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Cover Page Footnote

American University, Washington College of Law. Professor Popper would like to thank Washington College of Law students Ashley Hoornstra, Catherine Riedo, Mary Kate Rigney, and Krystal-Rose Perez for their help with this Article. Thanks are also due to Dean Claudio Grossman for his support. The student work was supported in part by a consultancy with the American Association for Justice Robert L. Habush Endowment.

THE AFFORDABLE CARE ACT IS NOT TORT REFORM

Andrew F. Popper⁺

I. LEGISLATIVE PATH OF THE PPACA DOES NOT INCLUDE CHANGES TO TORT LIABILITY	5
II. INITIATIVES BEYOND INSURANCE TO IMPROVE HEALTH CARE	7
III. RELATIONSHIP BETWEEN SUBROGATION, THE COLLATERAL SOURCE RULE, AND THE PPACA	11
A. <i>The Collateral Source Rule</i>	12
B. <i>Subrogation</i>	16
IV. COLLATERAL SOURCE AND CAPS	22
V. CONCLUSION	25

The Patient Protection and Affordable Care Act (“PPACA” or “Act”)¹ is not a vehicle for tort reform.² Nothing in the language or legislative history of the PPACA suggest a limitation on future damages available to patients injured as a result of medical malpractice.³ The PPACA was neither written to change state law on subrogation nor modify the rules prohibiting the introduction of evidence pertaining to collateral sources.⁴ Even advocates for tort reform in the medical

⁺ American University, Washington College of Law. Professor Popper would like to thank Washington College of Law students Ashley Hoornstra, Catherine Riedo, Mary Kate Rigney, and Krystal-Rose Perez for their help with this Article. Thanks are also due to Dean Claudio Grossman for his support. The student work was supported in part by a consultancy with the American Association for Justice Robert L. Habush Endowment.

1. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of the U.S. Code).

2. An ongoing dialogue suggests that the PPACA can be read as a tort reform statute. See generally David I. Auerbach, Paul Heaton & Ian Brantley, *How Will the Patient Protection and Affordable Care Act Affect Liability Insurance Costs?*, RAND CORP. (2014), http://www.rand.org/pubs/research_reports/RR493.html (finding that “[l]iability payments could decrease in states that limit awards based on payments from collateral sources. . . . Medicaid may increase subrogation against liability awards.”); Ann S. Levin, *The Fate of the Collateral Source Rule After Healthcare Reform*, 60 UCLA L. REV. 736 (2013); Joseph McGovern & John Morio, *Affordable Care Act Has Potential to Limit a Defendant’s Exposure for Future Medical Costs in New York Personal Injury Litigation*, JD SUPRA BUS. ADVISOR (Jan. 17, 2014), <http://www.jdsupra.com/legalnews/affordable-care-act-has-potential-to-lim-90674>.

3. Laura D. Hermer, *Aligning Incentives in Accountable Care Organizations: The Role of Medical Practice Reform*, 17 J. HEALTH CARE L. & POL’Y 271, 272 (2014) (articulating that “[t]raditional tort reform simply found no place in the [PPACA]”).

4. 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, 982–87, 996 (2012); Rebecca Levenson, Comment, *Allocating the Costs of Harms to whom They Are*

malpractice field acknowledge that, rather than a remedial limitation imposed upon aggrieved patients, the PPACA concerns health care and insurance.⁵ The only reference to liability limitation or tort reform in the PPACA is the section regarding a demonstration project designed to provide funding to states developing litigation alternatives or substitutes.⁶

The demonstration project provides participating states funding to assess the efficiency and reliability of its civil litigation model.⁷ This hardly constitutes federal tort reform.⁸ While the Act anticipates studying state processes, “liability as a tool for quality improvement is not discussed anywhere in the [PPACA], and it would appear to have been relegated to a fading player in the drama of health care quality improvement.”⁹

The legislative history of health care reform provides an even more enlightening view on federal tort reform. As discussed below, there was a concerted effort while the bill was navigating the legislative process to manufacture limitations on noneconomic and punitive damages in health care lawsuits into the PPACA.¹⁰ However, these measures were not included in the final version of Act.¹¹ When Congress preempts a field or adopts a significant, rights-altering policy, it is safe to assume that any major measures would be

Due: Modifying the Collateral Course Rule After Health Care Reform, 160 U. PA. L. REV. 921, 940–47 (2012).

5. Arthur L. Doenecke, Letter to the Editor, *Braley Avoids Obvious Need for Tort Reform*, THE DES MOINES REGISTER (Nov. 3, 2014, 12:38 AM), <http://www.desmoinesregister.com/story/opinion/readers/2014/11/03/us-senate-braley-avoids-obvious-need-tort-reform/18398755/> (emphasizing that “[i]t comes as no surprise that Bruce Braley, a trial lawyer by profession, likes the Affordable Care Act so much. Nowhere in the 2,000 plus pages of the law is there any mention of tort reform. The [PPACA] seems tailor-made for trial attorneys.”); Angie Drobnic Holan, *Tort Reform in the Health Care Law? No*, POLITIFACT (Jan. 21, 2011, 1:30 PM), <http://www.politifact.com/truth-o-meter/statements/2011/jan/21/anthony-weiner/tort-reform-health-care-law-no/>; Dr. Anthony Youn, *Health Care Act’s Glaring Omission: Liability Reform*, CNN (Oct. 5, 2012, 8:43 AM), <http://www.cnn.com/2012/10/05/health/youn-liability-reform/> (protesting that “for all of the Obama administration’s work in creating this 906-page federal law, there is one glaring omission that could decrease the cost of health care and help relieve the upcoming physician shortage. Medical liability reform.”); *Medical Liability Reform NOW!*, AM. MED. ASS’N 1, 25 (2015), ama-assn.org/go/mlmow.

6. Section 10607 of the Act “authorize[s] the Secretary of Health and Human Services to award demonstration grants to states for the development, implementation, and evaluation of alternatives to current tort litigation.” CHRIS L. PETERSON ET AL., CONG. RES. SERV., A COMPARATIVE ANALYSIS OF PRIVATE HEALTH INSURANCE PROVISIONS OF H.R. 3962 AND SENATE-PASSED H.R. 3590, 100 (2010), http://www.ncsl.org/documents/health/CRS_Rpt_Comp_HR3962_HR3590.pdf.

7. *See id.*

8. *See* Barry R. Furrow, *The Patient Injury Epidemic: Medical Malpractice Litigation as a Curative Tool*, 4 DREXEL L. REV. 41, 66, 104 (2011) (“Medical liability reform is only a minor component of the [PPACA], with demonstration projects to be funded.”).

9. *Id.*

10. *See infra* notes 32–34 and accompanying text.

11. *See infra* note 35 and accompanying text.

clearly evident, discussed at length, and debated extensively.¹² It is even more likely that after such a significant bill is signed into law, these rights-altering measures would be celebrated by the majority and bemoaned by the minority. That was, however, not the case with PPACA. While federal tort reform was debated extensively, the stark fact is that “the [PPACA] does not generally federalize medical liability[,] . . . reform litigation[,] or malpractice insurance generally.”¹³ Limiting a patient’s civil litigation rights or enhancing the options available to defendants in medical malpractice cases is absent from the Act. Instead, “the [PPACA] creates strong pressures for providers to integrate and coordinate their delivery of health care for Medicare recipients through centers, demonstration projects, and Medicare reimbursement incentives.”¹⁴ This hardly constitutes tort reform.

Those who believe the PPACA incorporates federal tort reform principles further suggest that the most notable and important aspect of the PPACA—the health insurance mandate—serves to simultaneously limit damages in medical malpractice cases and change the rules on admissibility of collateral sources.¹⁵ A tort judgment, or so goes the argument, should not cover future medical costs because federally mandated health insurance policies cannot cover these types of costs.¹⁶ The PPACA coverage, thereby, is the standard measure of damages in medical malpractice cases. The reasoning continues by suggesting that evidence of current or future coverage—currently deemed inadmissible in a number of states under the collateral source rule—should be rendered admissible, could serve to offset damages attributable to direct costs, or, at least, serve as a guideline.¹⁷

Taken together, if insurance plans will not cover future medical expenses under the Act, then those expenses cannot be factored into a personal injury award because they exceed the scope of the minimal coverage the PPACA requires. This postulation is simple, yet incorrect, because the PPACA does not impose limitations on future medical expenses in personal injury malpractice cases by virtue of its insurance mandate.¹⁸

First, there is nothing in the PPACA that mandates or even contemplates that outcome. The idea that the PPACA changes the rules on the admissibility of

12. See *infra* notes 33–34 and accompanying text.

13. Furrow, *supra* note 8, at 104.

14. *Id.* at 105.

15. See sources cited *supra* note 2.

16. See *infra* note 214 and accompanying text.

17. Mark Yagerman & Max Bookman, *How Obamacare May Limit Projected Expenses in Personal Injury Life Care Plans*, (2014), <https://cardozo.yu.edu/sites/default/files/YagermanBookan.HowObamacareMayLimitProjectedExpensesInPersonalInjuryLifeCarePlans.pdf>.

18. See *infra* notes 19–23 and accompanying text.

collateral sources or limits future damages is nothing more than the hope of those scavenging for vindication, and not the reality of the PPACA.¹⁹

Second, the few cases that have considered this contention have rejected it. In *Leung v. Verdugo Hills Hospital*,²⁰ the plaintiff, prevailing in a malpractice action, received both current and future compensatory damages.²¹ The defendant-hospital argued that if the plaintiff were to receive future costs, the collateral source rule limitation should be modified in accordance with a state statute.²² Because the PPACA rules on limitations of future “federally mandated . . . insurance options makes the prospect of future health insurance coverage for plaintiff anything but speculative[,]” the hospital argued, evidence of the plaintiff’s then current insurance should be admissible.²³

The court, dismissing the defendant’s arguments, recognized that the possibility of future medical insurance as contemplated in the PPACA did not form a basis to conclude that the plaintiff’s future needs would be met.²⁴ The court considered that the PPACA’s individual mandate “standing alone, is irrelevant to prove reasonably certain insurance coverage . . . because it has no tendency in reason to prove that specific items of future care and treatment will be covered, the amount of that coverage, or the duration of that coverage.”²⁵

Leung was exactly on point: the PPACA may not have been designed to cover all future losses a defendant caused and a plaintiff experiences, but it certainly does not limit a judgment or future needs. Introducing a current insurance policy, in contravention of the collateral source rule, is erroneous.²⁶ Further, introducing a current insurance policy to show what is unavailable through the PACCA insurance later on—and, more importantly, what should not be available in a personal injury case involving medical malpractice—is beyond speculative, fantasy, or perhaps defensive magical thinking.

19. See, e.g., *supra* note 2 (predicting a possible reduction in damages exposure to personal injury defendants as a result of the PPACA).

20. *Leung v. Verdugo Hills Hosp.*, No. B204908, 2013 WL 221654 (Cal. Ct. App. Jan. 22, 2013), *review denied* (May 1, 2013). On appeal from the Superior Court of Los Angeles County, the Second District Court of Appeal did not address the issue of the admissibility of future medical costs. *Leung v. Verdugo Hills Hosp.*, 282 P.3d 1250, 1261 (Cal. 2012). The California Supreme Court, however, reversed the court of appeals, ordering consideration of future insurance coverage in calculating damages. *Id.* On remand, the appellate court held, nonetheless, that the “mere possibility that private insurance coverage will continue, and the availability of government programs for the purchase of insurance, do not, in themselves, constitute relevant, admissible evidence of the future insurance benefits that a plaintiff is reasonably certain to receive.” *Leung*, 2013 WL 221654, at *11.

21. *Leung*, 2013 WL 221654, at *13.

22. *Id.* at *3.

23. *Id.* at *10.

24. *Id.* at *11.

25. *Id.*

26. *Id.*

There is another way to assess this contorted interpretation of the PPACA. While the PPACA was intended to provide universal health coverage,²⁷ the belief that every future cost associated with an act of malpractice would be covered by the minimal health insurance policy under the PPACA is at odds with reality. Future unanticipated costs associated with various types of therapy (e.g., occupational or physical) are not covered in any meaningful way by most insurance policies.²⁸ Future pain, loss of mobility, decline in function and appearance, and many other long-term effects of instances of malpractice are not covered in every health insurance policy the PPACA contemplates. However, these maladies are, and should be, covered in a malpractice judgment or settlement. The limits of the PPACA do not affect the capacity of courts to ensure that these malpractice-induced needs are met.

I. LEGISLATIVE PATH OF THE PPACA DOES NOT INCLUDE CHANGES TO TORT LIABILITY

The PPACA was introduced into the 111th U.S. Congress in September 2009,²⁹ and passed the U.S. Senate that December.³⁰ The Act then passed the U.S. House of Representatives with certain changes on March 21, 2010, and President Obama signed the bill into law shortly thereafter.³¹ During the Senate debate, there was considerable political pressure to incorporate tort limitation language (i.e., tort reform), particularly a provision capping damages.³² Proponents direct attention to § 6801 of the PPACA, which suggests that it was the “[s]ense of the Senate” that “health care reform presents an opportunity to address issues related to medical malpractice and medical liability insurance.”³³ During the floor debates, notably Republican Senate Minority Leader Mitch McConnell contended that the health care proposals under consideration failed to include any language limiting malpractice liability and urged his colleagues

27. Two years into the PPACA, there were still thirty-two million people without health insurance. Jason Millman, *Who Is Still Uninsured Under ObamaCare—and Why*, WASH. POST (Nov. 12, 2014), <http://www.washingtonpost.com/blogs/wonkblog/wp/2014/11/12/who-is-still-uninsured-under-obamacare-and-why/>.

28. *How to Avoid Surprise Medical Bills*, THE WALL ST. J., <http://guides.wsj.com/health/health-costs/how-to-avoid-surprise-medical-bills/> (last visited Oct. 9, 2015).

29. *H.R. 3590 (111th): Patient Protection and Affordable Care Act*, GOVTRACK.US, <https://www.govtrack.us/congress/bills/111/hr3590> (last visited Nov. 2, 2015).

30. *Id.*

31. *Id.*

32. See Stephan F. Hayes, *Obama Taps Ex-Trial Lawyer Lobbyist to Look at Tort Reform*, THE WEEKLY STANDARD (Sept. 10, 2009, 1:36 PM), http://www.weeklystandard.com/weblogs/TWSFP/2009/09/obama_taps_extrial_lawyer_lobb.asp; *In Gesture of Bipartisanship, President Obama to Discuss Medical Malpractice Reform Tonight*, ABC NEWS (Sept. 9, 2009, 4:36 PM), <http://blogs.abcnews.com/politicalpunch/2009/09/in-gesture-of-bipartisanship-president-obama-to-discuss-medical-malpractice-reform-tonight.html>.

33. Patient Protection and Affordable Care Act, H.R. 3590, 111th Cong. § 6801(a) (2010) (as amended by the Senate and House).

to rectify it.³⁴ Nevertheless, the Senate version of the bill upon its return to the House did not include any tort reform provisions.³⁵

After Senate passage, the House Rules Committee took up tort reform and the PPACA shortly before President Obama signed the bill into law. The Committee debated, but failed to pass, a proposal that would have added a section “based on the medical liability reforms adopted in Texas.”³⁶ Subsequent amendments touched on the subject without changing the fact that the Act does not limit tort liability.³⁷

Even before President Obama took office, the 110th Congress held seventeen hearings on access to healthcare,³⁸ often focused on enhanced subrogation³⁹ and relaxation of collateral source restrictions.⁴⁰ Yet, none of these proposals made it into the PPACA.⁴¹ Likewise, an effort to place caps on damages was thwarted.⁴² Other efforts to limit liability, including the America’s Healthy Future Act that “would have provided incentives through Medicaid for states to enact medical malpractice reforms,” also failed to pass.⁴³ In short, tort reform efforts were explicit and were explicitly rejected.

While President Obama paid lip service to tort reform supporters throughout the health care reform debate, he did not take the opportunity to speak on the topic when he signed the PPACA.⁴⁴ Later, speaking before a meeting of the American Medical Association, President Obama noted that there are “legally

34. Catharine Richert, *McConnell Gets It Right on Medical Malpractice Reform*, POLITIFACT.COM (Dec. 2, 2009, 6:08 PM), <http://www.politifact.com/truth-o-meter/statements/2009/dec/02/mitch-mcconnell/mcconnell-gets-it-right-medical-malpractice-reform/>.

35. *Id.*

36. COMM. ON ENERGY AND COMMERCE, H.R. REP. NO. 111-299, pt. 1, at 1175–76 (2009) (detailing Rep. Burgess’s proposed amendment which was similar to measures in place in Texas since 2003); *see also* *Archive of Summary of Amendments Submitted to the Rules Committee for H.R. 4872—Reconciliation Act of 2010*, U.S. HOUSE OF REP. COMM. ON RULES (Mar. 20, 2010, 6:20 PM), <http://democrats.rules.house.gov/amendment-summary/summary-amendments-submitted-rules-committee-hr-4872-reconciliation-act-2010>.

37. *See, e.g.*, H.R. 5243, 111th Cong. § 3513(b) (2010); SEQUESTER REPLACEMENT RECONCILIATION ACT OF 2012, H.R. REP. NO. 112-470, at 54, 85 (the section on liability reform that would have severely limited future damages, but was not passed).

38. H.R. REP. NO. 111-299, pt. 1, at 328 (2009).

39. H.R. 3200, 111th Cong. § 136 (2009).

40. *See* Todd, *supra* note 4, at 982 n.131.

41. *See id.* at 968–69.

42. LOUISE SLAUGHTER, COMM. ON RULES, H.R. REP. NO. 111-330, at 85–87 (2009). In its initial draft, the Affordable Health Care for America Act and the Medicare Physician Payment Reform Act of 2009—H.R. 3962—included caps on noneconomic and punitive damages and limited attorney fees; however, it also included a generous section on patient injury compensation that severely limited subrogation rights. *Id.*

43. S. REP. NO. 111-89, at 449 (2009).

44. Richert, *supra* note 34; *see also* Press Release, President Barack Obama, Remarks by the President and Vice President at Signing of the Health Insurance Reform Bill (Mar. 23, 2010) (containing no comments in the remarks by the President regarding tort reform).

vulnerable” doctors and other health care providers, but that was the extent of his comments on the subject.⁴⁵ President Obama’s inaction did not go unnoticed. Howard Dean, former Democratic National Committee Chairman, noted:

When you go to pass a really enormous bill like that, the more stuff you put in it, the more enemies you make, right? And the reason that tort reform is not in the bill is because the people who wrote it did not want to take on the trial lawyers in addition to everyone else they were taking on.⁴⁶

Another bill, the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010,⁴⁷ initially mandated the establishment of standards for the “coordination and subrogation of benefits and reimbursement of payments in cases of qualified health benefits and plans.”⁴⁸ However, the subrogation of benefits language was removed before the bill was ultimately enacted.⁴⁹ Consequently, there is nothing in the PPACA or subsequent legislation dictating new terms or criteria for subrogation of benefits or collateral source standards at the federal level.

II. INITIATIVES BEYOND INSURANCE TO IMPROVE HEALTH CARE

Beyond the insurance programs and substantive changes in insurance coverage (e.g., eliminating the practice of denying coverage based on a pre-existing condition),⁵⁰ the PPACA contemplates the possibility of various training programs and pilot initiatives.⁵¹ These programs, central to the massive effort to reconfigure health care, seek to allow most patients to maintain their current health insurance plans and current doctor-patient relationships.⁵²

45. See Richert, *supra* note 34.

46. *In Gesture of Bipartisanship, President Obama to Discuss Medical Malpractice Reform*, *supra* note 32.

47. Pub. L. No. 111-192, 124 Stat. 1280 (2010).

48. H.R. 3962, 111th Cong. § 236 (as introduced in the House on Oct. 29, 2009).

49. See Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010, Pub. L. No. 111-192, 124 Stat. 1280 (showing omission of proposed § 236 in enacted legislation).

50. Patient Protection and Affordable Care Act, 42 U.S.C. § 300gg-3 (2012).

51. See, e.g., *id.* at §§ 3023, 5301–5302 (2010) (providing examples of pilot and training programs); see also ANDREW COHEN, U. MASS. MED. SCH., CTR. FOR HEALTH L. & ECON., PATIENT PROTECTION AND AFFORDABLE CARE ACT (H.R. 3590)—PILOT PROGRAMS, DEMONSTRATION PROJECTS, AND GRANTS, 5–15 (Apr. 2, 2010), http://www.umassmed.edu/uploadedFiles/CWM_CHLE/Landing_Pages/Pilot%20Programs%20Demonstration%20Project%20and%20Grants%20in%20PPACA%204-26-10%20Final.pdf (detailing specific sections within the PPACA that provide funding for pilot programs to improve quality of healthcare access and training to expand the healthcare workforce).

52. 42 U.S.C. § 18011 (2011) (seeking to secure the right of individuals to maintain existing coverage). Suffice it to say that there is some disagreement on whether the PPACA achieved either of these goals. See, e.g., Peter Roff, *Obama Lied, My Health Care Died*, US NEWS (Oct. 11, 2013, 1:05 PM), <http://www.usnews.com/opinion/blogs/peter-roff/2013/10/11/obama-lied-i-lost-my-health-insurance-plan-due-to-obamacare; If Your Grandfathered Health Plan is Changed or>

In conjunction with these lofty goals, the PPACA also provides for a modest non-compulsory program designed to assist states considering options to streamline the healthcare process and attempting to reduce the cost of in-state malpractice claims (e.g., using arbitration to settle disputes between doctors and their patients who are victims of medical malpractice).⁵³ The premise for this program is mistakenly that both tort law and the civil justice system are fundamentally flawed. This troubling bias is articulated by Professor Abigail R. Moncrieff, who stated that “[i]f market forces or administrative enforcement works as well as or better than private litigation, then we ought to embrace rather than resist the Court’s assault on private actions. In that case, private actions might inefficiently replicate regulatory deterrence.”⁵⁴

This initiative is the closest the PPACA comes to suggesting tort reform. Notwithstanding the fact that compulsory arbitration in medical malpractice cases violates individuals’ Seventh Amendment right to a trial in an Article III court,⁵⁵ even permitting states under the PPACA to consider this option is a terrible idea.⁵⁶

Beyond this minor option in the Act, the most important, obvious, and highly ambitious goal of the PPACA is the mandate to create an accessible insurance acquisition system resulting in health coverage for all and reducing health care delivery costs in the long term.⁵⁷ This mandate, not the crabbed and distorted reading of a limitation on damages, is the ultimate goal of the PPACA.

This greater goal of insuring every U.S. citizen is inconceivably vast and particularly challenging. The number of programs required—and the

Cancelled, HEALTHCARE.GOV, <https://www.healthcare.gov/current-plan-changed-or-cancelled/> (last visited Aug. 12, 2015). Nonetheless, it is not the goal of this paper to assess whether these promises have been fulfilled.

53. 42 U.S.C. § 280g-15(a) (2012) (providing funds “for the development, implementation, and evaluation of alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or health care organizations”).

54. Abigail R. Moncrieff, *The Supreme Court’s Assault on Litigation: Why (and How) It Might Be Good for Health Law*, 90 B.U. L. REV. 2323, 2327 (2010).

55. See generally Mark E. Bunditz, *The High Cost of Mandatory Consumer Arbitration*, 67 LAW & CONTEMP. PROBS. 133 (2004); Jennifer Schulz, Comment, *Arbitrating Arbitrarily: How the U.S. Supreme Court Empowered the Arbitrator at the Expense of the Judge and the Average Joe*, 44 LOY. L.A. L. REV. 1269 (2011); David S. Schwartz, *Understanding Remedy-Stripping Arbitration Clauses: Validity, Arbitrability, and Preclusion Principles*, 38 U.S.F.L. REV. 49 (2003); Cory Tischbein, Comment, *Animating the Seventh Amendment in Contemporary Plaintiffs’ Litigation: The Rule, or the Exception?*, 16 U. PA. J. CONST. L. 232 (2013) (criticizing the Supreme Court for favoring arbitration, undervaluing the Seventh Amendment, and minimizing the importance and necessity of jury trials).

56. See Tischbein, *supra* note 55, at 233–34. Implementation of this initiative is suggested through the Public Health Services Act, which authorizes the Secretary of Health and Human Services “to award demonstration grants to states for the development . . . of alternatives to current tort litigation.” 42 U.S.C. § 280g-15(a) (2012).

57. See generally Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

commitment to a better process and outcome—remains historic.⁵⁸ There is no room for a self-interested anti-patient edict abolishing future medical costs in medical malpractice cases.

Naturally, in thousands of pages of legislation, it is possible that a given section of text scurries into a shadowy corner of a bill, waiting behind dense legislative undergrowth, which would surprise supporters of a bill. Thus far, such stealth language has yet to be found in the PPACA. While the PPACA is a complex law, it does not limit patient rights, decrease accountability for physician misconduct, reconfigure the notions of a fair trial by changing collateral source doctrine, or change current law on subrogation by insurance companies.

The PPACA funds both the Community Health Center Fund and the National Health Service Corps.⁵⁹ The Act underwrites the cost of the Prevention and Public Health Fund, which develops programs on disease prevention and wellness, such as the Patient-Centered Outcomes Research Trust Fund and the Health Insurance Reform Implementation Fund.⁶⁰ Beginning in 2010, “the [PPACA] included more than \$100 billion in direct appropriations over the 10-year period” essentially designed to adjust, support, and promote health insurance, health care, Medicare, public and community health initiatives, child and long-term care, and medical research.⁶¹ A twisted and biased interpretation of collateral source or subrogation involving third party claims is hardly the same concept.

As for the state programs, the PPACA authorizes the U.S. Department of Health and Human Services (HHS) to award states five-year grants to develop and test “alternatives to current tort litigation for resolving disputes over injuries allegedly caused” by health care professionals.⁶² In order to apply for an HHS grant, a state must submit an application to the HHS Secretary outlining its non-litigation alternative.⁶³ Each application undergoes “rigorous peer review by independent, scientific experts[,]” and the “[a]ward decisions . . . reflect peer review scores, program balance, technical merit[,] and feasibility.”⁶⁴

58. See generally C. STEPHEN REDHEAD, CONG. RESEARCH SERV., R41301, APPROPRIATIONS AND FUND TRANSFERS IN THE AFFORDABLE CARE ACT (2015), <https://www.fas.org/sgp/crs/misc/R41301.pdf> (detailing the forty-seven different mandatory appropriations of the ACA).

59. See generally Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education and Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 119 (2010); REDHEAD, *supra* note 58, at 4.

60. REDHEAD, *supra* note 58, at 4.

61. *Id.* at 3–4.

62. 42 U.S.C. § 280g-15(a)–(b) (2012).

63. *Id.* § 280g-15(c)–(d).

64. Press Release, The White House, Fact Sheet: Patient Safety and Medical Liability Reform Demonstration (Sept. 17, 2009), <http://www.whitehouse.gov/the-press-office/fact-sheet-patient-safety-and-medical-liability-reform-demonstration>.

The PPACA provides specific requirements of what constitutes an “alternative[] to current tort litigation.”⁶⁵ Such alternatives must facilitate dispute resolution and “promote a reduction of health care errors by encouraging the collection and analysis of patient safety data related to disputes by organizations that engage in efforts to improve patient safety and the quality of health care.”⁶⁶ Further, states must show that their plan furthers alternative dispute resolution, the disclosure of medical errors, and patient education concerning the difference between tort litigation and other available alternatives, while still allowing patients to sue.⁶⁷ The state plan, in addition, must neither conflict with current state tort law nor place limitations on patients’ legal rights or access to the justice system.⁶⁸ Finally, state grantees must provide the Secretary of HHS with annual reports that evaluate the effectiveness of the alternative(s).⁶⁹ This, again, is hardly suggestive of federal tort reform. The behavior of the federal government under the scope of the PPACA further serves to support this conclusion.

In June 2010, the Agency for Health Research and Quality opened a solicitation for more grant applications.⁷⁰ However, Congress did not appropriate the requested funding in 2012 and 2013.⁷¹ Moreover, President Obama’s 2015 fiscal budget does not include any explicit funding for these state run medical liability reform programs.⁷² The American Medical Association has called on Congress to make funds available for these grants.⁷³

In addition, there was an unsuccessful quest in the PPACA debate to encourage state pilot projects to include damage caps, which is classic tort reform.⁷⁴ Opponents overwhelmingly thwarted this suggestion, arguing that damage caps are patently unfair and reduce accountability, which, according to the Congressional Budget Office, directly results in an increase of patient deaths.⁷⁵ There is no evidence to support the belief that capping damages serves

65. Affordable Care Act § 10607; 42 U.S.C. § 280g-15(c)(2).

66. Affordable Care Act § 10607; 42 U.S.C. § 280g-15(c)(1)(B).

67. Affordable Care Act § 10607; 42 U.S.C. § 280g-15(c)(2).

68. 42 U.S.C. § 280g-15(c)(2)(H)–(I).

69. *Id.* § 280g-15(e)(1).

70. *Medical Liability Reform NOW!*, AM. MED. ASS’N 1, 33 (2015), ama-assn.org/go/mlrnw.

71. *Id.*

72. *Id.*

73. *Id.*

74. See Leonard J. Nelson, III, et al., *Medical Liability and Health Care Reform*, 21 HEALTH MATRIX 443, 476–77, 484 (2011) (finding that the push to encourage damage caps was led by Republicans and physician groups, but evidence showing the effectiveness of damage caps on health care costs was questionable). Furthermore, President Obama has argued that medical liability reform should be included in health care reform, but his support does not extend to damage caps. *Id.* at 504–05.

75. Sen. Dick Durbin on Medical Malpractice Reform at White House Health Summit, in WASH. POST (Feb. 25, 2010, 5:12 PM), <http://www.washingtonpost.com/wp-dyn/content/article/>

as a deterrence measure.⁷⁶ By failing to deter instances of malpractice, a federal cap on medical liability damages, therefore, would not significantly reduce the costs of health care.⁷⁷ In the end, the cap effort was ultimately not included in the PPACA.

As was the case with other efforts to pervert the PPACA and utilize its language to lessen patient rights, the very essence of the arguments forwarded by proponents suggesting that the PPACA contemplates tort reform were, in fact, considered by Congress and wholly rejected.

III. RELATIONSHIP BETWEEN SUBROGATION, THE COLLATERAL SOURCE RULE, AND THE PPACA

As mentioned earlier, one might conclude that because PPACA-approved insurance does not require compensation for future medical costs, and many people will only have the PPACA-mandated health insurance,⁷⁸ the source of funds should be known at trial, in contravention of the collateral source rule. Because insurers' recoupment through subrogation will be bounded by that limitation, the PPACA, in effect, limits tort liability. This tortured reasoning is simply incorrect.

Each state has its own subrogation and collateral source policies.⁷⁹ Some states permit only one of these doctrines, some permit both, while others prohibit both.⁸⁰ While the PPACA implicates "normative benefits accrued by continuing to impose the collateral source rule[,] it does not stabilize the various state approaches to subrogation.⁸¹ The importance of this distinctive matter is best framed by Professor Adam Todd, who states: "[t]he restrictions on full subrogation found in many jurisdictions allow the collateral source rule to

2010/02/25/AR2010022504290.html. As doctors and hospitals lose accountability, according to a study by the Congressional Budget Office, approximately 4,800 patients will die every year. *Id.* Senator Durbin argues that this finding, in conjunction with the Institute of Medicine's finding that 98,000 Americans die each year due to medical malpractice, justifies inclusion of medical errors into the bill. *Id.*

76. See Nelson, III, et al., *supra* note 74, at 448 (arguing that damage "caps do not adequately address the shortcomings of the current medical liability system with respect to both its deterrence and compensation goals").

77. See *id.* at 476 (concluding "[a]t this time it is not clear that a cap will significantly reduce health care costs . . . as result of federal medical liability reform").

78. See *id.* at 450 (finding that PPACA will always have a source of payment for future health care costs, even the insured who are unemployed).

79. See Todd, *supra* note 4, at 988 (finding that the collateral source rule and subrogation have a symbiotic relationship determined by the jurisdiction's relevant subrogation rule. Any proposed federal change to the collateral source rule would have to take into account each jurisdiction's subrogation rules).

80. See *id.* at 990–92 (finding that the common law rule of permitting contractual subrogation has come under assault by courts and legislatures who have adopted either one, both, or none of the subrogation and collateral source policies).

81. Todd, *supra* note 4, at 968 (finding that the Affordable Care Act does not settle the various and conflicting state approaches to subrogation and the collateral source rule).

survive because the rule plays an important administrative and equitable function in the determination of subrogation rights. As such, the rule is particularly important when full subrogation is prohibited or restricted.”⁸² “Abrogating the collateral source rule, absent subrogation,” Professor Todd posits, entitles a defendant to a reduction in liability, and, as a result, “allows the defendant to escape the full cost of the risk-taking behavior.”⁸³

A. *The Collateral Source Rule*

In 1854, the collateral source rule was first recognized in the United States in *Monticello v. Mollison*.⁸⁴ In *Monticello*, the Court correctly recognized that a person’s own insurance, like any other personal asset, should not enter into a determination of what should be paid by a party found to have caused the harm.⁸⁵ The *Monticello* ruling has since been diluted in numerous states.⁸⁶ A state survey shows a remarkable variation in the treatment of collateral sources.⁸⁷

States apply the collateral source rule inconsistently,⁸⁸ and many have adopted caps in medical malpractice cases.⁸⁹ Some states recognize the entire collateral source rule, including Arizona,⁹⁰ Arkansas,⁹¹ District of Columbia,⁹² Hawaii,⁹³

82. *Id.*

83. *Id.* at 986.

84. 58 U.S. 152, 155 (1854) (finding that “[t]he contract with the insurer is in the nature of a wager between third parties, with which the trespasser has no concern”); see Michael W. Cromwell, *Cutting the Fat Out of Health-Care Costs*, 62 OKLA. L. REV. 585, 589 (2010).

85. *Monticello*, 58 U.S. at 155.

86. See Richard C. Witzel Jr., *The Collateral Source Rule and State-Provided Special Education and Therapy*, 75 WASH. U. L. Q. 697, 701–05 (1997) (describing the development of the collateral source doctrine and its role in tort reform).

87. See Lori A. Roberts, *Rhetoric, Reality, and the Wrongful Abrogation of the Collateral Source Rule in Personal Injury Cases*, 31 REV. LITIG. 99, 101–02 (2012).

88. See *id.*

89. See Adam D. Glassman, *The Imposition of Federal Caps in Medical Malpractice Liability Actions: Will They Cure the Current Crisis in Health Care?*, 37 AKRON L. REV. 417, 431 (2004).

90. See *Lopez v. Safeway Stores, Inc.*, 129 P.3d 487, 491 (Ariz. Ct. App. 2006) (stating that the collateral source rule is “well established” in Arizona); but see ARIZ. REV. STAT. ANN. § 12-565 (2014) (permitting collateral source rule evidence to be introduced to the jury in malpractice actions).

91. See *Jewell v. Fletcher*, 377 S.W.3d 176, 190 (Ark. 2010) (permitting the collateral source rule, while recognizing that double recovery may result).

92. See *Dist. of Columbia v. Jackson*, 451 A.2d 867, 870 (D.C. Cir. 1982) (applying the common law collateral source rule within the District of Columbia).

93. See *Bynum v. Magno*, 101 P.3d 1149, 1154 (Haw. 2004) (applying the common law collateral source rule in Hawaii).

Illinois,⁹⁴ Kentucky,⁹⁵ Louisiana,⁹⁶ Maine,⁹⁷ Mississippi,⁹⁸ Montana,⁹⁹ Nebraska,¹⁰⁰ New Hampshire,¹⁰¹ New Mexico,¹⁰² North Dakota,¹⁰³ South Carolina,¹⁰⁴ South Dakota,¹⁰⁵ Vermont,¹⁰⁶ Virginia,¹⁰⁷ West Virginia,¹⁰⁸ and Utah.¹⁰⁹

94. *See* *Wills v. Foster*, 892 N.E.2d 1018, 1030 (Ill. 2008) (holding that Illinois permits the use of the collateral source rule).

95. *See* *Leighton v. CSX Transp., Inc.*, 338 S.W.3d 818, 820 (Ky. Ct. App. 2011) (stating that the collateral source rule is followed in Kentucky).

96. LA. CODE EVID. ANN. art. 409 (2013) (prohibiting introduction of collateral source evidence to jury); *see also* *Suhor v. Lagasse*, 770 So. 2d 422, 426–27 (La. Ct. App. 2000) (prohibiting application of the collateral source rule to federal aid programs, such as Medicare or Medicaid).

97. *See* *Potvin v. Seven Elms, Inc.*, 628 A.2d 115, 116 (Me. 1993) (permitting the collateral source rule and broadening the application even beyond tort actions); *but see* *Werner v. Lane*, 393 A.2d 1329, 1335–36 (Me. 1978) (applying the collateral source rule, but holding with proper discretion that the judge can allow collateral source evidence under certain circumstances).

98. *See* *Busick v. St. John*, 856 So. 2d 304, 309 (Miss. 2003) (stating that the collateral source rule is followed in Mississippi).

99. *See* *Thomsen v. State by & Through Dep't of Highways*, 833 P.2d 1076, 1078 (Mont. 1992) (prohibiting the introduction of collateral source evidence to the jury).

100. *See* *Mahoney v. Neb. Methodist Hosp.*, 560 N.W.2d 451, 457 (Neb. 1997) (recognizing application of the collateral source rule in Nebraska); *Huenink v. Collins*, 147 N.W.2d 508, 509 (Neb. 1966) (citing the collateral source rule in rejection of appellant's argument).

101. *See* *Moulton v. Groveton Papers Co.*, 323 A.2d 906 (N.H. 1974) (holding that New Hampshire observes the collateral source rule); *but see* *Cyr v. J.I. Case Co.*, 652 A.2d 685, 688 (N.H. 1994) (holding that collateral source evidence may still be admissible for another purpose).

102. *See* *Selgado v. Commercial Warehouse Co.*, 526 P.2d 430, 434–35 (N.M. Ct. App. 1974) (holding that the collateral source rule does not reduce damages recoverable from the tortfeasor, but collateral source evidence may be admissible to the jury for another purpose).

103. *See* *Keller v. Gama*, 378 N.W.2d 867, 868 (N.D. 1985) (upholding North Dakota's use of the collateral source rule).

104. *See* *Estate of Rattenni v. Grainger*, 379 S.E.2d 890 (S.C. 1989) (stating that South Carolina follows the collateral source rule).

105. *See* *Papke v. Harbert*, 738 N.W.2d 510, 536 (S.D. 2007) (prohibiting introduction of collateral source evidence to the jury).

106. *See* *Windsor Sch. Dist. v. State*, 956 A.2d 528, 542 (Vt. 2008) (applying the collateral source rule, which is recognized in Vermont).

107. *See* *Radvany v. Davis*, 551 S.E.2d 347, 348 (Va. 2001) (prohibiting introduction of collateral source evidence to the jury).

108. *See* *Kenney v. Liston*, 760 S.E.2d 434, 446 (W. Va. 2014) (prohibiting introduction of collateral source evidence to the jury).

109. *See* *Wilson v. IHC Hosps., Inc.*, 289 P.3d 369, 391 (Utah 2012) (holding that the jury cannot take the collateral source rule into account for jury verdict).

Other states have abrogated the collateral source rule, including Alabama,¹¹⁰ California,¹¹¹ Connecticut,¹¹² Georgia,¹¹³ Idaho,¹¹⁴ Michigan,¹¹⁵ Ohio,¹¹⁶ Rhode Island,¹¹⁷ Tennessee,¹¹⁸ Utah,¹¹⁹ and Washington.¹²⁰

Finally, some states permit use of the collateral source rule subject to various limitations, including Alaska,¹²¹ Colorado,¹²² Delaware,¹²³ Florida,¹²⁴

110. ALA. CODE § 6-5-545 (2014) (abrogating collateral source rule for evidence admissible at trial); *see also* *Marsh v. Green*, 782 So. 2d 223, 233 (Ala. 2000) (holding that the abrogation of the collateral source rule under § 6-5-545 is constitutional).

111. CAL. CIV. CODE § 3333.1 (West 2014) (abrogating the collateral source rule in medical malpractice cases).

112. CONN. GEN. STAT. § 52-225a (2014) (permitting the admission of collateral sources at trial); *see also* *Jones v. Kramer*, 838 A.2d 170, 177 (Conn. 2004) (narrowly interpreting § 52-225a to limit collateral source payments to those specifically corresponding to damages included in the jury's verdict).

113. GA. CODE ANN. § 51-12-1 (2014) (prohibiting the receipt of benefits from sources other than the defendant from operating to diminish the plaintiff's recovery of damages); *see also* *Anepohl v. Ferber*, 415 S.E.2d 9, 10 (Ga. Ct. App. 1992) (prohibiting admission of collateral source evidence to a jury).

114. IDAHO CODE ANN. § 6-1606 (West 2014) (abrogating the collateral source rule by requiring the decuation of payments from damage awards).

115. MICH. COMP. LAWS § 600.6303 (2014) (permitting collateral source evidence to be introduced to a jury).

116. OHIO REV. CODE ANN. § 2323.41 (West 2015) (replacing the common law collateral source rule in Ohio); *Jaques v. Manton*, 928 N.E.2d 434, 439 (Ohio 2010) (holding that the trial court erred in refusing to introduce collateral source evidence to the jury).

117. TIT. 9 R.I. GEN. LAWS ANN. § 9-19-34.1 (West 2014) (permitting introduction of collateral source evidence to the jury).

118. TENN. CODE ANN. § 29-26-119 (2014) (abrogating the collateral source rule in medical malpractice cases); *see also* *State Auto. Mut. Ins. Co. v. Hurley*, 31 S.W.3d 562, 566 (Tenn. 2000) (holding that the collateral source rule is not applicable in workers compensation cases).

119. UTAH CODE ANN. § 78B-3-405 (West 2014) (abrogating the collateral source rule in medical malpractice cases); *see also* *Wilson v. IHC Hosps., Inc.*, 289 P.3d 369, 384 (Utah 2012) (applying Utah Code Ann. § 78B-3-405).

120. WASH. REV. CODE § 7.70.080 (2015) (replacing the common law collateral source rule in the context of health injuries); *Adcox v. Children's Orthopedic Hosp. & Med. Ctr.*, 864 P.2d 921, 936 (Wash. 1993) (finding that the trial court erred in refusing to allow the jury to hear collateral source evidence but holding that the error was harmless).

121. *See Jones v. Bowie Indus.*, 282 P.3d 316, 328 (Alaska 2012) (holding that collateral source evidence should be excluded unless it is highly probative of malingering).

122. *See Roberts*, *supra* note 87, at 125 (discussing the Colorado legislature's provision for a "contract exception" so that the trial court can apply the collateral source rule for certain benefits following a damages verdict).

123. *See Miller v. State Farm Mut. Auto. Ins. Co.*, 993 A.2d 1049, 1056 (Del. 2010) (prohibiting evidence that the injured party received compensation or payment for tort-related injuries from a source other than the tortfeasor); *but see* DEL. CODE ANN. tit. 18 § 6862 (2014) (providing jurors factors to consider when collateral source evidence has been introduced at trial).

124. *See* FLA. STAT. ANN. § 768.76(1) (West 2015) (allowing the court to reduce the award by the total paid by some collateral sources); *Sheffield v. Superior Ins. Co.*, 800 So. 2d 197, 203 (Fla. 2001) (prohibiting the admission of collateral source evidence).

Indiana,¹²⁵ Iowa,¹²⁶ Kansas,¹²⁷ Louisiana,¹²⁸ Massachusetts,¹²⁹ Minnesota,¹³⁰ Missouri,¹³¹ New York,¹³² North Carolina,¹³³ Oklahoma,¹³⁴ Oregon,¹³⁵ Pennsylvania,¹³⁶ Texas,¹³⁷ Wisconsin,¹³⁸ and Wyoming.¹³⁹

125. See Ind. Code Ann. § 34-44-1-2 (permitting *some* collateral source evidence in personal injury and wrongful death cases to reduce the award).

126. See IOWA CODE ANN. § 668.14 (2015) (permitting some collateral source evidence); *but see* Collins v. King, 545 N.W.2d 310, 312 (Iowa 1996) (prohibiting evidence of loss of earnings from being introduced to the jury).

127. See Hayes Sight & Sound, Inc. v. ONEOK, Inc., 136 P.3d 428, 442 (Kan. 2006) (permitting the collateral source rule, but allowing a setoff in the amount defendants paid to settle plaintiff insurers' subrogation claim).

128. See Suhor v. Lagasse, 770 So. 2d 422, 423 (La. Ct. App. 2000) (prohibiting application of the collateral source rule to expenses written off by the operation of law governing Medicare).

129. See Corsetti v. Stone Co., 483 N.E.2d 793, 802 (Mass. 1985) (holding that evidence of collateral source income may be admissible in a tort action at the discretion of the trial judge).

130. MINN. STAT. ANN. § 548.251 (West 2015) (prohibiting the introduction of collateral source evidence, while permitting the court to reduce damage awards by offsetting some collateral source payments received by the plaintiff).

131. MO. REV. STAT. § 490.715 (2015) (prohibiting introduction of collateral source evidence to the jury, while permitting court to evaluate such evidence to determine the value of medical services).

132. N.Y. C.P.L.R. LAW § 4545 (McKinney 2015) (prohibiting the introduction of collateral source evidence to a jury, while providing that the court may reduce a jury award to offset receipt of some collateral sources).

133. See Cates v. Wilson, 361 S.E.2d 734, 737 (N.C. 1987) (prohibiting introduction of collateral source evidence of public benefits to a jury).

134. Estrada v. Port City Props., 258 P.3d 495, 505–07 (Okla. 2011) (applying the collateral source rule to retaliatory discharge proceedings prohibiting introduction of collateral source evidence of unemployment benefits to a jury).

135. Gragg v. Hutchinson, 176 P.3d 407, 410 (Or. Ct. App. 2007) (prohibiting collateral source evidence in civil actions for damages resulting from bodily injury or death); *but see* OR. REV. STAT. ANN. § 31.580 (West 2015) (allowing court to reduce damages by considering select collateral sources).

136. See Gallagher v. Pa. Liquor Control Bd., 883 A.2d 550, 557 (Pa. 2005) (permitting the introduction of collateral source evidence only when evidence of recovery is a material issue in the case).

137. See TEX. CIV. PRAC. & REM. CODE ANN. § 41.0105 (West 2014) (permitting the collateral source rule while limiting plaintiff's recovery to expenses that have been or must be paid by or for plaintiff); Haygood v. De Escabedo, 356 S.W.2d 390, 399–400 (Tex. 2011) (applying statute to limit evidence of damages to recoverable expenses).

138. WIS. STAT. § 893.55 (2015) (explicitly permitting collateral source evidence to be introduced to the jury in medical malpractice actions); *see also* Lagerstrom v. Myrtle Werth Hospital-Mayo Health Sys., 700 N.W.2d 201, 205 (Wis. 2005) (applying Section 893.55 to allow collateral source evidence to be introduced to determine the reasonable value of medical services).

139. Garnick v. Teton Cnty. Sch. Dist. No. 1, 39 P.3d 1034, 1042 (Wyo. 2002) (prohibiting the introduction of collateral source evidence to the jury, but holding that the trial court's error of admitting such evidence in this case was harmless).

B. Subrogation

Subrogation varies from state to state but, at a basic level, all iterations support “[t]he principle under which an insurer that has paid a loss under an insurance policy is entitled to all the rights and remedies belonging to the insured against a third party with respect to any loss covered by the policy.”¹⁴⁰ The relationship between subrogation and collateral source is fairly straightforward: “[S]ubrogation rules found in many jurisdictions retain the collateral source rule for important administrative and equitable purposes in the pre-verdict trial process. Only where an insurer exercises its subrogation rights directly against the defendant does the collateral source rule lose its purpose and abrogation would appear appropriate.”¹⁴¹

It is worth reviewing how each state treats subrogation. Some states only recognize subrogation as an equitable remedy, including Connecticut,¹⁴² Mississippi,¹⁴³ Montana,¹⁴⁴ Nebraska,¹⁴⁵ Nevada,¹⁴⁶ North Dakota,¹⁴⁷ South Carolina,¹⁴⁸ South Dakota,¹⁴⁹ and Tennessee.¹⁵⁰

There is also contractual subrogation based on a specific clause in an insurance policy.¹⁵¹ States relying on contractual subrogation include

140. J. Thomas Allen, *ERISA Subrogation and Reimbursement Claims: A Vote to Reject Federal Common Law Adoption of a Default “Make Whole” Rule*, 41 ARIZ. ST. L.J. 223, 227 (2009) (quoting BLACK’S LAW DICTIONARY 1467 (8th ed. 2004)).

141. Todd, *supra* note 4, at 997.

142. See *AJJ Enter., LLP v. Jean-Charles*, No. 36838, 2015 WL 5797101, at *9 (Conn. App. Ct. Oct. 13, 2015) (holding that the decision as to whether to apply the doctrine of equitable subrogation is at the discretion of the trial court).

143. See *Hare v. State*, 733 So. 2d 277, 285 (Miss. 1999) (recognizing the make whole doctrine of equitable subrogation).

144. See *Van Orden v. United Servs. Auto. Ass’n.*, 318 P.3d 1042, 1045 (Mont. 2014) (permitting only equitable subrogation that follows the make whole doctrine).

145. See *Jensen v. Bd. of Regents of Univ. of Neb.*, 684 N.W.2d 537, 541–42 (Neb. 2004) (permitting only equitable subrogation that follows the make whole doctrine).

146. See *Canfora v. Coast Hotels & Casinos, Inc.*, 121 P.3d 599, 604 (Nev. 2005) (permitting subrogation only when following the make whole doctrine).

147. See *Grinnell Mut. Reinsurance Co. v. Ctr. Mut. Ins. Co.*, 658 N.W.2d 363, 378 (N.D. 2003) (recognizing only equitable subrogation in certain circumstances).

148. See *Langehans v. Smith*, 554 S.E.2d 681, 683 (S.C. Ct. App. 2001) (recognizing equitable subrogation); *but see Shumpert v. Time Ins. Co.*, 496 S.E.2d 653, 658 (S.C. Ct. App. 1998) (holding that equitable subrogation overrides contractual subrogation).

149. See *Le Mars Mut. Ins. Co. v. Prehn*, 238 N.W.2d 274, 277 (S.D. 1975) (holding that the make whole rule overrides contractual subrogation obligations).

150. *Abbott v. Blount Cnty*, 207 S.W.3d 732, 735 (Tenn. 2006) (holding that the make whole doctrine of equitable subrogation controls regardless of contractual provisions).

151. See Gary L. Wickert, *The Societal Benefits of Subrogation*, CLAIMS JOURNAL (Dec. 6, 2012), <http://www.claimsjournal.com/news/national/2012/12/06/218682.htm>.

Arizona,¹⁵² Arkansas,¹⁵³ California,¹⁵⁴ Idaho,¹⁵⁵ Illinois,¹⁵⁶ Indiana,¹⁵⁷ Kentucky,¹⁵⁸ Maine,¹⁵⁹ North Carolina,¹⁶⁰ Vermont,¹⁶¹ and West Virginia.¹⁶²

Many state policies permit both equitable and contractual subrogation, including Colorado,¹⁶³ District of Columbia,¹⁶⁴ Iowa,¹⁶⁵ Maryland,¹⁶⁶

152. *See* *Kobold v. Aetna Life Ins. Co.*, 309 P.3d 924, 927 (Ariz. Ct. App. 2013) (holding that subrogation can only be enforced if the insurance contract has an explicit subrogation clause).

153. *See* *American Pioneer Life Ins. Co. v. Rogers*, 753 S.W.2d 530, 532 (Ark. 1988) (holding that equitable subrogation is not enforceable; only contractual subrogation is enforceable).

154. *See* *21st Century Ins. Co. v. Superior Court*, 213 P.3d 972, 976–77 (Cal. 2009) (recognizing the make whole rule, but holding that an insurer may specifically contract out of it and that only contractual subrogation is enforceable by law).

155. *See* *Rinehart v. Farm Bureau Mut. Ins. Co. of Idaho, Inc.*, 524 P.2d 1343, 1346 (Idaho 1974) (holding that contractual subrogation is not contrary to public policy).

156. *See* *Schultz v. Gotlund*, 561 N.E.2d 652, 653–54 (Ill. 1990) (permitting subrogation only if expressly included in contract provision).

157. *See* *Baxter v. I.S.T.A. Ins. Trust*, 749 N.E.2d 47, 56 (Ind. Ct. App. 2001) (recognizing contractual subrogation and applying the make whole rule, but not recognizing equitable subrogation).

158. *See* *Dodson v. Key*, 508 S.W.2d 586, 587–88 (Ky. 1974) (permitting contractual subrogation, but not equitable subrogation).

159. *See* *McCain Foods, Inc. v. Gerard*, 489 A.2d 503, 504 (Me. 1985) (permitting contractual subrogation, but not equitable subrogation).

160. N.C. GEN. STAT. § 58-48-20 (2014) (recognizing only contractual subrogation).

161. *See* *Utica Nat'l Ins. Co. v. Cyr*, 945 A.2d 361, 364 (Vt. 2008) (permitting contractual subrogation).

162. *See* *Ferrell v. Nationwide Mut. Ins. Co.*, 617 S.E.2d 790, 791, 793 (W. Va. 2005) (recognizing contractual subrogation).

163. *See* *DeHerrera v. Am. Family Mut. Ins. Co.*, 219 P.3d 346, 350–52 (Colo. Ct. App. 2009) (permitting both contractual and equitable subrogation and explicitly rejecting the make whole rule).

164. *See* *Nat'l Union Fire Ins. Co. v. Riggs Nat'l Bank*, 646 A.2d 966, 971 (D.C. 1994) (recognizing that subrogation can be equitable or contractual).

165. *See* *Allied Mut. Ins. Co. v. Heiken*, 675 N.W.2d 820, 824–25 (Iowa 2004) (recognizing both contractual and equitable subrogation).

166. *See* *Roberts v. Total Health Care*, 675 A.2d 995, 1001 (Md. Ct. Spec. App. 1996) (recognizing both contractual and equitable subrogation).

Minnesota,¹⁶⁷ New Hampshire,¹⁶⁸ New Mexico,¹⁶⁹ New York,¹⁷⁰ Oklahoma,¹⁷¹ Pennsylvania,¹⁷² Rhode Island,¹⁷³ Texas,¹⁷⁴ Washington,¹⁷⁵ and Wyoming.¹⁷⁶

Finally, there is statutory subrogation. Many states retain statutory subrogation in conjunction with equitable and contractual subrogation, including Delaware,¹⁷⁷ Florida,¹⁷⁸ Hawaii,¹⁷⁹ Kansas,¹⁸⁰ Louisiana,¹⁸¹ Massachusetts,¹⁸²

167. *See Westendorf by Westendorf v. Stasson*, 330 N.W.2d 699, 703 (Minn. 1983) (equitable subrogation applies unless a contract provision explicitly provides contrary guidance).

168. *See Chase v. Ameriquest Mortg. Co.*, 921 A.2d 369, 376 (N.H. 2007) (recognizing that subrogation can be equitable or contractual).

169. *See State Farm Mut. Auto. Ins. Co. v. Found. Reserve Ins. Co.*, 431 P.2d 737, 741 (N.M. 1967) (recognizing equitable and contractual subrogation).

170. *See Teichman by Teichman v. Cmty. Hosp.*, 663 N.E.2d 628, 630–31 (N.Y. 1996) (recognizing equitable and contractual subrogation).

171. *See Reeds v. Walker*, 157 P.3d 100, 113 (Okla. 2006) (holding that an insurance contract is subject to the make whole rule unless the contract expressly states otherwise).

172. *See Valora v. Pa. Emps. Benefit Trust Fund*, 939 A.2d 312, 320 (Pa. 2007) (permitting contractual subrogation only if it is also equitable in nature); *but see* 75 PA. CONS. STAT. ANN. § 1720 (West 2015) (prohibiting subrogation in motor vehicle liability insurance cases).

173. *See Credit Union Cent. Falls v. Groff*, 966 A.2d 1262, 1275 (R.I. 2009) (recognizing contractual subrogation); *Foot v. Geico Indem. Co.*, No. WC-2011-0040, 2013 R.I. Super. LEXIS 28, at *24 (R.I. Super. Ct. 2013) (recognizing make whole doctrine of equitable subrogation).

174. *See Fortis Benefits v. Cantu*, 234 S.W.3d 642, 648, 650 (Tex. 2007) (permitting both equitable and contractual subrogation, but holding that contractual provisions control).

175. *See Mahler v. Szucs*, 957 P.2d 632, 640–41 (Wash. 1998) (recognizing both contractual and equitable subrogation and the make whole doctrine).

176. *See Stilson v. Hodges*, 934 P.2d 736, 738–39 (Wyo. 1997) (recognizing contractual and equitable subrogation).

177. DEL. CODE ANN. tit. 18, § 3320(b) (2014) (permitting contractual subrogation); *see* *Baio v. Commercial Union Ins. Co.*, 410 A.2d 502, 506 (Del. 1979) (recognizing equitable subrogation).

178. FLA. STAT. ANN. § 768.76(4) (West 2015) (recognizing subrogation rights); *see* *Centex-Rodgers Constr. Co. v. Herrera*, 761 So. 2d 1215, 1216 (Fla. Dist. Ct. App. 2000) (recognizing contractual and equitable subrogation in health insurance claims).

179. HAW. REV. STAT. ANN. § 346-37(d) (West 2015) (permitting subrogation in health insurance claims); *see* *Peters v. Weatherwax*, 731 P.2d 157, 161 (Haw. 1987) (recognizing subrogation as a principle in equity).

180. KAN. STAT. ANN. § 40-3113a (2013) (permitting subrogation to the extent of duplicative personal injury protection); *see* *Durrett v. Bryan*, 799 P.2d 110, 116 (Kan. Ct. App. 1990) (allowing statutory limitations on subrogation to trump subrogation clauses in insurance contracts and with regard to PIP benefits).

181. LA. CIV. CODE ANN. art. 1825 (2014) (recognizing subrogation as conventional or legal).

182. MASS. GEN. LAWS ANN. ch. 231B(d), § 1 (West 2015) (recognizing subrogation); *see* *Hartford Cas. Ins. Co. v. N.H. Ins. Co.*, 628 N.E.2d 14, 19 n.7 (Mass. 1994) (recognizing equitable subrogation as a general rule by which insurers may recover); *Morin v. Blue Cross, Inc.*, 311 N.E.2d 914, 915–16 (Mass. 1974) (recognizing contractual subrogation rights).

Michigan,¹⁸³ Ohio,¹⁸⁴ Oregon,¹⁸⁵ and Utah.¹⁸⁶ Meanwhile, a few states prohibit subrogation altogether, including Georgia,¹⁸⁷ Missouri,¹⁸⁸ New Jersey,¹⁸⁹ and Virginia.¹⁹⁰

Having reviewed the states, one can only conclude that subrogation is alive, consequential, and unchanged by the implementation of the PPACA. Considering the fact that the rules are largely functional, the idea that the PPACA presented the opportunity to grossly tilt subrogation options and collateral source evidentiary limitations in favor of defendants is simply surprising. Moreover, there are essential remedies in medical malpractice cases that exceed the amount an insurance company could recover through subrogation. Given that tort recovery can include compensation beyond medical damages, (e.g., lost earnings, pain and suffering, loss of consortium, and diminished enjoyment of life), the scope of the compensable loss is broader than the scope of the insured loss.¹⁹¹

Because there are few, if any, medical insurance policies that do not have subrogation clauses, it is difficult for an insured person to enter into a relationship with an insurance company without agreeing to a subrogation

183. MICH. COMP. LAWS ANN. § 550.1401(5) (West 2015) (recognizing subrogation in health insurance cases); *see* *Auto-Owners Ins. Co. v. Amoco Prod. Co.*, 658 N.W.2d 460, 465 (Mich. 2003) (holding that the insurer is entitled to full reimbursement from the employer on the basis of equitable subrogation).

184. OHIO REV. CODE ANN. § 2323.41(A) (West 2015) (expressly recognizing contractual and statutory subrogation); *see* *N. Buckeye Edu. Council Grp. Health Benefits Plan v. Lawson*, 814 N.E.2d 1210, 1214 (2004) (holding that contractual subrogation overrides equitable doctrines such as the make whole doctrine).

185. OR. REV. STAT. ANN. § 742.538(7) (West 2015); *see* *Providence Health Plan v. Winchester*, 288 P.3d 13, 15–16 (Or. Ct. App. 2012) (interpreting subrogation as a contractual agreement between an insurance provider and an insured).

186. UTAH CODE ANN. § 78B-3-405(1) (West 2015) (recognizing subrogation rights); *see* *State Farm Mut. Auto. Ins. Co. v. Green*, 89 P.3d 97, 101, 104–05 (Utah 2003) (recognizing equitable subrogation and holding that “in the absence of express [contractual] terms to the contrary, the insured must be made whole before the insurer is entitled to be reimbursed from a recovery from the third party tort-feasor”) (citing *Hill v. State Farm Mut. Auto. Ins. Co.*, 765 P.2d 864, 866 (Utah 1988)).

187. GA. CODE ANN. § 33-24-56.1(e) (West 2015) (expressly prohibiting subrogation in medical and personal injury cases).

188. *See Nevils v. Group Health Plan, Inc.*, 418 S.W.3d 451, 457 (Mo. 2014) (holding that FEHBA does not preempt Missouri’s anti-subrogation rule).

189. N.J. STAT. ANN. § 2A:15-97 (West 2015) (establishing New Jersey’s anti-subrogation statute); *but see* *Levine v. United Healthcare Corp.*, 402 F.3d 156, 165–66 (3d Cir. 2005) (explaining that Section 2A:15-97 is not an anti-subrogation law, does not regulate insurance, and is preempted by ERISA).

190. *See Farmers Ins. Exch. v. Enter. Leasing Co.*, 708 S.E.2d 852, 856 (Va. 2011) (defining the anti-subrogation rule as prohibiting subrogation in cases in which injury was caused by the negligence of the insured).

191. *See* *Levenson*, *supra* note 4, at 943.

clause.¹⁹² The notion that insurance companies need even more leverage, via the PPACA, is completely outside the stated purposes of the PPACA—a law designed to expand the coverage of health insurance and improve the quality of medical care.

There is also the compelling argument that “the [PPACA] has no legal effect on the medical liability system and, therefore, is unable to create real reform in this area.”¹⁹³ It is true, however, that damage caps and medical malpractice cases are very much part of the health care discourse.¹⁹⁴ As discussed previously, the dialogue on future medical expenses and the collateral source rule is far from over.¹⁹⁵

Given the aforementioned facts, it is simply incorrect to assume that the PPACA would be the vehicle to undermine a patient’s legal claim to be compensated when he or she is the victim of medical malpractice or third party negligence. The PPACA was neither designed nor written to serve such a perverse objective.

Overall, damage caps are a terrible idea—a well-documented terrible idea at that.¹⁹⁶ They artificially limit damages,¹⁹⁷ deprive plaintiffs of much-needed

192. See Brendan S. Maher & Radha A. Pathak, *Understanding and Problematizing Contractual Tort Subrogation*, 40 LOY. U. CHI. L.J. 49, 85 (2008).

193. Rafael Andre Roberti, *The Disappearing Provision: Medical Liability Reform Vanishes from the Patient Protection and Affordable Care Act Despite State Court Split*, 4 LEGIS. & POL’Y BRIEF 145, 147 (2012).

194. See *supra* notes 38–43 and accompanying text.

195. See Levin, *supra* note 2, at 742 (discussing the need for collateral source rule reform now that the PPACA is in effect); *supra* Part III.A.

196. A number of states have found that caps on noneconomic damages violate the state Constitution. See, e.g., *Moore v. Mobile Infirmary Ass’n*, 592 So. 2d 156, 168–70 (Ala. 1991); *Atlanta Oculoplastic Surgery, P.C. v. Nestlehutt*, 691 S.E.2d 218, 220 (Ga. 2010); *Lebron v. Gottlieb Mem’l Hosp.*, 930 N.E.2d 895, 899, 914 (Ill. 2010); *Best v. Taylor Mach. Works*, 689 N.E.2d 1057, 1076–77 (Ill. 1997); *Brannigan v. Usitalo*, 587 A.2d 1232, 1235–36 (N.H. 1991); *Lakin v. Senco Prod., Inc.*, 987 P.2d 463, 474 (Or. 1999), *clarified by* 987 P.2d 476 (Or. 1999); *Sofie v. Fibreboard Corp.*, 771 P.2d 711, 721, 722, 723 (Wash. 1989); see also Amanda Edwards, Comment, *Medical Malpractice Non-Economic Damages Caps*, 43 HARV. J. ON LEGIS., 213, 218–19 n.42 (2006) (claiming that the MICRA deprives injured patients of full relief); Melissa C. Gregory, Note, *Capping Noneconomic Damages in Medical Malpractice Suits Is Not the Pancea of the “Medical Liability Crisis,”* 31 WM. MITCHELL L. REV., 1031, 1036–37 n.40 (2005) (explaining why courts in many states that use caps have struck them down as unconstitutional); David A. Matsa, *Does Malpractice Liability Keep the Doctor Away? Evidence from Tort Reform Damage Caps*, 69 J. LEGAL STUD. S143, S176 (2007) (discussing how caps undermine medical malpractice law); David Studdert et al., *Are Damages Caps Regressive? A Study of Malpractice Jury Verdicts in California*, 23 HEALTH AFFAIRS 54, 65–66 (2004) (cautioning against caps on damages).

197. See Edwards, *supra* note 196, at 225–26 (explaining how California defends the \$250,000 damages cap under the MICRA).

resources,¹⁹⁸ undercut the deterrent effect of the tort system,¹⁹⁹ skew settlement negotiations,²⁰⁰ and, theoretically, effectuate a wrongful taking.²⁰¹ Furthermore, caps on noneconomic damages prevent juries from undertaking their mission or mislead them into believing they are engaged in individualized justice only to later see their efforts undone.²⁰² Additionally, many argue that caps on noneconomic damages fail to reduce malpractice premiums or decrease total health care costs,²⁰³ and from an equitable perspective, caps are simply unfair to patients who have suffered because of a physician's negligence.²⁰⁴

Some jurisdictions have outright banned caps on damages.²⁰⁵ For example, in *Lebron v. Geottlieb Memorial Hospital*,²⁰⁶ the Illinois Supreme Court held

198. See Matsa, *supra* note 196, at S148 n.11, S175–76 (discussing how caps reduce compensation to victims).

199. See *id.* at S144, S176 (discussing how damage caps could undermine the deterrent effect of medical malpractice liability).

200. See Studdert et al., *supra* note 196, at 64 (describing how caps will influence a party's expectation of returns, which will impact settlement negotiation).

201. See Roberts, *supra* note 87, at 139–40 (explaining how defendant tortfeasors often end up with a windfall when the collateral source rule is not applied).

202. See, e.g., *Sofie v. Fibreboard Corp.*, 771 P.2d 711, 721 (Wash. 1989) (stating that the respondent tortfeasor's argument in favor of capping noneconomic damages “ignores the constitutional magnitude of the jury's fact-finding province, including its role to determine damages. Respondents essentially are saying that the right to trial by jury is not invaded if the jury is allowed to determine facts[,] which go unheeded when the court issues its judgment. Such an argument pays lip service to the form of the jury but robs the institution of its function. This court will not construe constitutional rights in such a manner.”).

203. Compare Carol J. Miller & Joseph Weidhaas, *Medical Malpractice Noneconomic Caps Unconstitutional*, 69 J. MO. B. 344, 350 (2013) (stating that “[c]ap supporters attribute medical malpractice to rising healthcare costs, but a national study showed that the direct cost of malpractice accounts for less than two percent of total national healthcare costs”), with Ryan T. Emery, *Unwise and Unnecessary: Statutory Caps on Non-Economic Damages in Medical Malpractice Cases and the Appellate Review Alternative*, 69 ALB. L. REV. 913, 916 (2006) (explaining that proponents of caps believe excessive non-economic damages lead to higher premiums).

204. See Emery, *supra* note 203, at 928–29 (concluding that statutory caps lead to arbitrary damage awards that are unfair to the plaintiff).

205. See, e.g., *Moore v. Mobile Infirmary Ass'n*, 592 So. 2d 156, 168–70 (Ala. 1991) (discarding legislative authorization of caps, presuming the statute was predicated upon outdated data, and holding that if the court were to “permit the legislature to act as the sole arbiter” such would “vacate our judicial role”); *Atlanta Oculoplastic Surgery, P.C. v. Nestlehutt*, 691 S.E.2d 218, 220 (Ga. 2010) (finding that a statute capping noneconomic damages violates the right to a trial by jury); *Best v. Taylor Mach. Works*, 689 N.E.2d 1057, 1076–77 (Ill. 1997) (rejecting the argument that the legislature annulled common law restrictions on caps, stating that “[t]he legislature is not free to enact changes to the common law which are not rationally related to a legitimate governmental interest”); *Brannigan v. Usitalo*, 587 A.2d 1232, 1235–36 (N.H. 1991) (invalidating a cap on damages statute, stating that “[i]f a court were to defer to a legislature's findings that the statute bore a ‘fair and substantial relation’ to the object of the legislation, it would be abdicating its judicial role”); *Lakin v. Senaco Prods., Inc.*, 987 P.2d 463, 474 (Or. 1999) (finding ORS 18.560(1) in violation of the Oregon Constitution); *Sofie*, 771 P.2d at 721–23 (concluding that the statutory limit on damages violates the right to trial by jury).

206. 930 N.E.2d 895 (Ill. 2010).

that a cap on damages violates the separation of powers clause in the Illinois Constitution because it infringes on a judge's remittur power.²⁰⁷ In *Atlanta Oculoplastic Surgery, P.C. v. Nestlehutt*,²⁰⁸ the Georgia Supreme Court found that a cap on damages violated a plaintiff's right to a jury trial.²⁰⁹ Additionally, as noted earlier, the *Leung* court considered the argument that the import of the PPACA was a constraint on damages for future medical costs—and then rejected it outright.²¹⁰

The fact that the PPACA's boldest hope is that all persons have health insurance does not mean that "future care and treatment will be covered."²¹¹ Because the PPACA does not cover all future care and treatment, the medical malpractice, i.e., tort, system continues to serve an important purpose by providing plaintiffs the financial resources they need and deserve.

IV. COLLATERAL SOURCE AND CAPS

Tort reformists believe caps on damages will drive down the cost of medical malpractice liability insurance; however, absent forced reductions by a state insurance commission, they do not.²¹² Notwithstanding the failure of caps to achieve anything other than reducing the accountability of negligent defendants and depriving funds for plaintiffs, defendants in malpractice cases have communicated the notable existence of the PPACA in an effort to skirt the collateral source doctrine, potentially limiting damages calculated in consideration of future medical care costs.²¹³

For example, defendants in medical malpractice claims advocate "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 [PPACA] since full coverage would kick in after six months of uninsured status."²¹⁴ Insurance companies, as a result, are attempting to influence federal and state legislatures to consider any economic recovery that goes beyond

207. *Id.* at 914.

208. 691 S.E.2d 218 (Ga. 2010).

209. *Id.* at 220.

210. *Leung v. Verdugo Hills Hosp.*, No. B204908, 2013 WL 221654, at *10–11 (Cal. Ct. App. Jan. 22, 2013).

211. *Id.* at *11.

212. Glassman, *supra* note 89, at 459 (analyzing what happened in California after the state legislature passed a statutory cap on noneconomic damages, concluding that the cap increased malpractice premiums).

213. Bruce G. Fagel, *The Collateral Source Rule Under the Affordable Care Act*, PLAINTIFF MAG. 1, 1 (Jan. 2014), http://plaintiffmagazine.com/Jan14/Fagel_The-Collateral-Source-Rule-under-the-Affordable-Care-Act_Plaintiff-article.pdf (stating that "[s]ince 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").

214. *Id.*

insurance payments to be a windfall.²¹⁵ Some states, unfortunately, have reacted. In a number of states, legislatures have enacted tort reform statutes that modify or eliminate the collateral source doctrine, which, in effect, “limit[s] economic damages to the amount the medical care provider accepted from the plaintiff’s health care insurer as satisfaction for the medical bills.”²¹⁶

There is no rational basis to assert that revealing existing insurance coverage at trial coupled with further damage caps will advance anything other than the bottom line for insurers. States have, in many ways, already slashed recovery potential for injured patients.²¹⁷ Believing that the PPACA would take a final bite of what remains is an erroneous interpretation. Moreover, experience in the field suggests this outcome is at odds with the best interests of the public.²¹⁸ Several examples that support this assertion follow.

In 1975, California enacted caps on medical malpractice with The Medical Injury Compensation Reform Act (MICRA).²¹⁹ The MICRA imposes a \$250,000 cap on compensation paid to victims for noneconomic injuries and eliminated the collateral source rule.²²⁰ Yet, even after the enactment of MICRA, malpractice liability insurance premiums continued to rise.²²¹ Next, California enacted California Insurance Code Section 1861.01, known as Proposition 103, which required insurance premium rollbacks of up to twenty percent.²²² Medical malpractice insurance premiums in California nevertheless stabilized; however, this stabilization was due to “the regulation of insurance rates, and not to caps on non-economic damage awards.”²²³ Finally, Civil Code Section 3333.1, part of the MICRA legislation, eliminated 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.”²²⁴ The statute also allows a defendant to present evidence of the plaintiff’s collateral source benefit, including health insurance.²²⁵ The California legislature rationalized that juries who knew about a plaintiff’s collateral source benefit would set damages at a

215. See Roberts, *supra* note 87, at 101–02.

216. *Id.* at 102.

217. See Sue Ganske, *Noneconomic Damages Caps in Wrongful Death Medical Malpractice Cases—Are They Constitutional?*, 14 FLA. ST. U. BUS. REV. 31, 32 (2015); Kenneth M. Sigelman, *Unhappy Birthday California’s Med-Mal Cap Turns 40*, 51 TRIAL 48, 48 (2015); Alan G. Williams, *The Cure for What Ails: A Realistic Remedy for the Medical Malpractice “Crisis,”* 23 STAN. L. & POL’Y REV. 477, 479 (2012).

218. See Furrow, *supra* note 8, at 47.

219. Glassman, *supra* note 89, at 458.

220. *Id.* at 458.

221. *Id.* at 459.

222. *Id.*

223. *Id.*

224. Fagel, *supra* note 213, at 29.

225. *Id.*

lower level.²²⁶ However, Section 3333.1 has done little to reduce increased insurance rates, generated little economic incentive to improve quality of care, and marginalized aggrieved patients by making it more difficult to find adequate representation.²²⁷

The Texas legislature codified the state position on the collateral source rule in Texas Civil Practices and Remedies Code Chapter 41.0105, which states that the “recovery of medical or health care expenses incurred is limited to the amount actually paid or incurred by or on behalf of the claimant.”²²⁸ In *Haygood v. De Escabedo*,²²⁹ the Texas Supreme Court, interpreting the statute, held that a claimant’s recovery of medical expenses are limited to those that have been or must be paid by or for the claimant.²³⁰ After *Haygood*, juries no longer heard evidence of the full amount of billed medical expenses, which reduces non-economic damages figures and settlement amounts.²³¹ As a result, damages calculated in consideration of “future medical expenses will be noticeably more complex than in the past,”²³² and could, in jury trials, yield ineffectual and inaccurate damage awards.²³³

A few other states have taken less direct approaches. For example, Oklahoma permits admission into evidence of paid-for medical expenses,²³⁴ while a similar North Carolina statute limits evidence of medical expenses only to the amount paid.²³⁵ The Colorado legislature weakened the collateral source rule by requiring trial courts to reduce the victim’s damage award by deducting whatever collateral source benefits the victim received.²³⁶ Indiana Code Section 34-44-1-2 allows the defendant to present evidence of write-offs or lowered payments to satisfy medical bills in a personal injury action.²³⁷ In Connecticut, courts allow evidence of collateral source payments and allow damages to be

226. *Id.* (citing *Fein v. Permanente Medical Group*, 38 Cal. 3d 137 (1983)).

227. Jonathan J. Lewis, *Putting Micra Under the Microscope: The Case for Repealing California Civil Code Section 3333.1(a)*, 29 W. ST. U. L. REV. 173, 185–86, 190, 192–93 (2001).

228. TEX. CIV. PRAC. & REM. CODE ANN. §41.0105 (West 2013).

229. 356 S.W.3d 390 (Tex. 2011).

230. *Id.* at 391.

231. Benjamin A. Geslison & Kevin T. Jacobs, *The Collateral Source Rule and Medical Expenses: Anticipated Effects of the Affordable Care Act and Recent State Case Law on Damages in Personal Injury Lawsuits*, 80 DEF. COUNSEL J. 239, 248 (2013).

232. *See id.* at 251.

233. Jamee Cotton, *How Much Are You Worth?: Why the Texas Supreme Court Took Tort Reform Too Far in Limiting the Admissibility of Certain Medical Expenses During Trial*, 45 TEX. TECH L. REV. 565, 591–92 (2013).

234. OKLA. STAT. ANN. tit. 12, § 3009.1 (West 2015).

235. N.C. GEN. STAT. ANN. § 8C-1, Rule 414 (West 2015).

236. Roberts, *supra* note 87, at 125 (citing COLO. REV. STAT. ANN. § 13-21-111.6 (West 2015)). Notable, however, is a part of the Colorado statute that “provides for a ‘contract exception’ and retains the collateral source rule for certain benefits.” *Id.*

237. *Id.* at 128 (citing IND. CODE ANN. § 34-44-1-2 (West 2010)).

“offset by the amount paid by collateral sources less any amount paid by the claimant to secure the benefit.”²³⁸

There is simply no public benefit to consumers from this strained approach to tort and insurance law, and it is impossible to conclude that any interests were served beyond those of the insurance industry.

Having reviewed the states, the question remains: does the PPACA further dilute the collateral source doctrine? The answer is a resounding no. As Professor Todd notes, the PPACA “appears to leave the collateral source rule unchanged despite the Act’s otherwise sweeping changes to the health insurance system and aspirations of providing universal healthcare coverage to all Americans.”²³⁹ To the extent it survives and prohibits the use of collateral sources, the collateral source rule saves jurors from making difficult calculations in an attempt to determine the actual medical damages paid by the plaintiff, a calculation that could drastically differ depending on the degree of insurance coverage.²⁴⁰ The rule simplifies this burdensome calculation to “a more straightforward, market-cost approach” more appropriate for jurors.²⁴¹

Consider the original intent of the collateral source rule. The rule was designed to prevent a *tortfeasor* from becoming unjustly enriched—not to prevent the victim from being compensated. Nevertheless, a number of states that have enacted tort reform statutes now focus on preventing the injured party from receiving a windfall.²⁴² It is unthinkable that additional remedial limitations are needed via the PPACA.

Even after generations of legislative debate and the passage of the PPACA, which was undertaken with an eye to greater efficiency in delivering health care services, nothing in the PPACA embraces the mistaken notion that modifying collateral source or enhancing insurance subrogation options would affect a savings of any consequence.

V. CONCLUSION

The idea that the PPACA operates as a stealth vehicle for tort reform perverts obvious congressional intent. Having failed to secure major federal tort reform, devotees of limiting accountability and restricting or eliminating access to the courts seized on the one successful piece of legislation they could find and

238. *Id.* at 130 (citing CONN. GEN. STAT. ANN. § 52-225a (West 2015)).

239. Todd, *supra* note 4, at 968.

240. *See id.* at 976.

241. *Id.* at 986.

242. *See* Donna P. Moye & William R. Moye, *The Collateral Source Rule: New Approaches to Loss Allocation*, FOR THE DEFENSE 66, 67 (2013), <http://www.tklaw.com/files/Publication/458482ad-ca11-43ef-a714-be7796cdc39d/Presentation/PublicationAttachment/29a639ba-35ab-4879-9d87-a4377d241189/FTD-1308-MoyeMoye.pdf> (highlighting a number of states that have moved away from the traditional collateral source rule).

claimed that it was designed to limit liability, allow admissibility of collateral sources, and enhance subrogation rights.²⁴³ The PPACA does no such thing.

The idea that the PPACA is technical tort reform designed to cap damages, render admissible collateral sources, or fundamentally change subrogation is absolutely wrong. For the PPACA to do so would change the civil liability system in a way that “undermines the traditional disincentives of tort law intended to compensate victims as well as to discourage negligent conduct.”²⁴⁴ The PPACA is not a shadowy tinkering of the health care system designed so one item on the tort reform agenda could be achieved. There are no covert lines in the PPACA, snuck in at the eleventh hour that suddenly resurfaced as a means to erode the rights of an injured patient or consumer. This was the nation’s political system at its best, passing legislation that furthered big ideas, a grand vision affecting all. When the PPACA is seen in that context, the notion that Congress was out to slice off small segments of consumer rights is simply ridiculous.

243. See, e.g., Joshua Congdon-Hohman & Victor A. Matheson, *Potential Effects of the Affordable Care Act on the Award of Life Care Expenses*, 11–12 (Coll. of the Holy Cross, Dept. of Econ. Faculty Research Series, Working Paper No. 12-01, 2013), http://college.holycross.edu/RePEc/hcx/Matheson-Congdon_ACATortAwards.pdf (arguing the PPACA indirectly, yet significantly, constitutes tort reform, suggesting the individual mandate limits damages calculated in consideration of future medical care); Kimberly Schroder, *The Patient Protection and Affordable Care Act May Be Plaintiffs’ Foe in Personal Injury Actions*, HALL RENDER LITIG. ANALYSIS (Dec. 10, 2012), <http://blogs.hallrender.com/litigation/2012/12/10/obamacare-may-be-plaintiffs-foe-in-personal-injury-actions/> (advocating for the preclusion of “full price” future medical expenses on the grounds that the PPACA’s individual mandate renders such evidence irrelevant).

244. Irma S. Russell, *The Logic of Legal Remedies and the Relative Weight of Norms: Assessing the Public Interest in the Tort Reform Debate*, 39 AKRON L. REV. 1053, 1065 (2006) (citing John C.P. Goldberg, *The Constitutional Status of Tort Law: Due Process and the Right to a Law for the Redress of Wrongs*, 115 YALE L.J. 524, 526 (2005) (stating that a vital and accessible civil justice system provides that “American citizens have a right to a body of law for the redress of private wrongs”)).