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In an effort to reduce the amount of compensation available to persons injured by medical malpractice and other torts, opponents of the civil justice system are proposing that claimants' recovery for future care expenses be limited to the maximum annual out-of-pocket limit for individuals covered by health plans under the Affordable Care Act ("ACA")[1], which in 2015 is $6,600.[2]

This proposal should be rejected for a number of reasons. First, it is based on unreliable assumptions about the ACA. Second, it misunderstands the scope of the maximum out-of-pocket limit, and because of that it is so impractical that it would be unworkable. Finally, it is bad public policy. Although the originating paper[3] frequently highlights the effects of the proposal on medical malpractice claimants, the proposal and the arguments against it extend to all those who suffer tort-related injuries.

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1. Joshua Congdon-Hohman & Victor Matheson, *Potential Effects of the Affordable Care Act on the Award of Life Care Expenses*, 24 J. FORENSIC ECON. 153, 153 (2013).

2. *Out-of-Pocket Maximum/Limit*, HEALTHCARE.GOV, https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/ (last visited Oct. 9, 2015).

3. *See* Congdon-Hohman & Matheson, *supra* note 1, at 153-60.

Unreliable assumptions: The proposal makes a number of unwarranted assumptions and errors about the scope and nature of health insurance under the ACA and the future stability of the law. These include: that the mandated benefits requirements will remain unchanged and be effectively enforced;[4] that the claimant will obtain and be covered by insurance over the entire period that tort-related medical expenses will be incurred;[5] and that the medical care that the claimant will require in the future will be covered by the claimant's health plan at the time that the care is needed and will be available from the claimant's health care providers.[6] None of these assumptions are valid.

Impractical and unworkable: Proponents acknowledge that, in addition to the maximum annual out-of-pocket limit ("MOOPL"), claimants are entitled to compensation for future medical expenses that their health plan does not cover.[7] But there is no way to predict how much that will be, since there is no way of knowing which health plans claimants will be enrolled in when they need the future care, whether the services that they will need will be covered by those plans, or whether they will incur additional out-of-pocket costs by having to go outside the plan to obtain the necessary services. These impracticalities flow from the proponents' apparent misunderstanding of the nature of the MOOPL, which is a limit only on certain "essential" services provided by in-network providers in a participant's own plan and is not in any way an across-the-board guarantee that a participant's health care spending will be capped at the annual limit.[8]

Bad public policy: The proposal would reduce the deterrent effect of the tort system, thereby reducing the quality of health care. It would shift costs from tortfeasors onto taxpayers, and impose further significant losses on innocent persons who sustained negligent injuries. Finally, the proposal would give critics of the tort system what amounts to sweeping changes that they failed to obtain through the democratic process.

I. THE PROPOSAL

The proposal to limit compensation for future medicals to the MOOPL appears to have originated in a paper drafted by two economics professors at the College of the Holy Cross in Worcester, Massachusetts, and was published in 2013 in the Journal of Forensic Economics.[9] The authors claim that, as a result of the "guaranteed issue" provisions in the ACA, "any victim

4. *Id.* at 159.
5. *Id.*
6. *See id.* at 153-60.
7. *Id.* at 153.
8. *See* HEALTHCARE.GOV, *supra* note 2.
9. *See generally* Congdon-Hohman & Matheson, *supra* note 1, at 153-60.

should be able to purchase health insurance" which meets "minimum standards for covered services."[10] Furthermore, because of the "individual mandate" in the ACA, the authors expect virtually everyone to purchase health insurance under the ACA.[11] Therefore, they claim, since the ACA limits the annual out-of-pocket costs for medical care "to a maximum of $6,250 plus the cost of a typical insurance policy in the individual market,"[12] that is the amount that persons injured by negligence should recover from defendants for their life care costs for medical care.[13]

Defendants quickly seized upon the MOOPL proposal as it has been discussed at several national meetings,[14] and motions to limit compensation for future medical expenses to the MOOPL have been filed in federal and state courts.[15] So far there have been no reported decisions, but the approach put forward in the proposal has been rejected in unpublished opinions by the U.S. District Court in Minnesota[16] and the California Court of Appeals.[17]

II. THE PROPOSAL MAKES UNREALISTIC ASSUMPTIONS ABOUT THE ACA

Supporters of the proposal make a number of unwarranted and erroneous assumptions about the ACA. They assert that claimants' health plans will give them access to a comprehensive, well-defined, and detailed set of medical services mandated by federal law, and that the services covered by their plans will not change over time.[18] The paper states, for example, that "the

10. *Id.* at 155.

11. *Id.* at 156-57.

12. *Id.* at 155. [sic] "In 2015, the maximum is $6,600 for an individual and from 2016 forward, it will be "indexed to the growth in the average health insurance premium." *See* HEALTHCARE.GOV, *supra* note 2; Richard S. Foster, *Estimated Financial Effects of the "Patient Protection and Affordable Care Act," as Amended*, CTRS. FOR MEDICARE & MEDICAID SERVS. 6 (April 22, 2010), http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/downloads/PPACA_2010-04-22.pdf.

13. Congdon-Hohman & Matheson, *supra* note 1 at 157. The authors of the paper want to further reduce the patient's recovery by "any pre-injury expected medical costs and penalties if uninsured." *Id.* at 159. In other words, a person who chooses to pay the penalty under the ACA for not purchasing insurance would have the penalty deducted from any compensation received for future medical expenses.

14. Bruce G. Fagel, *The Collateral Source Rule Under the Affordable Care Act*, PLAINTIFF 28 (Jan. 2014), http://plaintiffmagazine.com/Jan14/Fagel_The-Collateral-Source-Rule-under-the-Affordable-Care-Act_Plaintiff-article.pdf.

15. *See* Seth L. Cardeli, *Thwart the Assault on Future Medical Expenses*, 50 TRIAL 14, 19 n.4 (2014) (stating that MOOPL motions have been filed in federal and state courts throughout the country, including Alabama, California, Florida, Illinois, Michigan, Minnesota, Missouri, New York, Ohio, and Washington).

16. Halsne v. Health, No. 12-CV-2409 (SRN/JJG), 2014 WL 1153504, at *28–31 (D. Minn. Mar. 21, 2014).

17. Leung v. Verdugo Hills Hosp., No. B204908, 2013 WL 221654, at *5, 7, 11–12 (Cal. App. 2d Dist. Jan. 22, 2013).

18. Congdon-Hohman & Matheson, *supra* note 1, at 155, 157.

ACA sets minimum standards for covered services"[19] and that, in determining compensation for claimants beyond the MOOPL, life care planners, experts who estimate claimants' future health care needs, can consider which services "would normally be covered by the minimum insurance requirements mandated by the ACA . . . ."[20] As the following sections demonstrate, however, these assumptions are unsound because the ACA does not create a clearly-defined package of health care services that all health plans are required to provide.[21]

A. Shifting Standards for What Must Be Covered

The truth is that the essential benefits that the ACA requires health plans to cover are extremely vague and unstable.[22] The ACA describes them only in very general terms (such as "hospitalization" and "pediatric services"),[23] and leaves it up to the states to fill in the details.[24] Claimants may switch

19. *Id.* at 155.

20. *Id.* at 157; *see also* Mark S. Yagerman & Max Bookman, How Obamacare May Limit Projected Expenses in Personal Injury Life Care Plans (unpublished manuscript), *available at* https://cardozo.yu.edu/sites/default/files/YagermanBookan.HowObamacareMayLimitProjectedExpensesInPersonalInjuryLifeCarePlans.pdf ("Under the ACA, all plans will be required to meet a certain minimum coverage standard. Therefore, while it is true that there will be future variations above and beyond that minimum standard, it is also true that notwithstanding any such variation, all plans policies will maintain a certain required baseline. As such, at the very least, defendants will argue that the jury should be permitted to consider an attack on a life care plan that fails to take into account the fact that no matter what health care coverage a plaintiff may obtain in the future, any such coverage must meet the ACA's minimum requirements.").

21. Timothy Jost, *Implementing Health Reform: 'Minimum Value' Plans Must Have Hospital and Physician Coverage*, HEALTH AFF. BLOG (Nov. 4, 2014, 2:13 PM), http://healthaffairs.org/blog.

22. Nicholas Bagley & Helen Levy, *Essential Health Benefits and the Affordable Care Act: Law and Process*, 39 J. HEALTH POL., POL'Y, & L. 441, 448 (2014) (stating that the states have "no additional guidance or regulations on essential health benefits" leaving leaders to make decisions based on "vague guidance and guesswork").

23. *See* 42 U.S.C.A. § 18022 (2015) ("[The ACA states: ". . . T]he Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories: (A) Ambulatory patient services. (B) Emergency services. (C) Hospitalization. (D) Maternity and newborn care. (E) Mental health and substance use disorder services, including behavioral health treatment. (F) Prescription drugs. (G) Rehabilitative and habilitative services and devices. (H) Laboratory services. (I) Preventive and wellness services and chronic disease management. (J) Pediatric services, including oral and vision care.").

24. *See* Amanda Cassidy, *Health Policy Brief: Essential Health Benefits*, HEALTH AFF. 1 (May 2, 2013), *available at* http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_91.pdf ("[R]ather than establishing a national standard for these benefits, the Department of Health and Human Services (HHS) decided to allow each state to choose from a set of plans to serve as the benchmark plan in their state. Whatever benefits that plan covers in the 10 categories will be deemed the essential benefits for plans in the state."). A number of Democratic lawmakers, consumer groups, and providers have criticized this approach on the ground that the benefits could be inadequate. *Id.* at 3.

plans, each having its own coverage policies, or they might move to different states with different coverage requirements. Moreover, the essential benefits requirements do not apply to self-insured plans, employer plans in the large-group market, or plans that already existed when the ACA was enacted.[25] In addition, the administration has indicated that after 2015, it may alter how the states decide what services must be covered.[26]

Individual health insurance plans continue to have wide leeway in deciding which services they will cover at any point in time.[27] Since plans are written for one-year periods, each insurer is free to change the benefits offered, as long as the plan remains ACA-compliant, and consumers have a contractual right to enforce a particular benefits package only for the current year.[28] Under the ACA, plans must provide benefits that have an average cost for covered benefits, known as "actuarial value," equivalent to the "benchmark plan" within each of the essential benefits categories, but they do not have to replicate the specific benefits offered by the benchmark plan.[29] An example of the scope of plan discretion can be seen in the category of rehabilitative services and habilitative services and devices: since the two types of services (one focused on restoring skills and functions and the other on creating them) are listed in the same benefit category, unless prohibited by the state, plans can provide different mixes of the two services and can change the mix at any annual open enrollment period.[30] Furthermore, plans continue to be al-

25. *Id.* at 2 (defining large-group market as "generally companies with more than 100 employees").

26. *Id.*

27. Jennifer McCarthy, *The Complete Guide to Health Insurance*, THE SIMPLE DOLLAR, http://www.thesimpledollar.com/health-insurance-guide/ (last updated May 1, 2015) (referencing a comparison image that illustrates that 68% of Minnesota's health insurance plans do not cover labor and delivery, 60% do not cover mental health services, and 28% do not cover specialty drugs and only 45% of Massachusetts's plans cover hospitalization, hospital-based physician care and imaging); Cassidy, *supra* note 24, at 1 ("HHS estimates that 62% of plans in the individual market do not provide maternity coverage, 18% do not cover mental health services, and 9% do not cover the cost of prescription drugs").

28. *See Plan Year*, HEALTHCARE.GOV, https://www.healthcare.gov/glossary/plan-year/, (last visited November 16, 2015).

29. *See* Cassidy, *supra* note 24, at 2 ("The federal regulations do not require insurers to replicate the benefits in the benchmark plan; rather, the benefits offered must be 'actuarially equivalent' to those in the benchmark plan, meaning that the benefits are of approximately the same value in each of the ten required categories."); *see also* 42 U.S.C.A. § 18022(b)(4) (2015) (defining the required benefits package within each category and stating that the Secretary of HHS must not unduly weight benefits toward any category, discriminate on the basis of age, disability, or life expectancy, or fail to take into account the health care needs of diverse segments of the population).

30. *See* Sara J. Rosenbaum, *Habilitative Services Coverage for Children Under the Essential Benefit Provisions of the Affordable Care Act*, HEALTH POL'Y ISSUE BRIEFS, (May 2013), at 9 ("Since rehabilitative and habilitative services fall within the same benefit class, this presumably means that in selecting between the two habilitative services coverage options

lowed to decide whether or not a certain type of care is "medically necessary," and therefore will or will not be covered.[31] In short, as one commentator observed, "[t]here is no degree of certainty regarding the exact coverage a plaintiff will receive in the future or whether the law's requirements will stand the tests of time."[32]

B. The Problem of Out-of-Network Care and "Balance Billing"

In assuming that claimants will have access to a statutorily mandated set of benefits, the proposal also appears to suppose that claimants will be able to obtain all the medical care they need from providers who are within their plan networks.[33] However, one way that health plans control costs is by limiting the number of physicians, hospitals, laboratories, and other health care providers in their networks.[34] This is becoming a reality as reports surface stating that plans are currently creating narrow networks with smaller numbers of hospitals, physicians, and other providers.[35] As a result of the narrowing, this could mean that even if a claimant's providers are in the plan network at one point, they may no longer be in the plan in the future when the claimant needs their services.

If claimants cannot obtain the care they require within their health plan network, they will have to obtain care from out-of-plan providers or forgo the care if they cannot afford it.[36] Patients who obtain care from out-of-network providers often must pay more out-of-pocket than for care from network providers, since providers who are not in the plan network may be free to bill patients whatever they wish for the entire costs of care or for that portion of their charges that is not paid by the plan—this practice is known as

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under the rule (i.e., parity versus insurer-defined level of coverage), insurers may offer a lesser scope of habilitative coverage in favor of a richer rehabilitative benefit package.").

31. *See, e.g.*, David M. Studdert & Carole R. Gresenz, *Enrollee Appeals of Preservice Coverage Denials at Two Health Maintenance Organizations*, 289 JAMA 864, 864 (2003) (reporting that almost thirty-seven percent of appeals of denials of coverage by HMOs involved medical necessity disputes).

32. Cardeli, *supra* note 15, at 18–19.

33. *See generally* Congdon-Hohman & Matheson, *supra* note 1, at 153-60.

34. *See* Dianne McCarthy, *Narrowing Provider Choice: Any Willing Provider Laws After New York Blue Cross v. Travelers*, 23 AM. J.L. & MED. 97, 98 (1997).

35. *See* Reed Abelson, *More Insured, but the Choices Are Narrowing*, N.Y. TIMES, May 12, 2014, at A1 ("No matter what kind of health plan consumers choose, they will find fewer doctors and hospitals in their network—or pay much more for the privilege of going to any provider they want.").

36. Jim Burress, *Some Insured Patients Still Skip Care Because of High Costs*, KAISER HEALTH NEWS (June 10, 2015), http://khn.org/news/some-insured-patients-still-skip-care-because-of-high-costs// (according to Lydia Mitts, a senior policy analyst with the health care advocacy group, Families USA, "One in four adults who were fully insured for the whole year still reported they went without some needed medical care because they couldn't afford it.").

balance billing.[37] In fact, since the ACA only requires plans to pay for emergency services and certain types of preventive care that enrollees receive from out-of-network providers, claimants may have to pay the entire cost of out-of-network care themselves.[38] Moreover, more and more out-of-network physicians and hospitals are unwilling to accept any insurance payments whatsoever, requiring patients to pay the entire bill out-of-pocket and seek, on their own, whatever reimbursement they can get from their insurer.[39] The problem is worsened if patients are unaware that their care is being provided out-of-network until enormous bills start coming in, and even if made aware, may be unable to be treated by all in-network providers, especially in a complex hospital stay with multiple providers.[40]

The ACA requires HHS to impose network adequacy standards for plans that are sold on health exchanges.[41] The plans must "ensure a sufficient choice of providers," include "essential community providers" who serve low-income, medically-underserved populations,[42] and "maintain[] a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay . . . ."[43] As in the case of the essential benefits package, however, the ACA delegates the responsibility for establishing specific adequacy standards and making sure

37. JACK HOADLEY ET AL., BALANCE BILLING: HOW ARE STATES PROTECTING CONSUMERS FROM UNEXPECTED CHARGES?, CENTER ON HEALTH INS. REFORMS 3 (June 2015), *available at* http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2015/rwjf420966 (defining what a balance bill is in the article's introduction).

38. *See State Restriction Against Providers Balance Billing Managed Care Enrollees*, KAISER FAM. FOUND. (March 2013), http://kff.org/private-insurance/state-indicator/state-restriction-against-providers-balance-billing-managed-care-enrollees/ (last updated March 2013) ("The Affordable Care Act provides some protections for enrollees in need of emergency services, but does not prohibit balance billing by out-of-network providers.").

39. *See, e.g.*, Jen Christensen, *Obamacare: Fewer Options For Many*, CNN (Oct. 29, 2013, 6:41 PM), http://www.cnn.com/2013/10/29/health/obamacare-doctors-limited/ (according to CNN, for example, as of 2013, a hospital in Concord, New Hampshire, would not accept any insurance policies from any health plans from the state's marketplace, and similar limits are being imposed by medical centers at New York University, UCLA, and Emory); *see also* Sandra L. Decker, *In 2011 Nearly One-Third of Physicians Said They Would Not Accept New Medicaid Patients, But Rising Fees May Help*, 31 HEALTH AFF. 1673, 1679 (2012) (citing a 2011 study that found "Thirty-one percent of physicians were unwilling to accept any new Medicaid patients;; 17% would not accept new Medicare patients; and 18% of physicians would not accept new privately insured patients.").

40. *See* Tara S. Bernard, *Out of Network, Not by Choice, and Facing Huge Health Bills*, N.Y. TIMES, Oct. 19, 2013, at B1 (describing a patient's experience receiving care from out-of-network doctors working *in* an in-network hospital, not *for* the hospital, and being charged higher rates as a result).

41. 42 U.S.C.A. § 18031(c)(1) (2010).

42. *Id.*

43. Network Adequacy Standards, 45 C.F.R. § 156.230(a)(2) (2015).

that they are met to the states, which have adopted different types of standards, have limited enforcement powers,[44] and vary significantly in their efforts to wield the enforcement powers that they possess.[45] Therefore, malpractice and other tort claimants cannot assume that the networks provided by their health plans will be adequate to meet their future tort-related health care needs, or that the networks will remain adequate over time.

C. Uninsured and Uninsurable Americans

A further basic assumption underlying the proposal is that, thanks to the individual mandate and guaranteed issue provisions in the ACA, claimants will have health insurance.[46] But many people are exempt, practically or legally, from the mandate: "members of certain religious groups and Native American tribes; undocumented immigrants (who are not eligible for health insurance subsidies under the law); incarcerated individuals; people whose incomes are so low they don't have to file taxes . . . ; and people for whom health insurance is considered unaffordable (where insurance premiums after employer contributions and federal subsidies exceed 8% of family income)."[47] According to an estimate by Jonathan Gruber at MIT, forty percent of those who would lack insurance in the absence of the ACA are exempt under the law.[48]

Other individuals will not have insurance because they choose to pay the tax.[49] In 2015, the tax is $325 per person or 2 percent of yearly income; from 2016 on, the tax is $695 per person or 2.5 percent of yearly income.[50] Even

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44. *See, e.g.*, Paul Shukovsky, *Washington Insurance Commissioner Adopts New Provider Network Rules*, 23 HEALTH L. REP. 660, 660 (2014) (quoting a spokesperson for Washington State Insurance Commissioner as stating "we don't believe we have the authority to force an insurance company to contract with a provider").

45. *See* Sally McCarthy & Max Ferris, *ACA Implications for State Network Adequacy Standards*, ST. HEALTH REFORM ASSISTANCE NETWORK 12-16 (Aug. 2013), http://www.rwjf.org/content/dam/farm/reports/issuebriefsbriefs/2013/rwjf407486rwjf407486 (summarizing the approach taken by various states to different network adequacy standards).

46. Congdon-Hohman & Matheson, *supra* note 1, at 156 (stating that due to the individual mandate and the subsidies under the ACA, one should expect most persons to have to have insurance).

47. Cynthia Cox & Larry Levitt, *The Individual Mandate: How Sweeping?*, KAISER FAM. FOUND. (March 21, 2012), http://kff.org/health-reform/perspective/the-individual-mandate-how-sweeping/.

48. *Id.*

49. *See* Health Care Coverage and Federal Income Taxes, U.S. DEP'T OF HEALTH AND HUM. SERVS, http://www.hhs.gov/healthcare/facts-and-features/fact-sheets/health-coverage-and-federal-income-taxes/index.html (last visited on Feb 18, 2015) (stating that "A much smaller fraction of taxpayers, an estimated 2 to 4 percent, will pay a fee because they made a choice to not obtain coverage they could have afforded and are not eligible for an exemption.").

50. *See The Fee You Pay If You Don't Have Health Coverage*, HEALTHCARE.GOV, https://www.healthcare.gov/what-if-i-dont-have-health-coverage/ (last visited May 14, 2014).

after 2016, the tax is much cheaper than the cost for the least expensive bronze health insurance plan; in the state with the lowest premiums for health plans on its federal exchange in 2013, Minnesota, the premium for the least expensive bronze plan was approximately $1,320 a year.[51] Moreover, people who are not owed a federal income tax refund may decide to neither purchase insurance nor pay the tax, since the only recourse for the government if someone does not pay the individual mandate is to deduct it from their tax refund.[52]

One reason that proponents assume that all claimants will have health insurance is that those who do not have insurance when they are injured will purchase it because they have a duty to mitigate their damages.[53] If claimants failed to mitigate their damages by purchasing insurance, the reasoning seems to go, they would not be entitled to compensation from tortfeasors for the costs of future care that insurance would have covered.[54] This view is fundamentally incorrect because it confuses loss-mitigation with loss-transfer. According to the Restatement (Second) of Torts, "one injured by the tort of another is not entitled to recover damages for *any harm that he could have avoided* by the use of reasonable effort or expenditure after the commission of the tort."[55] The purchase of health insurance does not "avoid harm"; the MOOPL proposal merely transfers the losses caused by the harm from the tortfeasor to the claimant's health insurer. Claimants therefore are not required to purchase health insurance in order to mitigate their damages.

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51. *See Commerce Department Releases Rate Analysis – Minnesota Retains the Number One Rates in the Country*, MINN. DEP'T OF COM. (Sept. 27, 2013), http://mn.gov/commerce/insurance/media/newsdetail.jsp?id=209-86346.

52. *See* ANNIE L. MACH, CONG. RESEARCH SERV., R41331, INDIVIDUAL MANDATE UNDER THE ACA 3 (2015).

53. *See* Joseph A. H. McGovern & John D. Morio, *Affordable Care Act Has Potential to Limit a Defendant's Exposure for Future Medical Costs in New York Personal Injury Litigation*, MARTINDALE.COM (Jan. 14, 2014), http://www.martindale.com/personal-injury-law/article_Wilson-Elser-Moskowitz-Edelman-Dicker_2060248.htm (applying the duty-to-mitigate-damages rule, "because insurance is now available to everyone, regardless of any preexisting medical conditions, sound public policy would require an injured plaintiff to purchase insurance to pay for his future medical care"); *see also* Congdon-Hohman & Matheson, *supra* note 1, at 156 ("If the individual was uninsured prior to the accident, the additional out-of-pocket costs for medical care for any victim of an accident is a maximum of $6,250 plus the cost of a typical health insurance policy in the individual market less any government subsidies for the policy, the government imposed fine for not purchasing health insurance, and the medical care costs the individual would have expected absent the accident."). Prior to the ACA, the argument goes, uninsured claimants would not have been able to purchase health insurance to cover the medical costs associated with their malpractice injury because the injury would have been considered a pre-existing condition, but they can buy insurance now because of the guaranteed-issue requirements of the law.

54. *See* McGovern & Morio, *supra* note 54.

55. RESTATEMENT (SECOND) OF TORTS §918(1) (1979) (emphasis added).

D. The Unknowable Future of Health Insurance

A final assumption made by supporters of the proposal is that the law will remain in effect over the lifetime of the person seeking compensation for future medical expenses.[56] The authors themselves admit, however, that the ACA is still open to repeal by the federal government.[57] As stated by Congdon-Hohman and Matheson, "[i]n fact, the Republican Party has made the repeal of the ACA a primary plank of their election campaigns in both 2010 and 2012 (Sack 2010 and Cooper 2012)."[58]

Even if the ACA is not repealed in whole or in part, the effective dates of the requirements that are key to the proposal may be postponed, or their enforcement may be delayed.[59] In August 2013, for example, the maximum out-of-pocket cost limit was delayed for some insurers until 2015.[60] Similar delays have been announced for restrictions on retaining preexisting health plans and for the so-called employer mandate.[61] Furthermore, HHS has made it clear that it does not view enforcement as a high priority, as evidenced from the following statement on its website:

Our approach to implementation is and will continue to be marked by an emphasis on assisting (rather than imposing penalties on) plans, issuers and others that are working diligently and in good faith to understand and come into compliance with the new law. This approach includes, where appropriate, transition provisions, grace periods, safe harbors, and other policies to ensure that the new provisions take effect smoothly, minimizing any disruption to existing plans and practices.[62]

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56. *See* Congdon-Hohman & Matheson, *supra* note 1, at 159.

57. *See* Cardeli, *supra* note 15, at 19 ("As long as the law is subject to repeal or modification, there is no reasonable certainty that an individual will be subject to the ACA's mandate for the rest of his or her life.").

58. Congdon-Hohman & Matheson, *supra* note 1, at 159 ("Though Republican candidates vary on which specific parts of the law they would vote to repeal, the individual mandate is the clearest target. Without the mandate, the guaranteed issue requirement of the ACA which is what would allow plaintiffs to be able to purchase affordable insurance, would not be economically feasible for health insurers."). Some think that the prospects for repealing the ACA are looking brighter with predictions that the Republicans may win control of both houses of Congress in 2014.

59. *See* Robert Pear, *A Limit on Consumer Costs Is Delayed in Health Care Law*, N.Y. TIMES, Aug. 12, 2013, http://www.nytimes.com/2013/08/13/us/a-limit-on-consumer-costs-is-delayed-in-health-care-law.html?pagewanted=all (giving examples of various key components to ACA that have been delayed thus far).

60. *See id.*

61. *See* Nicholas Bagley, *The Legality of Delaying Key Elements of the ACA*, 370 N. ENG. J. MED. 1967, 1967-68 (2014); *see also* Timothy Stoltzfus Jost & Simon Lazarus, *Obama's ACA Delays — Breaking the Law or Making It Work?*, 370 N. ENG. J. MED. 1970, 1970 (2014).

62. *The Center for Consumer Information & Insurance Oversight, Affordable Care Act Implementation FAQs-Set 1*, CTRS. FOR MEDICARE & MEDICAID SERVS., http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs.html (last visited May 14, 2014).

Finally, some individuals may desire health insurance but have difficulty purchasing it.[63] The challenges they face could extend far beyond the well-publicized problems with online registration, such as long online waits, inability to open accounts, duplicate enrollments and other data errors, and missing information on the government website.[64] Although the ACA contains mechanisms that supposedly remove the incentive for health insurers to favor individuals who are healthier over sicker enrollees and therefore would be the most profitable,[65] insurers still have reasons to be selective in whom they enroll. For example, actuarial consultants have determined that the risk adjustment method used by the ACA pays health plans more for patients with certain conditions than patients with other conditions.[66] Health plans therefore can be expected to discourage certain types of patients from enrolling using cherry-picking techniques similar to those that they employed prior to the enactment of the ACA, such as how they structure their benefits packages and market their policies.[67] Nothing in the ACA forbids this insurer behavior.[68]

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63. *See Key Facts about the Uninsured Population*, KAISER FAM. FOUND. (Oct. 5, 2015), http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/ (stating that "many uninsured people cite the high cost of insurance as the main reason they lack coverage").

64. *See* Robert Pear et al., *From the Start, Signs of Trouble at Health Portal*, N.Y. TIMES, Oct. 12, 2013, http://www.nytimes.com/2013/10/13/us/politics/from-the-start-signs-of-trouble-at-health-portal.html (reporting on the problems with enrollment on the health insurance marketplace when the website first opened); *see also* Amy Goldstein, *HealthCare.gov Can't Handle Appeals of Enrollment Errors*, WASH. POST, Feb. 2, 2014, https://www.washingtonpost.com/national/health-science/healthcaregov-cant-handle-appeals-of-enrollment-errors/2014/02/02/bbf5280c-89e2-11e3-916e-e01534b1e132_story.html (reporting some of the issuing impacting individuals who tried to enroll in health plans through the health insurance marketplace during the first few months).

65. *See Explaining Health Care Reform: Risk Adjustment, Reinsurance, and Risk Corridors*, KAISER FAMILY FOUND. (Jan. 2014), http://kff.org/health-reform/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors/ (discussing in length the three risk programs (the "3R's"), which includes: risk adjustment, reinsurance, and risk corridors).

66. *See* Jason Siegel & Jason Petroske, *When Adverse Selection Isn't: Which Members Are Likely to Be Profitable (or Not) in Markets Regulated By the ACA*, MILLIMAN 2-3 (Dec. 2013) (The ACA risk-adjustment method, which is based on the method that CMS uses to risk-adjust premiums for Medicare Advantage Plans, only adjusts for certain conditions—those that are listed in CMS' Hierarchical Condition Categories (HCCs). Many conditions are not listed, and therefore, do not result in increased payments to the health plan after adjustments for risk. Risk-adjustment works by requiring all plans pay into a fund and making proportionately larger payouts from the fund to plans that enroll less healthy individuals. Plans that enroll more persons with HCC conditions will receive more from the fund than plans that enroll fewer persons with HCC conditions).

67. *Adverse Selection Issues and Health Insurance Exchanges Under the Affordable Care Act*, NAT'L ASSOC. OF INS. COMM'N. 3 (2011), http://www.naic.org/store/free/ASE-OP.pdf.

68. *See id.* at 3-5 (listing the key ACA provisions that address adverse selection).

III. THE PROPOSAL IS UNWORKABLE

The proposal not only makes unwarranted assumptions about the ACA but it is unworkable in practice. Proponents of the compensation limit acknowledge that claimants would be entitled not only to the MOOPL, but to any out-of-pocket expenses for care that their insurance did not pay for.[69] Yet there are likely to be many uncovered services,[70] and as discussed in the previous section, it will be impossible to predict what care claimants' health plans will cover in the future.

A. Unpredictable Out-of-Pocket Expenses for Out-of-Network Care

A major factor that confounds an attempt to calculate claimants' out-of-pocket costs for future medical care is that the services that claimants will need may not be available from a provider within their health plan network or from one who accepts payments from the claimant's plan.[71] Claimants may end up paying substantial sums out-of-pocket to obtain the care they need, and since the MOOPL only applies to the costs of care obtained within their health plan network,[72] there is no limit on how much claimants may have to pay to obtain care out of their network. In addition, the MOOPL does not include amounts that claimants in certain large group or self-insured plans who obtain out-of-network care may be required to pay out-of-pocket as a result of the practice known as "reference pricing," which makes plan members pay the difference between the price set by the plan for the service in question and what the out-of-plan provider charges.[73] Under the MOOPL

69. *See* Congdon-Hohman & Matheson, *supra* note 1, at 157 ("The life care planner also needs to specifically address which health care and living expenses would normally be covered by the minimum insurance requirements mandated by the ACA and which health expenditures would result in out-of-pocket costs to the plaintiff necessitating their inclusion in a damage award.").

70. *See* Yagerman & Bookman, *supra* note 20 ("Expenses such as long term care, nursing care, and homecare, which are known in the insurance industry as 'permanent confinement issues,' are hardly ever covered by health insurance. Those expenses are often extremely pricey, and are paid either out-of-pocket, or by short and long term disability insurance, if the individual has obtained such insurance.").

71. *See* Studdert & Gresenze, *supra* note 32, at 866 (one in five appeals of plan denials of coverage involved access to out-of-network services).

72. *See* HEALTHCARE.GOV, *supra* note 2 ("This limit does not have to count premiums, balance billing amounts for non-network providers and other out-of-network cost-sharing, or spending for non-essential health benefits.").

73. *See* U.S. Dep't of Labor, *FAQs About Affordable Care Implementation (Part XIX)*, U.S. DEP'T OF LABOR (May 2, 2014), http://www.dol.gov/ebsa/faqs/faq-aca19.html ("Until guidance is issued and effective, with respect to a large group market plan or self-insured group health plan that utilizes a reference-based pricing program, the Departments will not consider a plan or issuer as failing to comply with the out-of-pocket maximum requirements of PHS Act section 2707(b) because it treats providers that accept the reference amount as the only in-network providers, provided the plan uses a reasonable method to ensure that it provides adequate access to quality providers.").

proposal, claimants in theory are entitled to recover all of these out-of-pocket costs, but as noted in the previous section, it is impossible to predict what they will be. There is no way to determine in advance what services will be available within which plan networks, or how much claimants will have to pay out-of-pocket to obtain care outside the network.

B. Unpredictable Coverage for Future Care

Another reason the proposal is unworkable is that, as noted earlier, it is impossible to predict what health care claimants' plans will cover. During the time they will require care for tort-related injuries, claimants' circumstances are likely to change, resulting in changes in their health coverage.[74] People can be expected to purchase different amounts of coverage, for example, depending on whether they are young and healthy, marry, divorce, become pregnant, have children, age, or become ill or develop chronic medical conditions.[75] In addition, claimants may switch plans when they or a partner changes jobs or upon the death of a partner under whose plan they were insured.[76] Each plan will cover different services, and plans can alter what they cover over time.[77] Moreover, even if the care that a claimant needs is a mandatory benefit in one state, the claimant may move to a different state with different coverage requirements.[78] Since there is no way to know what coverage claimants will have under different plans, this makes predicting their out-of-pocket costs even more difficult.

Regardless of state benefit requirements, individual plans have broad discretion to limit what they cover: for example, limiting the annual number of patient visits to certain types of providers.[79] In addition, as noted earlier, the

74. Peter J. Cunningham & Linda Kohn, *Health Plan Switching: Choice or Circumstance?*, 19 HEALTH AFF. 158, 159 (2000) (discussing the most common reasons people change their health coverage).

75. *Id.* at 159-60.

76. *Id.* at 160.

77. *See What Marketplace Plans Cover,* HEALTHCARE.GOV, https://www.healthcare.gov/coverage/what-marketplace-plans-cover/ (last visited Nov. 10, 2015) (explaining that even within the same state, there can be differences in the health plans' covered services and procedures).

78. *Id.* (explaining that "some states require insurers to cover additional services and procedures.").

79. *See Frequently Asked Questions on Essential Health Benefits Bulletin* CTRS. FOR MEDICARE & MEDICAID SERVS. (Dec. 16, 2011), https://www.cms.gov/cciio/resources/files/downloads/ehb-faq-508.pdf ("Under the approach described in the Bulletin, a plan could substitute coverage of services within each of the ten statutory categories, so long as substitutions were actuarially equivalent, based on standards set forth in CHIP regulations at 42 CFR 457.431, and provided that substitutions would not violate other statutory provisions. For example, a plan could offer coverage consistent with a benchmark plan offering up to 20 covered physical therapy visits and 10 covered occupational therapy visits by replacing them with up to 10 covered physical therapy visits and up to 20 covered occupational therapy visits, assuming actuarial equivalence and the other criteria are met. Q: Can scope and duration limits be

fact that a plan covers a certain service does not guarantee that it will pay for it, since benefits administrators have broad discretion to determine whether care is "medically necessary" in specific instances.[80] Finally, plans may change the way they interpret and apply their coverage policies.[81] In short, there is no way to predict whether claimants will be insured for the future care that they will require.

These considerations recently led a California court in an unpublished opinion to reject a hospital defendants' argument that compensation for future medical expenses should be reduced because the malpractice claimant was currently insured:

> 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. To show the amount of future insurance coverage that is reasonably certain, the evidence would have to: (1) link particular coverage and coverage amounts to particular items of care and treatment in the life care plan, (2) present a reasonable basis on which to believe that this particular plaintiff is reasonably certain to have that coverage, and (3) provide a basis on which to calculate with reasonable certainty the time period such coverage will exist. The Hospital made no such foundational showing in the trial court, and on appeal appears to assume that even the most nonspecific evidence of future insurance, such as its availability through governmental programs, is admissible. Such evidence, standing alone, is irrelevant to prove reasonably certain insurance coverage as a potential offset against future damages, 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.[82]

Proponents of the MOOPL approach, such as Mark Yagerman and Max Bookman, in fact have conceded the unpredictability of future insurance coverage:

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included in the EHB [Essential Health Benefits]? A: Yes."); *see also* Yagerman & Bookman, *supra* note 20 ("[O]ther expenses, such as continuous physical therapy and occupational therapy, are often capped by most health insurance plans at a certain number of visits. These are known as 'frequency issues' by insurers. Life care plans often project extensive numbers of such visits, which often go beyond the frequency cap of even the highest quality health insurance policies. Therefore, to the extent that a plaintiff's health insurance contains a frequency cap, those non-covered expenses projected by the life plan will remain out-of-pocket.").

80. *See* Michael Bihari, *Medical Necessity*, ABOUT HEALTH, http://healthinsurance.about.com/od/healthinsurancetermsm/g/medical_necessity_definition.htm (last updated Dec. 15, 2014).

81. *See* McCarthy, *supra* note 27.

82. Leung v. Verdugo Hills Hosp., No. B204908, 2013 WL 221654, at *12 (Cal. App. 2d Dist. Jan. 22, 2013).

> A potent argument against allowing direct presentation of future health insurance coverage to the jury is that although the ACA's individual mandate will result in near-universal coverage, it does not account for the innumerable variations in coverage levels that are available. As an individual goes through life, he or she will likely go through several different insurance policies, all with various levels of coverage. The argument goes that it is impossible to predict what level of coverage an individual will have at any given point in the future, and that the ACA merely assures that the individual will have some coverage. Therefore, it is claimed that life care plans should remain free from attack in front of the jury on account of failure to factor in future health insurance.[83]

Yagerman and Bookman's only rejoinder is that health plans will have to meet the benefits requirements of the ACA.[84] As discussed in the previous section, however, the ACA's minimum requirements are insufficient to predict what future services a claimant's plan will cover.

C. Byzantine Billing Practices

Another consideration that will prevent calculating the amounts that claimants are due from tortfeasors for their non-insured out-of-pocket future care is the difference between the "list price" or what providers bill to "self-pay" patients, and what in fact they are paid by insurers.[85] Insurers negotiate varying discounts, and they typically depend on the market power of the provider versus that of the insurer.[86] States such as Texas, Missouri, California, Minnesota, Pennsylvania, Kansas, and Ohio are, either through statute or state court decisions, increasingly attempting to limit awards for past medical expenses—those incurred between the injury and the trial—to the amounts actually paid.[87] In 2011, the Texas Supreme Court went so far as to specifi-

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83. Yagerman & Bookman, *supra* note 20.

84. *Id.* ("Under the ACA, all plans will be required to meet a certain minimum coverage standard. Therefore, while it is true that there will be future variations above and beyond that minimum standard, it is also true that notwithstanding any such variation, all plans policies will maintain a certain required baseline. As such, at the very least, defendants will argue that the jury should be permitted to consider an attack on a life care plan that fails to take into account the fact that no matter what health care coverage a plaintiff may obtain in the future, any such coverage must meet the ACA's minimum requirements.").

85. *See Hospitals Generally Charge Self-pay Patients Top Price for Care, but Some Providers Now Offer Deep Discounts for Patients Who Pay with Cash*, DARK DAILY (July 26, 2013), http://www.darkdaily.com/hospitals-generally-charge-self-pay-patients-top-price-for-care-but-some-providers-now-offer-deep-discounts-for-patients-who-pay-with-cash-726#axzz3rfo9wduQ.

86. *See* Alan T. Sorensen, *Insurer-Hospital Bargaining: Negotiated Discounts in Post-Regulation Connecticut*, 51 J. INDUS. ECON. 469, 471-72 (2003).

87. *See, e.g.*, 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*

cally suggest that the same approach should, in addition to past medical expenses, also be applied to future medical expenses.[88]

The difference between the list price and what insurers actually pay to providers can be substantial.[89] One study found that insurers in 2004 paid hospitals only approximately 38 percent of their list price.[90] Furthermore, determining what insurers actually pay is extremely convoluted.[91] Health care economist Uwe Reinhardt called the process "chaos behind a veil of secrecy," noting that the "actual dollar payments have traditionally been kept as strict, proprietary trade secrets by both the hospitals and the insurers."[92] Other authors explain that:

> When it comes time to bill and pay, the parties execute a complex kabuki dance where the provider submits a bill for the full list price of the services performed, whereupon the insurer applies the discount to arrive at the pre-negotiated rate, and then pays to the provider a percentage of that rate specified by the health plan to which the patient is subscribed. This leaves the patient to pay the remainder as a 'coinsurance' payment.[93]

Now imagine the difficulty in trying to calculate the difference between list price and amounts paid by an insurer for *future* medical expenses. As one pair of authors observe,

> In addition to predicting the probable future treatment that a plaintiff might require, expert testimony may be needed to properly estimate, not just what the list price of that treatment is, but what amount actually would be paid, based on the historic contract terms between the plaintiff's insurer and the

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on Damages in Personal Injury Lawsuits, 80 DEF. COUNS. J. 239, 248 (2013); Robinson v. Bates, 857 N.E.2d 1195, 1200 (Ohio 2006) (holding that the defendant may introduce evidence of amounts "written-off" of medical bills since those amounts are *never* paid by any collateral source) (emphasis in original); *contra* Kenney v. Liston, 760 S.E.2d 434, 446 (W. Va. 2014) (holding that ". . .the collateral source rule permits an injured person to recover *all* of his or her reasonable medical costs that were necessarily required by the injury. Where a person's health care provider agrees to reduce, discount or write off a portion of the person's medical bill, the collateral source rule permits the person to recover the entire reasonable value of the medical services necessarily required by the injury. The tortfeasor is not entitled to receive the benefit of the reduced, discounted or written-off amount.") (emphasis in original).

88. *See, e.g.*, Haygood v. De Escabedo, 356 S.W.3d 390, 396-97 (Tex. 2011); Geslison & Jacobs, *supra* note 87 at 249 (noting that "[s]everal times in the *Haygood* opinion, the court used language like 'have been *or will be* paid,' 'have been *or must be paid*,' and 'paid or *to be paid*' to interpret Section 41.0105's 'actually paid and incurred' language.") (emphasis in original).

89. *See* Uwe E. Reinhardt, *The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy*, 25 HEALTH AFF. 57, 57 (2006).

90. *See id.*

91. *See id.* (quoting a leading expert on how hospitals price services, who stated "there is no method to this madness").

92. *Id.* at 62.

93. Geslison & Jacobs, *supra* note 87, at 243.

> healthcare provider. Additional unknowns must also be addressed, such as whether the plaintiff is expected to maintain his current health insurance, or what the future costs of the needed procedures are anticipated to be.[94]

D. Secondary-Payer Status of Public Insurance Programs

A further complication to the task of calculating claimants' future out-of-pocket expenses is that Medicare and Medicaid are entitled to recover their future medical payments from claimants' tort recoveries.[95] Medicare and Medicaid by statute are secondary payers.[96] Secondary payers are only required to pay for care that is not paid for by other sources.[97] Furthermore, secondary payers have a statutory right to be reimbursed by individuals they covered who also received funds from other sources to pay for future care.[98] In 2011, the Centers for Medicare and Medicaid Services (CMS) stated that Medicare intended to assert its right to reimbursement for future medical expenses in liability cases.[99] In 2012, CMS issued an Advanced Notice of Proposed Rulemaking (ANPRM) seeking input on how Medicare should ensure that it received the payments that it was due.[100] Since then, the Office of Management and Budget has withdrawn the proposed regulation.[101] However,

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94. *Id.*

95. *See* Medicare Secondary Payer and "Future Medicals" 77 Fed. Reg. 35917, 35919 (June 15, 2012) (to be codified at 42 C.F.R. pts. 405, 411); Salvatore G. Rotella, Jr., *Solving the Medicaid Secondary Payment Puzzle*, COMPLIANCE TODAY 32, 32-33 (August 2012), http://www.hcca-info.org/Portals/0/PDFs/Resources/Compliance_Today/0812/CT_0812_Rotella.pdf

96. *See Medicare Secondary Payer*, CTRS. FOR MEDICARE & MEDICAID SERVS. https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Medicare-Secondary-Payer/Medicare-Secondary-Payer.html (last updated January 30, 2014).

97. *See Medicare Secondary Payer for Providers, Physicians, Other Suppliers, and Billing Staff*, DEP'T OF HEALTH & HUMAN SERVS. 1 (Feb. 2015), https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MSP_Fact_Sheet.pdf.

98. *See* Fagel, *supra* note 14, at 3 (stating a claimant on Medicare, for example, may be required to establish a "Medicare Set-Aside Trust" from which Medicare can seek reimbursement for its future expenditures on behalf of the claimant. In the case of a Medicaid claimant, compensation for future medical expenses from a settlement or jury award is placed in a Special Needs Trust so that the claimant can continue to qualify for Medicaid despite the recovery, and if funds remain in the trust at time of the claimant's death, Medicaid is entitled to obtain reimbursement (via a lien) for medical expenses that it paid.); *see also* John J. Campbell, *Preserving Public Benefits in Physical Injury Settlements: Special-Needs Trusts and Beyond*, 2 NAELA J. 367, 374 (2006).

99. *See* 42 U.S.C. § 1395y(b)(2) (2011) (Medicare law only provides for reimbursement for future medical expenses specifically associated with workers compensation claims).

100. *See* Medicare Secondary-Payer and "Future Medicals," 77 Fed. Reg. 35917, 35917 (June 15, 2012) (to be codified at 42 C.F.R. pts. 405, 411).

101. *See* Sara Hansard, *CMS Withdraws Medicare Secondary Payer Proposed Rule*, MEDICARE REP. (Oct. 22, 2014), http://www.bna.com/cms-withdraws-medicare-n17179906172/.

the precarious fiscal state of public entitlement programs continue to pressure the government to try to recoup whatever it can from tort settlements and recoveries, potentially regardless of the amounts in settlements or awards allocated for future expenses.[102] Moreover, claimants who need significant future care will be disproportionately affected; their tort injuries will be so serious that they are likely to have lost private insurance and, therefore, be dependent on public programs such as Medicare for their future care.[103]

Tortfeasors should not be able to offset against the compensation they give claimants with the amount that claimants must pay to reimburse public programs such as Medicare.[104] Such an offset is precluded by the common law collateral source rule and by the language of statutory collateral source rules.[105] But providing claimants with the necessary compensation would require accurately predicting what medical care those public programs will cover in the future, how much they will pay, and how much they will seek to be reimbursed, which is impossible. The result is that claimants are likely to recover far less under the MOOPL proposal than they would need to enable them both to reimburse Medicare and pay their out-of-pocket expenses for future care.[106]

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102. *See* Hook Law Ctr., *Medicare Set-Aside Arrangements in Third Party Liability Cases*, HOOKLAWCENTER.COM (2012), http://hooklawcenter.com/pdf/pubs/personal-injury-consulting/hlc-medicare-set-aside-arrangements-in-third-party-liability-cases.pdf (citing "The Medicare Secondary Payor Act also applies to third party liability situations in which the settlement or award includes payment for *future* medical expenses. Medicare is not bound by the release with respect to an allocation for future medical expenses.").

103. *See* Fagel, *supra* note 14, at 4 (stating that "in most cases involving significant future medical costs, it is . . . likely that the plaintiff would have lost their private health insurance and gone on [Medicaid] or Medicare long before the resolution of their claim.").

104. *See* McGovern & Morio, *supra* note 54, at 1 (The authors state that "[i]n states that do not enforce the common law collateral source rule, which precludes the reduction of a personal injury award by the amount of compensation a plaintiff receives from a source other than the tortfeasor, such awards should be reduced to the cost of obtaining necessary insurance to pay for the [future] care, *so long as the insurer does not maintain a legal right of subrogation*.") (emphasis in original).

105. *See* Bryce Benjet, *A Review of State Law Modifying the Collateral Source Rule: Seeking Greater Fairness in Economic Damages Awards*, 76 DEF. COUNS. J. 210, 211 (2009) (the author states, "The majority of the statutes [modifying the collateral source rule] prohibit the recovery of damages that have been paid by a collateral source. However, these statutes generally exclude collateral payments for which there are subrogation rights, to ensure that a plaintiff is not undercompensated.").

106. *See* Rebecca Levenson, *Allocating the Costs of Harm To Whom They Are Due: Modifying the Collateral Source Rule After Health Care Reform*, 160 U. PA. L. REV. 921, 930 n.41 (2012) ("In some cases, subrogation can result in reductions from noneconomic as well as economic damages because, after the legal fees and costs of their suit, the claimant's economic damages may not satisfy the subrogation agreement."); *see* Gregory Pitts, Comment, *E.R.I.S.A. Subrogation as Interpreted Within the Seventh Circuit—A Roadmap for Managing First Dollar Recovery*, 35 J. MARSHALL L. REV. 765, 769-70 (2002); *see also* Hook Law Ctr., *supra* note 102 at 2 ("The Medicare Secondary Payor Act also applies to third party liability situa-

E. Unrealistic Role for Life Care Planners

A final point illustrating the unworkable nature of the MOOPL proposal is the unrealistic expectation that life care planners can predict claimants' non-insured out-of-pocket expenses for future medical care.[107] Life care planners are professionals who determine the future care that injured or ill persons require and how much those services will cost.[108] Their objective is "to develop accurate and timely cost information and specificity of service allocations that can be easily utilized by the client and interested parties."[109] To do this, they employ "sources that are reasonably available to the client."[110] Life care planners are not experts on the ACA, health insurance, or coverage for future services.[111] They do not have access to adequate information about individual plan coverage policies and practice, network breadth and depth, billing practices, and subrogation behavior that is available, much less to the information that would be necessary for them to produce a plausible estimate of how much compensation claimants would actually require. Yet that is what the authors unrealistically expect of them:

> [The proposal] suggests a new task for life care planners. As noted previously, under the old health insurance laws the task of the life care planner was to identify any medical and living expenses that are necessary for the victim but would not otherwise have been required in the absence of the accident. . .the life care planner also needs to specifically address which health care and living expenses would normally be covered by the minimum insurance requirements mandated by the ACA and which health expenditures.[112]

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tions in which the settlement or award includes payment for *future* medical expenses. Medicare is not bound by the release with respect to an allocation for future medical expenses.") (The report explains that, "if there is a sizable MSA [Medicare set-Aside Arrangement], the balance is usually funded with a structured settlement. The structured settlement is usually payable in annual installments. The remainder of the Set-Aside is divided by the remainder of the claimant's life expectancy and the structured pays annual deposits into the MSA based on a 'anniversary date' which cannot be more than one year after the settlement date. If the funds paid into the MSA from the structured settlement are exhausted before the next 'anniversary date' Medicare pays until such time as the next structured settlement payment is received.") *Id.* at 5.

107. *See* Congdon-Hohman & Matheson, *supra* note 1, at 157.

108. *See International Academy of Life Care Planners Standards of Practice*, INT'L ASSOC. OF REHAB PROF'LS (2009), http://www.rehabpro.org/sections/ialcp/focus/standards/ialcpSOP_pdf ("The Life Care Plan is a dynamic document based upon published standards of practice, comprehensive assessment, data analysis and research, which provides an organized, concise plan for current and future needs with associated cost for individuals who have experienced catastrophic injury or have chronic health care needs.").

109. *Id.*

110. *Id.*

111. *See id.*

112. Congdon-Hohman & Matheson, *supra* note 1, at 157.

In short, it is impossible to predict what health care services will be mandated in the future under the ACA, let alone what services that will not be covered under the act, whether insurers will cover those services, or what claimants will have to pay whether or not those services are covered. Neither life care planners nor anyone else will be able to make these predictions with any degree of accuracy. As a consequence, there is no way to award claimants their out-of-pocket expenses for future medical care as the MOOPL proposal contemplates.

IV. ADOPTING THE PROPOSAL WOULD BE BAD PUBLIC POLICY

The final reason that the MOOPL proposal should be rejected is that it is not in the public interest. It would abolish the collateral source rule, reducing the deterrent effect of the tort system and thereby reducing the quality of health care.[113] It would shift costs from tortfeasors to taxpayers, and impose further significant losses on innocent persons who sustained tort injuries. Finally, the proposal would give tort system critics what they were unable to obtain through the democratic process.

A. By Reducing the Deterrent Effect of the Tort System, the Proposal Would Reduce the Quality of Health Care

A noteworthy omission in the paper proposing the MOOPL limit is the absence of any discussion of deterrence such as the impact the proposal would have on incentives to provide proper medical care.[114] The omission is noteworthy because the authors are both economists, and economists usually contend that the primary purpose of the tort system is to minimize the cost of accidents by requiring tortfeasors to "internalize" their injury-creating costs of doing business and thereby incentivizing them to reduce injuries.[115] For economists, the tort system's internal imperative to make accident victims whole is interesting only because and to the extent that acting on the imperative creates optimal incentives for primary conduct. Otherwise, compensation payments are merely cash transfers with few effects on aggregate wealth.

The authors of the paper stand the conventional economic approach on its head. They focus solely on the "make whole" objective and say nothing about the effect their proposal would have on primary actors' incentives.[116]

113. *See generally id.* at 158-59; *see also infra* section IV.B. at 31 (even in states that have legislatively modified the common law collateral source rule, defendants typically are not entitled to an offset for insurance payments for future medical expenses).

114. *See* Congdon-Hohman & Matheson, *supra* note 1, at 157.

115. *See, e.g.*, Louis Kaplow & Steven Shavell, *Fairness Versus Wellness*, 114 HARV. L. REV. 961, 1021-27 (2001); Richard A. Posner, *The Economic Approach to Law*, 53 TEX. L. REV. 757, 764 (1975); Guido Calabresi & A. Douglas Melamed, *Property Rules, Liability Rules, and Inalienability: One View of the Cathedral*, 85 HARV. L. REV. 1089, 1107 (1972).

116. *See generally* Congdon-Hohman & Matheson, *supra* note 1, at 153-60.

Under their proposal, a major component of the costs of injuries, namely future medical care, would shift from an internal cost for the tortfeasor to an external cost borne by health insurance plans and taxpayers, thus incentivizing carelessness rather than reasonable behavior.[117]

By shifting the costs of malpractice and other tortious injuries away from tortfeasors, the proposal would effectively abolish the collateral source rule, which precludes the introduction of evidence of collateral payment for tortious injuries in order to maximize the deterrence of negligent behavior.[118] If the MOOPL proposal were in place, the incentives to avoid negligent injuries would be deficient. Healthcare costs constitute a large and growing portion of many tort victims' damages, and the proposal would shift responsibility for those costs above the current MOOPL from tortfeasors (and their third party liability insurers) to victims (and their first-party healthcare insurers). In effect, the premiums policyholders pay for first-party coverage would subsidize negligent actors by freeing them from financial responsibility for a substantial fraction of the costs attributable to their behaviors. The predictable results are that negligent behaviors will occur more often and will have consequences that are more severe.

Reducing the deterrent effect of the tort system is unacceptable in view of the amount of harm caused by negligence. According to a recent estimate, preventable harms to patients alone cause more than 400,000 premature deaths per year, making medical errors the cause of nearly one-sixth of all deaths in the U.S. per year.[119] The total number of treatment-related injuries exceeds the number of fatalities by far, as more than 6 million patients are thought to be injured iatrogenically each year.[120] The social cost of adverse medical events has been estimated to be between $393 and $958 billion per year.[121]

It may be tempting to respond to this point by observing that the proposal resembles no-fault insurance, which also shifts financial responsibility for losses to first-party insurers, and that the adoption of no-fault insurance did not cause drivers to operate motor vehicles more recklessly than before.[122] The observation has limited force, however, because drivers have other reasons to be careful. Accidents destroy negligent drivers' property, endanger

117. *Id.*

118. *See infra* section IV.B. at 31 (even in states that have legislatively modified the common law collateral source rule, defendants typically are not entitled to an offset for insurance payments for future medical expenses).

119. John T. James, *A New, Evidence-Based Estimate of Patient Harms Associated with Hospital Care*, 9 J. PATIENT SAFETY 122, 127 (2013).

120. John C. Goodman et al., *The Social Cost Of Adverse Medical Events, And What We Can Do About It*, 30 HEALTH AFF. 590, 591 (2011).

121. *Id.* at 593.

122. *What Does No-Fault Insurance Cover?*, ALLSTATE INS. CO. (January 2013), https://www.allstate.com/tools-and-resources/car-insurance/no-fault-insurance-cover.aspx.

their lives and health, cause their insurance premiums to rise,[123] and may jeopardize their licenses.[124] Medical malpractice is completely different. Aside from tort liability, malpractice causes little inconvenience to those who commit it. In fact, they may profit from it by being paid first for delivery of the services that cause patients harm and then a second time for correcting their mistakes.[125]

Nor do healthcare providers risk other serious consequences by harming patients. State medical boards are slow to investigate errors, slower to discipline providers, and slower still to censure them or restrict their licenses.[126] As a result, the likelihood that a hospital would suffer any regulatory censure as a result of harming a patient is also remote.

In the healthcare context, then, the tort system carries the heavy burden of creating incentives that motivate primary actors to do better than they otherwise would. The system's ability to perform this function is already impaired, not least because many states have capped patients' damage recoveries and restricted their ability to sue in other ways.[127] Yet recent evidence shows that the liability system continues to exert a patient-protecting effect.[128] The MOOPL proposal would endanger the system's continued success by further insulating providers from the costs of medical mistakes.

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123. Kim Peterson, *Car Accident? Here's How Much Your Rates Could Rise*, CBS (January 27, 2015, 12:01 AM), http://www.cbsnews.com/news/heres-how-much-your-rates-could-rise-after-an-accident/.

124. Melissa Crumish, *Actions That lead to the Loss of Driving Privileges*, DMV.ORG (June 10, 2012), http://www.dmv.org/articles/actions-that-lead-to-the-loss-of-driving-privileges/.

125. *See* Manoj Jain, *Medical Errors Are Hard for Doctor's to Admit, But it's Wise to Apologize to Patients*, WASH. POST (May 27, 2013), https://www.washingtonpost.com/national/health-science/medical-errors-are-hard-for-doctors-to-admit-but-its-wise-to-apologize-to-patients/2013/05/24/95e21a2a-915f-11e2-9abd-e4c5c9dc5e90_story.html.

126. *See* Peter Eisler & Barbara Hansen, *Thousands of Doctors Practicing Despite Errors, Misconduct,* USA TODAY (Aug. 20, 2013, 7:06 PM), http://www.usatoday.com/story/news/nation/2013/08/20/doctors-licenses-medical-boards/2655513/ (concluding that "[d]octors with the worst malpractice records keep treating patients: Among the nearly 100,000 doctors who made payments to resolve malpractice claims from 2001 to 2011, roughly 800 were responsible for 10% of all the dollars paid and their total payouts averaged about $5.2 million per doctor. Yet fewer than one in five faced any sort of licensure action by their state medical boards.").

127. *See* Zenon Zabinski & Bernard S. Black, *The Deterrent Effect of Tort Law: Evidence from Medical Malpractice Reform* 6 (Nw. Univ. Inst. Pol'y Res., Working Paper No. 13-xx, 2015), *available at* http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2161362.

128. *See id.* at 2 (finding strong evidence that patient safety generally falls after the reforms); Darius N. Lakdawalla & Seth A. Seabury, *The Welfare Effects of Medical Malpractice Liability*, 32 INT. REV. L. ECON. 356, 356 (2012) (asserting that malpractice liability leads to modest reductions in patient mortality; the value of these more than likely exceeds the cost impacts of malpractice liability).

B. The Proposal Would Be Costly For Taxpayers

The MOOPL proposal not only would shift costs from wrongdoers to innocent claimants, but from wrongdoers to taxpayers. Since health insurers would pay for future medical expenses, insurance premiums would rise.[129] The ACA provides government subsidies for those who cannot afford health insurance premiums, with the subsidies tied to the cost of the second-lowest-cost "silver" plan in their state.[130] Therefore, as premiums for those plans increased, the amount of taxpayer subsidies would have to be increased.[131] This is especially noteworthy given the extent of the subsidies. For example, they are available to individuals and families with incomes up to 400 percent of the federal poverty level; in 2015, this would include a family of four with an income of up to $97,000.[132]

The proposal also would conflict with the statutory rights of public programs such as Medicare to be reimbursed for their expenditures on care required to tort-related injuries.[133] As noted above, claimants who require future medical care for their injuries are likely to be on Medicare and Medicaid rather than to have private insurance.[134] The less compensation that claimants receive from tortfeasors for future medical costs, the less funds will be available to reimburse these programs. The drain on these programs would reduce the health care resources available to those claimants, as well as elderly, poor, and underserved individuals. As the North Carolina Supreme Court stated in *Cates v. Wilson*, "between defendants who tortiously inflict injury and innocent taxpayers who fund programs such as Medicaid, we think it better that the loss fall on the tortfeasor."[135]

Finally, the proposal would impose greater costs on taxpayers by pushing into poverty claimants whose future out-of-pocket expenses exceed their recoveries. The Kaiser Family Foundation reports that the inability to pay medical bills is a major cause of financial hardship:

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129. *See Rising Health Care Costs*, AHIP, https://www.ahip.org/Issues/Rising-Health-Care-Costs.aspx (last visited November 16, 2015).

130. *See* BERNADETTE FERNANDEZ, CONG. RESEARCH SERV., R431137 HEALTH INSURANCE PREMIUM CREDITS IN THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA) 9 (2014).

131. *See* AHIP, *supra* note 131.

132. *2015 Poverty Guidelines,* U.S. DEP'T OF HEALTH & HUMAN SERVS. (Sept. 3, 2015), http://aspe.hhs.gov/poverty/15poverty.cfm.

133. *See Reporting a Case*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Attorney-Services/Reporting-a-Case/Reporting-a-Case.html (last updated October 1, 2015, 4:56 PM).

134. *See* Fagel, *supra* note 14, at 4 (stating that "in most cases involving significant future medical costs, it is . . . likely that the plaintiff would have lost their private health insurance and gone on [Medicaid] or Medicare long before the resolution of their claim").

135. Cates v. Wilson, 361 S.E.2d 734, 739 (N.C. 1987).

> An estimated 1 in 3 Americans report having difficulty paying their medical bills – that is, they have had problems affording medical bills within the past year, or they are gradually paying past bills over time, or they have bills they can't afford to pay at all. Medical debt – and a host of related problems – can result when people can't afford to pay their medical bills. While the chances of falling into medical debt are greater for people who are uninsured, most people who experience difficulty paying medical bills have health insurance. Medical debt can arise when people must pay out-of-pocket for care not covered by health insurance or to which cost-sharing (such as deductibles) applies. Medical debt might also result from health insurance premiums that individuals find difficult to afford.[136]

The Kaiser Report notes that "the consequences of medical debt can be severe. People with unaffordable medical bills report higher rates of other problems – including difficulty affording housing and other basic necessities, credit card debt, bankruptcy, and barriers accessing health care."[137]

C. The Proposal Unfairly Would Impose Further Significant Losses on Persons Who Sustained Tort-Related Injuries

In view of the intractable problems associated with efforts to calculate claimants' out-of-pocket expenses described above, the MOOPL proposal would produce wildly inaccurate estimates of the amounts of compensation due claimants for the future medical expenses necessitated by their tort injuries. More than likely, claimants' recoveries would be insufficient to enable them to pay the out-of-pocket costs for the care they need, and the difference between what they recovered and what they might end up needing to pay could be substantial. Yet, while the tortfeasors' costs would be fixed by the amount of compensation they paid, the innocent claimants would be left to bear the entire risk that their recoveries would be adequate.[138]

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136. Karen Pollitz et al., *Medical Debt Among People With Health Insurance*, KAISER FAMILY FOUND. 1 (2014), http://kff.org/private-insurance/report/medical-debt-among-people-with-health-insurance.

137. *Id.*

138. *See* Cardeli, *supra* note 15, at 19 (arguing that "[w]hen a judge or jury determines what future medical expenses will be covered by a collateral source, the injured party bears all the risk. Any uncovered future medical expenses will come out of the injured party's pocket."). Indeed, persons who suffer malpractice injuries might receive no compensation whatsoever because they would be unable to find an attorney to represent them. Plaintiffs' attorneys, who are paid on a contingent fee basis, can only afford to take cases that offer the prospect of a sufficient amount of damages to justify the costs of pursuing them. Compensation for future medical expenses is a substantial component of the recoveries that claimants receive, "a defining damages variable." *See* Jason P. Ferrante, *The Affordable Care Act and Healthcare Litigation: Adjusting Our Thoughts on Future Economic Damages*, 6 CLEV. METRO. BAR ASS'N J. 12, 12 (2014). A report by the Rand Corporation, for example, estimated that medical costs comprised approximately 25 percent of total payments for medical liability. *See* DAVID I. AUERBACH ET AL., HOW WILL THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

The risk of such an unjust result led the district court in an analogous case to reject the government's argument that a service member's damages in a medical malpractice action against the military should be reduced because the military health program might pay medical expenses in the future.[139] The government maintained that the plaintiff would be entitled to these health care benefits because her husband would remain in the military.[140] The court disagreed, observing, "there can be no assurance that the Tricare/CHAMPUS program will continue for the balance of Mrs. Lawson's life, nor that the benefit levels will never change."[141]Accordingly, stated the court, "an offset based on speculative benefits would be an injustice because it would force Mrs. Lawson alone to bear the entire risk that her husband will continue to be employed by the Air Force, and that he will do so for the time required for him to attain retirement benefits which will continue without change for the rest of her life."[142] Thus the Court declined to offset Mrs. Lawson's damages award for anticipated benefits reasoning that may never be received.[143]

One reason why claimants are likely to be shortchanged by the MOOPL proposal, mentioned earlier, is that public programs such as Medicare may require reimbursement for medical expenses paid on behalf of the claimant that leave the claimant without sufficient funds to pay out-of-pocket expenses for future care. In states that retain the collateral source rule, the effect of the proposal would be to give the defendant an offset for 100 percent of the benefits that a claimant obtains from another source, exactly what the collateral source rule forbids. It is also important to understand that even in states that have legislatively modified the common law collateral source rule, either by

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AFFECT LIABILITY INSURANCE COSTS?, RAND CORP. 20-21 (2014), *available at* http://www.rand.org/pubs/research_reports/RR493.html. This holds true for settlements as well as court-ordered recoveries. The Rand report describes the effect of subrogation, for example, on the availability of legal representation: "Claim frequency is, in part, determined by the incentives that potential claimants and attorneys face in deciding whether to pursue claims, and norms regarding subrogation can alter the total amount of compensation available to an injured party. For example, in an environment in which subrogation generally does not occur, if Medicaid is expected to pay $500 for medical care and then a liability insurer is expected to make a payment of $1,000 to an injured party, a potential claimant should file a claim if the costs of doing so are less than $1,500. However, if subrogation were widespread, then Medicaid would recover $500 of the $1,000 payment from the liability insurer, leaving only $1,000 available in total compensation to the injured party and thus potentially reducing the incentive to file a claim in the first place." *Id.* at 43; *see also* Geslison & Jacobs, *supra* note 87, at 244 (arguing that "[i]n the vast majority of personal injury cases, the settlement amount or the damages awarded by the verdict were tied closely to the actual damages—primarily lost wages and medical costs—incurred as a result of the injury").

139. Lawson v. United States, 454 F. Supp. 2d 373, 415 (D. Md. 2006).

140. *Id.*

141. *Id.*

142. *Id.*

143. *Id.*

the terms of the legislation itself[144] and/or by judicial decision,[145] tortfeasors, typically, are not entitled to reduce claimants' recoveries by the amounts paid by insurance for future medical expenses or when recoveries are subject to governmental or contractual rights of subrogation.[146]

Another way in which the proposal would burden claimants with future medical expenses is by limiting their ability to obtain quality care. As noted

144. *See* CONN. GEN. STAT. ANN. § 52-225a(a), (b) (West 2014) ("In any civil action . . . wherein the claimant seeks to recover damages resulting from . . . personal injury or wrongful death . . . arising out of the rendition of professional services by a health care provider, . . . the court shall reduce the amount of such award . . . by an amount equal to the total of amounts determined to have been paid . . . . Upon a finding of liability and an awarding of damages by the trier of fact and before the court enters judgment, the court shall receive evidence from the claimant and other appropriate persons concerning the total amount of collateral sources which have been paid for the benefit of the claimant as of the date the court enters judgment."); IND. CODE ANN. § 34-44-1-2 (West 2010) ("In a personal injury or wrongful death action, the court shall allow the admission into evidence of . . . proof of collateral source payments . . . ."); MINN. STAT. ANN. § 548.251(1) (West 2008) ("'[C]ollateral sources' means payments related to the injury or disability in question made to the plaintiff, or on the plaintiff's behalf up to the date of the verdict . . . ."); 40 PA. CONS. STAT. ANN. § 1303.508(a) (West 2002) ("[A] claimant in a medical professional liability action is precluded from recovering damages for past medical expenses or past lost earnings incurred to the time of trial to the extent that the loss is covered by a private or public benefit or gratuity that the claimant has received prior to trial."); WASH. REV. CODE ANN. § 7.70.080 (West 2006) ("Any party may present evidence to the trier of fact that the plaintiff has already been compensated for the injury complained of from any source . . . .").

145. *See* Staats v. Wegmans Food Mkts., Inc., 63 A.D.3d 1573, 1574 (N.Y. App. Div. 2009) ("We conclude, however, that the court erred in granting defendant a further offset beyond that 27-month period, and we therefore modify the order accordingly. We agree with plaintiff that defendant failed to meet its burden of establishing 'with reasonable certainty,' i.e., by clear and convincing evidence, that plaintiff would remain entitled to the continued receipt of benefits from a collateral source."); Grell v. Bank of Am. Corp., No. 3:05-cv-1237-J-32HTS, 2007 WL 1362728, at *3 (M.D. Fla. May 7, 2007) ("Accordingly, the Court declines to set off potential future third party insurance or Medicare payments for future medical expenses."); Amlotte v. United States, 292 F. Supp. 2d 922, 924 (E.D. Mich. 2003) ("[P]ayments from a collateral source may not be set off against future medical expenses under Michigan law . . . ."); Parker v. Esposito, 677 A.2d 1159, 1162–63 (N.J. Super. Ct. App. Div. 1996) ("[T]he phrase 'if a plaintiff . . . is entitled to receive benefits,' [as used in collateral source statute,] refers only to those benefits to be paid post-judgment to which plaintiff has an established, enforceable legal right when judgment is entered and which are not subject to modification based on future unpredictable events or conditions. In other words, future collateral benefits are deductible [under collateral source statute] only to the extent that 'they can be determined with a reasonable degree of certainty.'"); Allstate Ins. Co. v. Rudnick, 761 So. 2d 289, 291-92 (Fla. 2000) (holding that future potential benefits under the medical payments coverage were not "available" within the meaning of the statute, requiring a court to reduce damages by amounts otherwise available from all collateral sources, and, thus, the remaining benefits did not require a setoff).

146. *See, e.g.*, OHIO REV. CODE ANN. § 2315.20(A) (West 2015) ("In any tort action, the defendant may introduce evidence of any amount payable as a benefit to the plaintiff as a result of the damages that result from an injury, death, or loss to person or property that is the subject of the claim upon which the action is based, except if the source of collateral benefits has a mandatory self-effectuating federal right of subrogation, a contractual right of subrogation, or a statutory right of subrogation . . . .").

earlier, patient choice already is being reduced as health plans establish "narrow networks."[147] If, due to the MOOPL proposal, the amount of compensation for future medical expenses were insufficient to cover the costs of out-of-network care, claimants might have no choice but to try to obtain care from providers within the network. Yet, the services they need might not be available within the network, the network's providers might be of substandard quality, or the services might have to be obtained from the providers who were responsible for the claimants' injuries in the first place. Similar concerns led the judge in a medical malpractice action against the Veterans Administration under the Federal Tort Claims Act to refuse to agree with the government that the plaintiff's compensation for future medical expenses should be reduced because of the availability of care from the VA:

> The amount of such possible, prospective medical benefits, if any, is far too speculative for the Court to place a figure upon. Moreover, were the Court to deduct a set-off for possible, prospective medical benefits, the set-off would, as a practical matter, unduly limit and virtually pre-determine not only the kind of medical care necessary for the treatment of the plaintiff's condition, but also the source of such medical care. This pre-determination would be somewhat burdensome because the plaintiff could not receive nursing home care or undergo outside surgical procedures without the approval of a Veterans' Administration physician. This pre-determination, moreover, would be especially onerous if it were to force the plaintiff to undergo treatment at a Veterans' Administration facility whose sister facility has caused the plaintiff to suffer the damages found in this case.[148]

By shifting the costs of malpractice and other tortious injuries from tortfeasors to those whom they injure, the MOOPL proposal would not only reduce the deterrent effect of the tort system, as discussed earlier, but would violate the other primary goals of the collateral source rule, namely, promoting corrective justice and preventing tortfeasors from receiving unjust enrichment.[149] As one prominent court classically recognized:

> In general the law seeks to award compensation, and no more, for personal injuries negligently inflicted. Yet an injured person may usually recover in full from a wrongdoer regardless of anything he may get from a "collateral source" unconnected with the wrongdoer. Usually the collateral contribution necessarily benefits either the injured person or the wrongdoer.

147. *See* Abelson, *supra* note 35, at A1 and accompanying text.

148. Powers v. United States, 589 F. Supp. 1084, 1108 (D. Conn. 1984) (internal citation omitted).

149. *See* Law v. Griffith, 930 N.E.2d 126, 132 (Mass. 2010) ("The purpose of the collateral source rule is tort deterrence. The tortfeasor is required to compensate the injured party for the fair value of the harm caused, and is not to benefit from either contractual arrangements of the injured party with insurers or from any gifts from others intended for the injured party.").

> Whether it is a gift or the product of a contract of employment or of insurance, the purposes of the parties to it are obviously better served and the interests of society are likely to be better served if the injured person is benefitted [sic] than if the wrongdoer is benefitted [sic]. Legal "compensation" for personal injuries does not actually compensate. Not many people would sell an arm for the average or even the maximum amount that juries award for loss of an arm. Moreover the injured person seldom gets the compensation he "recovers", for a substantial attorney's fee usually comes out of it. There is a limit to what a negligent wrongdoer can fairly, i.e., consistently with the balance of individual and social interests, be required to pay. But it is not necessarily reduced by the injured person's getting money or care from a collateral source.[150]

The corrective justice objective of the collateral source rule was recently reaffirmed by the Supreme Court of Appeals of West Virginia.[151] Noting that the rule has been "a staple of American tort law since before the Civil War,"[152] the court called it "a central part of the tort system's goal of requiring tortfeasors to make right their wrongful acts,"[153] adding that "[t]he primary unifying principle of tort law is one of corrective justice, that is, the law establishes a legal duty for a tortfeasor to repair any damage or losses carelessly inflicted upon a victim."[154]

D. The Proposal Would Deprive Injured Persons of a Legal Remedy

If the MOOPL proposal were adopted, claimants would risk not only being inadequately compensated for malpractice and other tort-related injuries, but also receiving no compensation whatsoever because they would be unable to find an attorney to represent them. Plaintiffs' attorneys, who are paid on a contingent fee basis, can only afford to take cases that offer the prospect of a sufficient amount of damages to justify the costs of pursuing them.[155] Com-

150. Hudson v. Lazarus, 217 F.2d 344, 346 (D.C. Cir. 1954). Hudson v. Lazarus, 217 F.2d 344, 346 (D.C. Cir. 1954).

151. Kenney v. Liston, 760 S.E.2d 434, 449 (W. Va. 2014).

152. *Id.* at 440.

153. *Id.* at 445.

154. *Id.*

155. *See* AUERBACH, *supra* note 138, at 43 ("Claim frequency is, in part, determined by the incentives that potential claimants and attorneys face in deciding whether to pursue claims, and norms regarding subrogation can alter the total amount of compensation available to an injured party. For example, in an environment in which subrogation generally does not occur, if Medicaid is expected to pay $500 for medical care and then a liability insurer is expected to make a payment of $1,000 to an injured party, a potential claimant should file a claim if the costs of doing so are less than $1,500. However, if subrogation were widespread, then Medicaid would recover $500 of the $1,000 payment from the liability insurer, leaving only $1,000 available in total compensation to the injured party and thus potentially reducing the incentive to file a claim in the first place.").

pensation for future medical expenses is a substantial component of the recoveries that claimants receive, "a defining damages variable" in the words of one commentator.[156] This holds true for settlements as well as court-ordered recoveries.[157] A report by the Rand Corporation, for example, estimated that medical costs comprised approximately 25 percent of total payments for medical liability.[158] Fewer persons injured by negligence therefore would obtain legal representation if the MOOPL proposal reduced their damages for future medical expenses.[159]

E. The Proposal Would Give Critics of the Tort System What They Were Unable to Obtain Through the Democratic Process

If, as is likely under the MOOPL proposal, tort claimants would be unable to obtain sufficient compensation to enable them to obtain future medical care, the effect would be as if the ACA imposed a cap on recoverable damages for health care expenses. When the ACA was before Congress, organizations representing medical professionals and other interest groups lobbied hard to have provisions limiting patients' rights to sue for medical malpractice included in the statute.[160] They failed.[161] As enacted by Congress and signed by President Obama, the ACA left the right to sue unaltered.[162]

After losing in the democratic process, critics of the tort system now seek to use the courts to accomplish their goals.[163] They contend that, even though Congress rejected their entreaties, courts should limit injured claimants' recoverable damages for future health care costs to the MOOPL that the act

156. Ferrante, *supra* note 138 at 12.

157. *See* Geslison & Jacobs, *supra* note 87, at 244 ("[I]n the vast majority of personal injury cases, the settlement amount or the damages awarded by the verdict were tied closely to the actual damages—primarily lost wages and medical costs—incurred as a result of the injury.").

158. AUERBACH, *supra* note 138 at 21.

159. *Id.* at 43.

160. *See* Leonard J. Nelson, III et al., *Medical Liability and Health Care Reform*, 21 HEALTH MATRIX 443, 445 (2011) ("Although it was highly unlikely that health care reform legislation would include damages caps, they were much discussed during the debate. In fact, damages caps emerged as a primary component of Republican alternatives to the proposed Democratic health reform bill.").

161. *See id.* at 444 ("[A]lternative medical liability reforms (e.g., disclosure and offer, health courts, safe harbors) . . . w[ere] not included in the final legislation.").

162. *Id.*

163. *See generally Tort Reform*, AM. MED. ASS'N, http://www.ama-assn.org/ama/pub/physician-resources/legal-topics/litigation-center/case-summaries-topic/tort-reform.page? (providing a comprehensive list of cases in which defendant argue for the limitation of recoverable damages for future health care costs).).

sets for individuals covered by conforming health plans.[164] In short, the proposal is an effort to sneak in through the side door restrictions on tort actions. Having failed to convince Congress to curtail claimants' rights, opponents of the liability system hope to gain a more favorable reception in federal and state courts.[165] Judges should not go along. By doing so, they would give litigation opponents a victory the democratic process denied them.

V. CONCLUSION

The MOOPL proposal is based on a host of unwarranted and erroneous assumptions and unrealizable expectations. From a policy standpoint, it contradicts the long-standing principle that persons sustaining medical malpractice and other tort-related injuries should be able to easily obtain all the health care they need as a result of their injuries.[166] Injured persons are already being denied adequate compensation for their injuries.[167] "[P]laintiffs on average recovered just over half their costs," observes Stanford professor Deborah Rhode, "and those with the most severe injuries ended up with only a third."[168] The MOOPL proposal would substantially worsen their plight. Winners under the proposal would be providers and liability carriers who commit and profit from patient injuries. The losers would be innocent persons who were left to bear the entire risk of inadequate recoveries, other members of their health plans who would bear increased insurance costs, and ultimately, the public. The proposal must be rejected.

164. *See, e.g.*, Stinnett v. Tam, 198 Cal. App. 4th 1412, 1418 (Cal. Ct. App. 2011) (reducing, upon defendant's motion, jury's award of $6,000,000 noneconomic damages to plaintiff to $250,000 pursuant to California's MICRA cap).

165. *See generally Tort Reform*, *supra* note 163 and accompanying text.

166. *See* Kenney v. Liston, 760 S.E.2d 434, 445 (W. Va. 2014) ("The primary unifying principle of tort law is one of corrective justice, that is, the law establishes a legal duty for a tortfeasor to repair any damage or losses carelessly inflicted upon a victim.").

167. *See* DEBORAH L. RHODE, ACCESS TO JUSTICE 31 (2004).

168. *Id.*