

DOES THE PATIENT PROTECTION AND AFFORDABLE CARE ACT END LIFE CARE PLANS AS WE KNOW THEM?

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In order to ensure those with catastrophic or life-long injuries are fairly compensated, personal injury attorneys often secure a life care plan that projects anticipated future health care costs allegedly necessitated by the tort. These life care plans have been a necessary, appropriate, and costly part of injury cases for much of the recent history of tort litigation. Lifetime costs of medications, doctor's appointments, and therapies quickly drive life care plan totals into the millions. An argument can be made that as a consequence of the Patient Protection and Affordable Care Act ("ACA"), these projections no longer accurately reflect the measure of damages, which allows respondents (whether insurers or defendants) to attack supporting expert reports as unreliable.

Damages in tort cases are designed to provide compensation for the injury caused – no more, no less. As such, Courts recognize that an injured person has a duty to mitigate his/her damages, and Courts generally will not allow an injured claimant to recover medical expense damages that exceed amounts actually incurred or that reasonably will be incurred.

The ACA contains several key provisions which are now effective and work in tandem to fundamentally alter how medical services are accessed and compensated. These provisions should operate to limit the injured person's recoverable damages for future medical care. First, the act contains an "individual mandate," (26 U.S.C.A. § 5000A; "Requirement to maintain minimum essential coverage") imposing a "penalty" on those who fail to conform. In essence, as law abiding United States citizens, the injured party must now obtain health insurance.

Second, the ACA contains a provision titled "Prohibition of preexisting condition exclusions or other discrimination based on health status." 42 U.S.C.A. § 300gg-3. This

provision means that insurers cannot turn away any individual because of the injuries he has suffered, even when they know with reasonable certainty that the individual's claim costs will far exceed his/her premiums paid. Prior to the ACA, an injured claimant could argue that the life care plans represented actual costs because the injury rendered him/her uninsurable. Now, even in cases involving lost limbs, severe burns, or traumatic brain injury, an individual will still be able to obtain and maintain health insurance benefits.



Third, the ACA sets forth yearly out-of-pocket maximum limits. Under 42 U.S.C.A. § 18022(c)(1), the sum of an individual's deductible and out-of-pocket expenses shall not exceed \$5,000 (exclusive of the cost of premiums, which average \$348 per month). This sum includes those medical services caused by the incident and those that are not. For 2015 and later, this cap will be adjusted as determined by the Secretary of the Department of Health and Human Services. 42 U.S.C.A. § 18022(c)(1)(B). However, the adjusted maximum will not ever approach the actual cost of services such as surgery or intense physical and occupational therapy.

Expert reports supporting life care plans are not yet taking into account the savings available under the ACA. This omission is substantial in terms of the actual value of any future medical expense needs and makes the reports unreliable under the standards set forth by Fed. R. Evid. §§ 401, 402 and *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579 (1993) and its progeny. In their current format, most life care plans presume that injured parties will violate the "individual mandate" imposed by law. Further, by not taking advantage of the ACA and the yearly out-of-pocket limits it offers, the plans assume a failure of the duty to mitigate damages. The duty to mitigate damages does not require an injured person to do what is unreasonable or impracticable. However, buying health insurance to cover preexisting conditions is no longer unreasonable or impracticable. Indeed, it is now required by federal law and available to everyone.

Claimants have asserted two primary arguments against consideration of the ACA in computing future damages. The first argument is that the insurance obtained under the ACA is a collateral source. The policy behind the collateral source rule is that the respondent should not benefit from reduced exposure because the injured person had his own health insurance. Although states are increasingly abolishing the collateral source rule and limiting the introduction of evidence of incurred med-

ical expense amounts (not what was written off by providers under agreements with health insurance companies, Medicaid, or workers' compensation schedules), reduced future damages under the ACA arguably are not a collateral source. In analyzing the reasonableness of future medical costs, the respondent has the right to expect that the injured person will take the steps legally available (and indeed required) to mitigate his/her expenses¹. Moreover, if part of the damages awarded or paid includes the annual policy premiums, the respondent funds the policy, and it is not a collateral source.

The second argument against the ACA is that following a future election, the ACA will be repealed. This article is not a forum for political debate, but given the millions of Americans who are benefiting from the ACA, a repeal may not be as likely as some think. Regardless, the ACA is the law now, and the ACA should be considered and followed as long as it remains operational law.

The 2014 provisions of ACA are in their infancy and too new for any binding precedent regarding application in these circumstances. However, in trying to establish precedent and convince Courts to accept the applicability of the ACA in computing future medical costs, there are three primary arguments to urge. First, taking advantage of the ACA falls within a claimant's duty to mitigate his/her damages. Second, the ACA is not a collateral source, particularly if the respondent is funding premiums as an element of damages. Third, experts who do not consider the ACA in their life care plans do not meet *Daubert* standards for reliability because in order to conform to the tort system's mandate of providing compensatory rather than windfall damages, assumptions made about a plaintiff's future ability to receive care must also change with this fundamental shift in federal law; the plans that do not do so are not reliable.

Application of the ACA can provide significant settlement savings or reduce the future damage claims presented to juries. For

example, most, if not all components, of a \$3 million, 20-year life care plan could be fully satisfied with 20 years of premium payments (average rate of \$348 per month for a total of \$83,520) and 20 years of yearly out of pocket maximum (currently \$5,000, for a total of \$100,000), a total payment of \$183,520 and a savings of over \$2.8 million². Even on smaller cases such as a spinal fusion or bilateral knee replacement, an award of \$50,000 for surgery and \$10,000 of physical therapy is not justified. The claimant would be compensated with 1-2 years of ACA coverage (\$9,176-\$18,352). If presented to the jury, applying the benefits of compliance with the ACA supports arguments that (1) the plaintiff is not prevented from receiving all of the medical treatment his/her physicians claim will be needed, and (2) the plaintiff is actually obtaining an extra benefit because not only are injury-related future medical expenses covered, but the awarded premiums will provide coverage for other health ailments (e.g., flu, diabetes, or allergy shots) not related to the incident.

When examining life care plans (or any large future damage claim), the ACA should be considered and strongly argued. There is no harm to the claimant – he/she receives compensation for all claimed medical expenses – but the savings for the respondent are significant.



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¹ The purchase of post-loss insurance to mitigate future losses is recognized by the Courts as part of the duty to mitigate. See, e.g., *In Pattee v. Georgia Ports Authority* (S.D.Ga. 2007) 512 F.Supp.2d 1372, 1381-2; *Maere v. Churchill* 452 N.E.2d 694, 699-700 (Ill.Ct.App. 1983) (plaintiffs refusal to purchase title insurance policy barred measure of damages that would have been recoverable); *Byzaska v. Olson*, 668 A.2d 1355, 1367 (Del. 1995) (evidence that free HIV testing was available presented a jury question as to whether plaintiff improperly failed to mitigate damages by incurring the expense of private HIV testing); *Sanford Bros. Boats, Inc. v. Vidrine* 412 F.2d 958, 973-974 (5th Cir. 1969) (seaman's failure to accept free medical services available at a nearby Marine Hospital barred him from recovering the cost of private medical care); *Fariss v. Lynchburg Foundry*, 769 F.2d 958, 965-66 (4th Cir. 1985) ("Nor is it sufficient to respond that an employer who discriminates in violation of the ADEA deserves to bear such a sizable and unanticipated penalty, for in most instances, the employee can easily avoid the risk of being uninsured by purchasing an individual policy of comparable value").

² Obviously, there are going to premium and out-of-pocket limit increases, which will be hard to estimate. But, if damages are reduced to present value, then an economist should be able to estimate the amount needed to cover such increases.