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The ACA Has Made The Collateral Source Rule Obsolete

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In almost half of U.S. jurisdictions, the common law collateral source rule bars defendants from reducing damages they might owe a plaintiff by showing that a "collateral source" paid a given amount. See Restatement (Second) of Torts § 902A (1979); see generally Bryce Benjet, A Review of State Law Modifying the Collateral Source Rule: Seeking Greater Fairness in Economic Damages Awards, 76 Def. Couns. J. 210 (2009) (noting that Arizona, California, D.C., Delaware, Georgia, Hawaii, Illinois, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Mississippi, Missouri, Nevada, North Carolina, South Carolina, Vermont, Virginia, West Virginia and Wisconsin retain the common law collateral source rule for some or all causes of action).

Indeed, "a majority of jurisdictions that have considered this question hold that a plaintiff can present to the jury the amount that a health care provider initially billed for the services necessarily rendered [i.e., the "billed charge" amounts], and not merely amounts that were later paid." Kenney v. Liston, No. 13-0427, 2014 — S.E. 2d — (W. Va. 2014). A product of when having insurance was a "fortuitous" luxury, the collateral source rule must be re-thought in the age of Obamacare. See John G. Fleming, The Collateral Source Rule and Loss Allocation in Tort Law, 54 Cal. L. Rev. 1478, 1478-80 (1966).

A recent case decided by the West Virginia Supreme Court of Appeals provides an example of the collateral source rule's application and reasoning justifying the rule. In Kenney v. Liston, Samuel Liston sustained injuries to his spine when John Kenney rear-ended the vehicle Liston was traveling in resulting in Liston incurring medical bills in excess of $70,000. At trial, Kenney's lawyers filed a motion in limine to limit his damages to the amounts actually paid by Liston and his private insurance carrier.

The trial court denied the motion, ruling that West Virginia's collateral source rule forbade introduction of any evidence showing that Liston's medical bills had been paid for by a third party. At trial, therefore, Liston was allowed to recover the amounts his medical providers billed him (i.e., the "billed charge" amount) as the "reasonable value of the plaintiff's medical services." See id. at *2-3.

On appeal, the West Virginia Supreme Court of Appeals explained that prohibiting both the introduction of evidence of collateral source payments to the jury and argument in post-trial motions that monies from a

"collateral source" should reduce damages was justified on a number of grounds. First, the plaintiff is entitled to the benefit of his bargain with the insurance company, not the defendant tortfeasor. See id. at *4 (internal citations and quotation marks omitted) ("A tortfeasor cannot take advantage of a contract or relationship between an injured party and a third person."); see also id. (internal citations and quotation marks omitted) ("[T]he wrongdoer should not benefit from the expenditures made by the injured party or take advantage of contracts or other relations that may exist between the injured party and third persons.").

Second, the West Virginia high court reasoned that "it is better for injured plaintiffs to receive the benefit of collateral sources in addition to actual damages than for defendants to be able to limit their liability for damages merely by the fortuitous presence of these sources." Id. at *5 (internal citations and quotation marks omitted).

Third, the court reasoned that "[b]ecause the law must sanction one windfall and deny the other, it favors the victim of the wrong rather than the wrongdoer." Id. at *6 (internal citations and quotation marks omitted).

Fourth, the court reasoned that "corrective justice" requires that all harms be compensated, not merely the "net loss to the injured party." Id. Finally, the court also must have implicitly recognized the ease of the application of the rule: trial courts need only reflexively forbid all evidence of collateral source payments and rely on the "billed" charge amounts as they appear on medical providers' invoices.

The Affordable Care Act necessitates reconsideration of each of these rationales. The ACA calls for a significant restructuring of the insurance market. The broad outlines of the law are well-known, but two aspects bear repeating here.

First, the individual mandate requires that almost all Americans become insured. Second, the ACA standardizes insurance contracts and reimbursement rates. For instance, the law prohibits: (1) lifetime limits on coverage; (2) rescinding coverage except in cases of fraud; (3) pre-existing condition exclusions; and (4) premium variations except those based on age, premium rating area, family composition and tobacco use. Indeed, as almost every American has heard, plans under the ACA come in one of four tiers: bronze, silver, gold and platinum.

These modifications of the insurance market severely weaken or completely undercut many of the rationales for the collateral source rule as identified by the West Virginia Supreme Court of Appeals. After the ACA's passage, it is unclear how a court can determine that a plaintiff is entitled to the benefit of his bargain with an insurance company when that plaintiff is required by federal law to obtain insurance and his menu of options and premiums have been standardized. Since nearly every American is now required to obtain insurance, that a plaintiff in a personal injury action has insurance is no longer a "fortuitous" event. Rather than a fluke, insured plaintiffs are the near-universal norm.

Moreover, the "corrective justice" rationale no longer has any force. If risk, premium and insurance contract terms are standardized, then reimbursement rates will become, or have become, more standardized. Indeed, medical providers almost never recoup their "billed charge." The uninsured population consists generally of rich individuals who choose not to buy health insurance and those that are too poor to afford it. The poor do not have the means to pay the billed charge, leaving the "one percent" to pay it. Thus, nearly everyone pays an amount less than the "billed charge."

For instance, if a doctor always bills out a given medical procedure for $5,000, but the doctor is never, or almost never, paid the full $5,000 because all (or nearly all) of his patients are insured, then how can it be said that $5,000 is the reasonable and necessary cost for that medical procedure? The "billed charge" amount is

essentially a meaningless number because regardless of what the doctor thinks the procedure is worth, the vast majority of the market is paying a lower price.

Rather, what the West Virginia Supreme Court of Appeals termed as the "net loss to the injured party," is rapidly approaching the full, "real" cost of the plaintiff's damages. See Kenney, 2014 WL 2565563, at *3. Surely the "reasonable cost" for a service cannot exceed the amount actually paid for that service. Considering the changed circumstances after the ACA, none of the West Virginia Supreme Court of Appeals' rationales for continuing the collateral source rule have much force.

Indeed, the West Virginia Supreme Court of Appeals left its holding open to attack when it stood by the principle that an "injured person is entitled to recover damages for reasonable and necessary" medical services rendered to him. Id. at *6. West Virginia and other jurisdictions have put themselves in an untenable situation by affirmatively stating on the one hand that all "collateral source" evidence is verboten and yet on the other stating that a plaintiff is entitled only to those "reasonable and necessary" charges. Without alternative forms of proof (i.e., what an insurance company with vast experience in the pricing of medical services thinks the service is worth), a court is placed in an impossible situation when required to instruct a jury to only award those "reasonable and necessary" charges.

For all of these reasons, the West Virginia high court and other jurisdictions that retain the common law collateral source rule should reconsider whether the assumptions underpinning this rule have any force in light of the ACA's standardization of much of the insurance market. The simplest and most equitable way to account for this sea change is to simply replace the "billed charge" amount with the amount actually paid by an insurance company for a given medical procedure.

This method accounts for the standardization in the insurance markets and compensates the plaintiff for the losses he actually sustained. This method is also just as easy to administer as the common law rule without any of the inequity. Indeed, several states around the country have enacted such laws. See, e.g., Conn. Gen. Stat. § 52-225a(a)-(b) (requiring post-verdict reduction of economic damages by amounts paid by collateral sources); Me. Rev. Stat. Ann. tit. 24, § 2906(2) (requiring post-verdict reductions in professional negligence cases by the amount paid or payable by a collateral source if the source has not exercised subrogation rights within 30 days after receipt of notice of the verdict).

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

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