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Raised Bill 5053
Public Hearing: February 21, 2020

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TO: MEMBERS OF JUDICIARY COMMITTEE
FROM: MICHAEL A. D'AMICO, CO-CHAIR, GENERAL TORT
COMMITTEE, CONNECTICUT TRIAL LAWYERS
ASSOCIATION

DATE: February 18, 2020

**RE: OPPOSITION TO RAISED BILL 5053, AN ACT CONCERNING
THE REDUCTION OF ECONOMIC DAMAGES IN A PERSONAL
INJURY OR WRONGFUL DEATH ACTION FOR COLLATERAL
SOURCE PAYMENTS MADE ON BEHALF OF A CLAIMANT**

In 1986, the Connecticut legislature passed a behemoth bill colloquially referred to as Tort Reform I. This massive bill was the product of extensive negotiations among all interested parties, including the insurance industry, business and the trial lawyers. These were complex and lengthy negotiations. This bill focuses on one piece of this extensive bill, seeks to change and upend what was negotiated 34 years ago and tip the equities in favor of careless wrongdoers and against those injured or killed by negligent conduct. This bill is intended to be a response to the unanimous Connecticut Supreme Court decision of *Marciano v. Jimenez* found at 324 Conn. 70 (2016) (**copy attached**) which changed nothing and simply held that the legislature meant what it said in 1986.

In sum, the Connecticut Supreme Court held in *Marciano* that the reasonable and necessary medical bills a jury awards to an injured victim may not be reduced by insurance payments made to the injured victim's doctors when the injured victim must pay back the insurer, in whole or in part, from the jury award received. In order to better understand the issues at play, a brief historical introduction to a rule known as the collateral source rule is necessary. As far back as 1922, the Connecticut Supreme Court wrote:



"The authorities, both numerically and in weight, agree that a defendant owes to the injured compensation for injuries the proximate cause of which was his own negligence, and that their payment by third parties cannot relieve him of this obligation; and that whether the motive impelling their payment be affection, philanthropy, or contract, the injured is the beneficiary of their bounty and not him who caused the injury. In short, the defendant has no equitable or legal claim to share in the amount paid for the plaintiff. The rule in a majority of the cases is that an injured person is entitled to recover, as damages, for reasonable medical, hospital, or nursing services rendered him, whether these were rendered him gratuitously, or paid for by his employer. Such service or such payment is for the benefit of the injured person. It is a gift to him. But since it is one of the elements of injury, he is entitled to recover the reasonable value of the service.

In principle the same case was presented to us in *Regan v. New York & N. E. R. Co.*, 60 Conn. 124, 130, 22 A. 503. A loss had been paid by an insurance company, and the party causing the loss claimed to have the insurance money deducted from the amount otherwise due. After a most elaborate consideration of the authorities, we held that there was no privity in such cases between one made primarily liable for such a loss and an insurance company. "How then," says the court, "can the defendant claim, as it does, the exclusive benefit of the insurance? It came to the plaintiff from a collateral source, wholly independent of the defendant, and which as to him was *res inter alios acta*." In *Denver & R. G. R. Co. v. Lorentzen*, 24 C. C. A. 592, 594, 79 F. 291, 293, 294, the plaintiff was permitted to recover for doctors' and nurses' bills incurred in effecting a cure for injuries suffered through defendant's negligence. It did not appear that plaintiff had paid these, but the inference might fairly be drawn that the brothers of the plaintiff paid them. In upholding the liability of the defendant, the court said: "The liability of the defendant company for the expenses in question rests upon the ground that they were rendered necessary by its neglect of duty, and that liability was not altered, no matter what arrangement the plaintiff may have made for their payment, or whether she ever pays them." *Brosnan v. Sweetser*, 127 Ind. 1, 26 N.E. 555; *Lewark v. Parkinson*, 73 Kan. 553, 555, 85 P. 601; *Varnham v. Council Bluffs*, 52 Iowa 698, 3 N.W. 792; *Sibley v. Nason*, 196 Mass. 125, 131, 81 N.E. 887. See, also, note to *Wells v. Minneapolis Baseball & Athletic Asso.*, Amer. Anno. Cas. 1914A, 922, 926 (122 Minn. 327, 142 N.W. 706); 1 Sedgwick on Damages (9th Ed.) § 67."



Roth v. Chatlos, 97 Conn. 282, 287-289

This holding summarizes the rationale for the collateral source rule as it existed at common law in Connecticut and most every other state in the nation: a wrongdoer should not receive the benefit of an insurance plan the injured person was fortunate to have purchased or earned. Instead a primary purpose of tort law is to deter bad conduct. The deterrent effect is obtained by requiring a wrongdoer to account for his bad conduct. His accountability should not be lessened by the medical insurance benefits obtained by the hard work and earnings of the injured victim. Up until Tort Reform I was passed in 1986, this remained the law of Connecticut. Tort Reform I changed this collateral source rule. This change allowed the wrongdoer to benefit from medical insurance that the injured person had purchased and reduce his accountability for medical bills by the amount paid by this medical insurance. So much for deterrence and accountability. But through complex negotiations, the tort reform bill limited the total destruction of the sound collateral source rule as it had existed in Connecticut for decades in two important ways: (1) any premiums paid by the injured person or his employer to get the medical insurance benefit were first deducted from the total medical bills paid before the wrongdoer was allowed to benefit. For example, if the injured party's medical insurer paid \$10,000 toward medical bills and the premiums paid over the policy period were \$6,000, then the net reduction from accountability for the wrongdoer is \$4,000. So if the medical expenses awarded by the jury were \$12,000, the wrongdoer would only have to pay \$8,000 instead of \$12,000; and (2) there is no reduction from accountability for the wrongdoer when the medical bills of the injured party were paid by a medical plan that can claim a right to be reimbursed from any monies awarded to the injured person. It is this second exception from accountability that this current bill seeks to erase despite the clear intent to the contrary by the legislature when Tort reform I was passed.

The *Marciano* Supreme Court decision, which was brought to trial by my law firm and subsequently appealed to the Connecticut Supreme Court,



made clear that the collateral source rule was and is based on sound reasoning: the need for tort law to have a deterrent effect on bad conduct; that tort reform made limited exceptions to this good rule; and that there is no reduction in accountability by a wrongdoer when an injured party has to pay back monies from her compensatory award to a medical plan that paid her bills.

The *Marciano* Court stated in part:

"This court has explained that the legislature, in enacting § 52-225a, sought to achieve an "equitable balance . . . between barring plaintiffs from recovering twice for the same loss, on the one hand, and preventing defendants from benefiting from reduced judgments due to collateral source payments, on the other." (Internal quotation marks omitted.) *Pikulski v. Waterbury Hospital Health Center*, 269 Conn. 1, 7, 848 A.2d 373 (2004). We have also recognized, in discussing the historical underpinnings of the collateral source rule, that "[t]he reason for the [collateral source] rule . . . is that a windfall ought not to be [***12] granted to a defendant . . . [and that] [i]f there must be a windfall certainly it is more just that the injured person shall profit therefrom, rather than the wrongdoer shall be relieved of his full responsibility for his wrongdoing." (Internal quotation marks omitted.) *Saint Bernard School of Montville, Inc. v. Bank of America*, 312 Conn. 811, 841, 95 A.3d 1063 (2014). In addition, we have emphasized that characterizing "insurance proceeds as pure double recovery overlooks the fact that the plaintiff presumably paid premiums to obtain those proceeds." *Id.*, 841-42. In enacting § 52-225a, the legislature has attempted to achieve an "equitable balance . . ." *Pikulski v. Waterbury Hospital Health Center*, *supra*, 7. In view of this history, we cannot conclude that the possibility of a windfall for a plaintiff is a bizarre result. We therefore reject the defendants' claim that we must consult the legislative history of § 52-225a to determine its meaning.

Marciano v. Jimenez, 324 Conn. 70, 78-79

This bill seeks to undo the lengthy and complicated negotiation that surrounded the passage of Tort Reform I. This end run should not be countenanced for to do so would necessarily require a need to re-examine the



other changes brought about by Tort Reform I that harmed injured victims and benefited the wrongdoer. Attempting to now expand tort reform further by erasing this exception is wholly unwarranted.

In addition there are many shortcomings of this bill. Unlike a traditional major medical insurance plan for which the plaintiff and her employer pays readily identifiable premiums that can be easily calculated, there is no straight forward manner to calculate the cost of the more complex plans which have rights of subrogation against an injured victims financial recovery. Subsection (c) of this bill is the current provision which mandates deduction of these costs for traditional major medical plans as discussed previous. These costs must be calculated and deducted because otherwise the wrongdoer receives the benefit of monies paid by the injured victim, her employer and the government.

A brief explanation is required for clarity. All medical insurance plans are barred by existing Connecticut law from seeking reimbursement from an injured victim's financial recovery. *See C.G.S. 52-225c*. The only medical plans that can seek recovery from the injured victim are those that pre-empt state law, or are otherwise authorized by state law. These include medical plans that are created by federal law under the Employee Retirement Income Security Act (ERISA); Medicare and Medicaid by way of examples. ERISA plans are generally self-funded by an employer's revenues, often insured in part with stop gap insurance, sometimes funded by pooled revenues of many employers joining together to create a pooled medical plan and overlaid with substantial administrative costs. It would be a monumental undertaking to acquire this cost information, if it could be acquired at all, in order to total the costs and arrive at any net reduction for the benefit of the wrongdoer. Government plans pose a much greater difficulty as we all pay into these government plans over our work life, in addition to tax payer contributions. How would one ever calculate these costs in order to arrive at a net reduction to benefit the wrongdoer? And is the government, be it the state of Connecticut or the federal government, both of which are operating with constrained budgets, going to fund and staff a department, to respond to



innumerable requests to calculate these costs for the many injured victims? Moreover, federal laws which allow for subrogation and reimbursement generally pre-empt state laws and thus the interplay between this proposed bill and federal law is a legal quagmire. And more fundamentally, why would we go through all this to benefit the wrongdoer anyway?

For all of the foregoing reasons, I, individually, and as Co-Chair of the General Tort Committee of the Connecticut Trial Lawyers Association, strongly oppose this bill.

Michael D'Amico
Co-Chair of the General Tort Committee
Connecticut Trial Lawyers Association

**Remainder of
Testimony
available for
public review in**

**Judiciary Committee
Room 2500**