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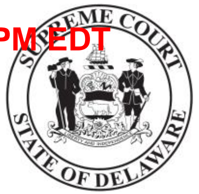

IN THE SUPREME COURT OF DELAWARE

JENNIFER L. SMITH, *Plaintiff-Appellant/* *Cross-Appellee*, v. DELAINE MAHONEY, *et al.*, *Defendants-Appellees/* *Cross-Appellants*.	: : : : : : : : : : :	Case No. 642, 2015 On Appeal from the Superior Court of the State of Delaware in and for Newcastle County, Case No. N12C-10-046 MMJ

APPELLANT'S REPLY BRIEF ON APPEAL AND CROSS-APPELLEE'S ANSWERING BRIEF ON CROSS-APPEAL

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SUMMARY OF ARGUMENT

1. Admitted. Because Medicaid allows medical providers to decide how to bill for services, including to receive payment without any write-off, and does not involuntarily impose write-offs as in Medicare, the rationale adopted in *Stayton v. Delaware Health Corp.*, 117 A.3d 521 (Del. 2015), does not extend to Medicaid.

2. Admitted. Interference with the jury's determination of appropriate damages, imposition of an irrebuttable presumption, and unequal treatment of Medicaid-eligible plaintiffs as compared to other similarly situated tort plaintiffs burdens constitutionally guaranteed rights.

3. Admitted. A rule deducting collateral sources from damages proven by a Medicaid-eligible plaintiff will limit access to the courts for plaintiffs, while imposing a new and improper burden on taxpayers.

SUMMARY OF ARGUMENT ON CROSS-APPEAL

4. Denied. Deducting speculative and hypothetical Medicaid write-offs for future medical expenses, which expenses were properly proven at trial and undisputed on appeal, is improper and has no basis in the law, given that Medicaid is intended as a temporary assistance program. Current Medicaid eligibility does not establish future Medicaid eligibility, and the present status of the plaintiff with respect to Medicaid has no relationship to present value of future medical expenses.

ARGUMENT

I. THIS COURT'S RATIONALE IN *STAYTON* SUPPORTS APPLICATION OF THE COLLATERAL SOURCE RULE TO MEDICAID WRITE-OFFS, EVEN WHEN NOT APPLICABLE TO MEDICARE WRITE-OFFS.

A. Medicaid Allows Medical Providers a Billing Choice Unavailable Under Medicare.

Defendant-Appellee Mahoney's Answering Brief does little more than restate the central question: Does *Stayton v. Delaware Health Corp.*, 117 A.3d 521 (Del. 2015), which held that the collateral source rule does not apply to Medicare providers' acceptance of deeply discounted reimbursements as payment in full, also apply to Medicaid write-offs? Appellant contends that those write-offs more closely resemble discounts voluntarily given by providers under agreements with private insurers, as in *Mitchell v. Haldar*, 883 A.2d 32 (Del. 2005), or voluntarily given by providers directly to patients, as in *Onusko v. Kerr*, 880 A.2d 1022 (Del. 2005). In both instances, this Court held that the collateral source rule applies to the providers' reduced medical bills.

Defendant argues that Appellant merely "intend[s] to reargue the Court's decision in *Stayton.*" Ans. Br. 7 (citing Opening Br. 9 n.5). Defendant is wrong. The cited footnote explicitly states that "Appellant does not challenge this Court's decision in *Stayton.*" Rather, Appellant argues that the crucial feature of the

Medicare program that led this Court to exclude Medicare write-offs from the collateral source rule does not apply to Medicaid write-offs.

Defendant points out that both Medicare and Medicaid are government programs, both prohibit providers from accepting Medicare/Medicaid discounted payments while billing the patient for the balance, and both authorize government liens on liability insurance proceeds to recoup its expenditure. Ans. Br. 8. Yet, none of these similarities speaks to the collateral source rule, and none was relied upon for *Stayton*'s holding.

Instead, this Court focused on the fact that Medicare write-offs are involuntary. If an individual is entitled to Medicare payment for health care services, "[t]he provider cannot seek reimbursement for its medical services from anyone other than Medicare." 117 A.3d at 524. Thus, the Court concluded, the write-offs were not "benefits bargained for by insureds," but rather "amounts that a healthcare provider is required to write off for Medicare patients." *Id.* at 531. On that basis, this Court concluded such write-offs "are not payments made to or benefits conferred on the injured party." *Id.* Rather, "the only entity that received a benefit from the write-offs were federal taxpayers." *Id.*

It is on this crucial point that Medicaid differs from Medicare. Neither program requires a provider to treat an eligible patient. However, after service has been rendered, *Stayton* indicated, the provider may not bill anyone except

Medicare. *Id*. at 524. The Court concluded that the provider cannot be deemed to have conferred a benefit on the patient if the provider had no choice in the matter. But Medicaid imposes no such restriction. A provider has the option of billing Medicaid for smaller but quicker compensation or pursuing a lien on an anticipated tort recovery for the full value of services. (Of course the provider is barred from seeking reimbursement from both).

Defendant states that "[o]nce a medical provider submits medical bills to Medicare/Medicaid, they must accept the Medicare/Medicaid payment in full satisfaction for his service" and "cannot accept a conditional payment from Medicare/Medicaid and then seek to recover the balance of its bill from the patient or even the patient's tort recovery." Ans. Br. 8. Neither Ms. Smith nor Dr. Grossinger argues otherwise. But the argument is not relevant to the question before this Court: When a doctor elects to accept the smaller Medicaid payment and "write off" the remainder of his bill, does the law give the benefit of that write-off to the injured plaintiff or instead permits a windfall to the tortfeasor.

Defendants' argument disputes *Stayton*'s statement that "Beneficiary participation is involuntary" in Medicare. 117 A.3d at 524. According to Defendant, beneficiaries can "opt out" simply "by choosing to not inform their providers that they are enrolled in Medicare and then personally pay the provider's bill." Ans. Br. 9. Even Defendant admits choosing that course is unlikely and

wholly unrealistic. *Id*. More importantly, such an evasion would still violate the Medicare regulation that *Stayton* relied on. 42 U.S.C. § 1395cc(A)(i) requires that the provider not "charge . . . any individual or any other person for items or services for which such individual *is entitled to have payment made under this subchapter*" (emphasis added). The fact that the patient concealed his Medicare-eligibility would not alter this requirement.

Defendant also intones, repeatedly, that, under the principles of tort compensation, plaintiff is entitled to full compensation for her injuries "but no more." Ans. Br. 5, 14, 15, & 39. The corollary of this principle, of course, "requires the injured party to be made whole exclusively by the tortfeasor and not by a combination of compensation from the tortfeasor and collateral sources." *Mitchell*, 883 A.2d at 38.

Defendants' argument does not assist this Court in determining whether Medicaid write-offs come within the collateral source rule. The rule itself is an exception to the general compensation principle, based on the proposition that, in deciding whether a "windfall" should be given to the injured plaintiff or to the guilty tortfeasor, the law leans in favor of the innocent plaintiff. *Stayton*, 117 A.3d at 527 (citing *Mitchell*, 883 A.2d at 38) ("A plaintiff who receives a double recovery for a single tort enjoys a windfall; a defendant who escapes, in whole or in part, liability for his wrong enjoys a windfall. Because the law must sanction

one windfall and deny the other, it favors the victim of the wrong rather than the wrongdoer."). *See also Restatement (Second) of Torts* § 920A, cmt. b (1979) ("to the extent that the defendant is required to pay the total amount there may be a double compensation for a part of the plaintiff's injury. But it is the position of the law that a *benefit that is directed to the injured party should not be shifted so as to become a windfall for the tortfeasor.*") (emphasis added).

Relatedly, Defendant argues that the deterrent impact of tort liability is fully served even where the amount of damages awarded is fortuitously reduced. Ans. Br. 9. Defendant offers no explanation for the proposition that the amount of a penalty is not relevant to its deterrent effect.[1] If Dr. Grossinger had treated Ms. Smith for free, for example, it can scarcely be argued that a tort recovery of zero would have much deterrent effect. It would instead serve as a subsidy for tortfeasors.

[1] Rational actors change their behavior once the cost of continuing their wrongful behavior outstrips their willingness to pay for it. As a result, tort law has long been considered to have a deterrent effect. *See* William M. Landes & Richard A. Posner, *The Economic Structure of Tort Law* 10 (1987). Under the economic principle that when cost exceeds utility, misconduct is deterred, punitive damages are assessed beyond compensatory principles "to deter the tortfeasor 'and others like him from similar misconduct in the future.'" *Sheppard v. A.C. & S. Co., Inc.*, 484 A.2d 521, 524 (Del. Super. Ct. 1984) (quoting *Restatement (Second) of Torts* § 908(1). Those principles are applicable here because the "collateral source rule appears to emphasize the deterrent and quasi-punitive functions of tort law." *State Farm Mut. Auto. Ins. Co. v. Nalbone*, 569 A.2d 71, 73 (Del. 1989).

B. Medical Providers Confer a Benefit on Their Patients by Choosing to Accept Medicaid Payments.

Defendant resists the conclusion that Dr. Grossinger conferred a benefit on Plaintiff by asserting the doctor made a choice to bill Medicaid, as if that resolves the issue. *See* Ans. Br. 9. Defendant offers no support for such a startling contention.

Instead, Defendant states that *Stayton* found that Medicare write-offs were not benefits conferred on patients and the same decision should be made here. However, a Medicare provider has no choice but to bill Medicare for services rendered. Where billing Medicare is mandatory, the federal taxpayer does realize the benefit of the reduced price imposed on the doctor or hospital. *Stayton*, 117 A.3d at 524 (citing 42 U.S.C. § 1395cc(a)(1)-(2)).

The situation is quite the opposite in the Medicaid program, where the provider has the option of seeking payment from the tortfeasor responsible for paying for the harm he has caused. In this case, for example, Dr. Grossinger's usual and customary charges for services rendered to Ms. Smith amounted to $22,911. He could have obtained full reimbursement via a lien on Ms. Smith's anticipated tort recovery. Alternatively, Dr. Grossinger could (and eventually did) bill Medicaid and receive the quicker and more certain recovery of $5,197.71. Medicaid imposed its own lien on Ms. Smith's recovery for that amount. *See* Ans. Br. 4.

By choosing to bill Medicaid, Dr. Grossinger essentially gifted Ms. Smith with $17,713.29, the amount she was able to keep from her tort award due to Dr. Grossinger's decision to bill Medicaid. That was certainly a benefit to Ms. Smith.

Defendant incorrectly asserts that it is the taxpayer who benefitted from the discounted medical bill. *Id*. at 10. It is true that in the vast majority of Medcaid pay-outs, there is no third party liability and reduced medical bills in fact save taxpayers money. But where there is a liability judgment, Medicaid imposes a lien up to the amount it has paid to the medical provider, regardless of whether that amount reflects a discount. *Stayton*, 117 A.3d at 524. The beneficiary in this instance is not the taxpayer who has received nothing, but Ms. Smith, whose tort judgment was released from Dr. Grossinger's $22,911 lien and subjected instead to Medicaid's lien of $5,197.71.

Defendant complains it "would be unconscionable to permit the taxpayers to bear the expense of providing free medical care to a person and then allow that person to recover damages for medical services from a tort-feasor and pocket the windfall." Ans. Br. 10 (quoting *Martinez v. Milburn Enters*., 233 P.3d 205, 211 (Kan. 2010)). But that is not the case here. Medicaid does not provide free medical care where a tortfeasor is responsible for the injury. Medicaid insists upon reimbursement by imposing a lien on the plaintiff's recovery up to the full amount paid by Medicaid. *Id*. at 18.

Defendant next contends that the decision to bill Medicaid in this case "was not a benefit upon Plaintiff but a business decision by Dr. Grossinger." Ans. Br. 14. The only evidence of the doctor's motive in this case is his own affidavit in which he calls the decision an "act of kindness to my patients." (App. A-36, ¶ 11). He also suggests that he and other providers will likely cease such actions if they result in "a financial benefit to the person who originally injured my patient, and not as a benefit to my patient." *Id*. These statements refute Defendants' characterization. Even if a doctor, originally determined to await the outcome of the case, decides to change plans and makes a "business decision" to obtain the assured earlier payment available from Medicaid as a result of his own cash flow needs, the rule proposed by Defendant, which casts that decision as determinative of the resolution of the collateral source rule, would create a perverse incentive on the part of defendants to lower their liability through delay and obfuscation in order to deny application of the collateral source rule.

In any event, the collateral source rule does not examine the motive of the collateral source. For example, in *Mitchell*, this Court applied the collateral source rule to discounts negotiated by Blue Cross. It is quite likely that the providers entered into that agreement for business reasons. Likewise in *Onusko*, the provider gave a significant discount to a patient who agreed to pay in cash. The fact that this was obviously a business decision did not preclude application of the collateral

source rule. Of course, providers may well have multiple motives for reducing their bills for certain patients. Defendants' suggestion that application of the collateral source rule depend on the motive of the collateral source is one that will involve courts in needless complexity.[2]

Defendant contends that *Stayton* suggested that "adjustments similar to Medicare write-offs made by private health insurance is also a benefit that an insurer obtains for itself, not for its insured. *Stayton*, 117 A.3d at 531 (quoting *Haygood v. De Escabedo*, 356 S.W.3d 390, 395 (Tex. 2011))." Ans. Br. 10. Defendant confesses this statement was mere "dicta." More importantly, the *Haygood* decision was not based on the common-law collateral source rule, but on the Texas court's construction of Texas Civil Practice & Remedies Code § 41.0105, which provides that "recovery of medical or health care expenses incurred is limited to the amount actually paid or incurred by or on behalf of the claimant." The Delaware legislature has not imposed such a narrow and restrictive limitation on the collateral source rule in this state. Unless the legislature does so, this Court's decision in *Mitchell* is controlling:

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[2] Defendant gives scant attention to *Onusko* and ignores *Mitchell* entirely. Defendant directs this Court instead to *Spectrum Health Continuing Care Group v. Anna Marie Bowling Irrevocable Trust*, 410 F.3d 304 (6th Cir. 2005), Ans. Br. 11-12, for no purpose other than to establish that when a provider has been paid by Medicaid, he or she cannot bill the patient for the balance. That proposition is not at issue here. The decision's relevance to this case lies in the court's recognition that the provider has the option of pursuing its lien or billing Medicaid. *See* Opening Br. 11-12. The provider's business reasons for billing Medicaid played no part in the court's decision.

> [W]hen an injured person has insurance which pays for the cost of treatment and hospitalization, in whole or in part, those payments inure to the benefit of the insured rather than the tortfeasor. Accordingly, the general rule is that the plaintiff's damages may not be reduced because of payments for treatment paid for by medical insurance to which the tortfeasor did not contribute.

883 A.2d at 38.

C. Letters of Protection Are Not "Unconscionable."

Appellant has maintained that, even if Medicaid discounts generally are not within the collateral source rule, the write-off in this case is. In this case, Ms. Smith signed an agreement that recognized a lien on any tort recovery arising out of her automobile accident and instructed her attorney to pay Dr. Grossinger out of the proceeds of that recovery. Subsequently, Dr. Grossinger conferred a substantial benefit on Ms. Smith by giving up his rights under that agreement and, instead, submitting his bill to Medicaid. Opening Br. 17-19.

Defendant argues in response that such "letters of protection," are "unconscionable contracts of adhesion." Ans. Br. 12. The argument borders on frivolous.

For a contract clause to be unconscionable, this Court has held, it must be shown to be both procedurally and substantively unfair. That is, "[t]here must be an absence of meaningful choice and contract terms unreasonably favorable to one of the parties." *Ketler v. PFPA, LLC*, 132 A.3d 746, 748 (Del. 2016) (citing

Tulowitzki v. Atlantic Richfield Co., 396 A.2d 956, 960 (Del. 1978). Neither is present in this case.

"Unconscionability," this Court has cautioned, "is a concept that is used sparingly." *Id*. at 748 (citing *Progressive Int'l Corp. v. E.I. Du Pont de Nemours & Co.,* No. C.A. 19209, 2002 WL 1558382, at *11 (Del Ch. July 9, 2002)). With respect to the procedural element, "[t]here is no deprivation of meaningful choice if a party can walk away from the contract." *Id*. Defendant has pointed out that there are "at least 37 practicing neurologists in New Castle County and another 30 physicians that specialize in pain management/physical medicine and rehabilitation," so that "Plaintiff was able to turn to many other providers." Ans. Br. 15.

As to the element of substantive unfairness, Defendant fails to understand the workings of a letter of protection. Ms. Smith was obligated to pay for the medical care she received. A letter of protection does not alter that obligation. Nor does her acknowledgment of the provider's medical lien on any tort recovery impose any new obligation. All states, including Delaware, authorize such medical liens. *See*, *e.g*., *Doroshow, Pasquale, Krawitz & Bhaya v. Nanticoke Mem'l Hosp., Inc*., 36 A.3d 336 (Del. 2012).

The only additional advantage obtained by providers under a letter of protection is a contractual responsibility on the part of the patient's *attorney* to pay

the provider's bills out of any tort recovery before distributing it. For that reason, courts around the country and in Delaware have held that letters of protection are enforceable contracts. *See* Opening Br. 14-15. Moreover, they are the result of a bargain between doctor and patient.[3] The patient receives medical care without having to pay for it at that time, while the doctor opts for the potential for receiving the full value of the bill if the litigation is successful.

Defendant cites *Kent General Hospital, Inc. v. Blue Cross & Blue Shield, Inc.*, 442 A.2d 1368, 1369-70 (Del. 1982), for the proposition that in Delaware, "a medical provider may not bring a suit against a tortfeasor's liability insurer,"[4] but instead, must either "bill Medicare/Medicaid or a private health insurer and accept the terms of its agreement with the those entities, or to bill the patient." Ans. Br. 13. That decision and the proposition it stands for is not relevant to this case. The question before this Court is whether a provider who decides to forego a medical lien of $22,911 on plaintiff's judgment and instead bills Medicaid, which will

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[3] Defendant treats Ms. Smith's argument as the use of an "asset" to bargain for a letter of protection and argues that her cause of action is not an asset but "simply a legal right." Ans. Br. 13. That stance mischaracterizes the bargain Ms. Smith struck with Dr. Grossinger over the timing and the amount of the payment. Even so, a cause of action is a species of property. *See, e.g.*, *Logan v. Zimmerman Brush Co.*, 455 U.S. 422, 428 (1982) (considering it "settled" that "a cause of action is a species of property"). After all, a cause of action may be assigned, *see Indus. Trust Co. v. Stidham*, 33 A.2d 159, 160 (Del. 1942), and it may be subrogated. *See Jeffries v. Kent Cnty. Vocational Tech. Sch. Dist. Bd. of Educ.*, 743 A.2d 675, 678 (Del. Super. 1999).

[4] The statute cited by Defendant, 21 Del. Code§ 2118(f)(4), provides that no insurer shall be joined "in an action by an injured party against a tortfeasor for the recovery of damages by the injured party." It does not speak to the situation where the provider seeks reimbursement for services rendered to an insured patient.

impose a lien of only $5,197.71, has conferred a benefit on plaintiff. Clearly he has, and the tortfeasor should not be given the financial benefit of that decision.

D. The Decision to Accept Medicaid Payments Was Not the Product of Law, But of a Private Transaction.

Defendants' final argument is little more than a rehash of earlier points. Appellant argued in her opening brief that the provider's acceptance of Medicaid as payment in full "can truly be deemed a 'benefit[] conferred on plaintiffs by providers, in the form of services gratuitously rendered at a price below the standard rate.'" Opening Br. 16 (quoting *Stayton*, 117 A.3d at 527). Defendant responds that the collateral source rule should not apply because "there is no loss or harm to Smith for the write-off." Ans. Br. 14. Even so, there is clearly a benefit because a responsibility previously undertaken, repayment in full from the proceeds of the lawsuit, is now discharged. Defendant does not explain why a plaintiff must show harm from the receipt of a collateral source benefit.

Defendant also seeks to distinguish this case from *Onusko* where this Court held that a provider's discount for payment in cash was within the collateral source rule. Defendant asserts that this case "did not involve the private transaction discussed in *Onusko,* but rather was based on rules and regulations established by Medicaid." Ans. Br. 14.

To the contrary, this case is very like *Onusko*. It is not clear from the record whether Dr. Grossinger's decision to bill Medicaid was the outcome of a "private

transaction" or a unilateral decision on Dr. Grossinger's part.[5] There is no reason that such a characterization should determine the applicability of the collateral source rule. The doctor made a decision to bill Medicaid, effectively allowing Ms. Smith to keep a larger portion of her tort recovery. The decision plainly confers a benefit on Ms. Smith, and she should receive the benefit of the collateral source rule.

[5] Indeed, there is a strong indication that plaintiff in *Onusko* received a discount for physical therapy not because it was privately negotiated, but because the provider "always reduces any bills if a patient is paying in cash." Appellant's Opening Br. at 13, *Onusko*, 880 A.2d 1022 (No. 503,2004), 2005 WL 1185740, at *13.

II. CONSTITUTIONAL PRINCIPLES APPROPRIATELY INFORM CONSIDERATION OF THE ISSUES HERE.

While Defendant takes no issue with Plaintiff's description of the rights to trial by jury or due process, she mistakenly asserts that these rights, anchored in the common law, may be taken away, Ans. Br. 16, relying on a Texas case. However, while the common law *qua* common law is certainly subject to evolution and change, rights based on the common law and incorporated into the Constitution as constitutional rights may only be changed through constitutional amendment. *See State v. Bender*, 293 A.2d 551, 554 (Del. 1972). That is true, even in Texas. *See Fin. Comm'n of Texas v. Norwood*, 418 S.W.3d 566, 587 (Tex. 2013) (holding that permitting a commission charged with administering a constitutional provision to tie the provision to legislative changes "utterly defeats the clear purpose of constitutionalizing it, which was to place the limitation beyond the Legislature's power to change without ratification by the voters [through constitutional amendment].").

A. Taking the Damages Decision From the Jury Violates the Right to Trial by Jury.

When article I, section 4 guarantees the right to a jury trial as "heretofore," heretofore is not subject to change through common law methodologies. Defendant does not dispute that the jury is "ordinarily" the judge of damages. Ans. Br. 17. Nonetheless, she cites no-fault insurance, workers compensation, and punitive

damages as exceptions that permit revision of the jury's determination of damages. These examples are inapposite for the jury-trial right does not attach to any of them.

No-fault and workers compensation are alternative reparations systems that guarantee compensation without proof of negligence and without the need for a jury. An insured is precluded from suing a tortfeasor for damages for which compensation is available under the no-fault statute. *Nalbone*, 569 A.2d at 73. Similarly, workers compensation is designed "'to provide a scheme for assured compensation for work-related injuries without regard to fault and to relieve employers and employees of the expenses and uncertainties of civil litigation.'" *Pennsylvania Mfrs. Ass'n Ins. Co. v. Home Ins. Co.*, 584 A.2d 1209, 1214 (Del. 1990) (citation omitted). In either case, there is no assessment, consistent with its common-law prerogatives embedded in the Constitution, for a jury to undertake.

The treatment of punitive damages also provide no basis to depart from the jury's role as judge of damages. Punitive damages do not constitute a form of compensation, *Jardel Co. v. Hughes*, 523 A.2d 518, 528 (Del. 1987), and thus not a decision in which the jury's role is preeminent and constitutionally guaranteed. Unlike compensatory damages where the jury makes a "factual determination" protected from revision by the jury-trial constitutional right, the jury's role in punitive damages is one of "moral condemnation" and subject to *de novo* review

for due process purposes. *Cooper Indus., Inc. v. Leatherman Tool Grp., Inc.*, 532 U.S. 424, 432 (2001).

B. Use of a Conclusive Presumption Also Interferes With the Jury Trial Right and Is Invalid as a Matter of Due Process.

As Appellant argued in her opening brief, a conclusive presumption about the reasonable value of the medical services she received takes that factual determination, long committed as a constitutional matter to the jury, away from that venerable institution, and cannot be reconciled with the constitutionally protected prerogative that resides in the jury. Defendant argues nothing to the contrary.

Her argument against application of an irrebuttable presumption is similarly inapt, essentially arguing that burden-shifting under rebuttable presumptions somehow also permit irrebuttable presumptions. Ans. Br. 19-20. On the contrary, by 1932, the U.S. Supreme Court recognized that it had "held more than once that a statute creating a presumption which operates to deny a fair opportunity to rebut it violates the due process clause of the Fourteenth Amendment." *Heiner v. Donnan*, 285 U.S. 312, 329 (1932). The principle articulated has never been regarded as infirm. Nor is it applicable only to irrebuttable statutory presumptions, as the due process clause applies as much to judicial action as it does to legislative action. *Ownbey v. Morgan*, 256 U.S. 94, 111 (1921) (due process "restrains state action, whether legislative, executive, or judicial"). Application of such a

presumption to determine reasonable medical value cannot be sustained, consistent with the Constitution.

C. Due Process Considerations Further Compel Allowing a Jury to Decide the Reasonable Value of Needed Medical Services.

Defendant denies that differential treatment of plaintiffs could violate due process, arguing that the argument is foreclosed by this Court's treatment of the issue with respect to Medicare. Ans. Br. 21. However, as Appellant has shown, her situation with respect to Medicaid is different than a Medicare recipient and more like a holder of private insurance. Moreover, her eligibility for Medicaid, which establishes her financial neediness, creates the issue discussed in *Lecates v. Justice of Peace Court No. 4*, 637 F.2d 898 (3d Cir. 1980), where it held that wealth cannot be the basis on which Delaware denies some litigants the rights guaranteed by trial by jury, if a meaningful opportunity to be heard is to occur. *Id*. at 909.

Defendant attempts to avoid that legal principle by asserting that it is limited to its facts and the imposition of a court administrative fee. Ans. Br. 21-22. The Third Circuit's decision is not so fact-bound.

D. The Medicaid Act's Equal-Access Mandate Further Informs the Inquiry.

Finally, Defendant denies that the equal-access provision in the Medicaid Act has any relevance to the issues before this court. Ans. Br. 23-24. The Act explicitly requires that each state commit to a plan that assures medical assistance

be made available in no lesser “amount, duration, or scope than medical assistance made available to any other such individual.” 42 U.S.C. § 1396a(10)(B)(i). Defendant does not dispute that the provision means the value of medical care for Medicaid patients must be the same as for non-Medicaid patients. She only contends that its value requirement is only relevant to the delivery of medical care, and not to how that value is otherwise assessed for other purposes.

In making the argument, Defendant provides no authority for the proposition that the equal value requirement applies in one arena assessing the value of medical services and no other. A plain reading of the statute, though, prohibits a state implementing a compliant Medicaid plan from devaluing a Medicaid patient’s care as compared to non-Medicaid patients. Denial of the collateral source rule based on a plaintiff’s Medicaid eligibility and use of the value of services received minus any Medicaid write-off establishes a reasonable value for the patient’s medical care at odds with this federal requirement. It provides another reason that Medicaid and Medicare, which has no equivalent requirement, should not be treated the same and why *Slayton*’s limitations on the collateral course rule should not be extended to Medicaid.

III. ABROGATION OF THE COLATERAL SOURCE RULE IN THIS AND SIMILAR CASES WILL CLOSE THE COURTHOUSE DOOR TO INDIGENT PLAINTIFFS.

Defendant does not quarrel with Ms. Smith's description of the fundamental constitutional right to access to the courts, but states the issue presented is whether Smith's access to the courts is dependent on her ability to recover the full measure of reasonable medical damages available to others, as though the obstacle are court fees capable of waiver. Ans. Br. 25-26. Fees are not at the heart of the issue presented.

In tort, compensatory damages ordinarily consist of lost wages, medical expenses, and mental or physical pain and suffering or non-economic damages. 22 Am. Jur. 2d Damages § 46. In cases brought by a Medicaid-eligible recipient, lost wages will necessarily be insubstantial because Medicaid provides medical assistance to people who have no income or whose income is extremely low. *See Milne v. Delaware Dep't of Health & Soc. Servs., Div. of Soc. Servs.*, 679 A.2d 1010, 1013 (Del. Super. 1995). If medical expenses are entirely written off or subject to subrogation, the Medicaid-eligible plaintiff will not have reason to pursue a case for recovery of those expenses, as no award would inure to her. That largely leaves the Medicaid-eligible plaintiff with a claim for non-economic damages. If that amount is likely to be insignificant, a plaintiff has little incentive to vindicate her rights in court – and a lawyer dependent on a contingency fee

cannot justify the time such a case would take. As two researchers at the American Bar Foundation observed, "[w]hen lawyers, especially the most skilled, are unable to take certain kinds of cases on a contingency fee basis, meaningful access to the civil justice system for injured people is diminished." Stephen Daniels & Joanne Martin, *The Texas Two-Step: Evidence on the Link Between Damage Caps and Access to the Civil Justice System*, 55 DePaul L. Rev. 635, 669 (2006).

Defendants' answer to this problem is to encourage the use of alternative dispute resolution means that do not involve a jury trial or to make a settlement demand. Ans. Br. 27-28. However appropriate that might be in certain cases, it remains no substitute for a plaintiff's right to access the courts and litigate a resolution of the dispute. After all, the federal Constitution's "Due Process Clauses protect civil litigants who seek recourse in the courts, either as defendants hoping to protect their property or as plaintiffs attempting to redress grievances." *Logan*, 455 U.S. at 429. Thus, due process "prevent[s] the States from denying potential litigants use of established adjudicatory procedures, when such an action would be 'the equivalent of denying them an opportunity to be heard upon their claimed right[s].'" *Id*. at 429-30 (quoting *Boddie v. Connecticut*, 401 U.S. 371, 380 (1971)). These access to court rights cannot be as easily dismissed as Defendant suggests.

REPLY TO APPELLEES' CROSS APPEAL

IV. THE SUPERIOR COURT CORRECTLY REJECTED CONSIDERATION OF POSSIBLE WRITE-OFFS FOR FUTURE MEDICAL EXPENSES AS SPECULATIVE.

A. Question Presented.

Whether the Collateral Source Rule applies to possible future Medicaid write-offs for future medical expenses solely because the plaintiff is a current Medicaid recipient? This issue was raised in Defendant-Appellees' motion below to Alter or Amend the Judgment (App. A-18 to A-24), and in oral argument below. (App. B-27).

B. Scope of Review.

The application of the Collateral Source Rule to future medical expenses is a question of law subject to *de novo* review. *Stayton*, 177 A.3d at 526.

C. Merits of Argument

The court below recognized that, unlike Medicare, "Medicaid enrollment is optional," that "Medicaid recipients are encouraged to exit Medicaid as soon as possible," and that it is not uncommon for them to do so "due to an increase in income or resources, or by obtaining private health insurance coverage." Court Op. 9. The court therefore concluded that future eligibility for Medicaid "is purely speculative and conjectural." *Id.* On that basis, the court correctly rejected Defendants' contention that future medical expenses be reduced by some estimated Medicaid write-off. *Id.*

Defendant in fact agrees that it is "speculative that a Medicaid recipient will continue to receive such benefits in the future." Ans. Br. 40. Nevertheless, Defendant contends that the "speculative nature of a plaintiff's future eligibility for Medicaid benefits should not prevent *Stayton*'s applicability to the calculation of future medical expenses for Medicaid recipients." *Id*. at 36.

There is no reason to apply a different rule than courts generally employ when the plaintiff seeks damages for future medical expenses: It is the plaintiff's burden to establish through expert testimony the reasonable value of the future medical services the plaintiff will reasonably require. Plaintiff here met that burden, and Defendant does not challenge Plaintiff's proof of future medical expenses. Instead, Defendant appears to advocate that Plaintiff has an additional burden of proving a negative—that she will not have reason to seek Medicaid's assistance for her proven future medical needs.

Much of Defendants' argument addresses the irrelevant proposition that the reasonable value of future expenses must be reduced to present value to take into account inflation. *See* Ans. Br. 32-35. Such a reduction respects the jury's determination of future expenses by assuring that money paid in the present can supply the requisite funds needed in the future. However, none of this discussion about reductions to present value supports the proposition that the reasonable value

of future medical expenses can be equated to the current reimbursements issued for such services by Medicaid.

Defendant attempts to suggest that deduction of speculative and hypothetical future Medicaid write-offs constitutes nothing more than a form of reduction of future expenses to present value, but has no basis for such an assertion other than her own *ipse dixit*. As Ms. Smith previously established, enrollment in Medicare is voluntary, and eligibility is generally based on income and resources. 16 Del. Admin. C. § 14100. Qualifying individuals must apply and be accepted, *id*. at § 14100.5, and must reapply every 12 months to remain eligible. *Id*. at § 14100.6. A Medicaid recipient may become ineligible for a number of reasons, including receipt of income greater than the qualifying maximum. *Id*. at § 14660. Moreover, prematurely deducting for possible collateral sources takes the decision away from the treating physician who wishes to bill the full amount of the treatment based on compensation available from the judgment and instead imposes an involuntary acceptance of the more limited Medicaid payment. In other words, under Defendants' approach, a defendant can dictate whether a treating physician is limited to Medicaid reimbursement.

Defendants' reliance on *Russum v. IPM Development Partnership LLC*, No. K13C-03-022, 2015 WL 4594166 (Del. Super. Ct. July 15, 2015), is also of no assistance. *See* Ans. Br. 36-37. The Superior Court in that case required reduction

of future medical expenses to account for Medicare discounts. As the court subsequently explained in denying plaintiff's motion for reargument, its decision was premised *on the certainty* that future medical expenses will be covered by Medicare and that "under Medicare, the provider must submit a bill to the Medicare agency for reimbursement. The provider cannot seek reimbursement for its medical services from anyone other than Medicare." *Russum v. IPM Dev. Partnership LLC*, No. K13C-03-022, 2015 WL 4885480, at *3 (Del. Super. Ct. Aug. 14, 2015).

By contrast, the court in this case based its ruling on the fact that Medicaid differs from Medicare: Whether a recipient will be eligible for Medicaid in the future "is purely speculative and conjectural." Court Op. 9. It is equally speculative whether the future provider of plaintiff's medical services will choose to bill Medicaid.

This Court has emphasized that "a plaintiff cannot recover speculative or conjectural damages." *Stayton*, 117 A.3d at 534. The flip side of that proposition must also be true: a defendant cannot reduce a plaintiff's damages on the basis of speculation or conjecture. Plaintiff proved the reasonable value of future medical expenses needed as a result of Defendants' tortious conduct. Nothing more was required, and the trial court correctly ruled that there could be no reduction of the

jury's proper verdict on the basis of hypothetical future write-offs. Its decision on this issue should be affirmed.

CONCLUSION

Differences between the relevant government programs compel a conclusion that *Stayton*'s determination of the status of the collateral source rule for Medicare recipients should not be extended to Medicaid. Unlike Medicare, medical providers treating patients eligible for Medicaid have options about who and how they bill and thus is capable of making a decision that confers a benefit upon a tort plaintiff, just as they do in instances where the patient is covered by private health insurance. Any other approach to Medicaid potentially transgresses the federal Medicaid scheme, which explicitly prohibits a state from valuing medical services provided under Medicaid differently from non-Medicaid funded services, as well as fundamental rights to trial by jury, access to the courts, and due process.

In addition, there is no warrant to speculate about Medicaid eligibility in the future and what any write-off might be so as to justify a reduction of proven future medical expenses.

For the foregoing reasons, the decision of the trial court regarding past medical expenses should be reversed, and the decision regarding future medical expenses should be affirmed.

Date: May 2, 2016 Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing Appellant's Reply Brief on Appeal and Cross-Appellee's Answering Brief on Cross-Appeal was served via e-file File & Serve Xpress on this 2nd day of May, 2016 upon the following counsel:

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