



The Collateral Source Rule under the Affordable Care Act

The need to prevent a double discount of plaintiff's future medical-care cost damages

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Since the enactment of the Affordable Care Act (ACA) the defense bar has moved quickly to add the ACA as a collateral source that could potentially reduce most of an injured plaintiff's recovery for future medical-care costs. At several recent national meetings, authors have presented research papers that suggest that the ACA should simplify and reduce calculations of future medical damages by limiting those costs to "health insurance premiums and out-of-pocket limits less any pre-injury expected medical costs and penalties if uninsured."

Defense firms are now suggesting to courts that the jury should only award six months of future medical-care costs and the premiums, deductibles and co-pays for a bronze level health insurance coverage under the ACA since full coverage would kick in after six months of uninsured status. All insurance plans under the ACA must provide certain

required benefits, including ambulatory patient services, emergency services, hospitalizations, mental health care, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, chronic disease management and other services that would subsume most if not all of plaintiff's future medical-care costs. Plaintiffs in all personal-injury cases should expect the defense to try to significantly reduce any award for future medical-care costs, citing the ACA. This issue will need to be addressed and dealt with in every case of personal injury that has future medical-care needs.

Traditional Collateral Source Rule in personal-injury tort cases

The Restatement Second of Torts section 920A(2) defines the traditional common-law collateral-source rule that "payments made to or benefits conferred on the injured party from other sources are not credited against the tortfeasor's

liability, although they cover all or a part of the harm for which the tortfeasor is liable." Thus, the plaintiff can collect both past and future medical-care costs, even if health insurance paid some of those past costs and may be expected to pay medical-care costs in the future. The recent case of *Howell v. Hamilton Meats* (2011) 52 Cal.4th 541, limits plaintiffs' recovery to the actual amount paid by their health insurance for past medical-care costs, and *Corenbaum v. Lampkin* (2013) 215 Cal.App.4th 1308, appears to extend this limitation to future damages.

Most private health-insurance contracts contain a reimbursement provision that allows the health insurer to collect the money paid for a plaintiff's past medical care when the plaintiff recovers such damages from a third party. This provision prevents a double recovery for the plaintiff by allowing the health insurer to recover the costs of care when the plaintiff recovers past and future medical-care costs from a third-party tort



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claim. The defense argument in *Howell* focused on the lack of legal support or rationale for a plaintiff receiving damages for the amount of medical care billed when the health insurer could only recover from the plaintiff the amount of money actually paid for such care. Most health-insurance contracts provide for a substantial reduction between the amount billed for care and the amount actually paid. In addition to the subrogation clauses in most private health-insurance contracts, public insurance programs (Medi-Cal and Medicare) have an absolute right to recover the amount paid for past medical-care costs paid for a beneficiary/plaintiff. Under *Brown v. Stewart* (1982) 129 Cal.App.3d 331, Medi-Cal benefits are exempted from the collateral-source definition under Civil Code section 3333.1 which otherwise allows a jury to consider health-insurance payments and benefits in medical-malpractice cases.

Collateral source benefits allowable as evidence in medical-malpractice cases

Civil Code section 3333.1, which was part of the MICRA legislation in 1975, specifically abolished the traditional collateral-source rule for medical-malpractice cases and allowed a shifting of the liability for a plaintiff's medical-care costs from a defendant health-care provider to the plaintiff's health-insurance company. The statute allows the defendant in a medical-malpractice case to introduce evidence to a jury of collateral-source benefits to the plaintiff, including health insurance. The rationale for this statute was that "the legislature apparently assumed that in most cases the jury would set plaintiff's damages at a lower level because of its awareness of plaintiff's "net" collateral source benefits." (*Fein v. Permanente Medical Group* (1983) 38 Cal.3d 137.) To prevent a "double deduction," since a jury would presumably not award damages for medical-care costs paid for by the plaintiff's health insurance, under

section 3333.1 (b) "No source of collateral benefits shall recover any amount against the plaintiff."

The constitutionality of this statute was upheld by the California Supreme Court in *Barme v. Wood* (1984) 37 Cal.3d 174, where the Court held that the providers of collateral source benefits have no vested right to reimbursement and that subdivision (b) was rationally related to the legitimate goals of MICRA. This section did not affect the reimbursement/subrogation rights of health insurance carriers in those personal injury cases not involving a health-care provider. This public-policy tradeoff, which aims to prevent both a double recovery and a double deduction, is at the basis of understanding how and when the ACA may be applicable in a personal injury tort claim.

Reimbursement/Subrogation rights under the ACA

There are two parts of the ACA and each should have a different outcome with regard to subrogation/reimbursement. The defense will conveniently ignore the public health-insurance part of the ACA, which greatly expands Medicaid in most states. Most of the current public focus on the ACA has involved the health-insurance exchanges that resemble traditional private health-insurance with premiums, deductibles, and co-pays. As basically an extension of the existing private health-insurance market, it is likely that such private plans under the ACA will have the right of reimbursement for any monies paid for an insured's health-care costs, although it is not clear from the ACA legislation that private insurance carriers will invoke such a right.

However, the largest expansion of health insurance under the ACA involves an expansion in Medicaid in those states that allowed such an expansion, which has included California. It is anticipated that the expansion of Medicaid and the Children's Health Insurance Program (CHIP) will provide coverage for an

additional 17 million individuals in the U.S. This expansion basically involves raising the level of income, below which families and individuals are eligible for Medicaid. California's Medicaid program, Medi-Cal, has an absolute right to assert a lien against the recovery in any third-party tort claim.

Thus, even in medical-malpractice cases under Civil Code section 3333.2 which allows introduction of collateral-source benefits paid and payable for medical-care costs, Medi-Cal is exempted specifically because it is a federal program funded by the taxpayers. In *Brown v. Stewart* the Court noted "the legislature, in enacting MICRA, was aware that the Governor would not be willing to use general funds to pay for malpractice premium increases." According to the court, such would be the effect of precluding reimbursement of Medi-Cal payments. (*Brown v. Stewart*, 129 Cal.App.3d at p. 341.)

The Court extended that reasoning to apply to Medicare payments as well in *Jordan v. Long Beach Community Hospital* (1988) 248 Cal.Rptr. 651. [This case was decertified by the Supreme Court on other grounds]. But the reality for at least the last 30 years is that both Medi-Cal and Medicare have the right of reimbursement from the plaintiff for any money paid for past medical-care costs. Attorneys in filing a personal-injury claim are required to notify Medi-Cal and/or Medicare about such a claim, which allows Medi-Cal and Medicare to assert their lien for past medical expenses paid on behalf of the plaintiff.

If the injured plaintiffs have Medi-Cal or Medicare as their health insurance at the time of injury, such collateral source benefits would be excluded in any personal injury case, including medical-malpractice cases. However, the import of the defense attempt to use the ACA is not on past damages, but rather on future medical-care costs. Even judges who have previously excluded any reference to the ACA in past years because of the



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speculation involved with such a proposed legislation will now be faced with a U.S. Supreme Court approval of this law, *National Federation of Independent Business v. Sebelius* (2012) __ S.Ct. __, 132 S.Ct. 2566. Despite attempts by the U.S. House of Representatives to “de-fund Obamacare,” it is clearly the law of the land and the ACA’s required benefits, premium costs and other specifics are no longer speculation. Thus, dealing with the attempt by the ACA to eliminate most of plaintiff’s future medical-care costs requires focusing on the Medi-Cal and Medicare aspects of any personal injury case that involves future medical-care costs.

Applicability of Medi-Cal and Medicare to future medical-care costs

Most injured plaintiffs who have significant future medical-care costs and who are on Medi-Cal at the time of resolution of their case will qualify for a special needs trust, which will allow them to maintain eligibility for Medi-Cal benefits into the future. There is no reason to change health insurance from Medi-Cal to a private health-plan under an ACA health insurance exchange. By the time of resolution of the case, the plaintiff will know and understand what benefits have been provided under Medi-Cal, and thus what would be expected to continue in the future.

Once Medi-Cal is paid for any past medical-care costs, a plaintiff with a special needs trust may continue to obtain Medi-Cal benefits in the future. Medi-Cal retains the right of reimbursement for all such future benefits paid on behalf of the plaintiff. Medi-Cal is allowed to assert a lien against any amount remaining in the plaintiff’s special needs trust at the time of their death. Thus, the injured plaintiff does not get a double recovery, because their estate must repay Medi-Cal for any future medical-care benefits that are paid. Since the plaintiff must repay Medi-Cal for any medical-care benefits paid for in the future, there is no reason to lower

plaintiff’s recovery for future medical-care costs. There will be no double recovery under current law if the jury does not consider future Medi-Cal benefits that may be paid for the plaintiff’s future medical care.

Medicare’s right to recover for future medical-care costs paid now requires that a plaintiff establish a Medicare Set Aside Trust, specifically to protect Medicare’s interest. Although the specific rules and regulations for such Medicare Set Aside Trusts are still in progress, unlike Medi-Cal which collects money paid only after the plaintiff dies, Medicare requires that the plaintiff set aside sufficient money in advance of any future payments to pay for what Medicare might pay for in the future. Again, there is no double recovery for the plaintiff since Medicare will recover whatever it might pay for future medical-care benefits. Any plaintiff who is on either Medi-Cal or Medicare will be considered to have health insurance already and will not qualify for a health-insurance exchange under the ACA. Medi-Cal and Medicare do not and would not require plaintiff to transfer to another health-care plan under the ACA.

This is critical to understanding the purpose and effect of the ACA. As enacted by Congress and signed into law, the purpose of the ACA was to expand health-insurance coverage to most of the 45 million Americans who do not have health insurance. The ACA does not require or allow those on Medi-Cal or Medicare to transfer to a private health-insurance exchange.

In any personal-injury case where the defense attempts to introduce evidence of the premium costs and benefits of the ACA to reduce plaintiff’s claim for future medical-care expenses, a clear distinction must be drawn between those cases where plaintiff will be expected to continue on Medi-Cal or Medicare and/ or will establish a Medicare Set-Aside Trust.

In cases involving children or young adults who have not paid enough into Medicare through work, a Medicare Set-

Aside Trust may not be necessary because the plaintiff would not qualify for Medicare benefits even after two years of a permanent disability. In such cases, where the plaintiff is likely to have received Medi-Cal benefits between the time of their injury and the time of the resolution of their claim, the defense would have to prove that the plaintiff would both lose their Medi-Cal benefits and then wait six months before qualifying for full health-insurance coverage under the ACA.

The only logic to such a position is that it would provide a basis to shift the financial responsibility for plaintiff’s future medical-care costs away from a negligent defendant and thus lower plaintiff’s recovery for such future-care costs. Where an injured plaintiff has Medi-Cal and has past medical care paid for under the Medi-Cal program, there is no logical reason why the plaintiff should drop their Medi-Cal, then go uninsured for six months, simply to provide a basis for the defendant to shift responsibility for plaintiff’s future medical-care costs. Since any such injured plaintiff facing the probability of the need for future medical care can utilize a special needs trust to protect their eligibility for Medi-Cal coverage, there is no reason to drop such coverage and then sit uninsured for six months simply to benefit the defendant.

In those cases where a plaintiff has paid into Medicare sufficiently to qualify for Medicare benefits after two years of disability, Medicare requires that the plaintiff establish a Medicare Set-Aside Trust, which allows Medicare to pay for plaintiff’s future care costs. Once a Medicare Set-Aside Trust is established, the cost of which is part of plaintiff damages, there is no reason or basis for the plaintiff to then purchase private health insurance under the ACA health insurance exchange.

If a patient has private health insurance at the time of resolution of their case, the defense will argue that if the plaintiff loses their health insurance



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because their injury prevents employment, which usually provides such health insurance, then the ACA should apply, with damages limited to the premiums, deductibles, and co-pays. However, in most cases involving significant future medical costs, it is more likely that the plaintiff would have lost their private health insurance and gone on Medi-Cal or Medicare long before the resolution of their claim.

Thus, only in those rare circumstances where a plaintiff has no health insurance both at the time of their injury and at the time of the resolution of their case would the defense be able to argue the applicability of the ACA. Even in such cases, if the private health insurance which the defense would have the plaintiff purchase, claims a reimbursement right under federal law similar to that claimed by self-funded plans under ERISA, then such a right of reimbursement would still require a jury to award plaintiff the full cost of future medical-care expenses that are reasonably certain to be required for plaintiff's future medical-care needs. The California

Supreme Court held in *Barme v. Wood*, 37 Cal.3d at p. 180, fn. 6, "that the right of reimbursement enjoyed by some of the other collateral sources enumerated in Sec. 3333.1 subdivision (a) may be guaranteed by federal law. Under federal supremacy principles, of course, in such cases MICRA provisions will have to yield." (*Brown v. Stewart* (1982) 129 Cal.App.3d 331, 341.)

The defense bar in personal-injury tort cases will aggressively push for the introduction of evidence about the ACA before a jury. They will claim, through their experts, that the ACA, effectively minimizes any damages for future medical-care costs in all medical-malpractice cases under Civil Code section 3333.1, and in all non-health-care defendant cases where they can assert such a claim. This is because the defense bar has been told that the ACA "may well have indirectly resulted in a great deal of tort reform." It is therefore essential that this claim be challenged in every case where such evidence would otherwise result in a double deduction of plaintiff's future medical-care damages. Otherwise, any

plaintiff will face a double reduction of their damages for future medical-care costs.



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