A Grim Prognosis? The Collateral Source Rule in Pennsylvania Medical Malpractice Actions After the Affordable Care Act

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ABSTRACT

Since the passage of the Patient Protection and Affordable Care Act ("ACA") in 2010, the percentage of individuals carrying health insurance in the United States has consistently increased. An unintended consequence of the ACA is that it has undermined the historical justification of the collateral source rule. The collateral source rule, which precludes a defendant from introducing evidence of a plaintiff's insurance coverage, has persisted for nearly 150 years primarily because insurance coverage was not the ubiquitous product that it is today.

In Pennsylvania, the intersection of the ACA and the collateral source rule has especially affected the medical malpractice field. An increasing number of insured plaintiffs in Pennsylvania medical malpractice lawsuits are able to collect twice for their future medical expenses—once when their heath insurance provider pays the plaintiffs' medical bills, and again when defendants pay these same bills.

The collateral source rule is not only incongruous with the ACA, but it also conflicts with state legislation, such as the Medical Care Availability and Reduction of Error Act ("MCARE Act"). The MCARE Act demonstrates a clear public policy reflecting the legislature's desire to reduce physicians' medical malpractice liability premiums and to retain competent physicians in the Commonwealth. The continuance of the collateral source rule, and its perpetuation of double recoveries, is directly at odds with such public policy.

This Comment discusses the evolution of the collateral source rule in Pennsylvania and reviews the seminal cases that have shaped the

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rule's application in medical malpractice proceedings. Additionally, this Comment explains how state legislation, primarily the MCARE Act, altered the collateral source rule's function. Finally, this Comment presents three practical avenues by which the Commonwealth can amend or abrogate the collateral source rule that are both consistent with existing public policy and protective of injured plaintiffs.

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I. INTRODUCTION

With the reaffirmation of the Patient Protection and Affordable Care Act[1] ("ACA") in *King v. Burwell*,[2] the individual mandate[3] of health

1. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).
2. King v. Burwell, 135 S. Ct. 2480 (2015).
3. *See* I.R.C. § 5000A (2010) (requiring individuals to obtain minimum essential coverage with limited exceptions).

insurance appears to be here to stay for the time being.[4] The Supreme Court's *King* decision preserved the widespread availability of healthcare in the United States, and, in doing so, has brought considerable attention to an unintended area of the law—the collateral source rule.[5] More specifically, the ACA has greatly affected the way in which the collateral source rule is viewed in the medical malpractice field. Pennsylvania's evidentiary procedures and substantive law governing the medical malpractice field have failed to keep up with new state and federal legislation, and, as a result, place extensive financial burdens on physicians in the Commonwealth.[6] This failure is particularly evident with regard to the collateral source rule.

When a physician is negligent in treating a patient, the physician may be liable to the patient based on a medical malpractice cause of action. When the patient brings suit against the physician, not only will the patient present evidence of the physician's negligence, but she will also present to the jury evidence of the damages sustained as a result of the physician's negligence. Such damages will likely be composed of past damages—those damages incurred up to the time of the lawsuit[7]—as well as future damages—those damages expected to be incurred after the conclusion of the lawsuit.[8] However, because of the persistence of the collateral source rule, the jury will not be presented with evidence indicating whether the patient carries health insurance to assist with the payment of these medical expenses.[9] The inequitable result of the

4. *See generally* Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566 (2012) (upholding the constitutionality of the individual mandate). President-elect Donald Trump has argued both for and against a full repeal of the ACA, so it is difficult to foresee the future of the law with any certainty. *See* Reed Abelson, *Donald Trump Says He May Keep Parts of Obama Health Care Act*, N.Y. TIMES (Nov. 11, 2016), http://nyti.ms/2fHJPFD.

5. *See generally* Adam G. Todd, *An Enduring Oddity: The Collateral Source Rule in the Face of Tort Reform, The Affordable Care Act, and Increased Subrogation*, 43 MCGEORGE L. REV. 965 (2012); Rebecca Levenson, Comment, *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 (2012).

6. See Marcy L. McCullough, Comment, *Prescribing Arbitration to Cure the Common Crisis: Developing Legislation to Facilitate Arbitration as an Alternative to Litigating Medical Malpractice Disputes in Pennsylvania*, 110 PENN ST. L. REV. 809, 810 (2006) (noting an increase in liability insurance premiums for Pennsylvania doctors).

7. *See infra* Part II.C.2.a.

8. *See infra* Part II.C.2.b. The plaintiff will also likely seek damages for pain and suffering, but, for the purposes of this Comment, such "non-economic" damages will not be discussed in detail.

9. *See infra* Part II.A. In fact, references to such collateral sources can result in a mistrial. *See, e.g.*, Larkin v. N.J. Transit Rail Operations, No. 3409 EDA 2013, 2015 Pa. Super. Unpub. LEXIS 3397, at *28 (Pa. Super. Ct. Sept. 16, 2015) ("[D]efense counsel's reference in opening statement to [plaintiff's] receipt of disability benefits was undoubtedly improper and so prejudicial as to warrant a mistrial . . . .").

physician's inability to introduce this evidence is that some plaintiffs in medical malpractice proceedings are compensated for hundreds of thousands of dollars of medical expenses, but only a tiny fraction of these expenses are actually paid by the plaintiff in the form of policy premiums and deductibles.[10]

This inequity, which originated at a time when health insurance was not the ubiquitous product it is today,[11] has become more prevalent with the continued application of the ACA. Nowadays, more plaintiffs are covered by health insurance when their medical malpractice claims arise.[12] Additionally, the ACA prohibits insurance companies from denying coverage for pre-existing conditions,[13] which means that even uninsured plaintiffs may obtain health insurance after they suffer harm at the hands of a doctor.

The purpose of this Comment is to discuss avenues by which the Pennsylvania General Assembly can cure the inequities currently present in the medical malpractice field. Medical malpractice liability insurance carriers and the doctors that they insure are facing unnecessary, heightened costs that can be lessened if certain actions are taken to amend or abrogate the collateral source rule.[14] Part II of this Comment discusses the history of the collateral source rule in Pennsylvania, as well as some of the seminal cases addressing the collateral source rule in Pennsylvania medical malpractice actions.[15] Additionally, Part II introduces and analyzes recent Pennsylvania legislation, primarily the MCARE Act,[16] which amended the common law collateral source rule in the Commonwealth.[17]

Most importantly, Part III of this Comment discusses and recommends alternatives to the collateral source rule, many of which have been employed in other states with great success.[18] Ultimately, this Comment recommends that the Pennsylvania General Assembly or judiciary extend the holding and reasoning in *Moorhead v. Crozer Chester Medical Center*[19] to future medical expenses.[20] Under such a

10. *See* ASPE OFFICE OF HEALTH SERVICES, HEALTH INSURANCE MARKETPLACE PREMIUMS FOR 2014, 11 (2013), http://bit.ly/2gf2Ajc (noting that the average premium after tax credits for a family of four in Pennsylvania with an income of $50,000 is $282).

11. *See infra* Part II.A.

12. *See infra* notes 30–32 and accompanying text.

13. 42 U.S.C. § 18001 (2010).

14. *See infra* Part III.B–D.

15. *See infra* Part II.A–B, D.

16. Medical Care Availability and Reduction of Error (MCARE) Act, 40 PA. CONS. STAT. §§ 1303.101–910 (2014).

17. *See infra* Part II.

18. *See infra* Part III.

19. Moorhead v. Crozer Chester Med. Ctr., 765 A.2d 786 (Pa. 2001).

20. *See infra* Part III.D.

system, future medical expenses awarded to plaintiffs in medical malpractice lawsuits can be calculated by awarding the maximum yearly out-of-pocket cost of obtaining insurance under the ACA.[21]

II. BACKGROUND

A. *The Collateral Source Rule in the Commonwealth*

1. Common Law History

The collateral source rule, which states that "payments from a collateral source shall not diminish the damages otherwise recoverable from the wrongdoer,"[22] has a long and complex history in Pennsylvania courts. In the 1871 case *Pennsylvania Railroad Co. v. Keller*,[23] Pennsylvania Supreme Court Chief Justice Oswald Thompson discussed a concept very similar to the contemporary collateral source rule.[24] He argued that it was necessary for a plaintiff to recover wrongful death damages regardless of the monetary effect that the decedent's death had on a surviving plaintiff, stating that:

> [The failure to have such a system] would prevent compensation where the survivors are absolutely benefited by the death, either as gainers by a distribution of the property of the deceased, or by the riddance of a troublesome charge. The controversies which would arise, if this were the rule, would be repugnant and offensive to the sensibilities of every person.[25]

The decedent's death in this case happened to bring financial gain to the plaintiff, but Chief Justice Thompson recognized that the plaintiff's fortuitous gain should not diminish the defendant's liability.[26]

Although the prism through which the contemporary collateral source rule is viewed has evolved, the rule's logic and practice remain largely the same.[27] Pennsylvania courts, as well as most courts in other

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21. *See id.*

22. Johnson v. Beane, 664 A.2d 96, 100 (Pa. 1995). *See also* RESTATEMENT (SECOND) OF TORTS § 920A(2) (AM. LAW INST. 1979) ("Payments made to or benefits conferred on the injured party from other sources are not credited against the tortfeasor's liability, although they cover all or a part of the harm for which the tortfeasor is liable.").

23. Pa. R.R. Co. v. Keller, 67 Pa. 300 (1871).

24. *Id.* at 307.

25. *Id.*

26. *Id.*

27. That is, more recent cases regarding the collateral source rule turn on the availability of insurance as opposed to a windfall gained by property being passed to a beneficiary or from the discharge of a debt, as was the case in *Keller*. For a slightly more contemporary discussion of the collateral source rule in Pennsylvania, see Ridgeway v. Sayre Elec. Co., 102 A. 123, 125 (Pa. 1917) ("[I]n an action for personal injuries, it has been held uniformly that the defendant cannot show, either as a bar to the action or in

jurisdictions, have uniformly upheld the collateral source rule[28] since its inception.[29]

One prevailing rationale for the collateral source rule's persistence in Pennsylvania is the desire to prevent a defendant from benefitting when a plaintiff was insured for the loss at issue.[30] Historically, this made sense because the rate at which individuals across the country carried health insurance was considerably lower when the collateral source rule was introduced.[31] In modern times, however, the significance of this rationale fades, particularly within the realm of medical malpractice. The ACA has made great strides in reducing the percentage of the population without health care insurance.[32] Today, the likelihood that a plaintiff in a medical malpractice action is insured is less of a chance occurrence and more of a statistical probability.[33]

An oft-criticized aspect of the collateral source rule, and one that has affected medical malpractice claims in Pennsylvania, is that the rule favors windfall double recoveries for plaintiffs that carry insurance.[34] With the dramatic increase in the percentage of individuals that carry

reduction in damages, that the injured person received, or is entitled to receive, compensation for his injuries in the form of insurance or otherwise.").

28. *See, e.g.*, Boudwin v. Yellow Cab Co., 188 A.2d. 259, 259–62 (Pa. 1963); Denardo v. Carneval, 444 A.2d 135, 140–41 (Pa. Super. Ct. 1982); Deeds v. Univ. of Pa. Med. Ctr., 110 A.3d 1009, 1012–14 (Pa. Super. Ct. 2015).

29. The collateral source rule was first adopted in the Supreme Court's *Monticello* decision. *See* Monticello v. Mollison, 58 U.S. 152, 155 (1855). The Court borrowed from well-established English common law when it noted that "[an] insurer does not stand in the relation of a joint trespasser, so that satisfaction accepted from him shall be a release of others." *Id*.

30. *See, e.g.*, Beechwoods Flying Serv., Inc. v. Al Hamilton Contracting Corp., 476 A.2d 350, 353 (Pa. 1984) ("[The collateral source rule is] intended to prevent a wrongdoer from taking advantage of the fortuitous existence of a collateral remedy.").

31. *See* CHRISTOPHER J. CONOVER, AM. ENTER. INST., AMERICAN HEALTH ECONOMY ILLUSTRATED 88 (2012), http://bit.ly/2d1bTnR (indicating the uninsured rate has dropped more than eighty percent over the last seventy years, but acknowledging many of the uninsured rates prior to 1970 are estimates due to a lack of informational surveys from that time period).

32. *See* Barack Obama, *United States Health Care Reform: Progress to Date and Next Steps*, J. AM. MED. ASS'N, at E3 (published online July 11, 2016) (noting that since the passage of the ACA, the uninsured rate has dropped by 43 percent). The ACA, colloquially referred to as "Obamacare," was signed into law by President Obama, and the potential bias of President Obama's article is not lost on the author of this Comment.

33. *See* Dan Diamond, *Thanks, Obamacare: America's Uninsured Rate is Below 10% for First Time Ever*, FORBES (Aug. 12, 2015), http://bit.ly/2fqsJi3 (reporting that CDC data shows 90.8 percent of Americans currently have health insurance).

34. *See* Levenson, *supra* note 5, at 929–30 (detailing the arguments for and against the collateral source rule, including potential double recoveries).

health insurance, more plaintiffs are being paid twice for their injuries—once by their health insurance carrier and once by the defendant.[35]

B. *An Original Step Toward Fair Compensation Before the MCARE Act:* Moorhead v. Crozer Chester Medical Center

In order to better understand the evolution of the collateral source rule in medical malpractice actions and to identify the noteworthy issues that double recoveries present, a discussion of relevant Pennsylvania case law and legislation is necessary. This discussion will identify the major policy concerns facing the medical malpractice field.

1. Case Background

In *Moorhead v. Crozer Chester Medical Center*,[36] the plaintiff, Catherine Baxter, was a patient at Crozer Chester Medical Center ("Crozer"), where she fell and was injured.[37] Baxter, a Medicare recipient, successfully sued Crozer for medical malpractice.[38] During the trial, the court reserved for itself the issue of measuring the compensation for Baxter's past medical expenses.[39] Baxter argued that she was entitled to the reasonable value of her past medical expenses, calculated by the sum of her medical bills, which was $108,668.31.[40] Crozer, on the other hand, claimed that Baxter was entitled only to the amount that Medicare actually paid on her behalf, which totaled $12,167.40.[41] Crozer asserted that the difference between these two values—$96,500.91—was a Medicare write-off[42] and not part of Baxter's reasonable value of medical services.[43] Since this portion of the bill was not paid by anyone, Crozer

35. As a general matter, subrogation rights sometimes allow for insurers to recoup funds they have paid when an insured recovers twice for injuries. *See* discussion *infra* Part II.C.2.

36. Moorhead v. Crozer Chester Med. Ctr., 765 A.2d 786 (Pa. 2001).

37. *Id.* at 787.

38. *Id.*

39. *Id.*

40. *Id.*

41. *Id.*

42. As a voluntary participant in the Medicare program, Crozer accepted $12,167.40 as full and complete payment for Baxter's medical bills. *Id.* at 789. The difference between the billed and paid amounts, referred to as a "write-off" or "set-off," was forgiven per the contractual agreement between Crozer and Medicare. While this Comment will not delve into the subject of Medicare write-offs, for a detailed discussion of write-offs and their intersection with the collateral source rule see Michael W. Cromwell, Comment, *Cutting the Fat Out of Health-Care Costs: Why Medicare and Medicaid Write-Offs Should Not Be Recoverable Under Oklahoma's Collateral Source Rule*, 62 OKLA. L. REV. 585, 594–99 (2010).

43. *Moorhead*, 765 A.2d at 791.

argued, Baxter should not be able to recover it.[44] The Pennsylvania Supreme Court ultimately held that Baxter was entitled to only the amount actually paid by Medicare, and thus, the $96,500.91 difference between the billed amount and the amount paid by Medicare was not part of the "reasonable value" of her medical expenses.[45]

This decision was significant with regard to the collateral source rule because the court found there were no collateral source implications with reducing Baxter's past medical expenses.[46] Instead, the court noted "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."[47] The *Moorhead* decision represented an important first step toward fair compensation for medical malpractice claims in Pennsylvania. After this case, plaintiffs were barred from collecting the windfall difference between billed medical expenses and the amount actually paid by insurers.[48] As was the case in *Moorhead*, there can be a substantial difference between the amount billed for medical services and the amount actually paid by a collateral source.[49]

After *Moorhead*, numerous lingering issues remained. *Moorhead* did not discuss whether past medical expenses paid for by a *private* insurer would be subject to a similar write-off.[50] The Pennsylvania General Assembly addressed this issue with the enactment of the MCARE Act, which essentially precluded plaintiffs from recovering past medical expenses paid by a private insurer.[51] Also, *Moorhead*'s application to *future* medical expenses was unclear. This issue remains

44. *Id.* at 788.

45. *Id.* at 791.

46. *Id.* at 790; *cf.* Rose v. Via Christi Health Sys., 78 P.3d 798, 806 (Kan. 2003) (holding that the collateral source rule does apply to the written-off portion of a plaintiff's medical bills when the plaintiff is insured through Medicare).

47. *Moorhead*, 765 A.2d at 791.

48. *Id.*; *see also* Watts v. Hollock, No. 3:10cv92, 2011 U.S. Dist. LEXIS 139166, at *29 (M.D. Pa. Dec. 5, 2011).

49. *See* Cromwell, *supra* note 42, at 596 (noting that Medicare and Medicaid will typically pay about one-third of the amount billed by providers). *See also* George A. Nation, *Determining the Fair and Reasonable Value of Medical Services: The Affordable Care Act, Government Insurers, Private Insurers and Uninsured Patients*, 65 BAYLOR L. REV. 425, 427–30 (2013) (discussing how hospitals inflate the cost of services in their chargemaster, an extensive price list, with the expectation that such charges will be negotiated prior to payment).

50. *See* Uwe E. Reinhardt, *The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy*, 25 HEALTH AFF. 57, 61 (2006) (noting that payments from private health insurers account for about one-third of hospitals' net revenues, and such companies often have billed charges discounted 50 percent or more).

51. *See* MCARE Act discussion *infra* Part II.C.

unresolved, but this Comment argues in Part III that future medical expenses should be subject to similar write-offs.[52]

C. *Responding to a Medical Malpractice Crisis–The MCARE Act*

1. Passing the MCARE Act

In 2002, Pennsylvania was arguably in the midst of a medical malpractice crisis.[53] Doctors faced increasingly high medical malpractice insurance premiums, which forced many to leave the Commonwealth and practice elsewhere.[54] In response to this crisis, and in furtherance of a public policy to reduce malpractice insurance rates,[55] the Pennsylvania General Assembly passed the MCARE Act in 2002.[56]

The MCARE Act created an independent state agency that, among other things,[57] established a patient compensation fund within the Commonwealth Treasury.[58] The MCARE Fund,[59] as it came to be known, pays medical malpractice claims against providers who participate in the MCARE Fund after the providers' primary insurance coverage is exhausted.[60] To pay for the operation of the Fund and

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52. *See infra* Part III.D.

53. See Kristen R. Salvatore, Comment, *Taking Pennsylvania Off Life Support: A Systems-Based Approach to Resolving Pennsylvania's Medical Malpractice Crisis*, 109 PENN ST. L. REV. 363, 363–77 (2004).

54. *Id.* at 363.

55. Medical Care Availability and Reduction of Error (MCARE) Act, 40 PA. CONS. STAT. §§ 1303.102(2)–(3) (2014)("Access to a full spectrum of hospital services and to highly trained physicians in all specialties must be available across this Commonwealth . . . [and t]o maintain this system, medical professional liability insurance has to be obtainable at an affordable and reasonable cost in every geographic region of this Commonwealth.").

56. *Id.* §§ 1303.101–910; s*ee also* Hosp. & Health Sys. Ass'n of Pa. v. Pennsylvania, 77 A.3d 587, 603 (Pa. 2013) ("MCARE comprises social legislation specifically designed . . . to ensure that Pennsylvania citizens have access to the care they need by incentivizing health care professionals to stay in Pennsylvania, or move to Pennsylvania, and fulfill those needs.").

57. *See* Salvatore, *supra* note 53, at 375–76 (discussing the General Assembly's concerted effort to reduce and eliminate medical errors by implementing heightened institutional oversight of health care providers and creating the Patient Safety Authority).

58. 40 PA. CONS. STAT. § 1303.712(a). The MCARE Fund is established within the State Treasury, but the administration of the MCARE Fund is controlled by the Insurance Department. *Id.* § 1303.713(a).

59. *Id.* § 1303.712(a).

60. Currently, the primary insurance limit for health care providers is $500,000 per occurrence and $1,000,000 in the annual aggregate. *Id.* § 1303.711(d)(2)(i). Hospitals must carry a primary policy limit of $500,000 per occurrence and $2,500,000 in the annual aggregate. *Id.* § 1303.711(d)(2)(iii).

administration of claims, providers pay a mandatory annual assessment,[61] much like an insurance premium. The Fund's purpose is to lessen the burden of medical malpractice liability insurance costs, thereby keeping physicians in the Commonwealth.[62]

2. The MCARE Act's Effect on the Collateral Source Rule and Subrogation

Some scholars have suggested that the common law collateral source rule persists largely because of an insurer's ability to subrogate funds paid to a plaintiff for past medical expenses.[63] Such a system prevents a plaintiff's "double recovery" because an insurer will step in to assert its right to be repaid for these medical expenses when the plaintiff is paid twice.[64] In passing the MCARE Act, the Pennsylvania General Assembly amended both the common law collateral source rule and subrogation rights in medical malpractice actions.[65] However, in amending the subrogation rules in medical malpractice actions, the MCARE Act falls short, at least in part, of prohibiting a plaintiff's double recovery.[66] In order to understand the MCARE Act's failings in this regard, it is necessary to first examine the full breadth of the changes created by the MCARE Act.

a. Past Medical Expenses

In addition to creating the MCARE Fund, the MCARE Act also dramatically changed the application of the collateral source rule in medical malpractice lawsuits.[67] The more defendant-friendly rule established by the MCARE Act states that a plaintiff in a medical malpractice action is barred from recovering *past* medical expenses or lost wages if private or public health insurance covered those expenses.[68]

61. *Id.* § 1303.712(d). Prior to June of 2011, additional funding for the MCARE Fund was also obtained through the imposition of surcharges related to moving violations. *See id.* § 1303.712(m) (2011) (repealed 2011).

62. *See* Pa. Med. Soc'y v. Dep't of Pub. Welfare, 39 A.3d 267, 271 (Pa. 2012).

63. *See, e.g.*, Todd, *supra* note 5, at 987–88 (discussing how the collateral source rule has persisted in some ways because of an insurer's ability to recover its interests from the plaintiff's award).

64. Typically, an insurer can assert its rights to compensation for a plaintiff's medical expenses when the insurer has already paid for these expenses. *See, e.g.*, Jacobs v. Ne. Corp., 206 A.2d 49, 53 (Pa. 1965) (discussing the basic tenants of subrogation).

65. 40 PA. CONS. STAT. § 1303.508(a) (2014) (amending the collateral source rule); 40 PA. CONS. STAT. § 1303.508(c) (amending subrogation rights for past medical expenses).

66. *See infra* Part II.C.2.b.

67. 40 PA. CONS. STAT. § 1303.508(a) (2014).

68. *Id.*

However, the Act does carve out a large exception for public benefits paid with a federal right of reimbursement, indicating that these benefits are not covered by the new iteration of the collateral source rule.[69] Accordingly, a plaintiff could recover for medical costs covered by a public insurer, but such a recovery would be limited to the amount actually paid by the public insurer under the *Moorhead* decision.[70]

For example, because Medicaid includes a statutory right of reimbursement,[71] Medicaid will exercise its subrogation rights over any funds paid to the plaintiff for billed medical expenses.[72] While government-insured plaintiffs are technically compensated twice for their past medical expenses—once by the insurance carrier and once by the defendant—the government insurance carrier, i.e. Medicaid, will pursue the plaintiff for reimbursement.[73] In effect, the MCARE Act's new application of the collateral source rule precludes a plaintiff's double recovery for past medical bills paid by a government-sponsored insurance plan because of the government's subrogation rights to the plaintiff's second recovery.[74]

The MCARE Act also ushered in another important change[75] to the medical malpractice landscape—the inability of a private insurer to

69. *Id.* § 1303.508(d)(4).

70. Moorhead v. Crozer Chester Med. Ctr., 765 A.2d 786 (Pa. 2001); *see also supra* Part II.B.

71. *See* 42 U.S.C. § 1395y(b)(2)(B)(iii)(2015).

72. ERISA, which regulates employer-sponsored health care plans, is another federal program that is occasionally involved in a plaintiff's health care, and it typically has a reimbursement right. Unlike Medicare or Medicaid, this reimbursement right is not found within the statute itself but is found within the contractual language of most qualified plans. *See* Amber M. Anstine, Comment, *ERISA Qualified Subrogation Liens: Should They be Reduced to Reflect a Pro Rata Share of Attorney Fees?*, 104 DICK. L. REV. 359, 360 (2000).

73. 42 U.S.C. § 1395y(b)(2)(B)(iii).

74. 40 PA. CONS. STAT. § 1303.508(d)(4).

75. Beyond changes to the collateral source rule and subrogation, the MCARE Act also introduced a periodic payment provision codified at 40 PA. CONS. STAT. § 1303.509(b)(2) (2014). Periodic payment provisions are a common medical malpractice tort reform that allows for a defendant to periodically pay a plaintiff's future medical expenses over the course of the plaintiff's life. *See* Joanna M. Shepherd, *Tort Reform's Winners and Losers: The Competing Effects of Care and Activity Levels*, 55 UCLA L. REV. 905, 935 (2008). If the plaintiff died before the entirety of the judgment was paid, the defendant would not be liable for the remainder. *Id.* This Comment will not focus on periodic payment provisions or their effectiveness, but for a detailed discussion of periodic payment provisions and their effect on medical malpractice settlements, see Ronen Avraham, *Current Research on Medical Malpractice Liability: An Empirical Study of the Impact of Tort Reforms on Medical Malpractice Settlement Payments*, 36 J. LEGAL STUD. 183 (2007).

exercise its subrogation right for medical expenses.[76] This change is particularly important because, unlike a public insurer such as Medicare or Medicaid, a private insurer will not be able to recoup any money a defendant pays to cover a plaintiff's past medical expenses.[77] However, a private insurer's inability to subrogate generally aligns with Section 1303.508(a) of the MCARE Act, which states that a medical malpractice plaintiff may not recover for past expenses paid for by a private insurer.[78] Thus, the Pennsylvania General Assembly made sure that privately insured plaintiffs, just like publicly insured plaintiffs, could not recover their past medical costs twice. In the case of a publicly insured plaintiff, double recovery is not possible because of the government's subrogation rights.[79] In the case of a privately insured plaintiff, the MCARE Act precludes recovery from a defendant of past medical expenses covered by private insurance.[80]

Although these MCARE Act provisions make clear the General Assembly's intent to prohibit plaintiffs from obtaining double recoveries for past medical costs, no language exists in the MCARE Act to prevent double recovery of *future* medical expenses. This silence is problematic for a number of reasons, most importantly because future medical expenses can account for some of the largest expenditures in medical malpractice lawsuits.[81] Additionally, the MCARE Act was signed into law well before the ACA took effect; thus, the drafters of the MCARE Act likely did not contemplate near-universal health care coverage or its potential effect on future medical damages. Accordingly, the ever-increasing percentage of insured Pennsylvanians is incongruent with the reality that the MCARE Act allows double recoveries of future medical expenses.

b. Future Medical Expenses

Unlike past medical expenses, which can be readily calculated and paid by looking at a plaintiff's medical bills or a public insurer's billing rate, future medical damages are much more difficult to accurately

76. 40 PA. CONS. STAT. § 1303.508(c) ("[T]here shall be no right of subrogation or reimbursement from a claimant's tort recovery with respect to a public or private benefit covered in subsection (a).").

77. *Id*.

78. *Id*. § 1303.508(a).

79. *Id.* § 1303.508(d)(4).

80. *Id*. § 1303.508(c).

81. *See* Sarah R. Levin, Comment, *The Medical Malpractice System and the Payment of Future Medical Damages: On Life Support Elsewhere, Resuscitated in Louisiana*, 68 LA. L. REV. 955, 958–59 (2008) (noting that the typical driving force behind large medical malpractice verdicts is economic damages, including future medical costs).

ascertain.[82] Typically calculated by a life care planner, these damages are mere estimates of the medical care a plaintiff will likely need for the rest of his or her life.[83] Future medical costs can include services such as future doctor visits, prescription expenses, long-term care, in-house nursing, transportation, or a myriad of other medical needs.[84] Such costs can amount to huge sums.

These future medical expenses raise a significant question for doctors and liability insurers alike. Should a defendant be liable to a plaintiff for an enormous amount of future medical damages when the ACA requires the plaintiff carry health insurance that covers many of these costs? The question becomes even more compelling when considering that the ACA prohibits insurance carriers from denying health care coverage because of preexisting medical conditions.[85] Now, even a previously uninsured plaintiff may obtain affordable insurance after his or her injury.[86]

Further complicating this situation are the insurers' subrogation rights. Pursuant to the MCARE Act, health insurance companies are not able to assert their subrogation rights over a plaintiff's medical malpractice award for past medical expenses, but there is no mention of an insurer's ability to subrogate future medical expenses.[87] The ACA, meanwhile, provides no subrogation provision for insurers.[88] Thus, for future medical expenses, the defendant pays the plaintiff after an award or settlement, and the insurance carrier periodically pays the plaintiff's medical bills without an ability to subrogate.[89] Such an arrangement perpetuates double recoveries for plaintiffs, particularly for those plaintiffs with private health insurance.[90]

82. *See* Watts v. Hollock, No. 3:10cv92, 2011 U.S. Dist. LEXIS 139166, at *30 (M.D. Pa. Dec. 5, 2011) ("[T]he precise amount of future medical expenses are [sic] inherently speculative.").

83. *See* Deeds v. Univ. of Pa. Med. Ctr., 110 A.3d 1009, 1012 n.3 (Pa. Super. Ct. 2015) ("A certified life care planner reviews medical records and bills to formulate an expert opinion projecting the future medical costs of an individual over her lifetime.").

84. *See, e.g.*, Reges v Nallathambi, No. 1199 WDA 2012, 2013 Pa. Super Unpub. LEXIS 2088, at *3–4 (Pa. Super. Ct. Sept. 30, 2013) (discussing various types of future medical expenses required by a plaintiff in medical malpractice suits).

85. 42 U.S.C. § 300gg-1 (2010).

86. *Id.*

87. 40 PA. CONS. STAT. § 1303.508(c) (2014).

88. *See* Todd, *supra* note 5, at 982 n.131.

89. *See infra* Part III.

90. *See id.*

D. *Failure to Extend Moorhead to Future Medical Expenses:* Cleaver v. United States

Unfortunately, given their interrelatedness, the aforementioned concerns regarding future medical expenses manifest in even relatively straightforward cases. Take, for example, a patient who seeks treatment at a hospital after complaints involving his urinary tract.[91] The doctor treating the patient fails to recognize the signs and symptoms of kidney disease, and the delay in treatment causes the patient irrevocable kidney damage such that the patient will need a kidney transplant in the future.[92] The patient will have significant future medical expenses related to his damaged kidney.[93] Notably, however, the patient is insured through Medicare.[94] The *Moorhead* court explained that any past medical expenses should be paid at the billing rate of the government-sponsored insurance provider;[95] should future medical expenses be paid at the same rate? This was the question addressed by the United States District Court for the Western District of Pennsylvania in *Cleaver v. United States.*[96]

1. Case Background

The facts of the above example were taken from the *Cleaver* case. As discussed above, the plaintiff in *Cleaver* was injured as the result of the doctor's failure to diagnose a kidney condition.[97] The plaintiff sued his provider for the cost of future medical expenses related to his injury.[98] Prior to trial, the defendant filed a motion in limine seeking to require that plaintiff's past and future medical expenses be measured using Medicare billing rates.[99] The defendant argued that because the plaintiff was approved for Medicare based on his disability, and because the plaintiff contended he would be disabled for the rest of his life, then Medicare billing rates should be applied to future medical expenses as well.[100]

91. Cleaver v. United States, No. 08-425, 2012 WL 912729 (W.D. Pa. Mar. 15, 2012).
92. *Id.* at *1.
93. *Id.* at *2.
94. *Id.*
95. Moorhead v. Crozer Chester Med. Ctr., 765 A.2d 786, 791 (Pa. 2001).
96. Cleaver v. United States, No. 08-425, 2012 WL 912729 (W.D. Pa. Mar. 15, 2012).
97. *Id.* at *1.
98. *Id.*
99. *Id.*
100. *Id.* at *2.

The plaintiff, however, noted that the *Moorhead* decision applied only to the issue of past medical expenses.[101] In making this argument, the plaintiff explained that there was no guarantee that Medicare would insure him for the rest of his life, so using Medicare billing rates as the reasonable value of his medical expenses was misplaced.[102]

In its analysis, the *Cleaver* court briefly noted that the *Moorhead* decision was dispositive with regard to past medical expenses; such expenses are recovered at the Medicare billing rate as long as the health care provider accepts this rate.[103] However, the court declined to adopt the same standard for future medical expenses, noting that "[t]his jurisdiction has never extended *Moorhead*'s holding and rationale to encompass recovery of damages for future medical expenses."[104] The court explained as part of its rationale that there was no guarantee that Medicare would exist in perpetuity.[105] Accordingly, the defendant's motion in limine to exclude future medical costs beyond the Medicare billing rate was denied.[106]

The *Cleaver* court's refusal to extend *Moorhead*'s holding to future medical expenses created a serious dilemma after the introduction of the ACA. Should a defendant be forced to pay medical costs to a plaintiff who will already be covered by insurance?[107] Or, should the tortfeasor be liable for the amount of harm caused, consistent with the collateral source rule?[108]

III. ANALYSIS

Currently, Pennsylvania's collateral source rule successfully prohibits double recoveries for past medical expenses.[109] Under the MCARE Act, privately insured plaintiffs may not collect past medical

101. *Id.* at *3.
102. *Id.* at *3. This argument is often cited when discussing Medicare or Medicaid billing rates as applied to future medical expenses. *See, e.g.*, Watts v. Hollock, No. 3:10cv92, 2011 U.S. Dist. LEXIS 139166, at *30 (M.D. Pa. Dec. 5, 2011) ("Fairness and public policy dictate that the burden of any risk regarding future medical costs or changes in insurance contribution rates should fall on the defendants not the plaintiffs.")
103. *Cleaver*, 2012 WL 912729, at *2. The court also cited to cases where defendants argued to extend *Moorhead*'s holding to future medical expenses in circumstances outside the realm of medical malpractice. *Id.*
104. *Id.* at *3.
105. *Id.*
106. *Id.*
107. *See* Levenson, *supra* note 5, at 931 (discussing the argument that the primary purpose of tort law is fair compensation to the victim and that the collateral source rule does not further this purpose).
108. *Id.* at 928–29 (discussing the argument that deterrence is a primary purpose of tort law and the collateral source rule accomplishes this purpose).
109. *See supra* Part II.C.2.a.

expenses covered by their health insurance.[110] Likewise, publicly insured plaintiffs can collect for past medical expenses covered by their insurance, but this double recovery is extinguished when the public insurer exercises its right of subrogation.[111] However, when it comes to future medical expenses, the MCARE Act is lacking in its ability to stop plaintiffs' double recoveries. This double recovery is antithetical to Pennsylvania's public policy of keeping doctors' medical liability insurance rates low.[112] Accordingly, the Pennsylvania General Assembly or judiciary is warranted in amending the means by which plaintiffs recover future medical expenses in medical malpractice lawsuits.

A. *Why Amending Pennsylvania's Collateral Source Rule in Medical Malpractice Actions is Practical*

Admittedly, there are strong countervailing public policies against offsetting future medical expenses. For instance, a common argument against abrogating the collateral source rule is that it is unfair for the tortfeasor—in this case, a doctor—to benefit from the plaintiff's insurance coverage.[113] Additionally, many scholars point to the deterrence value that the collateral source rule provides to tortfeasors as a reason for its continued existence.[114] Patients may be safer in a legal landscape that deters harmful or negligent conduct.[115] Although these public policies make sense in theory, they do not accomplish their goals in practice. Physicians, by and large, do not pay out-of-pocket for the

110. *See id.*
111. *See id.*
112. *See* Medical Care Availability and Reduction of Error Act, 40 PA. CONS. STAT. §§ 1303.102(2)–(3) (2014). While not geared specifically towards medical malpractice, another Pennsylvania statute that helped doctors reduce large awards is found in Pennsylvania's Fair Share Act, codified at 42 PA. CONS. STAT. § 7102(a.1)(1) (2014). The Fair Share Act amended Pennsylvania's comparative negligence scheme. *Id.* In a case involving multiple tortfeasors, the new law ended the requirement that financially solvent co-defendants make the plaintiff whole if other co-defendants could not pay their share. *See* William J. Ricci & Thomas Finarelli, *Understanding the "New Reality" of Pennsylvania's Fair Share Act*, 2012 EMERGING ISSUES 6215 (2012) (LEXIS) (discussing Fair Share Act's applicability to medical malpractice proceedings).
113. *See, e.g.*, Johnson v. Beane, 664 A.2d 90, 100 (Pa. 1995) ("The principle behind the collateral source rule is that it is better for the wronged plaintiff to receive a potential windfall than for a tortfeasor to be relieved of responsibility for the wrong."); J. Zachary Balasko, *A Return to Reasonability: Modifying the Collateral Source Rule in Light of Artificially Inflated Damage Awards*, 72 WASH. & LEE L. REV. 16, 21 (2015) ("[T]he rule validates a windfall in favor of the plaintiff to prevent a windfall in favor of the defendant.").
114. *See, e.g.*, Ann S. Levin, Comment, *The Fate of the Collateral Source Rule After Healthcare Reform*, 60 UCLA L. REV. 736, 751–52 (2013) (noting that one justification for the collateral source rule is that it may increase deterrence for tortfeasors).
115. *See id.*

harm that they cause to patients.[116] Rather, plaintiffs' awards or settlements are paid by liability insurance carriers, which at least partially dampens any deterrence value the collateral source rule creates.[117]

Moreover, the historical rationale for the collateral source rule—that the rule "prevent[s] a wrongdoer from taking advantage of the fortuitous existence of a collateral remedy"[118]—is now a relic of history. Today, an increasing number of individuals are insured thanks to the ACA[119] and the Health Insurance Exchanges.[120] Additionally, the ACA expanded Medicaid in most states, meaning even more citizens are being granted access to quality, affordable health care.[121] The individual mandate component of the ACA assures that a plaintiff's status as insured is not fortuitous; it is now legally required.[122]

With so many insured plaintiffs in medical malpractice lawsuits and no ability to stop plaintiffs from recovering twice for future medical expenses, the parties who bear the brunt of these extra payments are medical liability insurance carriers and, by extension through higher insurance premiums, the doctors themselves.[123] Increasing medical

116. *See* Kathryn Zeiler, *Medical Malpractice Liability Crisis or Patient Compensation Crisis?*, 59 DEPAUL L. REV. 675, 691 (2010) (noting that in a Texas study, only 1.5 percent of large payout claims had payments above a physician's primary liability policy limit).

117. *See* Christian D. Saine, Note, *Preserving the Collateral Source Rule: Modern Theories of Tort Law and a Proposal for Practical Application*, 47 CASE W. RES. L. REV. 1075, 1091 (1997) (noting the argument that the prevalence of liability insurance may "create a buffer between the defendant and his tort liability obligations . . . .").

118. Beechwoods Flying Serv., Inc. v. Al Hamilton Contracting Corp., 476 A.2d 350, 353 (Pa. 1984).

119. *See* U.S. DEP'T OF HEALTH AND HUMAN SERV., Nationwide Nearly 11.7 Million Consumers are Enrolled in 2015 Health Insurance Marketplace Coverage (March 10, 2015), http://bit.ly/1ERGWsm.

120. 42 U.S.C. § 18031(b)(1)(A). Health Insurance Exchanges, often called Insurance Marketplaces, are state-run entities that "facilitate[] the purchase of qualified health plans[.]" *Id.*

121. Initially, the Supreme Court struck down the ACA's provision that *required* states to expand Medicaid to all non-elderly citizens with incomes below 133 percent of poverty line. *See* Nat'l Fed'n of Ind. Bus. v. Sebelius, 132 S. Ct. 2566, 2605–09 (2012). However, states still retained the ability to *voluntarily* expand Medicaid, as was suggested by the federal government. *Id*. at 2607. *But see, e.g.*, *Last Week Tonight with John Oliver* (HBO television broadcast Nov. 1, 2015), http://itsh.bo/2cnoDkg (noting that 20 states have not expanded Medicaid despite the federal government paying no less than 90 percent of the expansion).

122. I.R.C. § 5000A (2010)

123. U.S. GEN. ACCOUNTING OFFICE, MEDICAL MALPRACTICE INSURANCE: MULTIPLE FACTORS HAVE CONTRIBUTED TO INCREASED PREMIUM RATES, GAO-03-702 (2003), http://www.gao.gov/assets/240/238724.pdf ("GAO found that losses on medical malpractice claims — which make up the largest part of insurers' costs — appear to be the primary driver of rate increases in the long run.").

liability insurance rates will continue to have a detrimental impact on doctors' abilities to continue practicing medicine in the Commonwealth.[124] With Pennsylvania's clear public policy promoting the retention of skilled doctors and the availability of quality health care,[125] the Pennsylvania General Assembly should amend the collateral source rule to prohibit plaintiffs in medical malpractice lawsuits from collecting their future medical costs twice.

Although the introduction of the ACA has created a predicament in the medical malpractice arena, means exist to remedy the problem and create greater equity for plaintiffs and defendants. The following sections of this Comment will discuss the options available to the General Assembly to resolve medical malpractice claims in an equitable manner, including: 1) allowing the introduction of evidence pertaining to the plaintiff's insurance coverage at trial, thereby affecting the collateral source rule and its role as an evidentiary rule;[126] 2) abrogating the collateral source rule at the verdict stage, as has been done in New York;[127] or 3) extending the *Moorhead* holding to future medical expenses to allow for a publicly insured plaintiffs to recover only the billing rates related to their medical expenses.[128] All three systems accomplish the same two goals. First, these systems ensure that plaintiffs are compensated fairly for their medical bills.[129] Second, they lessen the burden on the physicians and the physicians' liability insurers such that claim payments and malpractice premiums will decrease.[130]

B. *Abrogating the Collateral Source Rule and Allowing the Jury to Fairly Decide Plaintiffs' Damages*

One way that the Pennsylvania General Assembly can preclude double recoveries by plaintiffs in medical malpractice lawsuits is to allow juries to hear evidence regarding a plaintiff's insurance coverage.[131] Such a system would eliminate the collateral source rule's function as a rule of evidence.[132] In this system, a defendant physician

124. *See* Salvatore, *supra* note 53, at 363 (noting that some doctors chose to leave Pennsylvania due to rising medical liability insurance rates).

125. *See* Medical Care Availability and Reduction of Error (MCARE) Act, 40 PA. CONS. STAT. §§ 1303.102(2)-(3)(2014).

126. See infra Part III.B.

127. *See infra* Part III.C.

128. *See infra* Part III.D.

129. *See infra* Part III.B–D.

130. *See id.*

131. *See* ALA. CODE § 6-5-545 (2016).

132. *See* Levenson *supra* note 5, at 940–41 (discussing the collateral source rule as both a rule of evidence and a rule of damages). Viewed as a rule of evidence, the collateral source rule prevents a defendant from introducing evidence of a plaintiff's

could introduce evidence regarding the plaintiff's public or private health insurance (or lack thereof) so that the jury could make an informed decision regarding damages. This approach has been adopted in Alabama, pursuant to the Alabama Medical Liability Act of 1987.[133]

Alabama's abrogation of the collateral source rule allows a defendant to introduce evidence of a "plaintiff's medical or hospital expenses [that] have been or will be paid or reimbursed."[134] Alabama's statute is incredibly broad, and if such a statute were adopted in Pennsylvania, it would encompass all plaintiffs in Pennsylvania medical malpractice cases.[135] Importantly, a provision in the Alabama statute allows plaintiffs to introduce evidence of "the cost of obtaining reimbursement or payment of medical or hospital expenses."[136] This provision also permits plaintiffs to indicate the cost at which they acquired their insurance. Thus, plaintiffs are able to provide to the jury the costs of their premiums, co-payments, and deductibles that were paid to obtain care.[137]

Interestingly, the Alabama statute does not *require* the jury or the court to offset economic damages by the amount of collateral source payments.[138] In fact, a jury is within its discretion to completely disregard evidence of a plaintiff's insurance and award damages that have already been paid by the plaintiff's health insurance carrier.[139] Alabama courts have grappled with the constitutionality of this

insurance at trial due to the perceived prejudicial impact such insurance coverage may have on the plaintiff. *Id.* at 940–42. Conversely, when viewed as a rule of damages, the collateral source rule blocks insurance information from evidence under the theory that a defendant should not benefit from a plaintiff obtaining insurance prior to a loss. Richard C. Ausness, *An Insurance-Based Compensation System for Product-Related Injuries*, 58 U. PITT. L. REV. 669, 708 (1997).

133. ALA. CODE § 6-5-545. Numerous other states have also passed similar reforms to the collateral source rule. *See, e.g.*, ALASKA STAT. § 12-565(a) (2015) (allowing evidence of a plaintiff's health insurance in medical malpractice actions); ARIZ. REV. STAT. ANN. § 12-565(A) (2015) (allowing the evidentiary admission of insurance benefits, except those with a right of subrogation); CAL. CIV. CODE § 3333.1(a) (2015) (allowing the defendant to introduce evidence of a plaintiff's insurance in medical malpractice lawsuits, except insurance with a right of subrogation).

134. ALA. CODE § 6-5-545(a).

135. Although if a plaintiff did not include damages for medical expenses, no collateral source rule concerns would arise.

136. ALA. CODE § 6-5-545(a).

137. 2-40 MICHAEL L. ROBERTS, ALABAMA TORT LAW § 40.12 (6th ed. 2015) (LEXIS).

138. *See* Benjamin B. Coulter, *No Longer as Good as Dead: The Continued Revival of Alabama's Medical and Hospital Expense Exception to the Collateral Source Rule a Decade After Marsh*, 42 CUMB. L. REV. 299, 316–17 (2011) (recommending that the Alabama Legislature amend the statute to make clearer how courts should apply the provision).

139. *See id.* at 317.

provision,[140] and there are certainly concerns raised when a jury is tasked with such a complicated discretionary function–namely, jury confusion and inconsistent results.[141] Admittedly, the system is far from perfect. A defendant may provide ironclad proof of a plaintiff's collateral benefits but have this evidence disregarded or misapplied by a jury when calculating damages.[142]

Despite these concerns, the Alabama system still assures that victims of medical negligence are compensated fairly for their injuries, and it also typically prevents plaintiffs from obtaining windfall double recoveries of past and future medical expenses. If Pennsylvania were to adopt a comparable statute allowing evidence of collateral sources to be introduced at trial, the General Assembly should require the jury to deduct collateral source payments from the allocation for past and future medical expenses. Doing so would allay any concerns of jury confusion and uniformly apply the provision to all medical malpractice cases.

C. *Abrogating the Collateral Source Rule at the Post-Verdict Stage – An Examination of N.Y. C.P.L.R. § 4545(a)*

Whereas the Alabama collateral source statute vests considerable, and perhaps excessive, discretion with the jury to potentially offset payments from collateral sources, the New York statute assigns this task to the court in a post-verdict hearing.[143] New York's decision to allow a judge to deduct payments from past or future collateral sources from the verdict assuages the two concerns created with the Alabama system: jury confusion and inconsistent verdicts.[144] Additionally, the New York system *requires* the court to offset verdicts based on sufficient evidence

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140. American Legion Post No. 57 v. Leahy, 681 So. 2d 1337, 1347 (Ala. 1996) (noting that a "standardless submission to the jury" of damages and collateral source evidence would violate the Alabama Constitution's due process provision), *overruled by* Marsh v. Green, 782 So. 2d 223 (Ala. 2000).

141. *See* Todd, *supra* note 5, at 976.

142. *See, e.g.*, Killian v. Meiser, 792 F.Supp. 1217, 1220 (N.D. Ala. 1992) ("[Such an instruction to the jury] is tantamount to telling the jury that it can, with impunity, reduce any justifiable verdict by the amount of money plaintiff may receive from a collateral source, but that it need not do so, or, for that matter may punish a greedy plaintiff and give him nothing in an otherwise meritorious case.").

143. *See* N.Y. C.P.L.R. § 4545 (Consol. 2015). Other states utilize a system similar in nature to New York's system. *See, e.g.*, IDAHO CODE § 6-1606 (2015)("Evidence of payment by collateral sources [without a right of subrogation] is admissible to the court after the finder of fact has rendered an award."); MICH. COMP. LAWS §§ 600.6303(1)–(2)(2015) ("[I]f the court determines that all or part of the plaintiff's expense or loss has been paid or is payable by a collateral source, the court shall reduce that portion of the judgment which represents damages paid or payable by a collateral source . . . .").

144. *See* Todd, *supra* note 5, at 976.

of the collateral source, which achieves the ultimate goal of eliminating plaintiffs' double recoveries.[145]

In New York civil actions, evidence of collateral source payments—such as health insurance—is admissible only for the court to determine whether the plaintiff "was or will, with reasonable certainty, be replaced or indemnified, in whole or in part, from any collateral source."[146] Notably, collateral sources with statutory rights of reimbursement, such as Medicare, Medicaid, and ERISA, are outside of the New York system's purview.[147] However, because the ACA is leading to more plaintiffs' being insured through private carriers, New York's statute is affecting an increasing amount of its citizens.[148]

Moreover, the New York statute's language indicates that collateral source evidence is not admissible during trial.[149] Rather, the trial is completed as if the common law collateral source rule were applicable.[150] If a verdict is reached in favor of the plaintiff, the defendant must request a separate collateral source hearing prior to the entry of judgment.[151] At this hearing, the defendant must present some competent evidence that the plaintiff was or will be compensated for the loss from a collateral source.[152]

During the collateral source hearing, the New York statute requires that the defendant show with reasonable certainty that a collateral source has compensated, or will compensate, the plaintiff for the damages that were awarded at trial.[153] New York courts have interpreted this requirement to mean that a defendant must show that it is highly probable the plaintiff will have continued eligibility of coverage or benefits.[154]

145. N.Y. C.P.L.R. § 4545(a) ("If the court finds that any such cost or expense was or will, with reasonable certainty, be replaced or indemnified from any such collateral source, it shall reduce the amount of the award by such finding.").

146. *Id.*

147. *Id.* However, as discussed previously in Part II.C.2.a., subrogation rights of the public insurer typically quell concerns for double recoveries by plaintiffs.

148. *See* Diamond, *supra* note 33.

149. *See, e.g.*, Young v. Knickerbocker Arena, 722 N.Y.S.2d 596, 599 (N.Y. App. Div., 2001) ("The relevant rule is that evidence that [an] alleged tort-feasor carries liability insurance is not admissible as potentially prejudicial.") (emphasis omitted) (quoting Allen v. Harrington, 550 N.Y.S.2d 79, 81 (N.Y. App. Div. 1989)).

150. *See id.*

151. Firmes v. Chase Manhattan Auto. Fin. Corp., 852 N.Y.S.2d 148, 159 (N.Y. App. Div. 2008) ("It has been held that an application for a collateral source hearing may be timely made any time before the judgment is entered.")

152. *See id.* at 161 (noting that the evidentiary burden for obtaining a collateral source hearing is less than the burden to secure a setoff of damages during the hearing).

153. N.Y. C.P.L.R. § 4545(a).

154. *Young*, 722 N.Y.S.2d at 599.

To date, New York courts have not determined whether this "high probability" standard is met when evidence of a plaintiff's insurance through the ACA is introduced at a collateral source hearing. However, in *Peralta v. Quintero*,[155] the United States District Court for the Southern District of New York held that the defendant had met the burden to secure a collateral source hearing when he subpoenaed Medicaid records and contended the plaintiff could obtain coverage through the ACA.[156] The court noted that such evidence may not have been sufficient for the defendant to actually obtain a setoff of any damages, but the evidence was sufficient to grant the hearing.[157]

While New York courts continue to grapple with the weight they place on ACA coverage in securing collateral source hearings and offsetting verdicts, this system still presents many advantages over the Alabama system and the current Pennsylvania system. Unlike the Alabama system, where the jury may or may not offset damages, the New York scheme requires the court to offset a plaintiff's damages if the defendant can show a "high probability" that the plaintiff had or will have collateral sources pay for damages incurred.[158] From a practical standpoint, New York's statute is superior to Alabama's in that the complicated process of determining what damages should be offset, as well as what coverage is likely to exist in the future, is left for the court to decide.[159] Thus, the serious concerns of jury confusion and inconsistent results are eliminated.[160] Moreover, and perhaps most importantly, New York's collateral source rule statute *requires* the court to offset damages awarded to a plaintiff who has a high probability of benefitting from collateral source payments.[161]

New York's statute is also advantageous because it is inherently fair for a number of reasons. First, the statute prevents double recoveries that the collateral source rule has enabled for over a century.[162] Second, the "high probability" requirement protects plaintiffs whose insurance coverage may not exist in perpetuity because judges will offset future economic damages only when it is likely the plaintiff will be able to take

155. Peralta v. Quintero, 12cv3864-FM, 2015 U.S. Dist. LEXIS 18807, at *27–28 (S.D.N.Y. Jan. 26, 2015).
156. *Id.*
157. *Id.*
158. N.Y. C.P.L.R. § 4545(a).
159. *Id.*
160. *See* Todd, *supra* note 5, at 976 ("A jury's calculation of damages can be made much easier when the intricacies of collateral benefits are excluded from consideration by the jury and reserved for consideration by the judge in post-verdict proceedings.").
161. N.Y. C.P.L.R. § 4545(a).
162. *See supra* notes 22–33 and accompanying text.

advantage of such collateral sources.[163] Thus, the New York statute allays one of the biggest concerns associated with the collateral source rule—that plaintiffs may be forced to take a setoff when their potential eligibility for benefits is uncertain.[164] Lastly, if a plaintiff's damages are offset as a result of a collateral source payment, the plaintiff is entitled to reimbursement for the preceding two years' worth of premiums, as well as the projected premium cost of maintaining the coverage in the future.[165] Accordingly, a defendant is not liable for damages that have already been or will be paid, and the plaintiff is compensated for past and future insurance premiums to ensure that the necessary coverage exists for as long as is needed.

D. *Extending the* Moorhead *Ruling to Future Medical Expenses*

While Pennsylvania is free to adopt a statutory scheme similar to Alabama's or New York's system, to do so would require a legislative overhaul of the MCARE Act or the Pennsylvania Rules of Evidence. Admittedly, to do so would be an arduous task.[166] The Pennsylvania judiciary, however, should mitigate the abundance of double recoveries in medical malpractice lawsuits by extending the *Moorhead* decision—which defined the reasonable value of medical expenses as the amount actually paid by the insurance provider[167]—to include future medical expenses rather than solely past medical expenses. To do so would provide fair compensation to plaintiffs based on damages actually incurred and align with Pennsylvania's existing public policy as evinced by the MCARE Act.[168]

The *Moorhead* decision requires that past medical expenses be paid based on the amount paid by the insurance provider and not based on what health care providers billed for their services.[169] The issue before the court at that time did not include the reasonable value of future

163. *Id.*
164. *See, e.g.*, Cleaver v. United States, No. 08-425, 2012 WL 912729, at *3 (W.D. Pa. Mar. 15, 2012).
165. N.Y. C.P.L.R. § 4545(a).
166. For instance, Pennsylvania's Fair Share Act was initially passed in 2002. 42 PA. CONS. STAT. § 7102(a.1)(1) (2002). However, the statute was deemed unconstitutional for procedural reasons in DeWeese v. Weaver, 880 A.2d 54 (Pa. Commw. 2005), *aff'd sub nom*. DeWeese v. Cortes, 906 A.2d 1193 (Pa. 2006). The statute was finally passed again, 12 years later, at 42 PA. CONS. STAT. § 7102 (2014).
167. *See supra* Section II.B.
168. The author is cognizant of the argument that the judiciary's extension of *Moorhead* may be tantamount to judicial activism. However, see Christopher Peters, *Adjudication as Representation*, 97 COLUM. L. REV. 312, 315–17 (1997) for a discussion regarding judicial activism and its potential democratic legitimacy, especially when the judiciary aims to fill legislative gaps.
169. Moorhead v. Crozer Chester Med. Ctr., 765 A.2d 786, 791 (Pa. 2001).

medical expenses and whether such expenses should be subject to a similar write-off. In *Cleaver*, the United States District Court for the Western District of Pennsylvania reviewed the issue of the reasonable value of future medical expenses, but it chose not to extend the *Moorhead* holding.[170]

Despite the *Cleaver* decision, the Pennsylvania judiciary still retains the ability to extend *Moorhead*, and it should do so for a number of reasons. Initially, the extension of *Moorhead* to future medical expenses is perfectly aligned with Pennsylvania's public policy of retaining skilled physicians and fostering an environment where medical liability insurance remains affordable.[171] With fewer inflated verdicts due to high future medical expenses, physicians will be more likely to remain in the Commonwealth because of lower insurance premiums.[172] When the collateral source rule is next challenged, the judiciary should also look to other legislation, such as the Fair Share Act[173] and recently enacted apology legislation,[174] as further evidence of the General Assembly's intent to lessen the burden of physicians' liability insurance rates.

Moreover, extending *Moorhead* to future medical expenses is consistent with the evolving health insurance climate. The ACA has dramatically increased the percentage of those who carry health insurance.[175] Although the common law collateral source rule historically served its purpose of protecting the fortuitous occasion where a plaintiff carried insurance, that environment no longer exists.[176] The individual mandate component of the ACA requires that individuals carry health insurance, and the number of uninsured Americans has dropped and will likely continue to do so.[177] Therefore, the perpetuation of the collateral source rule's application to future medical expenses no longer coincides with the reality of today's average plaintiff.

Should the judiciary extend *Moorhead* to include future medical damages, it would need to determine the fair value of such damages. The most equitable way to do this is to compensate the plaintiff based on the plaintiff's maximum annual cost of insurance, including the cost of

170. Cleaver v. United States, No. 08-425, 2012 WL 912729, at *3 (W.D. Pa. Mar. 15, 2012).

171. Medical Care Availability and Reduction of Error (MCARE) Act, 40 PA. CONS. STAT. §§ 1303.102(2)–(3)(2014).

172. *See* Salvatore, *supra* note 53, at 363.

173. 42 PA. CONS. STAT. § 7102(a.1)(1) (2014); *see also supra* note 112.

174. *See* Benevolent Gesture Medical Professional Liability Act, 35 PA. STAT. § 10228.3 (2014) (deeming inadmissible any benevolent gestures, i.e. apologies, made by a health care provider to a patient).

175. *See* Obama, *supra* note 32, at E3.

176. *See supra* notes 31–33 and accompanying text.

177. *See* Diamond, *supra* note 33.

premiums, deductibles, and other out-of-pocket costs.[178] The court can readily calculate these costs based on the current maximum payments established by the Department of Health and Human Services.[179] From this publicly available information, defendants can prove these costs with a fair degree of probability.[180] This avenue of compensation is inherently fairer than the current system because a plaintiff's future damages may be more or less than initially estimated.[181] Compensating plaintiffs so that they may obtain health insurance with no out-of-pocket costs to cover future medical needs—even those potentially unrelated to the current suit—assures that plaintiffs are paid no more or no less than deserved.

Accordingly, extending the *Moorhead* decision to future medical damages would allow for an evenhanded resolution to determining a plaintiff's economic damages. Furthermore, if the judiciary extends the *Moorhead* holding to future medical expenses, the extension would be well within Pennsylvania's clear public policy of maintaining a flourishing medical services market while lessening the burden that medical liability insurance premiums place on doctors.[182] For these reasons, the extension of the *Moorhead* decision to include future damages presents the most equitable, and perhaps the most feasible, means by which Pennsylvania can prevent double recoveries and the perpetuation of the collateral source rule.

IV. CONCLUSION

The collateral source rule's persistence in medical malpractice actions has been undermined by the ACA's passage. The doctrine, which for over a century has relied on the "fortuitousness" of insurance, has been subject to many reform attempts. For instance, with regard to Pennsylvania medical malpractice actions, the General Assembly passed the MCARE Act, which partially abrogated the collateral source rule for past medical expenses. Despite these reforms, the collateral source rule

178. *See* HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,825 (Feb. 27, 2015) (noting that the maximum out-of-pocket cost for an individual under the ACA, non-inclusive of premiums, is $6,850).

179. *Id.*

180. *See* Wujcik v. Yorktowne Dental Assocs., 701 A.2d 581, 584 (Pa. Commw. 1997) ("[T]he law . . . requires a plaintiff to produce evidence which establishes, with a fair degree of probability, a basis for assessing damages.") (citing Shoenenberger v. Hayman, 465 A.2d 1335, 1339 (Pa. Commw. 1983)).

181. *See* Watts v. Hollock, No. 3:10cv92, 2011 U.S. Dist. LEXIS 139166, at *30 (M.D. Pa. Dec. 5, 2011) ("[T]he precise amount of future medical expenses are [sic] inherently speculative.").

182. Medical Care Availability and Reduction of Error (MCARE) Act, 40 PA. CONS. STAT. §§ 1303.102(2)–(3) (2014).

continues to allow plaintiffs to collect windfall double recoveries for future medical expenses, an area of damages left largely undisturbed by the MCARE Act. This double recovery is at odds with Pennsylvania's public policies of reducing physicians' medical liability premiums and keeping competent physicians in the Commonwealth.

Some states have attempted to restrict double recoveries of future damages by allowing either the jury or the court to offset awards where a plaintiff is likely to be compensated by a collateral source. However, Pennsylvania's best option to combat the potential for double recoveries in medical malpractice lawsuits is to extend the *Moorhead* holding to future damages. In determining the fair and reasonable value of such future damages, Pennsylvania courts should award plaintiffs the maximum out-of-pocket costs for premiums, deductibles, and other costs of obtaining health insurance through the ACA. This system assures fair compensation for plaintiffs by preventing double recoveries, and it is consistent with Pennsylvania's existing goals of fostering a high-quality healthcare system within the Commonwealth.