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The Collateral Source Rule and the Affordable Care Act: Implications for Life Care Planning and Economic Damages

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Abstract:

Life care planning has become a well-established specialty practice to determine the future care needs and costs related to permanent disabling conditions. In concert with the collateral source rule, this paper investigates the potential effects of the *Affordable Care Act* (ACA) on the determination of economic damages related to the evaluee's long-term care needs. The collateral source doctrine is explained. Given the climate of the collateral source doctrine, and the uncertainty of the *ACA* as challenges continue in both the United States Congress and the U.S. Supreme Court, there is an ongoing debate among life care planning and economic professionals on the implications for future practice and development of the life care plan.

Background

In a recent case (*Tucker v. Cascade General, Inc.*, 2014), Tucker brought a civil action for sustained and life-altering injuries while working for Cascade, a shipyard repair service for vessels, as a bilge and clean-up worker. The accident caused indisputable injuries, when a latch cover fell through the hatch opening and hit Tucker in the head. The issue of liability was easily established with Cascade being held responsible for the problems in handling the hatch cover by the crew (*A preponderance of the evidence supports the conclusion the upper pump room hatch cover was a very unusual, if not unique, and hazardous design.* p. 36). Injuries to Tucker were readily established through a narrative of what occurred on the day of the accident and by numerous medical reports, as well as Tucker's post-injury impairments and restrictions resulting in a significant reduced capacity to work as well as a reduced quality of life.

Plaintiffs Experts Methodology

In preparing his life care plan, Fountaine met with Tucker and his family in their home, consulted with Mr. Tucker's physicians and medical providers, who informed Fountaine of their prognoses for Tucker's necessary future care. Based upon these discussions, Fountaine determined the need for future medical care and treatment for the remainder of Mr. Tucker's life. Fountaine prepared a life care plan that included necessary items for medical services, vocational services, domestic assistance, and prescription medications. Mr. Tucker's attending physician, Dr. Nicacio, reviewed Fountaine's life care plan and agreed the services were necessary. Fountaine obtained the costs for his life care plan by contacting Tucker's actual providers and providers in his geographic area.

The defense argued a portion of Tucker's medical care would be covered by Medicare, as per his Medicare Set Aside (MSA). Based on expert testimony, the court found the fees and charges set forth by the MSA do not provide a fair and comprehensive projection of the costs Tucker will incur for medical services over the course of his life. The court declined to rely upon the MSA to set Tucker's future medical expenses.

Regarding past medical expenses, the court determined it is unreasonable to seek reimbursement for amounts that were never paid. Rather, in this court's view, an award for past medical expenses based upon the actual amount expended is appropriate. At trial Fountaine conceded the past medical expense figure was not the actual amount paid to the physicians, but rather represented the amount billed.

Damages became the central focus of this case:

Tucker is entitled to reimbursement for his loss of earnings and the impairment to his earning capacity; for medical expenses, past and future; and for any economic components of his injuries, pain and suffering, and the impact of his injury on his ability to engage in activities that contribute to his quality of life (p. 43).

Based upon the expertise of two witnesses, Dr. E. Silberberg, an economist, and J. Fountaine, a rehabilitation counselor and case manager (life care planner), the court addressed the damage issues of lost earnings, the loss of household services, and medical and life care expenses. Following extensive debate and discussion, the court awarded Tucker the following (adjusted to present value):

Past lost wages	*$139,542*
Future earnings	*$1,045,850*
Household services	*$169,946*
Past medicals	*$138,225*
Future medicals	*$583,624*

The total economic award was $2,077,187 (p. 52), plus another $8,000,000 for pain and suffering (p. 55). During the course of the trial an expert in MSAs testified on behalf of Tucker that the *Workers' Compensation Medicare Set-Aside Arrangement* is to remain secondary to any settlement, whether it be in workers' comp or liability; however, the government (the defendant) asked "the court to use medical costs projected by the MSA to determine these future expenses" (p. 20); the court did not allow the request. This case sets the stage for an identification and discussion of

several issues that come into play in determining damage awards and serves as a very instructive exercise related to the development and presentation of life care plans and other economic damages. These issues are discussed in the following sections.

The Collateral Source Rule

According to *Black's Law Dictionary* Free Online Legal Dictionary (2015), the collateral source rule is the "doctrine that if an injured party receives compensation for its injuries from a source independent of the tortfeasor, the payment should not be deducted from the damages that the tortfeasor must pay." In cases involving injury and potential damages (such as in the case of *Tucker v. Cascade General*), the collateral source rule and doctrine prohibits the admission of evidence that the plaintiff has received compensation from some source other than the damages sought against the defendant. The primary problem with this rule is that defendants often argue that a plaintiff should not be able to receive additional compensation after having received compensation from another source, such as personal insurance, Medicare, or some other source. By relying only on damages as requested by the plaintiff, or decided upon by a jury, it may be claimed that the plaintiff will be over-compensated for the liability. The jury in such cases may not have information prior to making their own determination on damages, as instructed by the court.

The history of the rule established the notion that if anyone was going to benefit from compensation for damages, shouldn't it be the injured party and not the entity who injured that person? For example, if the defendant or the jury had prior information of the plaintiff's collateral source income or benefit, the defense would argue that the amount received prior to the jury award should be subtracted from that award. It may also be argued that the collateral source rule helps to reduce further negligence when a jury or court determines that a full settlement to the injured party is due. If the defendant anticipates that part of the damages will be covered by a collateral resource, this argument maintains that they may be less diligent with issues of potential liability.

While determining issues surrounding the collateral rule falls more to attorneys and the court, it is prudent for rehabilitation counselors, case managers and economists to become generally familiar with collateral source issues. It is also notable that rules vary by state and jurisdiction. For example, in the Tucker case, an expert presented information related to MSAs following a request by the defendant to reduce the damage award for future medicals (case was litigated in federal court in Oregon). The court did not allow the request, nor did the court use the MSA cost guidelines.

Evidence vs. Damages

Evidence refers to the data or sources of information that are provided to the court through a report or expert testimony. An example of evidence would be the cost figures for past lost earnings, future lost earnings, and past and/or future medical expenses. Damages are the amount of dollars that are awarded to the plaintiff, if any, that are rationalized from the evidence provided by experts or some other source. For example, evidence for past medical expenses usually fall within the categories of being "billed" or "paid" in conjunction with such court-determined caveats as premiums, evidence of "reasonableness," admissible compensation benefits, or some other form of subrogation. In terms of damages, the court, depending on the jurisdiction (Social Security Administration, workers' compensation, Long Term Disability, or civil litigation), can follow the recommendations of experts, and rely on evidence that was demonstrated by what was either billed, paid, or adjusted in some way, such as a post-verdict reduction in civil cases. In civil cases, courts have some discretion in allowing or not allowing considerations related to off-setting the cost of some damages where liability is found. This was evident in the Tucker case where the court considered the testimony of an MSA expert, but chose to not alter the damage recommendations offered by the plaintiff's vocational expert (p. 20). Each state has varying precedents established through case law and/or legislation on collateral set-aside issues (see Appendix A: *50-State Survey: Collateral Source Rules*). It may be that, independent of any attempt to factor in to the determination of damages with respect to collateral sources, case law and judicial determinations are central to a case and may have little to do with the testimony of various experts.

Exceptions to the Collateral Source Rule

Considerable variability among the states exists with respect to the application of collateral sources. A careful review of the Matlock chart (2013, see Appendix A) clearly highlights how different states apply the collateral source rule. In attempting to alter the collateral source rule through tort reform, a clear interpretation of how to apply the rule is not always available. For example, the *in limine motion*-related to an actual case (*Anderson v. Central Washington Hospital*, 2012) from the State of Washington best illustrates some of the difficulties for both attorneys and the courts. Attorneys for the plaintiff in this case argued that the collateral source rule and doctrine (Revised Code of Washington, RCW, 7.70.080) for the State of Washington was unconstitutional as a violation of the doctrine of separation of powers . . . and must yield to the long-standing judicial rule of evidence. The court ruled:

These matters having come upon Plaintiff's Motion regarding the unconstitutionality of RCW 7.70.080 and to exclude any evidence or testimony of compensation from collateral sources, and following briefing and argument; the Court finds the statute is unconstitutional and that the common law collateral source rule bars evidence of such payments, IT IS ORDERED THAT:

Plaintiff's motion to exclude all collateral source

payments is GRANTED.

In *Diaz v. State of Washington*, (2012), which was cited in *Anderson* (2012), the court addressed the issue of a potential conflict of interest between the RCW 7.70.080 regulation and ER 408. RCW 7.70.080 allows "any party to introduce evidence of compensation received by the plaintiff from any source" (*Diaz v. State of Washington*, p. 3). On the other hand, ER 408 "precludes admission of settlement evidence to prove liability for or invalidity of a claim or its amount (Spillane, 2013, p. 2). This apparent conflict of interest regarding the disclosure of a $400,000 pre-trial settlement, highlights the issue being one of disclosure to the jury about the settlement. Under RCW 7.70.080, the disclosure might be allowed; under ER 408, the disclosure of the settlement would be precluded. According to Spillane (2013), the trial court "refused to admit evidence of the $400,000 settlement" which resulted in a mistrial. At the second trial, the court ruled "that the evidence of the settlement was admissible under RCW 7.70.080" (*Diaz*, ibid., p. 1). The jury in second trial, while being instructed on the $400,000 settlement, awarded no damages to the plaintiff; on appeal, the decision in the second trial was affirmed.

In a very real sense, legal decisions regarding the collateral source rule are outside the role and function of an expert. In the case examples of *Anderson* (2012) and *Diaz* (2012), the conflict of interest involving the two rules (RCW 7.70.080 and ER 408) highlights the difficulty that exists for the court, at least in the State of Washington, when it comes to the application of the law regarding collateral sources. A review of the Matlock chart (2013) reveals the complexity of this issue given the wide variance in state laws and regulations.

Billed vs. Paid Past Medical Expenses

Compensation for "actually billed" versus "actually paid" medical charges is a varying issue among all fifty states. Court cases and legislatures are beginning to alter how states determine the use of various collateral sources and write-offs (see Appendix A). Some states, like Colorado, simply use the "billed" charges for determination of reimbursement. A few states, like Texas, rely solely on a "paid" approach. The determination of damage awards becomes more complex in other states. For example, these selected states have the following rules:

Alaska	Billed with a post-verdict reduction for both insurance and Medicaid/care
Maryland	Billed, except MedMal which is Billed with post-verdict reduction
Louisiana	Billed, but Medicaid is Paid; Medicare is Billed
Nevada	Billed, but with workers' compensation admissible
Delaware	Billed, except post-verdict reduction with MedMal only

Not all states offer clear guidance, like the states of Colorado (billed) or Texas (paid) on the collateral source issue. A growing number of states have struggled with the complexities of private insurance, Medicare, Medicaid, medical malpractice, post-verdict reductions with a few collateral sources, but not for others, and subrogation (when payment is received from another source which must be paid back after a damage award). While state courts have guidelines to determine damage awards, established by case law, in *Tucker*, a federal case, the expert provided information on medical and life care plan costs which were deemed reasonable, including what was "billed" for past medical services provided. However, "this court's view, an award for past medical expenses based upon the actual amount expended is appropriate . . . . the actual amount paid is the appropriate measure of damages" (p. 49). In *Briant and Briant v. Seattle Children's Hospital* (2013), the court relied on the rule WPI 30.07.01-02 which "permitted [plaintiff] to recover the reasonable value of medical services they receive, not the total of all bills paid" (p. 2). According to Matlock (2013), the defendant "should only be liable for the market-value of services rendered. The market-value of services isn't the amount billed but the amount actually accepted by the healthcare provider because providers often overcharge and do not bill the actual amount in order to compensate for the uninsured" (p. 2). In *Tucker* with regard to future expenses as identified in the life care plan, the court allowed the full charged amount (adjusted for present value) of the plan even with the denial of defendant's request to reduce the award based on an adjustment for a workers' compensation of a Medicare Set-Aside. The state of Oregon's rules on collateral sources (as established by *White v. Jubitz Corp*, 2008) is predicated on "billed" evidence with a post-verdict reduction, not "paid" evidence. Yet, according to the Collateral Source Rule Reform: SB 323, Or. Rev. Stat. § 18.580 (1987), the State of Oregon "permits a judge to reduce awards for collateral source payments, excluding life insurance and other death benefits, and benefits related to retirement, disability, pension plans, and federal social security" (p. 7). According to Warren and Mechler (2009), "some states have explicitly confronted this matter, requiring any evidence of payments by the collateral sources to be presented to the judge for a reduction, but only after the trier of fact has rendered its verdict" (p. 211).

Adjustments, Discounts, and Mark-Downs

In some states (see Appendix A) the courts admit only undiscounted bills and do not allow evidence of reductions to form the basis of verdicts or damage awards (Moye & Moye, p. 67). A discounted amount is a result of negotiations for the healthcare provider's business . . . the amount the provider

accepts for its services seems to be an implicit statement of value (Matlock, p. 2). To illustrate, the case of *Stanley v. Walker* (2009) deals with the admissibility of evidence related to medical bills. Walker, the plaintiff, was injured in a car accident with the defendant admitting liability, leaving only the issue of damage awards for the jury to decide. The plaintiff's bills for medical expenses totaled $11,570 and following a negotiation with the healthcare providers, the amount was discounted to $6,820. This is the amount the defendant wanted to present to the jury at trial. Plaintiff objected to this disclosure stating that this would be in violation of the collateral source rule. The trial court disallowed the defendant's request which was also affirmed by the appeals court. The defendant appealed again to the Indiana Supreme Court which in a 3-2 decision reversed the lower court indicating that the defendant should have been allowed to present the discounted bills before the jury. Flora (2012) in commenting on this case, observed that:

Under Indiana law (Rule 413) an injured person is entitled to recovery for the "reasonable value" of medical expenses. The rule provides that evidence of medical bills is prima facie evidence of the "reasonable value . . . what this means is simply that the bills are presumably the reasonable cost, though they can be rebutted. The [Indiana Supreme Court] majority decided that the defendant is entitled to use the actual cost paid as evidence of reasonable value (p. 3).

The *Stanley* case illustrates of the application of the collateral source rule related to the issue of billed versus actual past medical charges and whether or not either piece of information can be presented to a jury. It also illustrates how a court can rule during the process of trial and appeal, namely interpreting law and regulations on collateral sources. In the *Stanley v. Walker* case (2009), the higher court over-ruled two lower courts and set a precedent on the meaning of "reasonable value" of medical costs:

that medical providers inflate [medical] rates so that they can negotiate with insurance providers for lower rates. Further, the disparity between billed rates and rates paid by Medicare or Medicaid . . . . are far less than that paid by a private insurance company (p. 5).

Accordingly, experts providing testimony related to past medical charges may very well encounter ambiguities related to the intent and meaning of the law, and determinations of the court in interpreting the law regarding past billed versus paid medical costs.

Collateral Sources in Federal Cases

For experts, the rules for federal cases, or federal sources of damage resolution, bring another set of regulation. For example, in *Crowther v. Consolidated Rail Corp.* (2012):

plaintiff Crowther brought a negligence action against the railroad under the Federal Employee's Liability Act (FELA). The plaintiff had worked for the railroad about thirty years as both a laborer and a supervisor. He claimed that this work caused cumulative, or wear-out, injuries allegedly because the railroad neglected to provide adequate tools for the job. Following the jury finding for the defendant, the plaintiff appealed contending that the trial was hindered by a variety of errors — among them was that the trial judge erroneously allowed the defendants to introduce evidence that Crowther was getting around $3000 per month in disability benefits under the Railroad Retirement Act. The court thus refused to apply the rule against admitting evidence of a defendant's receipt of compensation for injury from a source collateral to the defendant (p. 1).

The Appeals court disagreed by relying on an earlier ruling (*McGrath v. Consolidated Rail Corp.*, 1998) consistently with *FRE 403* stating that a court "has discretion to exclude otherwise relevant evidence if its probative value is substantially outweighed by the danger of unfair practice." In *Crowther*, the court did not permit the jury to decide the case independent of their knowledge of a collateral source income (i.e., the $3,000 per month disability benefit). In *McGinnis v. Taitano* (1998), the court appeared to decisively strike down a motion to preclude the defendant from introducing evidence of collateral source payments to the plaintiff.

On the other hand, federal courts have consistently ruled that the collateral source rule does not apply in cases related to the *Comprehensive Environmental Response, Compensation and Liability Act* (CERCLA) primarily because claims are made by one or both parties since both entities could be liable for the issue being adjudicated (Goodstein, 2013).

The Affordable Care Act

The *Affordable Care Act* (ACA) (sometimes referred to as ObamaCare) was enacted on March 23, 2010, and upheld by the U.S. Supreme Court on June 28, 2012. The goal of the ACA is to assure that Americans will have greater access to affordable, quality health insurance, and reduce the growth in U.S. health care spending (*ObamaCare Facts*, 2014). The major features of ACA as identified from this source include:

- ACA does not regulate a person's health care; it regulates the health insurance and some of the worst practices of the for-profit healthcare industry.
- Allowing persons of age 26 or less to stay on their parents' health policy.
- Stopping insurance companies from denying coverage, charging a person higher premiums, dropping a person from a plan (whatever the reason), preventing insurance companies from making unjustified premium rate hikes, preventing insurance companies from denying insurance to persons with pre-existing conditions, expanding Medicaid to millions of people in states that choose to expand the program, and providing tax breaks for small businesses while requiring large businesses (more than 50 employees) to insure all

employees.
- Expanding health coverage to millions of uninsured Americans.

The individual mandate which requires all Americans to obtain insurance or pay a penalty is enhanced by the federal government's "marketplace" for obtaining health insurance (*HealthCare.gov*). For persons having difficulty obtaining insurance due to costs, the government provides for "subsidized health insurance" based on income which may qualify persons for Medicaid, Medicare, or related programs.

The ACA Controversy

Since its inception, the passage of the *Affordable Care Act* has been controversial. Several entities joined in bringing the issue of constitutionality of the ACA before the U.S. Supreme Court in 2012. The *American Association of Medical Colleges* (AAMC), in a released statement (June 28, 2012), applauded the Court's ruling on the ACA (where all provisions remain in effect), and further noted the expected demand for additional physicians to meet the needs of the anticipated required medical services. The AAMC is a not-for-profit association representing 141 accredited medical colleges in the United States. On the other hand, Siegel (2014) suggested that the ACA will result in the over-use of the emergency room as well as the heavy demand on physicians, especially given the anticipated shortage of medical care providers in future years. In the meantime, a pending U.S. Supreme Court case (*King v. Burwell*, 2014) will challenge another aspect of the ACA. Under the current ACA law, individuals may purchase competitively priced health insurance on American Health Benefit Exchanges which may be run by either individual states or the federal government. The issue in this case addresses the possible tax credits for eligible Americans, depending on whether they purchase insurance from a state exchange or a federal exchange. The ACA authorizes the tax credit for state exchanges only as an incentive for states to develop the exchanges. If the U.S. Supreme Court overturns the ACA, it is estimated that millions of Americans will suddenly be without health insurance.

Implications for the Life Care Planner

Life care planning is a longstanding tool of case management used to coordinate current and future medical and rehabilitation needs for people who experience a serious injury or illness. A 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 costs, for individuals who have experienced catastrophic injury or have chronic health care needs (*Standards of Practice for Life Care Planners*, 2015).

Assuming that the usual collateral source rule is relevant to the plaintiff's case and that a collateral source such as health insurance cannot be factored in to off-setting a damage award, the jury is asked by the plaintiff to assume that all future medical costs will be "out of pocket" (Yagerman & Bookman, 2012). Consistent with the life care planning *Standards of Practice*, life care plans do not take into consideration insurance benefits held by the plaintiff. Life care plans project needs years and sometimes decades into the future. The life care planner, per the *Standards of Practice*, "researches options and costs for care, using sources that are reasonably available to the client" (p. 9) and "it is a detailed document that can serve as a lifelong guide to assist in the delivery of health care services" (p. 6). In Preston and Johnson (2012) there are 99 Consensus and Majority Statements derived from Life Care Planning Summits held in 2000, 2002, 2004, 2006, 2008, 2010 and 2012. Accordingly, life care plans shall be:

#51 "objective and consistent"
#52 "lifelong and flexible"
#82 "be transparent and consistent"

Life care planners shall:

#86 "assess the reliability, validity and accuracy of data and methods"
#91 "utilize research that is reasonable, relevant and appropriate"
#98 "Best practices for identifying costs in Life Care Plans include: verifiable data from appropriately referenced sources, costs identified are geographically specific when appropriate and available, non-discounted/market rate prices, and more than one cost estimate, when appropriate."

Life care planners cannot know with reliability what the courts or legislative bodies may choose to do in the future; the traditional life care planning methodology remains the same (Weed, 2010; Weed and Johnson, 2006).

The ACA will require all citizens of the United States to acquire/possess health insurance or pay a penalty. How this development will impact a damage award taking into account the collateral source rule(s) remains unknown and indeterminable by the life care planner until decided by the court. Some may argue the collateral source rule will continue to prevent a jury from receiving all relevant evidence, including insurance benefits received by the plaintiff, thus, setting the stage for the plaintiff to receive a "double" benefit for a disability or injury. Others note that allowing collateral source information into a deliberation may benefit the liable party. Since there does not appear to be any case law or precedent on the issue of the ACA, the future only knows how this issue will be resolved. Nevertheless, it remains outside the role and function of the life care planner. According to legal authors Yagerman and Bookman (2012),

The question that will be litigated in the coming months and years is whether it remains fair to continue to force the fiction upon the jury that future medical expenses projected

by a plaintiff's life care plan will be paid 100% out-of-pocket, when in the post-ACA world, that will be the same for almost no one (p. 2).

This view is generally supported by Congdon-Hohman and Matheson (2012) who suggest that with the ACA, there should be life care plan limits for future medical costs since all persons would be required to have insurance that would have included pre-injury and expected medical costs (i.e., regular medical visits as part of one's expected life style). Conversely, the real costs related to a life care plan could be reduced to those "out of pocket" expenses as a result of the injury and not already covered by personal insurance required under the ACA. Congdon-Hohman and Matheson, both economists, go so far as to suggest that the "role of the life care planner should evolve into determining which life care expenses are covered under the minimum insurance requirements mandated by the ACA and which entail additional expenditures beyond those covered by health insurance" (p. 153).

While the traditionally held view of the collateral source rule may still prevail in many states, the court may consider evidence on benefits received by the plaintiff and make a post-jury "correction" on damages decided by the jury. If juries are allowed to consider evidence of insurance benefits, this could have a significant impact on the expert's recommendation related to projected costs in a life care plan.

The ACA provided for enhanced payments for primary care services provided to Medicaid patients for the years of 2013 and 2014, but expiring in 2015 (Patterson, Andrilla & Skillman, 2014). While Medicaid fees were allowed to increase for primary care services "approximately by 73%" (p. 1), according to results of a study by Urban Institute (Zuckerman, Skopec & McCormack, 2014), the fees "would fall an average of 42.8% for all states in 2015" (p. 8). The problem may seem that life care planners and related experts will have a degree of difficulty estimating and projecting costs for a person with a disability in future years, and further compounded when testifying experts, the courts, and juries address the issue of collateral sources (i.e., Medicaid), especially given the complexities of state-by-state rules. However, with this degree of uncertainty as to what the future holds in this scenario, the *Standards of Practice* dictate the life care planner's actions and the ACA cannot be reasonably relied upon as a source for consideration mandating healthcare coverage in the future. Further, the variability between insurance and annual adjustments and benefits has been and remains unreliable for consideration in projecting future costs.

Impacting the Role of the Life Care Planning Expert

The life care planner's role may be impacted by an attempt to use of any ACA mandated health insurance coverage as a collateral source for identified damages in a life care plan. If, or when, damage awards are subrogated to a collateral source such as an insurance benefit, the plaintiff stands to lose a dollar amount that would have been otherwise received from the damage award. In many instances, full damage awards plus any funds from a collateral source may be received by the plaintiff. Part of the long-standing rationale of the collateral source rule is that the defendant must not be rewarded if there is liability for which they are responsible.

Based on the *Standards of Practice for Life Care Planners* (2015), the life care planner is expected to "maintain objectivity" by "facilitating understanding of the life care planning process" (p. 10). Therefore, life care planners must be consistent in their methodology and application of the *Standards of Practice* when developing a life care plan. This is not to purport how the daily work of life care planning should be done but, rather, describes how the daily work is done. Life care planners therefore must realize "this approach is not unique, created for, nor isolated to the forensic setting, but is the methodology of our clinical practice." (p. viii) (Choppa, Field & Johnson, 2006). If requested to take additional steps to identify collateral source off-sets (i.e., via an ACA mandated health insurance policy from a private carrier), this must be performed transparently after the comprehensive assessment, data analysis and research is completed otherwise one's objectivity may be in question. The life care planner is not to move outside their area of expertise and training by purporting to know what the future holds for an insurance program so vulnerable to repeal or revision. The life care planner should not become an advocate by assisting with the objective of reducing the damage award through a collateral source. Further, the *Standards of Practice* Section IV, Standard 10 states:

The life care planner may engage in forensic applications.

If the life care planner engages in practice that includes participation in legal matters, the life care planner:

- *a. Acts as a consultant to legal proceedings related to determining care needs and costs in the role of an impartial advisor to the court.*
- *b. May provide expert sworn testimony regarding development and content of the life care plan.*
- *c. Maintains records of research and supporting documentation for content of the life care plan for a period of time consistent with requirements of applicable authoritative jurisdictions.*

Conclusions

1. The collateral resource rule with respect to damages and related to litigation varies by jurisdiction. A review of the Matlock chart (Appendix A) indicates the wide variance of how the collateral source doctrine is applied in each of the states.

2. The ACA mandate presents a new scenario for covering individuals with health care benefits. While the

ACA's intent is to provide universal health care insurance with a component that prevents the exclusion of a "pre-existing" condition, the life care planner should remain clear of incorporating changes to their work solely based on the ACA with regard to future damages as there is yet to be a clearly articulated manner in which life care planners will be impacted by this insurance program.

3. Careful consideration by the life care planner may be warranted when consideration is given to incorporating collateral source data and set-asides.

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Appendix A: 50 State Survey Collateral Source Rule & Write-offs.
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Appendix A
50-State Survey: Collateral Source Rule & Write-Offs

(States: [1] Paid Evidence Only; [2] Billed Evidence Only; [3] Hybrid)

	Private Insurance		Medicare/Medicaid		
State	**Maximum Recovery**	**Evidence Accepted**	**Maximum Recovery**	**Evidence Accepted**	**Authority + Notes**
ALABAMA[3]	Billed	Billed, paid & premiums	Billed	Billed, paid & premiums	Ala. Code §12-21-45, 6-5-22: essentially circumventing the need for a "billed v paid" distinction. *also admissible*: Plaintiff's obligation to repay Collateral Source
ALASKA[3]	Billed + post-verdict reduction	Billed (implied)	Billed + post-verdict reduction	Billed	Alaska Stat. § 9.17.070., Alaska Stat. § 9.55.548: limits damages to amounts exceeding that already paid by a collateral source in MedMal cases (except for CS in the form of death benefits and fed programs where subrogation is required by law). *Reid v. Williams*, 964 P.2d 453, 456 (Alaska 1998). *Jones v. Bowie Industries, Inc.,* 282 P.3d 316 (Alaska 2012).
ARIZONA[3]	Billed	MedMal: Billed, paid, & premiums Other: Billed	Billed	MedMal: Billed, paid, & premiums Other: Billed	*Lopez v. Safeway Stores, Inc.*, 129 P.3d 487, 496 (Ariz. 2006). A write-off is considered a collateral source.
ARKANSAS[1]	Paid	Paid	Paid	Paid	**Ark. Code** § 16-55-212(b).
CALIFORNIA[1]	Paid	Paid	Paid	Paid	**Insurance:** *Howell v. Hamilton Meats & Provisions, Inc.,* 52 Cal. 4th 541, 550, 257 P.3d 1130, 1134 (2011), reh'g denied (Nov. 2, 2011). **Medicare/caid:** *Hanif v. Hous.* Auth., 200 Cal. App. 3d 635, 639, 246 Cal. Rptr. 192, 194 (Ct. App. 1988).
COLORADO[2]	Billed	Billed	Billed	Billed	Colo. Rev. Stat § 13-21-111.6 (2008) allows a reduction of the verdict by the amount paid by the CS EXCEPT where the payments arose from contractual obligations intended to benefit the injured party. *Barnett v. American Family Mut. Ins. Co.*, 843 P.2d 1302, 1309 (Colo. 1993). *Crossgrove v. Wal-Mart Stores, Inc.,* 280 P.3d 29 (Colo. Ct. App. 2010) aff'd, 2012 CO 31, 276 P.3d 562 (Colo. 2012).
CONNECTICUT[3]	Billed + post-verdict reduction	Billed	Billed + post-verdict reduction	Billed	*Hernandez v. Marquez*, 377482, 2004 WL 113616 (Conn. Super. Ct. Jan. 5, 2004). Conn. Gen. Stat. Ann. § 52-225 (West) recovery is reduced post-verdict by the total amount of collateral sources paid minus premiums paid for the benefit.
DELAWARE[3]	Billed	Billed	MedMal: Post-verdict reduction Other: Billed	Billed	*Mitchell v. Haldar*, 883 A.2d 32 (Del. 2005). Del. Code Ann. tit. § 18 6862.
FLORIDA[3]	Billed + post-verdict reduction	Billed	Billed	Billed	Under Fla. Stat. § 768.76(1) (2008): the write-off is a collateral source. REDUCTION: by the amount contributed by the CS less the cost of consideration for that benefit. Note: no reduction for Medicare/Medicaid/ Workers' Comp/gov programs because the Federal government has a right to subrogation claims.

State	Private Insurance: Maximum Recovery	Private Insurance: Evidence Accepted	Medicare/Medicaid: Maximum Recovery	Medicare/Medicaid: Evidence Accepted	Authority + Notes
GEORGIA[2]	Billed	Billed	Billed	Billed	Ga. Code Ann., 51-12-1 CSR is applicable in tort cases, **but not applicable in breach of contract** cases: *Amalgamated Transit Union Local 1324 v. Roberts*, 263 Ga. 405, 434 S.E.2d 450 (1993). *Olariu v. Marrero*, 549 S.E.2d 121 (Ga. 2001) A write-off is a collateral source (adhering to the traditional CSR).
HAWAII[2]	Billed	Billed	Billed	Billed	Traditional CSR: *Bynum v. Magno*, 101 P.3d 1149 (Hawaii 2004).
IDAHO[3]	Billed + post-verdict reduction	Billed	Billed + post-verdict reduction	Billed	Idaho Code Ann § 6-1606 (2008). *Dyet v. McKinley*, 81 P.3d 1236 (Idaho 2003).
ILLINOIS[3]	MedMal: Billed + post-verdict reduction Other: Billed	Billed	MedMal: Billed + post-verdict reduction Other: Billed	Billed	*Wilson v. Hoffman Group, Inc.*, 546 N.E.2d 524, 530-31 (Ill. 1989). "reasonable value" of medical services is the amount billed the provider. **MedMal cases**: 735 Ill. Comp. Stat. § 5/2-1005 (2008). Reduction post-verdict – 50% of the benefits provided for lost wages by private or governmental disability programs, 100% of the benefits provided for medical/hospital/nursing or caretaking charges (BUT NOT for benefits where there is a right of subrogation, or where the reduction would exceed 50% of the award). Done by Application for Reduction w/in 30 days of the judgment
INDIANA[3]	Billed	Billed & paid	Billed	Billed & paid	*Shirley v. Russell,* 663 N.E.2d 532 (Ind. 1996); *Stanley v. Walker*, 906 N.E.2d 852 (Ind. 2009); Ind. Code § 34-44-1-1 (2008). The CSR does not bar evidence that a lesser amount was accepted by a medical provider, but evidence that payment came from a third-party is INADMISSIBLE. The CSR does NOT apply to write-offs because they are not payments. Inadmissible evidence for Personal Injury/Wrongful death actions: payments of life insurance or death benefits, insurance benefits for which plaintiff or his family paid for directly, and *payments made* by the state/US or its agencies.
IOWA[3]	Billed	Billed, paid & premiums	Billed	Billed, paid & premiums	Plaintiff is entitled to reasonable value of services and can show this through billed and paid amounts, and expert witness testimony as to reasonableness. *Pexa v. Auto Owners Ins. Co.*, 686 N.W.2d 150 (Iowa 2004) Iowa Code § 668.14. Iowa Code § 147.136: MED MAL Cases prohibits an award that includes any losses replaced or indemnified by insurance or gov/employment benefit programs.
KANSAS[3]	Billed	Billed & paid	Billed	Billed & paid	Follows common law CSR: Rst. 2d Torts § 920A(2). State statute ruled unconstitutional (60-3802) *Martinez v. Milburn Enterprises*, *Inc*., 290 Kan. 572, 233 P.3d 205 (2010). The source of the CS payment is inadmissible, but the billed & paid amounts may be used to establish reasonableness of medical services because the Write-off is not a CS.
KENTUCKY[2]	Billed	Billed	Billed	Billed	*Baptist Healthcare Sys., Inc. v. Miller*, 177 S.W.3d 676 (Ky. 2005). (no mention of write-offs specifically).
LOUISIANA[3]	Billed	Billed	Medicaid: paid, Medicare: billed	Medicaid: paid, Medicare: billed	*Griffin v. Louisiana Sheriff's Auto Risk Ass'n*, 802 So. 2d 691 (La.App. 1 Cir. 2001) writ denied, 801 So. 2d 376 (La.App. 1 Cir. 2001). **Medicaid/care**: because Medicaid is free for its recipients, they cannot recover the write-off, but Medicare recipients can recover it since they pay consideration for it. *Bozeman v. State*, 879 So.2d 692 (La. 2004).

State	Private Insurance: Maximum Recovery	Private Insurance: Evidence Accepted	Medicare/Medicaid: Maximum Recovery	Medicare/Medicaid: Evidence Accepted	Authority + Notes
MAINE[3]	MedMal: post-verdict reduction if coll. Source *doesn't* subrogate w/in 30 days Other: Billed	Billed	MedMal: post-verdict reductions for Medicare/caid and Soc. Sec. if Def makes Pf whole for any subrogation claims Other: Billed	Billed	Professional negligence case: post-verdict reduction by the amount paid by a CS if the source has NOT exercised its subrogation rights w/in 30 days after notice of the verdict. Reductions are taken for Medicare/Medicaid, Social Security (provided that the Def. makes the plaintiff whole for any related subrogation claims.) Me. Rev. Stat. Ann. tit. 24,§ 2906(2) (2008). *Barday v. Donnelly*, CV-04-508, 2006 WL 381876 (Me. Super. Jan. 27, 2006).
MARYLAND[3]	MedMal: Billed+ post-verdict reduction motion Other: Billed	Billed+ evidence of reasonableness	MedMal: Billed+ post-verdict reduction motion Other: Billed	Billed+ evidence of reasonableness	Evidence of CS payments admissible to show malingering or an exaggeration of an injury, if alleged. Plaintiffs are entitled to the "reasonable value" of medical services, and the court hasn't said which amount that is, but it has said that neither amount properly establishes the value. The plaintiff must offer some evidence that the amount charged was fair and reasonable." See, e.g., *Simco Sales Service v. Schweigman*, 205 A.2d 245, 249 (Md. 1964) (plaintiff satisfied burden where hospital's director of admissions and accounts testified that the hospital charges were fair and reasonable and were the customary charges made by the hospital for such services). Md. Code Ann., Cts. & Jud. Proc. § 10-104(e)(1) (West 2008). (Damages claims under $25,000 do not need supporting evidence of reasonableness.) *Brethren Mut. Ins. Co. v. Suchoza*, 212 Md. App. 43, 66 A.3d 1073, 1076 (2013)
MASSACHUSETTS[3]	MedMal: mandatory post-verdict reduction Other: Billed	Billed	MedMal: mandatory post-verdict reduction Other: Billed	Billed	Healthcare liability claims: mandatory post-verdict reduction by the amount paid by a CS, off-set by amount of premiums/consideration paid. Mass. Gen. Laws ch. 231, § 60G(a) (2008). **Medicaid Write-offs ARE payments.** and are "not a proper element of damages in a malpractice action." *Sylvestre v. Martin*, SUCV2003-05988, 2008 WL 82631 (Mass. Super. Jan. 4, 2008).
MICHIGAN[3]	Billed + Mandatory post-verdict reduction less premiums paid	Billed	Medicaid: billed Medicare: billed + post-verdict reduction	Billed	Mich. Comp. Laws § 600.6303 (2008). **Medicaid payments are not a collateral source.** See *Shinholster v. Annapolis Hosp*., 660 N.W.2d 361, 372-73 (Mich App. 2003), *aff'd in part rev'd in part* 671 N.W.2d 539 (Mich 2004). A write-off "has not been paid, nor is it payable, such that it is not a collateral source." *Detary v. Advantage Health Physicians, PC*, 308179, 2012 WL 6035024 (Mich. Ct. App. Nov. 29, 2012) appeal denied, 493 Mich. 970, 829 N.W.2d 862 (2013).
MINNESOTA[3]	Billed + post-verdict reduction	Billed	Billed + post-verdict reduction	Billed	*Swanson v. Brewster*, 784 N.W.2d 264. **Write-offs are collateral source**s and must be deducted by trial court from a jury award. Minn. Stat. Ann. § 548.251 (West). CSR still applies, but amount paid by CS is reduced from verdict.
MISSISSIPPI[2]	Billed	Billed	Billed	Billed	**Medicare/caid**: *Robinson Property Group, L.P. v. Mitchell*, 7 So.3d 240 (Miss. 2009). *Wal-Mart Stores, Inc. v. Frierson*, 818 So. 2d 1135, 1139 (Miss. 2002). (paid amount admissible for impeachment purposes only)
MISSOURI[2]	Billed	Billed	Billed	Billed	*Washington by Washington v. Barnes Hosp*., 897 S.W.2d 611, 619 (Mo. 1995), *Smith v. Shaw,* 159 S.W.3d 830, 832 (Mo. 2005). CS payments admissible when plaintiff makes financial condition an issue.

State	Private Insurance: Maximum Recovery	Private Insurance: Evidence Accepted	Medicare/Medicaid: Maximum Recovery	Medicare/Medicaid: Evidence Accepted	Authority + Notes
MONTANA[3]	Personal Injury: post-verdict reduction Other: Billed	Billed	Billed	Billed, but not yet specifically addressed	Mont. Code Ann. 27-1-308, when award >$50,000 and Plaintiff is fully compensated for damages, recovery is reduced by CS payments that are not subject to subrogation (less premiums Plaintiff paid for 5 previous years). *Fretts v. GT Advanced Technologies Corp.*, CV 11-160-M-CWM, 2013 WL 816684 (D. Mont. Mar. 5, 2013). Medicare/caid remains unaddressed. *Elliott v. Goulet*, 2012 WL 8530906 (Mont.Dist.) (Trial Order).
NEBRASKA[3]	Billed + post-verdict reduction	Billed	Billed	Billed	Neb. Rev. Stat. 44-2819 (2008), bodily injury or wrongful death cases: evidence of medical reimbursement insurance is inadmissible. reduction by amt of nonrefundable medical reimbursement insurance minus premiums paid. **Medicare/caid payments**: excluded from the statute and covered by traditional CSR.
NEVADA[2]	Billed	Billed (but worker's comp benefits may be admissible)	Billed	Billed	Write-offs are collateral sources. *Tri County Equip. & Leasing v. Klinke*, 286 P.3d 593 (Nev.2012) (Gibbons, J. concurring). *Alexander v. Wal-Mart Stores, Inc.*, 2:11-CV-752 JCM PAL, 2013 WL 427132 (D. Nev. Feb. 1, 2013).
NEW HAMPSHIRE[2]	Billed	Billed	Billed	Billed	*Carson v. Maurer*, 424 A.2d 825 (N.H. 1980), overruled by *Community Resources for Justice, Inc. v. City of Manchester*, 154 N.H. 748 (2007) on other grounds.
NEW JERSEY[3]	Billed + post-verdict reduction	Billed	Billed	Billed	N.J. Stat § 2A: 15-97 – **Verdict reduced by amount of CS payment (other than workers' comp and life insurance) less premiums paid**. *Perreira v. Rediger*, 778 A.2d 429 (N.J. 2001). *Cockerline v. Menendez*, 411 N.J. Super. 596, 988 A.2d 575, (App. Div. 2010).
NEW MEXICO[2]	Billed	Billed	Billed	Billed	*Summit Properties, Inc. v. Pub. Serv. Co. of New Mexico*, 2005-NMCA-090, 138 N.M. 208, 118 P.3d 716.
NEW YORK[3]	Billed + post-verdict reduction	Billed	Billed + post-verdict reduction	Billed	N.Y. C.P.L.R. LAW § 4545 (McKinney 2008). 4545(a): MedMal: evidence admissible of indemnification from a CS, verdict reduced accordingly (minus amount of premiums paid for past 2 years). 4545(b): actions against a public employer for PI/wrongful death evidence admissible of CS payment, but not CSes that are entitled to liens against recovery, to reduce verdict accordingly (minus premiums). 4545(c): PI/ injury to property/ wrongful death – evidence admissible of CS payment, but not CSes that are entitled to liens against recovery, to reduce verdict accordingly (minus 2 yrs of premiums + amt of maintaining such benefits). 4545(d): charitable contributions – are not considered collateral sources, inadmissible to reduce award.
NORTH CAROLINA[2]	Billed	Billed	Billed	Billed	*Fallis v. Watauga Med. Ctr., Inc.*, 132 N.C. App. 43, 510 S.E.2d 199 (1999). *Young v. Baltimore & O. R. Co.*, 266 N.C. 458, 463, 146 S.E.2d 441, 444 (1966).
NORTH DAKOTA[3]	Billed + post-verdict reduction	Billed	Billed + post-verdict reduction	Billed	*N.D. Cent. Code Ann.* § 32-03.2-06 (West).
OHIO[3]	Billed	Billed & paid (if no subrogation right) + premiums paid	Billed	Billed & paid (if no subrogation right) + premiums paid	*Ohio Rev. Code Ann.* § 2315.20 (West 2008). *Robinson v. Bates*, 112 Ohio St. 3d 17, 857 N.E.2d 1195 (2006).

State	Private Insurance: Maximum Recovery	Private Insurance: Evidence Accepted	Medicare/Medicaid: Maximum Recovery	Medicare/Medicaid: Evidence Accepted	Authority + Notes
OKLAHOMA[1]	Paid	Paid	Paid	Paid	12 O.S. § 3009.1 (2011). Cases filed pre-Nov 1., 2011: no precedent, *Brown v. USA Truck, Inc*., 2013. WL 653195 (W.D. Okla. 2013).
OREGON[3]	Billed + post-verdict reduction MOTION	Billed	Billed + post-verdict reduction MOTION	Billed	**Write-offs are collateral source payments.** Or. Rev. Stat. Ann. § 31.580 (West). *White v. Jubitz Corp*., 219 Or. App. 62, 182 P.3d 215 (2008) aff'd, 347 Or. 212, 219 P.3d 566 (2009). *Cohens v. McGee*, 219 Or. App. 78, 180 P.3d 1240, 1241 (2008).
PENNSYLVANIA[3]	MedMal: paid, Other: billed	MedMal: paid, Other: billed	MedMal: paid, Other: billed	MedMal: paid, Other: billed	*Nigra v. Walsh*, 2002 PA Super 113, 797 A.2d 353 (2002). CSR does not apply to Write-Offs in **MedMa**l: *Moorhead v. Crozer Chester Medical Center*, 564 Pa. 156, 765 A.2d 786 (2001) (abrogated on other grounds). 40 P.S. § 1303.508: Subrogation right eliminated in certain instances.
RHODE ISLAND[3]	MedMal: Billed Other: billed	MedMal: Billed & paid & premiums Other: billed	Billed	Billed	Trial courts split. Some have found R.I. *Gen. Laws Ann*. § 9-19-34.1 (West) unconstitutional. *Maguire v. Licht*, C.A. PC1999-3391, 2001 WL 1006060 (R.I. Super. Aug. 16, 2001); *Esposito v. O'Hair*, 886 A.2d 1197 (R.I. 2005). **Medicare/caid**: Jacqueline G. Kelley, Esq., Stephen P. Sheehan, Esq., *Collateral Source Rule Applies to Medicaid Without Exception for Medical Malpractice Cases*, R.I. B.J., November/ December 2006, at 17. In trial, jury instructed to reduce award by any sum equal to the difference be- tween what plaintiff contributed and what it received from collateral source (if CS evidence is introduced).
SOUTH CAROLINA[2]	Billed	Billed	Billed	Billed	*Covington v. George*, 597 S.E.2d 142, 144 (S.C. 2004).
SOUTH DAKOTA[2]	Billed	Billed	Billed	Billed	*Cruz v. Goth*, 2009 S.D. 19, 763 N.W.2d 810. *Papke v. Harbe*rt, 2007 S.D. 87, 738 N.W.2d 510, 530. **Evidence of Write-offs is not permissable: Plaintiff is entitled to recover the *reasonable value* of medical services which is a question for the jury. Ruling that either amount is the reasonable value makes the other value inherently *unreasonable.*** SDCL § 21-3-12, MedMal exception: evidence that special damages were paid for or are payable by insurance (not subject to subrogation or that was purchased privately) or state/fed gov't programs (not subject to subrogation).
TENNESSEE[3]	MedMal: paid Other: billed	MedMal: paid Other: billed	MedMal: paid Other: billed	MedMal: paid Other: billed	*Tenn. Code Ann*. § 29-26-119 (2008). A Plaintiff may recover unsubrogated moneys. *Cassie Nalawagan v. Hai v. Dang*, No. 06 2745 STA dkv, 2010 WL 4340797, at *2–*3 (W.D.Tenn. Oct.27, 2010). *Calaway ex rel. Calaway v. Schucker*, 2:02-CV-02715-STA, 2013 WL 960495 (W.D. Tenn. Mar. 12, 2013).
TEXAS[1]	Paid	Paid	Paid	Paid	*Tex. Civ. Prac. & Rem. Code Ann*. § 41.0105 (West). *Haygood v. De Escabedo*, 356 S.W.3d 390 (Tex. 2011), reh'g denied (Jan. 27, 2012).
UTAH[3]	MedMal: Billed + post-verdict reduction for unsobrogated moneys Other: billed	Evidence to establish reasonableness	MedMal: Billed + post-verdict reduction for unsobrogated moneys Other: billed	Evidence to establish reasonableness	Requested damages need only be "reasonable and necessary." *Gorostieta v. Parkinson*, 17 P.3d 1110 (Utah 2000); *Hansen v. Mountain Fuel Supply Co.*, 858 P.2d 970, 981 (Utah 1993). *Utah Code Ann.* § 78B-3-405 (West). What evidence is admissible to establish "reasonable and necessary" has yet to be determined, but a district court held in 2012 that only the billed amount is permitted. *Sanchez v. Cache Valley Specialty Hosp., LLC*, 2012 WL 6057104 (Utah Dist. Ct.) (Trial Order).

State	Private Insurance: Maximum Recovery	Private Insurance: Evidence Accepted	Medicare/Medicaid: Maximum Recovery	Medicare/Medicaid: Evidence Accepted	Authority + Notes
VERMONT[2]	Billed	Billed	Billed	Billed	*Windsor School Dist. v. State*, 956 A.2d 528 (Vt. 2008).
VIRGINIA[2]	Billed	Billed	Billed PAID in federal court	Billed PAID in federal court	*Acuar v. Letourneau*, 531 S.E.2d 316, 320 (Va. 2000); *Va. Code Ann.* § 8.01-35 (2008). Write-offs are akin to payments. FEDERAL COURT: **The collateral source rule does not apply to the illusory "charge"** of $96,500.91 since that amount was not paid by any collateral source. See *McAmis v. Wallace*, 980 F. Supp. 181 (W.D. Va. 1997).
WASHINGTON[2]	Billed	Billed	Billed	Billed	*Diaz v. State*, 175 Wash. 2d 457, 285 P.3d 873 (2012) preempting RCWA 7.70.080 (2006).
WEST VIRGINIA[2]	Billed	Billed	Billed	Billed	*Keesee v. General Refuse, Inc*., 604 S.E.2d 449, 452 (W.Va. 2004). Case law does not indicate that the court has evaluated the specific issue of writeoffs and their implication under the CSR. *State Farm Mut. Auto. Ins. Co. v. Schatken*, 230 W. Va. 201, 737 S.E.2d 229, 237 (2012).
WISCONSIN[2]	Billed	Billed	Billed	Billed	*Leitinger v. DBart, Inc.*, 736 N.W.2d 1 (Wis. 2007).
WYOMING[2]	Billed	Billed	Billed	Billed	*Garnick v. Teton County School Dist. No. 1*, 39 P.3d 1034, 1041 (Wyo. 2002).
WASHINGTON D.C.[2]	Billed	Billed	Billed	Billed	*Hardi v. Mezzanotte*, 818 A.2d 974, 984 (D.C. 2003); *Calva-Cerqueira v. United States*, 281 F.Supp.2d 279, 295 (D.D.C. 2003) dismissed, 04-5005, 2004 WL 2915332 (D.C. Cir. Dec. 16, 2004).

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