CLM Claims & Litigation Management Alliance™
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CLM 2016 Midwest Conference
June 23, 2016 in Omaha, NE

The Affordable Care Act: Palliative Care vs. Hospice Services – A Claims and Litigation Perspective on Today's Cost of Dying Comfortably

I. Introduction

There is an upcoming election, but the Affordable Care Act (ACA) is here to stay. The ACA has the potential to provide mediators, arbitrators and courts enough objective information to cap a Plaintiff's future medical needs to the recovery of premiums and out-of-pocket expenses. Such an application may eventually create an overall reduction in indemnity payments for medical malpractice carriers, and their insureds. This presentation will provide an overview of the ACA, obstacles within litigation, summaries of recent defense favorable case law and orders, and initial recommendations for how to develop an affirmative defense for those complex medical malpractice cases which involve extensive palliative care. Although laws vary amongst states we recommend making similar, continuous and consistent efforts across state lines in order to reach the ultimate goal of all courts automatically allowing and applying the objective costs provided by the ACA as evidence towards mitigation of Plaintiff's future damages.

II. The Affordable Care Act

On June 25, 2015 the United States Supreme Court upheld the ACA and Obama announced, "The Affordable Care Act is here to stay". For the first time in United States history healthcare is no longer fortuitous as the ACA requires and allows all Americans-including those with pre-existing conditions- to obtain health insurance, or face penalties. The ACA is designed to move individuals from the uninsured to the insured by: increasing industry competition resulting in lower premiums for the consumer, readily available comparison shopping through the exchanges, subsidies, and tax penalties. Under the ACA, there is a limit of maximum coverage plans on annual out of pocket expenses of $6,350 for individuals and $12,700 for families. [1] Each state established their own marketplace exchange wherein individuals can purchase a Qualified Health Plan "QHP". QHP's are defined as coverage plans that provide the Essential Health Benefits ("EHB") required by the ACA.[2] An EHB plan is one that provides the following benefits as required by law:

a) Ambulatory patient service,
b) Emergency services,
c) Hospitalization
d) Maternity and newborn care,

[1] The 2014 out of pocket maximum. Inflation will be accounted for each year.
[2] 42 U.S.C. §18021(a)(1)

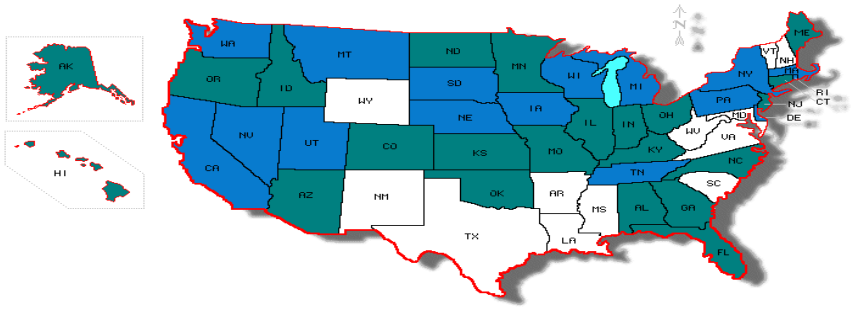
e) Mental health and substance abuse use disorder services, including behavioral health treatment, prescription drugs,
f) Rehabilitative and habilitative services and devices,
g) Laboratory services,
h) Preventative and wellness services and chronic disease management, and
i) Pediatric services, including oral and vision care. [3]

The ACA as detailed above is a federally mandated available insurance option making future health insurance coverage for anyone absolute, and no longer speculative. See *National Federation of Independent Business v. Sebelius,* 132 S.Ct. 2566. Such a mandate as recognized by the highest Court will now require lower courts to provide additional reasoning behind decisions to keep the ACA out of the courtroom. Our focus will be on Rehabilitative and habilitative services and devices and how they may impact claims and litigation.

III. A Claims and Litigation Perspective of the Obstacles and the Lower Court's Reluctance: The Collateral Source Rule, Plaintiff's Duty to Mitigate and Bifurcation

In application of the ACA, the law of precedent in relation to the collateral source rule, duty to mitigate damages, and bifurcation will require introduction of persuasive authority in order to create and feed the change needed for its evidentiary consideration. The common law collateral source rule is a complete bar to insurance in the courtroom. Recently, in *Deeds v. University of Pennsylvania Medical Center*, 110 A.3d 1009 (2015) the court reversed a defense verdict because the ACA was mentioned one time during trial. Today, after Collateral Source and Medical Liability Reform, only 13 states and the District of Columbia still adhere to the Common law collateral source rule. *See Exhibit 1*. [4]

Exhibit 1



Source: diymaps.net (c)

[3] 42 U.S.C §18022(b) and 45 C.F.R. §156.110
[4] See http://www.atra.org/issues/collateral-source-rule-reform; and NC Rule of Evidence 414

 **Collateral Source Reform States**

 **Medical Liability & Collateral Source Reform States**

The states with a modified the common law rule, particularly if they have a medical liability reform component, are the most likely to apply and allow evidence of the ACA.[5] Early ACA legal positions argue the ACA alone makes the main justifications behind the common law collateral source rule invalid.[6] While it will be essential to develop such arguments in those states that have strongly upheld the rule, it is more beneficial for our purposes to focus currently on those states which have abolished or modified the rule and make attempts to establish good law as precedent to fight the pure common law rule another day.

In addition to the Collateral Source Rule modification, those states that have adopted case law of a Plaintiff's duty to mitigate damages, and/or bifurcation can also assist in the establishment of legal precedent. A state with a strong legal precedent of a Plaintiff's duty to mitigate in tort cases will more likely be inclined to consider evidence of the ACA to establish actual financial loss. Another relevant legal consideration is bifurcation. Bifurcation is the division of a trial into two parts; commonly liability and damages. In most states a bifurcated trial mirrors Rule 42(b) of the Federal Rule of Civil Procedure, as statutorily permitted providing wide discretion of application the trial judge. A request of bifurcation of the issue of insurance and/or damages may result in a judge being more willing to entertain evidence on the ACA.

Therefore, we recommend focusing your development of an affirmative defense at the trial level in three stages. First, with those states that have modified the common law rule, particularly if they have a medical liability component, as they are the most likely to apply an ACA cap. Second, with those states that although may be holding on to aspects of the collateral source rule, they provide a strong combination of bifurcation and duty to mitigate damages case law, while using precedent from the first stage. And finally the third stage would turn to focus on those states that have not historically considered collateral source rule reform and/or do not support other supportive case law such as bifurcation or the general duty of plaintiff to mitigate damages.[7]

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[5] However, even some states with a modified common law rule, such as Florida, have refused to allow evidence of the ACA. *See* Florida Circuit Court Judge Lisa Small's September 25, 2015 Order in *Judkins v. Chipotle Mexican Grill, Inc.*, where she denied *Defendant's* Motion in Limine to include evidence of the Affordable Care Act on the Plaintiff's claimed current medical expenses.

[6] J. Hipp and C. Lilling. Can the Affordable Care Act Be Used to Mitigate Future Damages? Litigation Management. Winter 2004, pgs. 35-38.

[7] An example of a state that falls in this category is Texas. The Texas Supreme Court has held that the "collateral source rule has long been a part of the common law of Texas." *Haygood v. De Escabedo*, 356 S.W.3d 390, 394 (Tex. 2011). In addition, while a plaintiff must mitigate damages, the duty only arises if it can be done with "trifling expense or with reasonable exertions" and an instruction on mitigation of damages requires the evidence to "clearly show that the plaintiff's decision not to mitigate caused further damages" and "sufficiently guide the jury in determining which damages were attributable to the plaintiff's decision not to mitigate." *See Formosa Plastics Corp., USA v. Kajima Int'l, Inc.*, 216 S.W.3d 436, 459 (Tex. App. 2006). Finally, Texas only bifurcates trials based on types of damages, not separately based on liability and damages. TX CIV PRAC & REM § 41.009 (West).

IV. Today's Cost of Dying Comfortably

Existing Precedent: Defense Favorable Case Law and Orders

To date, only one known Order exists enforcing the ACA and capping Plaintiff's future medical damages by calculating the ACA annual premium plus the maximum amount of annual out of pocket expenses, then multiplying by the amount of years ineligible for Medicaid/ Medicare. In addition, guidance to establish reasonable certainty and creating the admissibility of future insurance coverage such as the ACA now exists. Additional orders have created small victories that may also be persuasive at a lower district level, and have the potential to assist in the creation of an appealable issue if placed on record to support an argument.

Enforcing the ACA: Alijah Jones et al v. Metro Health Medical Center et al
On April 13, 2015 Judge Ronald Suster in the Court of Common Pleas Cuyahoga County, OH granted in part Defendants filed motion to enforce damages caps pursuant to RC 27744.05[8] and granted in full Defendants motion for set-off of collateral benefits following a Plaintiff's verdict of $14,500,000. The jury awarded damages in the following categories: $500,000 for Alijah's past economic damages, $8,000,000 for Alijah's future economic damages, $5,000,000 for Alijah's economic damages, and $1,000,000 for Ms. Stewart's loss of consortium claim.

Ultimately the noneconomic damages and Ms. Stewart's loss of consortium claim were capped at $250,000. The $500,000 in past economic damages and $8,000,000 for future economic damages were considered under R.C. 2744.05(B)[9] allowing collateral benefits to be deducted from defendant MetroHealth as a political subdivision. Ohio precedent allows, "A political subdivision is entitled to a set-off for collateral benefits only to the extent that such benefits are actually included in the jury's award, and is entitled to an off set of future benefits only to the extent that they can be determined with a reasonable degree of certainty." Buchman v. Board of Educ., 73 Ohio St. 3d 260, 266 (1995).

Experts in elder law, life care planning and nursing established, through their testimony, that the premium for health insurance pursuant to the ACA is between $2,000 and $8,000 per year, and the maximum out of pocket expense is between $6,300-$6,500 per year.

The court determined that Alijah is Medicare eligible at age 22, and the Affordable Care Act will fill the gap during any lapse. They determined that the ACA premium would be $8,000 a year, with $6,500 for maximum out-of-pocket expenses then multiplying by the amount of years he could at most be ineligible for Medicaid and/or Medicare, they determined annual maximum totals of $116,000. The Court relied on evidence indicating Medicare would cover 80% of customary and ordinary care. They determined that for all categories except Transportation, Home Care and Housing, should be set off in their entirety and the amount remaining should be set off by 80% to account for what Medicare would cover, adding the ACA for an 8 year period until the Plaintiff would become eligible for Medicare, then

[8] R.C. 2744.05(C)(1) states: "[i]n wrongful death actions brought pursuant to Chapter 2125 of the Revised Code, damages that arise from the same cause of action, transaction or occurrence, or series of transactions or occurrences and that do not represent the actual loss of the person who is awarded the damages shall not exceed two hundred and fifty thousand dollars in favor of any one person."
[9] R.C. 2744.05(B) collateral benefits are to be deducted from any award against a political subdivision recovered by a claimant

deducted the previous three years allocated to Transportation. The final cap on future damages was therefore determined to be $2,951,291. The entire verdict was reduced to $3,451,291.

The ACA Reasonably Certain Test: Leung v. Verdugo Hills Hospital

This court denied use of the availability of the ACA alone as a defense to future medical damages without additional supportive evidence. The court then laid out guidelines for future use in order to prove the amount of future insurance coverage is "reasonably certain". In regards to the ACA the court stated, "the mere possibility that private insurance coverage will continue, and the availability of government programs for the
purchase of insurance, do not, in themselves, constitute relevant, admissible evidence of the future insurance benefits that a plaintiff is reasonably certain to receive. To show the amount of future insurance coverage that is reasonably certain, the evidence would have to:

(1) Link particular coverage and coverage amounts to particular items of care and treatment in the life care plan,
(2) Present a reasonable bases on which to believe that this particular plaintiff is reasonably certain to have that coverage, and
(3) Provide a basis on which to calculate with reasonable certainty the time period such coverage will exist."

We will refer to this later as the "ACA reasonably certain test."

Bolster your Record: Additional Orders

First Bankers Trust Company, Inc, et al.. v. Memorial Medical Center, et al.

On April 2, 2015, Illinois Circuit Judge Patrick W. Kelley ordered defendants were able to produce evidence of the Affordable Care Act only as to its effect on the actual reasonable costs of medical services. They were not able to refer in any manner to the Act's effect on out of pocket costs payable by Plaintiff or on insurance coverage that may be available to Plaintiff.

Marcia Christy Guardian v. Humility of Mary Health Partners

On May 4, 2015, Ohio Judge Andrew D. Logan denied in part a Motion in Limine to exclude reference to Medicaid or the Affordable Care Act. The court found that it "cannot restrict reference to the Affordable Care Act as it is the law of the land." Defendants were permitted to present their own damage assessments for future care, while still allowing Plaintiffs to introduce "full-billed" rates for future medical damages.

Donaldson et al. v. Advantage Health Physicians, PC, et al.

Michigan Judge George S. Buth denied Plaintiff's omnibus motion in limine to preclude Defendants from referencing the ACA and Plaintiff's potential coverage under the Act. The Court found that health insurance provided under the ACA is "reasonably likely to continue into the future" and that its discussion before the jury was permissible under Michigan's modified collateral source rule MCLA 600.6303(1), which allows the court to reduce a portion of judgment based on collateral source evidence.

Hernandez v. County of Orange

On September 30, 2014, California Superior Court Judge Frederick P. Aguirre reserved Plaintiff's motion to preclude evidence or reference to past or future medical insurance coverage, including the Affordable

Care Act. While he did not deny the motion outright, this Order left the question of the Affordable Care Act up for debate.

Developing an ACA Affirmative Defense & Determining a Premium for Palliative Care

Thomas Geroulo, from Weber Gallagher in Pennsylvania has taken the lead and leap focusing a portion of his practice to assist in nationwide coordination on the applicability of the Affordable Care Act to claims of future medical damages. In a recent A TransRE and Weber Gallagher Discussion entitled "Evolving Claim and Defense Strategies Under the ACA" attorney Geroulo provided an excellent outline to assist us in tackling the ACA. Although we have recommended rolling out the affirmative defense in stages amongst those states more likely to rule favorably at a trial level, we recommend making similar, continuous and consistent efforts across all states in discovery, and mediation in order to gain an early attention of all courts. Therefore, we will follow Weber Gallagher's lead with many recommendations, while providing some additional detail to assist us in furthering our goal.

Identifying the Cases

Weber Gallagher: treat this defense as a matter of routine, no different than a statute of limitations. In those states we have identified as part of the first stage, there is less of a risk at treating this defense as a matter of routine and it is encouraged that we do so in those cases with the likelihood of any future medical damages. However, in the second and third stage states, we recommend to a focus on only those cases with future damages alleged or considered to be in excess of $500,000, or an amount which could be greatly impacted by the potential ACA application.

As Answers are typically due prior to retaining experts it is necessary that the information in order to determine impact be available to the litigation management team almost immediately. Therefore, we recommend using the calculation provided in Alijah Jones et al v. Metro Health Medical Center et al, which will require knowledge of the State's ACA annual premium and out of pocket (OOP) expenses and the age of the patient.

$$\frac{\text{State ACA annual max premium + max amount of annual OOP expenses}\ X\ \text{years ineligible for Medicaid/ Medicare}}{\text{Potential Cost of Lifetime Future Medicals}}$$

Although it may be arguable that the ACA premium plan is not recoverable since health care insurance is required to be purchased by all, there are variances in premium amounts even within each state. The Plaintiff may argue that they would have preferred a differing lesser premium plan prior to their injury. Therefore, to create an easier application for the court we recommend in these early stages to argue that the max premium amount found within a state should also be included in the calculation. Once we feel more confident in our applications, we can then move to apply the duty to mitigate damages precedent.

The Answer

Weber Gallagher recommended affirmative defense sample language, "The Plaintiff has a duty to mitigate all damages with specific reference to future medical damages and under the Patient Protection and Affordable Care Act has a federally mandated mechanism in which to do so." In those states we

have identified as part of the first stage, the above language or some variation above should be plead. In the second and third stage states, we recommend pleading the defense only in those identified cases, as recommended above.

Written Discovery

Weber Gallagher: Serve discovery tailored to the issue classified as "Insurance Interrogatories", or some equivalent title covering every conceivable type of coverage; additional focus on marketplace interrogatories; and request tax returns for previous 3-5 years. We recommend serving the above type or similar discovery in all cases and all states, whether or not the affirmative defense has been plead. With the rapid change of case law in this new area it is possible that by the time trial comes around the ACA may be admissible, and amending an answer based on information already obtained via written discovery versus retaking a deposition is more cost effective.

Experts

Weber Gallagher: Ideal situation would be to use Insurance Actuary, Life Care Planner (LCP), and Economist who operate under the assumptions of granting the Plaintiff a platinum plan in the marketplace at the average national (or possibly regional rates) + out of pocket maximum. Ensure that the LCP and Economist have a two tiered approach with a traditional LCP and an ACA based plan. Focus on Leung v. Verdugo Hills Hospital "reasonable certain" test: 1) link particular coverage and coverage amounts to particular items of care and treatment in the life care plan; 2) present a reasonable basis on which to believe that this Plaintiff is reasonably certain to have that coverage; and 3) provide a basis on which to calculate with reasonable certainty the time period such coverage will exist. In those states we have identified as part of the first stage, the cost benefit to obtain all three types of experts mentioned by Weber Gallagher may eventually outweigh the risk of admissibility, as it is our view that evidence of the ACA will more than likely be admissible at trial in these states. However, until we have more certainty, we recommend for all "identified cases" rather than obtaining all three experts to first piggy back off of the Plaintiff's life care plan, and higher a consulting specialist in government benefits and/or health insurance broker to then determine the correct plan for the needs of the Plaintiff. If home health is at issue in any "identified cases" we also recommend a consulting specialist in government benefits who can find a state waiver program to provide health care coverage. Home health needs are often not covered, or only a portion covered depending on the requirements as outlined in the state EHP.

Depositions

Webber Gallagher: Revisit all "Insurance Interrogatories" at the deposition stage in more detail. It is strongly encouraged to establish ACA relevant testimony through depositions in all cases and states. In those states we have identified as part of the first stage, we also recommend consideration of a pre-deposition hearing with the judge in order to ask for an early ruling of the permissibility of an ACA line of questioning. Preparation at this hearing may be the key to early education of the judge, and it is recommended that educational materials such as the Defense Life Care Plan, and the state specific minimums, premiums, etc. be provided in support of the request. In the second and third stage states, however, there is no recommendation at this time for a pre-deposition hearing even for those "identified cases" only.

Mediation

Webber Gallagher: Why not offer to purchase the insurance in a settlement setting after developing experts? Mediation provides an equal opportunity amongst all states to attempt arguing mitigation of damages without the interference of evidentiary rulings. As Webber Gallagher eluded, even if a case does not appear as though it will settle in full at mediation, consider offering to purchase the best state plan from the marketplace for that year, and offer to set aside in an immediate trust. We have

calculated the range of cost to fund health insurance under the ACA for a permanently disabled 35 year old male rated to the average age of 50 years old with the range given in Alijah v Jones the cost to annuitize ranges $230,425.67-$406,042.66. Release and Covenant Not to Sue language would need to be developed for the case to continue to trial, to take into account this portion of the settlement as a consideration or set-off to any additional award to the Plaintiff.

Release and Covenant Not to Sue language would need to be developed for the case to continue to trial, to take into account this portion of the settlement as a consideration or set-off to any additional award to the Plaintiff. It is also recommended that if such an offer is made at mediation, but not accepted consider filing an Offer of judgment for future damages. The court may look favorably at any gesture of an offer, and may be then forced to further consider the ACA as a mandate and not speculative throughout the remaining course of trial.

Trial

Webber Gallagher: Motion in Limine/Daubert type hearing to eliminate the element of surprise. Expect Plaintiff arguments of prejudice, collateral source rule and that the ACA is a controversial law that may not exist in years to come. Response should focus on the satisfaction of factors in Leung; a discussion on the policy of the Collateral Source Rule in your jurisdiction and how the element of luck/fortuity has been eradicated; and seek the permission to at least cross examine the Plaintiff's expert on the issue to preserve for appeal. A Daubert type response should focus on obvious arguments such as methods and reliance on ever increasing peer reviewed or government issues publications. In addition, we recommend a request to bifurcate liability and damages. Because a bifurcated trial will likely be up to the judge's discretion the litigation team should consider whether they may be in front of a favorable judge on this issue. In these initial more difficult stages, it is recommended to find cases under the specific trial judge where bifurcation has occurred, future damages cases of any kind would be preferable. Bifurcation may eliminate arguments of prejudicial effect that are often advanced by plaintiffs on these issues, and may result in a judge more willing to entertain evidence on the ACA.

During trial, ensure testimony is established by both the ACA Plaintiff and Defense experts, so the court does not have to speculate and can determine application of a capped amount with a reasonable certainty. In the first stage states, if the court has not permitted ACA into the courtroom, still push to request proffered testimony in order to create an appellate issue.
In drafting a jury charge instruction consider the state specific EHB plan which would outline premium amounts and out of pocket costs, already established through expert testimony. One may even consider the argument, that the EHB plan as a mandated authority of the state should be provided in the charge, as it is very similar to the state life expectancy charts often used.

Post-trial, if there is a Plaintiff's verdict simply request additional time to prepare motions. We want to ensure that we take the strongest cases to the appellate level first. We recommend involving regional ACA expert attorneys at the initial potential appellate stage to determine the strength of an appeal. Costs benefit analysis, as in any case going up for appeal, should be performed to determine full pursuit.

V. CONCLUSION

As we are at the early stages of creating ACA precedent, we remind and recommend the litigation team to treat all future damages cases with potential application of the ACA thoughtfully and carefully in all

states. There exist states, which provide a great opportunity to establish solid early ACA precedent. Again, we recommend making similar, continuous and consistent efforts across state lines as outlined above in order to reach the ultimate goal of all courts automatically allowing and applying the objective costs outlined by the ACA as evidence towards mitigation of Plaintiff's future damages.