2016 CLM Annual Conference
April 6-8, 2016
Orlando, FL

Using Obamacare to Reduce Damages in Your Personal Injury Case

I. Introduction

Often claims for future medical expenses in personal injury actions comprise the largest component of a plaintiff's damages claim. To escalate these costs plaintiffs use life care planners who typically have played no role in the plaintiff's medical care and will not play a role in the plaintiff's future medical care. Furthermore, they often have no knowledge of the costs of care to date or the average cost of caring for individuals with the conditions they are opining about.

Another fundamental problem with life care plans is that they assume the plaintiff will pay retail prices for all medical needs on an out-of-pocket basis going forward, despite the fact that there are significantly cheaper options available that would afford the same level of care.

The Patient Protection and Affordable Care Act ("Affordable Care Act" or "ACA") now guarantees that all legal residents will have access to insurance for life, whether it be public or private insurance. They cannot be denied coverage or be discriminated against on the basis of their medical condition. Moreover, the ACA requires that all legal residents purchase insurance. Thus, by complying with the law and acting as a reasonable consumer, the plaintiff will never incur the costs that will be identified in life care plans. In this presentation, we will discuss how proper discovery, the presentation of experts, knowledge of the venue's collateral source rules, and mediation can be used to demonstrate the plaintiff's actual out-of-pocket future costs (real compensatory damages) and expose the fiction of life care plans.

II. The ACA

The ACA was adopted by Congress on March 23, 2010, and deemed Constitutional by the United States Supreme Court in National Federation of Independent Business v. Sebelius, 132 S. Ct. 2566 (2012). In its simplest form, the law provides that all legal residents in the United States shall be provided health insurance regardless of their health or financial situation.

The ACA contains five essential components designed to improve access to health care and health care insurance markets: (1) the individual mandate; (2) minimum essential benefits; (3) guaranteed issue requirement; (4) the employer mandate; and (5) tax credits and subsidies. All qualified health plans must provide "minimum essential coverage," including most medical

care, hospitalization, prescription medication, mental health and substance abuse, rehabilitation services and devices, lab services, chronic disease management, and pediatric services.

As explained by the Sixth Circuit Court of Appeals in Thomas More Law Center v. Obama (651 F.3d 529 [6th Cir. 2011]), the ACA's essential components are "designed to improve access to the health care and health insurance markets, reduce the escalating costs of health care, and minimize cost-shifting." Most relevant to defendants are three of these five essential components of the ACA.

A. State Exchanges and "Minimum Essential Benefits"

First, the ACA provides for the creation of state-operated "health benefit exchanges" which allow individuals and small businesses to leverage their collective buying power to obtain price-competitive health insurance (see 42 U.S.C. § 18031; Thomas More Law Ctr., 651 F.3d at 534). These exchanges provide a place where the uninsured, individuals, families, and small employers can shop for and buy the new products and are designed to make insurance more accessible and affordable, thereby reducing the number of uninsured (see 42 U.S.C. § 18031[b]; see also Florida v. U.S. Dep't Health & Human Servs., 648 F.3d 1235 [11th Cir. 2011]).

All "qualified plans" on the state exchanges are required to provide "minimum essential coverage." The "minimum essential coverage" required must include:

- Ambulatory patient services
- Emergency room services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse
- Prescription drugs
- Rehabilitative services and devices
- Lab services
- Preventive and wellness services and chronic disease management
- Pediatric services

26 U.S.C. § 1302(b).

Importantly, for these minimum coverage plans, the ACA limits the annual amount of out-of-pocket medical expenses that can be incurred (see 26 U.S.C. § 5000A[d]-[e]). The 2016 limit for individuals is $6,850 and $13,700 for families.

To meet the minimum essential coverage requirement, each state was required to designate a "benchmark plan." The designated benchmark plan establishes the specific level of coverage that every health insurance policy sold in the state must meet. The benchmark plan was chosen from among 10 existing plans in each state, as specified in federal guidance: the three largest small-group plans in the state, based on enrollment; the three largest state employee health plans, based on enrollment; the three largest federal employee health plans, based on enrollment, and the state's largest commercial HMO plan.

B. "Individual Mandate"

The ACA's "individual mandate," took effect in 2014 and requires every "applicable individual" to obtain "minimum essential coverage" or pay a penalty which will be imposed as a tax on the taxpayer's return (see 26 U.S.C. § 5000A; Nat'l Fed'n of Indep. Bus., 132 S. Ct. at 2581; Thomas More Law Center, 651 F.3d at 534). There are three exemptions to this requirement: (i) religion; (ii) individuals not lawfully present in the United States and (3) incarcerated individuals (see 26 U.S.C. § 5000A). The penalty for individuals was the greater of 1% of the taxpayer's total household income or $95 in 2014; the greater of 2% of the taxpayer's total household income or $325 in 2015, and will be the greater of 2.5% of the taxpayer's total household income or $695 in 2016. After 2016, the amount of the penalty will be indexed for the cost of living.

C. "Guaranteed Issue Requirement"

The "guaranteed issue requirement" bars insurance companies from denying coverage to individuals with pre-existing conditions (see 42 U.S.C. §§ 300gg-19[a] to -39[a]; 42 U.S.C. § 18001; Thomas More Law Ctr., 651 F.3d at 534). It works in conjunction with the "community rating requirement," which prohibits insurance companies from charging higher rates to individuals based on their medical history (see 42 U.S.C. § 300gg; Thomas More Law Ctr., 651 F.3d at 534). Thus, insurers may not establish eligibility rules based upon health status-related factors including: health status; medical condition (both physical and mental illnesses); claims experience; receipt of health care; medical history; genetic information; evidence of insurability (including conditions arising out of acts of domestic violence); and disability (see 42 U.S.C. § 300gg-4).

A health insurance issuer also may not establish "lifetime limits on the dollar value of benefits for any participant or beneficiary; or . . . annual limits on the dollar value of benefits for any participant or beneficiary," for minimum essential benefits (see 42 U.S.C. § 300gg-11). Additionally, health insurance carriers must provide coverage to dependent children until the age of 26 (see 42 U.S.C. § 300gg-14).

D. Future Insurance Coverage Is Not Speculative

While some will argue that future coverage under the ACA is speculative, the act has now survived two challenges at the United State Supreme Court (see King v. Burwell, 135 S.Ct. 2480 [2015]; National Federation of Independent Business v. Sebelius, 132 S. Ct. 2566 [2012]). Furthermore, even if some changes are made to the ACA, two of its main pillars will not go away: (1) the guaranteed issue requirement and (2) the insurance industry

No candidate presently running for office is seeking to undo the guaranteed issue aspect of the ACA, which provides that no person can be denied access to insurance by virtue of a preexisting condition or injury. Since the law took effect, 11.7 million individuals have enrolled in the ACA marketplace, and as of March 2015, the United States Department of Health and Human Services reported that a total of 16.4 million U.S. residents had enrolled for coverage through the ACA. Many of these individuals did not previously have insurance. Thus, to

eliminate the guaranteed issue requirement would mean that these same people who just became insured could then see their insurance taken away. The reality is no candidate is proposing that as an option. The other reality is that the insurance industry is not going away. Thus, it is reasonably certain that a plaintiff will have access to insurance for life.

III. Challenging the Common Law Collateral Source Rule

A. Common Law Collateral Source Rule

The biggest impediment to reducing damages by insurance has been the common law collateral source rule. The common law collateral source rule prohibits a defendant from reducing damages the plaintiff receives in a tort case by third-party payments received by the plaintiff. Generally, collateral sources are payments made by a third-party to the plaintiff, or by a medical provider on the plaintiff's behalf as a result of the plaintiff's injuries. The majority of states have modified the common law rule to varying degrees. Of those states, a few have abolished the collateral source rule for only certain actions, such as medical malpractice. Others have limited consideration of collateral sources to only post-verdict proceedings.

B. Prior Barriers in Common Law Jurisdictions to Discussion of Insurance are Weakened by the ACA

In states that still adhere to the common law collateral source rule, one of the primary justifications for the rule has been that a plaintiff should not be penalized for having the foresight to purchase insurance for his or her own benefit prior to the subject accident. Likewise, courts have held that a defendant should not benefit from a plaintiff's prudence in obtaining such insurance. These rationales, however, no longer apply because, as a result of the ACA, procuring health insurance for the care of an injured plaintiff is no longer a matter of a plaintiff's foresight, investment, or prudence. Instead, it is mandated by federal law.

Furthermore, courts did not want defendants to take advantage of benefits the plaintiff had procured for himself or herself using the plaintiff's own funds (see e.g., Moidel v. Peoples Natural Gas Co., 397 Pa. 212 [1959]; Denardo v. Carneval, 297 Pa. Super. 484 [Pa. Super. Ct. 1982]). Where, however, the collateral benefit has been obtained using funds from the defendant, whether in whole or part, courts permitted the defendants to take advantage of those benefits. Since in many cases, insurance to be purchased in the future would be purchased using funds from the defendant, the traditional rationale would not apply.

Collateral sources were also precluded in the past due to the potential prejudice they could have upon the jury (see Trump v. Capek, 267 Pa. Super. 355 [Pa. Super. Ct. 1979]). In this regard, there was a concern that the jury would punish the plaintiff for seeking damages despite the fact that the plaintiff was insured. Now, however, all individuals must maintain insurance and the jurors are subject to the same mandate.

Finally, the common law collateral source rule was intended to prevent the defendant from avoiding payment. No one is suggesting that the defendants should have to pay zero because of the availability of insurance. Instead, defendants seek to return compensatory

damages to their true nature, i.e. to replace actual out-of-pocket costs. Since now everyone is guaranteed access to insurance, to award more than would have to be paid in light of the insurance is to convert a compensatory award into a punitive one.

Significantly, in Stayton v. Delaware Health Corp., 2015 WL 3654325 (Del. 2015), Chief Justice Strine of the Supreme Court of Delaware acknowledged that it may be time to revisit the common law collateral source rule in light of the enactment of the ACA:

> [T]he case before us calls into question the wisdom of applying the collateral source rule - itself an exception to the general rule of damages that a plaintiff is entitled to be made whole and nothing more – in its current form, in an era where we are closer to achieving universal healthcare, and where rising healthcare costs are reducing access to care and harming our nation's economic health.

Id. at *11.

C. Prior Barriers in States with Modified Collateral Source Rules Have Been Weakened

Prior to the ACA, even in states that had modified their collateral source rules, defense attempts to offset damages based on insurance were often unsuccessful. That was largely due to the fact that plaintiffs could have been denied access to insurance in the future because of their preexisting condition or because insurance was often tied to employment. Now, under the ACA, they cannot be denied access to insurance and they can purchase similar coverage in the individual market.

D. Further Legal Arguments to Challenge Collateral Source Rules

1. Mitigation of Damages

A plaintiff may not be compensated for damages which he could have avoided by reasonable efforts or expenditures. This is known as the doctrine of mitigation of damages or avoidable consequences. Utilization of the doctrine requires that the defendant, who has the burden of proof, plead it as an affirmative defense. Thus, a defendant could now argue that a plaintiff's duty to mitigate damages requires them to purchase an insurance policy which covers the care that they will need in the future, thereby mitigating the defendant's costs for future medical expenses.

2. Reasonable Value

The plaintiff has the burden of proving that the claimed past and future medical expenses are both reasonable and necessary. Life care planners often base their medical prices on what is charged rather than what is actually paid. In healthcare pricing, however, there is often a huge difference between the amount charged (billed rate) and the amount actually accepted as payment, sometimes up to eight times higher (see George A. Nation III, 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, 432 [2013]). As for the billed

amounts, medical providers do not even expect the billed amounts to be paid (id. at 430). They are "grossly exaggerated" and "fictitious" (id. at 429). In fact, because so many patients pay less than the billed rates, "hospital bills have been called 'insincere, in the sense that they would yield truly enormous profits if those prices were actually paid'" (Howell v. Hamilton Meats & Provisions, Inc., 52 Cal. 4th 541, 561 [2011], quoting "The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy," 25 Health Affairs 57, 63 [2006]; see Daughters of Charity Health Servs. of Waco v. Linnstaedle, 226 S.W.3d 409, 410, n. 1 [Tex. 2007] [noting that full charges are "actually paid by less than five percent of patients nationally"]). A number of other courts have acknowledged this great discrepancy and its relationship to the reasonable value of medical care (see e.g., Moorhead v. Crozer Chester Medical Center, 765 A. 2d 786 [Pa. 2001]; Temple University Hospital v. Healthcare Management Alternatives, Inc., 832 A.2d 501 [Pa. Sup. 2003]; Nassau Anesthesia Assoc. P.C. v. Chin, 32 Misc.3d 282, 285 [N.Y. Sup. Ct. Nassau Cty., 2011]).

Indeed, if prior to the passage of the ACA less than five percent of patients paid billed rates,that number will now be even less. Thus, it is a virtual certainty that where a life care planner relies on billed rates, the plaintiff will never incur all of those costs. Rather the amounts received as payment are a far better indicator of reasonable value than the amount unilaterally listed as the charge by the provider (see e.g., Children's Hospital Central California v. Blue Cross of California, 226 Cal.App.4th 1260, 1274 [Cal. App. 2014]) [holding that reasonable market value, or fair market value, is the price that a willing buyer would pay to a willing seller, not what a provider unilaterally says their services are worth]). Defendants, therefore, should try to redefine reasonable value as what will be paid in the marketplace as opposed to what is charged.

3. "Opening the Door"

Generally, evidence of the existence of or lack of insurance is excluded at trial for public policy purposes. Evidence of collateral sources, however, may be allowed in situations where the plaintiff has "opened the door." When the plaintiff has offered such evidence first, the defendant may impeach the plaintiff by offering further evidence regarding plaintiff's insurance coverage, medical expenses, treatment history, etc. Common examples of where a plaintiff may open the door is when the plaintiff's economist includes insurance as part of the lost earnings claim or where the plaintiff claims he did not have sufficient funds to pay for medical care.

IV. Results

A. Positive Outcomes

Several courts in California, Ohio, Hawaii, Arizona, Georgia, and Arkansas have already permitted ACA evidence to reduce plaintiff's alleged damages. Some courts have allowed ACA evidence to provide for a post-trial collateral source offset. Others have allowed evidence of ACA and Medicare-related offsets. Furthermore, courts have allowed discussions of the ACA insofar as it affects reasonable costs of medical services. (A list of favorable decisions is annexed).

B. Negative Results

A number of courts have precluded admission of ACA evidence. Some of the earlier decisions relied on arguments that the continued viability of ACA/insurance is too speculative. Another court held that the collateral source rule was violated by cross-examination that included ACA. There, the defense verdict was vacated for a new trial. Other courts have held that Medicare and Medicaid were collateral sources and the defendants were precluded from presenting evidence of the rates paid by such government programs. For example, in Joerg v. State Farm (2015 WL 5995754 [Fl. 2015]), the court excluded evidence of the plaintiff's eligibility for future medical benefits from Medicare and Medicaid. The court reasoned that it is too speculative to attempt to calculate damage awards based upon benefits that a plaintiff has not yet received and may never receive.

C. *Positive Trends*

A number of courts have recently demonstrated a broader willingness to permit a discussion of reasonable value in terms of what is actually paid instead of what is charged so long as the defendant does not address the particular plaintiff's insurance coverage.

For example, the Supreme Court of Montana, in Meek v. Montana Eighth Judicial Court (379 Mont. 150 [2015]), held that evidence of the reasonable value of medical services can be challenged by reference to Medicare paid rates assuming the defendant did not mention that the specific plaintiff was covered by Medicare. Furthermore, the same court, in Reese v. Stanton (381 Mont. 241 [2015]), noted that, pursuant to Meek, the plaintiff may introduce evidence of original charges for medical services, but the defendant "is free to contest the reasonableness of those bills as a measure of damages."

Similarly, in Massachusetts, defendants are permitted to show the range of payments accepted for the types of services the plaintiff received, even though the actual paid amounts were inadmissible (see Law v. Griffith, 930 N.E.2d 126 [Mass. 2010]).

Likewise, in Georgia, a common law collateral source rule state, a federal court judge recently ruled that while evidence of insurance is inadmissible to show the plaintiff had insurance, it was admissible to show the reasonable value of future care (Houston v. Publix Supermarkets, Inc., 2015 WL 4581541 [N.D. Georgia 2015]).

And in Mississippi, another common law state, the Mississippi Supreme Court recently ruled that discovery of collateral sources was permissible because it could be relevant to the reasonable value of medical care (see Williams v. Memorial Hospital at Gulfport and Nikkita Barr, No. 2015-IA-00792-SCT (Miss. Sup. Ct. July 15, 2015)).

V. Case Implementation

A. *Pleadings*

Defendants should plead mitigation and collateral sources as affirmative defenses in jurisdictions where applicable.

B. Depositions

Depositions serve as an essential tool in evaluating and undermining plaintiff's alleged damages. Taking depositions of the plaintiff's treating providers and significant lien holders is significant to determine the range of payments they accept and whether they accept less than the full billed amounts. Depositions of plaintiff's life care planner and economist can be used to expose the fiction of their life care plan. Defendants should challenge plaintiff's experts to (1) determine whether they are an expert on the reasonable value of the cost of medical care, (2) learn how they determined the costs of care (i.e., sources), (3) gain their acknowledgement of the disparity between what is billed and what is paid and (4) and to seek the conclusion that few people actually pay the full billed rates.

C. Defense Experts

Parties must utilize experts to testify regarding the plaintiff's life care plan and the reasonable costs of medical care and insurance. Under the current tort system, awards for future medical expenses are based on projections made by a life care planner and an economist. In attacking damages, the defendant will most likely have to prove that the plaintiff's insurance will cover the needs claimed in the plaintiff's Life Care Plan; the cost of maintaining such insurance; and the projected costs to maintain such insurance over the duration of the future medical expenses award. This will require a combination of experts in health insurance, medicine and economics. Defendants should also retain an expert in medical billing practices to define reasonable value as what is paid versus what is charged and to provide the necessary data to support, without relying on the plaintiff's particular insurance coverage.

D. Mediation

Even before trial, the availability of insurance through the ACA may be more effectively raised in settlement discussions. Defendants should prepare multiple cost scenarios, including the annuity cost of the plaintiff's life care plan, the annuity cost of the plaintiff's life care plan with insurance, the annuity cost of the defendant's life care plan, the annuity cost of the defendant's life care plan with insurance, and the annuity cost of the plaintiff's life care plan utilizing the proper paid rates for the medical goods and services identified in the life care plan. Additional savings can be realized on these annuitized cost projections by utilizing medical underwriting. The structured settlement consultant will ascertain rated ages from the life insurance carriers. From these analyses, you can then work with your defense team and annuity broker to develop settlement options. The guaranteed income tax free annuities that are used to fund the structured settlements add a protective layer to the plaintiff knowing that they cannot outlive their settlement. Those options can include utilizing special needs trusts and Medicare Set Asides as further vehicles to provide for a plaintiff's future needs at more realistic values. In the end, the goal is to demonstrate to plaintiff, utilizing all available insurance and public benefit options, how their medical care can be maximized using the amounts being offered in settlement.