicial inquiry, there are but few questions that are more peculiarly and exclusively within the province of the jury than those of negligence and the want of contributory negligence."); People *ex rel.* Dept. of Pub. Works v. Donovan, 369 P.2d 1, 4 (Cal. 1962) (holding that "[t]he jury is entitled to and should consider those factors which a buyer would take into consideration in arriving at a fair market value"); Frederick S. Levin, *Pain and Suffering Guidelines: A Cure for Damages Measurement "Anomie,"* 22 U. MICH. J. L. REFORM 303, 310 (1989) (outlining the discretion juries have in awarding pain and suffering damages). Further, Justice Souter once proclaimed that "juries are smarter than judges." *Justice David Souter: "Juries are Smarter than Judges,"* CONSTITUTIONAL ACCOUNTABILITY CTR. (Apr. 2, 2009), https://www.theusconstitution.org/blog/justice-david-souter-juries-are-smarter-than-judges/.

[183] *See* 833 N.E.2d 847, 853–54 (Ill. 2005).

[184] *See id.* at 854 (explaining that "*prima facie* reasonableness of a paid bill can be traced to the enduring principle that the free and voluntary payment of a charge for a service by a consumer is presumptive evidence of the reasonable or fair market value of that service").

introducing testimony of an expert with the requisite knowledge of the "usual and customary charges for such services" that concludes that the charges are reasonable.[185] Further, the defense is allowed to dispute the reasonableness of the charges by "casting suspicion on the transaction."[186] The court noted that this process does not differ from a process that plaintiffs regularly engage in—arguing for damages related to future medical bills, which are often speculative.[187] In entirety, "[t]he admission of the bill into evidence simply allows the jury to *consider* whether to award none, part, or all of the bill as damages."[188]

### *D. Medicare, Medicaid, and ACA Approaches*

When it comes to the public sector of healthcare, the collateral source rule's application becomes even more muddled, and the biggest issue is inconsistency. Inconsistency is an issue regarding these programs because it is a national program that provides equal access for low-income Americans. This fundamental problem gets to the heart of why the collateral source rule is essential—we do not want to place defendants or plaintiffs in different positions because of their socioeconomic statuses.[189]

The emerging trend regarding cases involving these programs is for jurisdictions to apply their formulation of the collateral source rule, absent a few of the Amount Billed jurisdictions inconsistently using that approach. The reason courts are hesitant to extend the collateral source rule to public forms of healthcare boils down to public healthcare undermining the fundamental justifications for having a collateral source rule in the first place.

[185] *Id.* (describing a form of a "battle of the experts" situation); *see also* Emily Pincow & Alexis Kellert, *The Battle of the Experts*, AM. BAR ASS'N (Nov. 26, 2018), https://www.americanbar.org/groups/litigation/committees/mass-torts/practice/2018/the-battle-of-the-experts/.

[186] *Arthur*, 833 N.E.2d at 854 (The court does not offer examples of what this evidence looks like, but we can speculate that it would be something akin to data showing that the services rendered are highly inflated to other providers in the market, etc.).

[187] *See id.*

[188] *Id.* (emphasis in original). By considering the entirety of the evidence, this approach avoids arbitrary awards based on inflated numbers. *See, e.g.*, Victor E. Schwartz & Cary Silverman, *Truth in Damages: Florida Juries Should Base Personal Injury Awards on Actual Costs of Treatment, Not Inflated Medical Bills*, SHOOK, HARDY & BACON L.L.P. 3, https://www.fljustice.org/files/124353479.pdf (analyzing a study that found 90% of healthcare providers would accept 61% of the total bill as full payment for such services).

[189] *See* discussion, *supra* Section I.A.

In particular, these forms of healthcare undermine "foresight theory" and the "windfall" argument.

As stated above, the foresight theory rewards individuals for maintaining private insurance.[190] Absent an incentive to procure private insurance, the collateral source rule lacks strength because it provides a double layer of protection for individuals who choose to protect themselves. Yet, the Supreme Court's decision in *National Federation of Independent Businesses v. Sebelius* padded the foresight theory's rationale in cases where the victim has public insurance.[191] By declaring the individual mandate unconstitutional, individuals still have an incentive to procure insurance, whether private or public, which falls in favor of keeping a collateral source rule for cases involving public insurance.

Regarding the windfall argument, defendants argue that individuals receiving Medicare should not be afforded the luxury of the collateral source rule because they did not contribute to Medicare.[192] However, as pointed out by the Northern District of Oklahoma in *Simpson v. Saks Fifth Ave., Inc.*, this argument only holds true if the United States is the defendant.[193] Only then would the payments not be from a collateral source.[194] Regardless, defendants press on. They argue that plaintiffs should not be allowed to recover if there is a Medicare or Medicaid write-off because the plaintiff was never legally liable for it, which would actually be a double recovery because they do not pay for the insurance and receive full benefits of a judgment.[195] However, is this argument any different from a privately issued insurance policy versus a gratuitous payment by a family member?[196] It is illogical to create separate categories of plaintiffs if a jurisdiction already applies an Amount Billed approach.[197] If a jurisdiction applies a particular approach, it should be consistent in its application. Indeed, proponents of a consistent application in

[190] *See* discussion, *supra* Section I.A.

[191] *See* 567 U.S. 519, 587–88 (2012).

[192] *See* Overton v. United States, 619 F.2d 1299, 1305 (8th Cir. 1980).

[193] No. 07-CV-0157-CVE-PJC, 2008 WL 3388739, at *2 (N.D. Okla. Aug. 8, 2008).

[194] *Id.*

[195] *See* Bozeman v. State, 879 So. 2d 692, 704–06 (La. 2004).

[196] *See* Bynum v. Magno, 101 P.3d 1149, 1156–57 (Haw. 2004).

[197] *Compare* Law v. Griffith, 930 N.E.2d 126, 132–33 (Mass. 2010) (holding that evidence of discounted amounts (i.e., write-offs) are not permissible evidence), *with* Sylvestre v. Martin, No. SUCV2003-05988, 2008 WL 82631, at *4 (Mass. Super. Jan. 4, 2008) (holding that Medicaid write-offs may be deducted from a damages award).

these cases point to the administrative convenience of the rule when facing complex fact questions of a victim's insurance status.[198]

Another area that produces some inconsistent results in the recovery of Medicare and Medicaid write-offs is subrogation.[199] Subrogation is a contractual device that serves as a form of indemnification where the insurer steps in the insured's shoes.[200] The insurer gains all of the insured's rights in a lawsuit for which the insurer paid out a claim but is also subject to the same defenses that may be asserted against the insured.[201] Therefore, it is typical in a case where the collateral source rule is invoked for an insurer to subrogate the claim for medical expenses.[202] However, insureds still reserve the right to negotiate their policy to pay a high premium in return for the insurer's waiver of subrogation rights.[203]

Medicare has a statutory right to subrogation should the United States be the provider of the plan.[204] However, this right of subrogation is only to the extent that the bill has been paid, which does not include write-offs.[205] Yet, as discussed above and in Section II.B., these programs are multi-payer (state and private), which means that private insurers that participate in the program may still reserve the right to subrogate the entire amount billed.[206] These conflicting arrangements have produced muddled results among courts.[207] As

[198] *See* Adam G. Todd, *An Enduring Oddity: The Collateral Source Rule in the Face of Tort Reform, the Affordable Care Act, and Increased Subrogation*, 43 MCGEORGE L. REV. 965, 985 (2012) (discussing the variety of options insureds have regarding plans under the ACA, Medicare, and Medicaid); *see also* discussion, *supra* Section II.B. (describing the types of Medicare and Medicaid plans); discussion, *infra* Section IV.A (providing an overview of subrogation).

[199] *See, e.g.*, Singh *ex rel.* Singh v. Long Island Jewish Med. Ctr., No. 23954/02, 2006 WL 431635, at *2 (N.Y. Sup. Ct. Feb. 17, 2006) (an Amount Billed state that permits recovery of collateral source write-offs if the collateral source is entitled by law (i.e., through Medicare or Medicaid) to liens against any recovery of the plaintiff).

[200] KENNETH S. ABRAHAM & DANIEL SCHWARCZ, INSURANCE LAW AND REGULATION 287 (7th ed. 2020).

[201] *Id.*

[202] *See id.* (explaining that health insurance is one of the most prominent instances of subrogation claims).

[203] *See* Todd, *supra* note 198, at 984.

[204] 42 U.S.C. § 1395y(b)(2)(B)(iv).

[205] *See id.*

[206] *See* discussion, *supra* Section II.B(describing the dual nature of the Medicare and Medicaid programs).

[207] *Compare* Singh *ex rel.* Singh v. Long Island Jewish Med. Ctr., No. 23954/02, 2006 WL 431635, at *6 (N.Y. Sup. Ct. Feb. 17, 2006) *with* Weston v. AKHappytime, LLC, 445 P.3d 1015, 1028 (Alaska 2019).

mentioned above, the inconsistencies only further plaintiffs' administrative arguments that courts should not create categories of victims determined by their socioeconomic status of having public versus private insurance.

## IV. THE PROPOSED SOLUTION FOR A REFORMED SYSTEM

Many commentators have attempted to create a working solution for the collateral source rule and public healthcare within the current framework.[208] This Section takes a prospective look at the potential for a single-payer healthcare system and the framework the Biden administration has proposed. Doing so encompasses the best rationales from the current applications mentioned in Section III and provides logical options for future legislatures and courts to take.

### *A. Universal Healthcare*

The most ambitious progressives have the goal of ensuring healthcare for all through a single-payer federally run program.[209] The social impacts of this legislation have the potential to produce widespread benefits.[210] However, a universal system could kill medical expense awards altogether. In a system where no bill could ever be traced back to the victim, how could courts possibly justify awarding damages that simply are not present? Indeed, some countries with national healthcare providers do not permit recovery of medical services received in tort cases at all.[211] However, this could create

[208] *See, e.g.*, Ann S. Levin, *The Fate of the Collateral Source Rule after Healthcare Reform*, 60 UCLA L. REV. 736, 757–58 (2013) (proposing an outright abolishment of the collateral source rule or a hybrid system in which the rule is kept, but takes in factors such as premiums paid, like the Reasonable Value approach); Gary T. Schwartz, *National Healthcare Program: What its Effect Would be on American Tort Law and Malpractice Law*, 79 CORNELL L. REV. 1339, 1341 (1994) (proposing keeping the rule as is, abolishing the rule, or creating a system of subrogation).

[209] Andrea S. Christopher, *Single Payer Healthcare: Pluses, Minuses, and What it Means for You*, HARV. HEALTH PUBL'G (June 27, 2016), https://www.health.harvard.edu/blog/single-payer-healthcare-pluses-minuses-means-201606279835.

[210] *Id.* (discussing the long-term savings from spending (both federally and individually), targeting childhood obesity, increasing physical wellbeing, etc.); *See* Schwartz, *supra* note 208, at 1349–51, 1354.

[211] *See* Schwartz, *supra* note 208, at 1346 (providing the examples of England and Sweden as countries with national health providers that do not permit recovery of medical expenses).

the worst of both worlds—it would produce careless "victims" unable to recover anything when injured.[212]

A significant reason courts have been willing to uphold the collateral source rule in situations where the victim is a Medicare or Medicaid recipient is because of insurers' right of subrogation or reimbursement.[213] Subrogation would be necessary for a universal system because universal healthcare frustrates all the plaintiff's justifications for having a collateral source rule in the first place.[214] Because some states do not permit full subrogation or a right of reimbursement by insurers, Congress must ensure that if it enacts a single-payer system, it includes an absolute right to subrogation by the federal government in any claim in which it paid medical benefits, including settlements.[215] Therefore, although nearly all tort law principles are derived from state law, I argue that this task should be the prerogative of Congress, not states, to create a uniform system of recovery. I will first address how an adequately implemented subrogation system could improve the current state of the collateral source rule and tort recovery, and then I will propose the practical solution on how to administer the program.

A national subrogation method for medical expenses under a universal system has two primary benefits, compensating for the natural extinction of the collateral source rule that follows universal healthcare. First, subrogation attacks the double recovery issue that defendants repeatedly argued against since the initial efforts of tort reform.[216] Plaintiffs may view this as a loss, but subrogation has been a catalyst to keeping premiums low in private insurance.[217] This principle also translates to a single-payer system—if the government reserves the right to subrogate a claim, it keeps the total spending cost lower, which then helps lower taxes. Second, it allocates the ultimate financial responsibility to the wrongdoer rather than the taxpayer, feeding

[212] *See id.* at 1357 (explaining that a universal healthcare system would produce a higher lack of care in victims because of the perceived safety net a universal system provides without receiving any recovery for their injuries).

[213] *See* discussion, *supra* Section III.D.

[214] A universal system defeats the arguments regarding double recovery, fairness, and the "foresight theory." *See* discussion, *supra* Section I.A.

[215] *See* discussion, *supra* Section I.A. (arguing that an insured may benefit from the abrogation of the collateral source rule if increased subrogation leads to lower premiums). *See also* N.J. REV. STAT. § 2A:15-97 (2013); N.Y. GEN. OBLIG. § 5-335 (Consol. 2009); N.C. GEN. STAT. § 12.0319 (1978); VA. CODE ANN. § 38.2-3405 (1973); CONN. GEN. STAT. § 52-225c (2012) (exemplifying states that do not permit full subrogation of claims by insurers).

[216] ABRAHAM & SCHWARCZ, *supra* note 200, at 288.

[217] *Id.*

into the first benefit of subrogation.[218] By ensuring that the defendant still bears the responsibility, it advances the most important justifications of the collateral source rule: fairness and deterrence.[219] A single-payer system built on subrogation would reconcile the inherent conflicts of the collateral source rule because it balances on the modern tort principles of compensation while keeping an economic benefit for injured plaintiffs.

Before delving into the proposed system, it is essential to recognize that three traditional forms exist for an insurer to subrogate the insured's claim.[220] First, the insurer may subrogate through a post-verdict award of medical damages, referred to as a reimbursement claim where the insurer has a lien on the judgment.[221] Second, the insurer may subrogate through a derivative action against the defendant once a plaintiff commences an action.[222] Third, an insurer may subrogate through direct action against the defendant before the insured brings a claim.[223] Due to the sheer size of personal injury claims filed in the United States annually, derivative and direct actions would be nearly impossible to accomplish; thus, the system should be built on post-verdict reimbursement claims.[224]

There are two hurdles that a universal system built on subrogation faces. The biggest hurdle is on the plaintiff's side, which comes from a lack of incentive for personal injury claimants to bring claims in the first place. If a significant portion of the damages owed to a claimant is removed, what serves as the motivation to hire an attorney and fight a lawsuit that can potentially take up to two years? The other hurdle is on the side of the United States in this scenario, which comes from collecting the reimbursement

[218] *Id.*

[219] *Id.*

[220] Todd, *supra* note 198, at 994–95 (explaining the approaches insurers may take to subrogate a claim and how the collateral source rule applies to such situations).

[221] *Id.* at 994. Reimbursement usually supplements the collateral source rule, whereas subrogation is an alternative to the rule. Schwartz, *supra* note 208, at n.11.

[222] Todd, *supra* note 198, at 994.

[223] *Id.* at 994–95 (explaining that this will often defeat the collateral source rule's purpose).

[224] *See* Steven Peck, *Personal Injury: What are the Major Causes and Statistics?*, PECK LAW GROUP (June 29, 2013 4:56 PM), https://www.premierlegal.org/personal-injury-what-are-the-major-causes-and-statistics/ (explaining that personal injury suits are an "overwhelming and major part of [the] litigation process" in the United States because there are over 31,000,000 annual injuries, 400,000 annual personal injury claims filed in court, and 16,000 annual personal injury trials conducted). Because the entirety of subrogation claims would be consolidated to the United States federal government under this system, it is impractical to expect derivative and direct subrogation claims for medical benefits to survive.

payments. How is the United States expected to monitor every single personal injury case? Further, what happens if the plaintiff settles out of court? These are real issues that must be addressed before creating a universal healthcare system.

Before discussing how the United States can overcome the collection of personal injury reimbursements, I will address how Congress could design the system to incentivize victims to bring claims. The foremost incentive for claimants to still bring their claims in the first place is because of the availability of other damages, especially lost wages and pain and suffering.[225] Additionally, with claimants having more resources available to them because of having their healthcare costs already paid for, there is a higher likelihood that claimants are not financially strained when seeking an attorney.[226]

The two incentives mentioned above are natural phenomena; however, Congress must still affirmatively ensure that claimants bring their claims when medical expenses are paid by a universal healthcare program. The most attractive option would be to create a tax credit for claimants in the amount of 10–20% of the damages allocated to medical expenses from a settlement or jury award. Tax credits are reductions in the amount of taxes that a taxpayer owes, making a drastic difference in a taxpayer's bill compared to a deduction.[227] A tax credit creates the perfect incentive for individuals to bring claims under a universal system for two reasons. First, the United States already provides tax deductions for qualified medical expenses; a system exists to extend it to medical expense damage awards.[228] Second, medical expenses are not the sole reason for lawsuits, and a tax credit would end up

[225] *See, e.g.*, Justin Ziegler, *Pain and Suffering Settlement Examples: Car Accidents and More (2021)*, JZ HELPS (Sept. 6, 2021), https://www.justinziegler.net/much-money-can-get-pain-suffering/ (providing an example of a personal injury case where pain and suffering constituted 97% of the settlement).

[226] *See generally* Frank M. McClellan et al., *Do Poor People Sue Doctors More Frequently? Confronting Unconscious Bias and the Role of Cultural Competency*, 470(5) CLINICAL ORTHOPAEDICS AND RELATED RSCH. 1393, 1394–95 (2012) (finding, contrary to popular belief, that affluent people do in fact sue more often, which is typically the result of having access to legal resources that poorer individuals do not have).

[227] *Credits and Deductions for Individuals*, IRS (last updated June 24, 2021), https://www.irs.gov/credits-deductions-for-individuals; Tina Orem, *Tax Deductions Guide and 20 Popular Breaks in 2021*, NERDWALLET (Apr. 12, 2021), https://www.nerdwallet.com/article/taxes/tax-deductions-tax-breaks.

[228] *Publication 502 (2020), Medical and Dental Expenses*, IRS (last updated Mar. 4, 2021), https://www.irs.gov/publications/p502.

serving as a supplemental damage.[229] A tax credit gives individual taxpayers the ability to recoup on the very thing paying for their medical expenses under a universal system—taxes.

While a system built on subrogation sounds ideal, how will the United States collect? Unlike insurance companies that are often directly involved with their subrogation claim, even if it is passive subrogation, the United States would genuinely be a bystander to the litigation. To resolve this issue, Congress and state legislatures could, in statutory subrogation, mandate the judicial branch to allocate damages in a court-approved settlement or jury award to set aside.

### *B. Biden's ACA Expansion*

Under President Biden's plan, courts should adopt something akin to the Alabama medical-expense-recovery statute. President Biden's goal is to provide everyone access to healthcare for every American at a reasonable cost to the consumer but has yet to introduce his preferred method of achieving this goal.[230] Should President Biden use a measure that ensures that every American has healthcare, such as reinstating the individual mandate or providing blanket coverage for all currently uninsured Americans, Congress should enact legislation that removes the necessity of the collateral source rule but still prevents insurance payments from prejudicing a plaintiff.

> The Alabama statute regarding the collateral source rule provides as follows:
>
> > (a) In all civil actions where damages for any medical or hospital expenses are claimed and are legally recoverable for personal injury or death, evidence that the plaintiff's medical or hospital expenses have been or will be paid or reimbursed shall be admissible as competent evidence. In such actions upon admission of evidence respecting reimbursement or payment of medical or hospital expenses, the plaintiff shall be entitled to introduce evidence of the cost of obtaining

[229] *See* David Goguen, *Damages: How Much is a Personal Injury Case Worth?*, NOLO, https://www.nolo.com/legal-encyclopedia/damages-how-much-personal-injury-32264.html (last visited Nov. 18, 2021) (listing seven other types of damages litigants seek in personal injury cases besides medical expenses).

[230] *See* discussion, *supra* Section II.B.

> reimbursement or payment of medical or hospital expenses.
>
> (b) In such civil actions, information respecting such reimbursement or payment obtained or such reimbursement or payment which may be obtained by the plaintiff for medical or hospital expenses shall be subject to discovery.
>
> (c) Upon proof by the plaintiff to the court that the plaintiff is obligated to repay the medical or hospital expenses which have been or will be paid or reimbursed, evidence relating to such reimbursement or payment shall be admissible.[231]

On its face, it may not seem like the perfect solution because it effectively abrogates the collateral source rule.[232] It has survived multiple constitutional challenges[233] and is criticized for failing to completely abrogate the collateral source rule because it only addresses the element of evidence and not damages, whereas the traditional true or other statutes abrogating the rule address both elements.[234] All this statute does is remove the collateral source rule's presumption that the plaintiff does not have insurance—which would be irrelevant if President Biden successfully expands the ACA—but still allows the plaintiff to recover whatever the jury determines the fair value, which is a fact-intensive analysis.[235] The fact that it does not address the damages element is a positive function of the construction of the statute because it removes the mandatory deduction of damages that other statutes that abrogate the collateral source rule carry.[236]

Creating a mandatory deduction upon the finding that the plaintiff's insurance did not pay the sticker price is prejudicial because it deprives the

[231] Ala. Code § 12-21-45 (2013).

[232] *See* Am. Legion Post No. 57 v. Leahey, 681 So. 2d 1337, 1346–47 (Ala. 1996).

[233] *See* Danielle A. Daigle, *The Collateral Source Rule in Alabama: A Practical Approach to Future Application of the Statutes Abrogating the Doctrine*, 53(4) Ala. L. Rev. 1249, 1252–56 (2002).

[234] *See id.* at 1260–61.

[235] *Cf.* Ala. Code § 12-21-45 (2013); *see* AMF Bowling Ctrs., Inc. v. Dearman, 683 So. 2d 436, 438 (Ala. Civ. App. 1995) (concluding that the plaintiff is not necessarily entitled to the full amount of medical expenses, but what the jury determines after all evidence of collateral sources are introduced).

[236] *See, e.g.*, Tex. Civ. Prac. & Rem. Code § 41.0105.

benefit of the bargain from the plaintiff, which is the inherent flaw with the Amount Paid approach.[237] Furthermore, failing to consider the cost it took the plaintiff to get the deduction is prejudicial because not doing so limits the reasonable evidence the jury can consider, which is the inherent flaw with the Reasonable Value approach.[238] Finally, failing to consider whether the sticker price was a fair price for the expense in the first place is prejudicial because it does not take market forces into account, which is the inherent flaw with the Amount Billed approach.[239] By leaving the question of damages open-ended, it places these factors in the hands of who should ultimately be answering these questions of fact—the jury.

Below is a recommended collateral source statute relating to admissible evidence and a recommended collateral source jury instruction to accomplish the objectives set forth above properly:

Sample Collateral Source Evidence Statute[240]

> (a) In all civil actions where damages for any medical or hospital expenses are claimed and are legally recoverable for personal injury or death, any and all evidence relating to the medical or hospital expenses shall be admissible as competent evidence. Competent evidence includes, but is not limited to, the amount the plaintiff was originally billed, the amount the plaintiff paid, whether the plaintiff has insurance, the cost it took the plaintiff to procure the insurance, and data regarding the average costs of the procedure.

Sample Jury Charge[241]

> (a) You are instructed that a wrongdoer who commits a tort is liable for the whole loss caused by his or her actions, and any compensation received by the injured party from a source wholly independent of the wrongdoer will not lessen the damages recoverable from the wrongdoer. You are instructed that the amount of any health insurance benefits

[237] *See* discussion, *supra* Section III.B.

[238] *See* discussion, *supra* Section III.C.

[239] *See* discussion, *supra* Section III.A.

[240] This sample statute is partially derived from Ala. Code § 12-21-45 (2013).

[241] This sample jury charge is partially derived from the jury charge in *Robinson v. Borg-Warner Protective Servs. Corp.*, 31 P.3d 1041, 1045 n.4 (Okla. 2001).

> received by the plaintiff should not be deducted from any actual damage amount you may award to him or her.
>
> (b) In determining the reasonable value of the medical or hospital expenses owed to the plaintiff, you are to consider any and all evidence introduced during trial related to medical or hospital expenses.
>
> (c) The amount owed for medical or hospital expenses may not be greater than the amount originally billed to the plaintiff but may not be less than the actual amount paid by the plaintiff or the plaintiff's insurance.

## CONCLUSION

The collateral source rule has been subject to significant reform throughout the past half-century. With public healthcare continuing to become the norm for more Americans, legislatures and courts must prepare for this dramatic shift in the United States' social landscape. These bodies must not overlook this small but significant rule of evidence and damages. By carefully reviewing the current applications of the collateral source rule, the future of the collateral source rule can be adjusted without outright ending medical expense awards (abrogating the rule). The adjustment would also conform to the modern-day tort principle of compensating the victim rather than punishing the defendant. The rise of public healthcare may provide the necessary opportunity to find a proper middle ground and address the collateral source rule's inadequacies from the defendant's perspective, while maintaining many of the benefits that plaintiffs use to justify the rule.