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The Impact of the Affordable Care Act on Personal Injury Litigation

A Plan to Defend Against Claims for Future Medical Costs, Life Care Plans, and Loss of Health Insurance

I. Introduction to the Patient Protection and Affordable Care Act ("ACA")

The ACA is now the law in the United States. There are twenty-seven (27) federally-facilitated marketplaces. There are sixteen (16) state-based marketplaces, in addition to the District of Columbia. There are seven (7) states that maintain partnership marketplaces.

According to the McKinsey Center for U.S. Health System Reform and Health and Human Services, more than 8 million people enrolled in the health exchange between October 2013 and March 2014 (7.3 million paid their first month's premium). Another 4.8 million people were enrolled in Medicaid and CHIP. As a result, the rate of uninsured individuals dropped from 18% to 13.4%. 265 of 282 insurance carriers that participated in the health exchange in 2014 remained part of the exchange in 2015. 70 new insurance carriers became part of the exchange in 2015 (for a total of 335 participating insurance carriers). 40% more plans were offered across the 50 states in 2015.

There are a number of accolades and criticisms of the ACA. The ACA has been lauded for dramatically increasing the number of insured individuals, providing comprehensive coverage, ten (10) essential benefits and free preventative care. The ACA has also been praised for precluding denial of coverage due to pre-existing medical conditions. In addition, it has been projected that the ACA will reduce the federal budget by more than $100 billion over next 10 years.

On the other hand, the ACA has also been criticized because employers may eliminate employer-based insurance plans, some plans are permitted to restrict their networks and millions of individuals with private health insurance may lose their current plan. Some have argued that government involvement in the ACA may raise overall health care costs and that tax penalties through the IRS are an ineffective means of enforcement.

There have been several recent challenges to the ACA, which are of note:

(1) U.S. House of Representatives v. Burwell et al., Case No. 1:14-cv-01967 (D.D.C. 2014): This was the first lawsuit ever filed by a chamber of Congress

against the President and the Administration, challenging the Executive Branch's payments for health care subsidies, where no public funds have been appropriated. The House of Representatives sought an injunction prohibiting the Treasury Department from paying any subsidies to insurers until an appropriations law is enacted.

(2) King v. Burwell et al., 135 S. Ct. 2480 (2015): The United States Supreme Court upheld as constitutional the outlay of premium tax credits to qualifying persons in every state, with respect to those exchanges established by the states, as well as the federal exchange established by the Department of Health and Human Services. While the petitioners had argued that the plain language of the statute provided eligibility for tax credits only to those persons in states with state-operated exchanges, the Court rejected this interpretation.

II. Benefits Under the ACA

There are ten (10) essential minimum insurance policy requirements under the ACA: 1) outpatient care; 2) emergency room visits; 3) hospital inpatient care; 4) pre- and post-natal care; 5) mental health and substance use disorder services; 6) prescription drugs; 7) physical and occupational therapy; 8) lab tests; 9) preventative services; and 10) pediatric services.

Insurers in each state may consider the following 5 (five) factors when setting insurance premiums: age; geographic location; tobacco use; individual vs. family enrollment and plan category. (Source: Healthcare.gov). The states may limit which of these factors can affect premiums. Insurers may not consider gender or pre-existing conditions (including current health status and claims history) when setting premiums under the ACA.

The premium rate factors considered by insurers vary in each state. For example, in New York State, which has a state-based marketplace, the following factors are considered: members in household; residing county of applicant(s); age of dependent children; and income for subsidy pricing. The age of the applicant and tobacco use are not considered when setting premium rates. Florida is a "federal marketplace" based state, which not only considers members in household, residing county of applicant(s), and income for subsidy pricing, but also the age of applicant(s) and tobacco use. The reference materials also contain information on factors considered in California (state-based) and New Jersey (federal).

III. Rates Under the ACA

In order to provide some idea of the rates under the ACA in different counties and states, we have provided some figures that are contained within your reference materials. The reference materials contain 2015 rates, comparative 2014-2015 rates and a synopsis of relevant benefits for the following counties and states: five boroughs, New York; Los Angeles County, California; Broward County, Florida; and All Counties, New Jersey.

IV. ACA Exclusions, Eligibility and Foundation to Establish Modified Adjusted Gross Income ("MAGI")

There are certain benefits that are typically limited or excluded under ACA plans. The benefits that are excluded from ACA plans include long-term care, home modifications and vehicle modifications. The benefits that are limited under the ACA plans include rehabilitative services, home health care and skilled nursing facilities.

To be eligible to receive benefits under the ACA, one must live in the United States, be a United States citizen, national or legal alien, and have a Modified Adjusted Gross Income (MAGI) over the Federal Poverty Level. Those who are not eligible to receive benefits under the ACA include prisoners, Medicare recipients, illegal aliens and those who do not qualify by income.

Affordable Care Act eligibility for subsidized health insurance is calculated using a household's Modified Adjusted Gross Income (MAGI). For most individuals, MAGI will be equal to Adjusted Gross Income. The MAGI determination includes the following factors: wages, salaries, and tips; taxable or tax exempt interest; taxable amount of pension, annuity or IRA distributions; Social Security benefits; business income, capital gain, other gains (or losses); unemployment compensation; dividends; alimony received; rental income; and taxable refunds, credits, or offsets of state and local income taxes. The MAGI determination excludes the following factors: workers' compensation; veterans' disability payments and child support received.

There are several categories of individuals that are not eligible/not required to obtain coverage, including Medicaid or Medicare recipients, less than 100% of poverty level, those who are Social Security disabled and those who are receiving Social Security benefits (age 65+).

There are several methods of establishing a foundation for the MAGI minimum in a personal injury lawsuit: (i) plaintiff's income (elicited through a deposition admission or signed tax return); (ii) spouse's income (elicited through a deposition admission or signed tax return); (iii) records regarding a plaintiff's pension, disability pension, cashed out annuity, etc.; and (iv) through a vocational expert.

V. Experts

There are several tactics for reducing or eliminating the costs set forth in a plaintiff's life care plan. The life care plan itself is a creation of the plaintiff's bar. Because it is a plan for the future, it is inherently speculative. To refute a plaintiff's life care plan, the defense should use actual costs incurred from the date of the accident through trial to establish the actual medical payment baseline. The defense should also use actual documented costs to rebut speculative future costs and use a workers' compensation or no-fault print out listing all costs incurred. In order to provide some idea of the discrepancies between life care plan estimates calculated by a plaintiff's expert and those

of a defense expert, please refer to the reference materials, which contain some charts that effectively illustrate these disparities.

The defense experts needed in order to effectively refute a plaintiff's life care plan include the following: (1) Licensed Health Insurance Broker; (2) Life Care Planning Expert; (3) Vocational Expert; and (4) Economic Expert.

The Licensed Insurance Broker Expert should be licensed to sell health insurance coverage through the exchange marketplace in the state in which your Plaintiff resides. There are several organizations that can provide guidance on identifying ACA certified brokers, including: the National Association of Health Underwriters (NAHU); the Independent Insurance Agents and Brokers of America; the National Association of Insurance and Financial Advisors and Professional Insurance Agents. In addition to ACA certification, brokers may also have other certifications including: a Health Insurance Associate (HIA) Certification; a Registered Health Underwriter (RHU) Certification; a Certified Employee Benefit Specialist (CEBS) Certification or a Professional Academy for Health Management (PAHM).

Lewis Brisbois is currently working with a member of NAHU, who has created multiple courses specifically catered to ACA education. This member is ACA-certified in several states, as well as HIA, PAHM, and RHU certified. Our expert is licensed in fourteen (14) states, including New York, California and Florida. There is a complete list of these states contained within the reference materials. Our expert is also currently working with several other insurance brokers in various states to ensure LBBS will have a licensed insurance broker expert in every state.

VI. Essential Elements to be Established by Experts

There are several essential elements to be established by experts in refuting a plaintiff's life care plan. It is necessary to demonstrate the defense experts' qualifications, licensing, and training, in addition to establishing expertise in ACA health care plan offerings, ACA eligibility and an individual's medical needs. The expert should determine the most appropriate ACA plan considering the individual's medical needs. Criteria to be considered by the defense expert include whether the individual is eligible for the ACA, the services needed are covered by the ACA health care plan, and the total of the health care costs incurred are limited to the annual premium and out-of-pocket limits.

Each expert will have a particular set of essential elements that should be established. A Licensed Health Insurance Broker should establish the following essential elements: (1) determine the skills, interests, aptitudes and work history of Plaintiff; (2) demonstrate capacity to return to work force; (3) demonstrate salary range and benefits of alternative occupation; (4) establish date by which Plaintiff can work; and (5) demonstrate that Plaintiff in alternative occupation will be: (a) eligible for affordable health insurance coverage through his employer, or (b) eligible for individual coverage under the ACA.

A Vocational Expert should establish the following essential elements: (1) determine skills, interests, aptitudes and work history of Plaintiff; (2) demonstrate capacity to return to work force; (3) demonstrate salary range and benefits of alternative occupation; (4) establish date by which Plaintiff can work; and (5) demonstrate that Plaintiff in alternative occupation will be: (a) eligible for affordable health insurance coverage through his employer, or (b) eligible for individual coverage under the ACA.

A Life Care Planning Expert should establish the following essential elements: (1) evaluate actual costs incurred by plaintiff (all medical costs paid to date); (2) evaluate all injuries, treatment and medical reports including deposition testimony and medical experts; (3) show that virtually all of the medical costs projected in plaintiff's life care plan are covered under the delineated categories of coverage in the pertinent state's "Synopsis of Benefits"; and (4) prepare the Future Life Care Plan distinguishing between "List Cost" and "Negotiated Costs" available to Health Insurers and demonstrate both in the Life Care Plan.

An Economic Expert should establish the following essential elements: (1) demonstrate the qualifications of the economist in analyzing growth rates for medical care; (2) establish the average growth rate for health insurance based on data from the past; (3) testify as to the statistical evaluation prepared by the Government to predict Health Care Expenditure projections; and (4) project the cost of plaintiff's future premiums for health insurance using an accepted growth rate or growth rate range.

VII. Litigation Strategy

The first step in the defensive litigation strategy is to assert appropriate affirmative defenses, which provides notice to the plaintiff at the commencement of the action that these affirmative defenses will be raised throughout the course of the litigation. The assertion of affirmative defenses at the inception of the litigation lays a foundation for discovery concerning plaintiff's mitigation of damages, or failure to mitigate damages. Should plaintiff fail to provide the discovery sought in connection with the ACA-related affirmative defenses, the defense will be well-poised for future motion practice.

There are five (5) sample affirmative defenses within your reference materials. The first sample affirmative defense seeks to exclude from any judgment or verdict against the defendants those amounts which have been, or will, indemnify plaintiff, for any past or future claimed medical costs, health care, life care, or other economic loss or benefit that is offered, or provided under or in connection with the Patient Protection and Affordable Care Act. The second sample affirmative defense is asserted in the event that the court treats ACA benefits as a collateral source. The third sample affirmative defense asserts that the plaintiff failed to take reasonable measures to mitigate the damages allegedly suffered. The fourth sample affirmative defense asserts that in the event that plaintiff failed to obtain coverage available to him, which he is eligible to obtain, then plaintiff has failed to mitigate his damages and cannot recover for such failure. The fifth sample affirmative defense asserts that to the extent that Plaintiff failed to take reasonable steps to avail himself of the resources, service benefits and coverage available to him under the Affordable Care Act, then Plaintiff failed to mitigate his damages and cannot recover for such failure.

There are also some supplemental ACA-related discovery items that should be incorporated into a standard Notice for Discovery & Inspection. There is a sample discovery demand provided in your reference materials. Some of the supplemental items that should be incorporated into a Notice for Discovery & Inspection include demands for identification of all health insurance coverage providers who provided coverage to the plaintiff individually, or to a Family member under a family plan for the time period of one (1) year prior to the date of the incident up through and including the present. With respect to this coverage information, defendants should demand HIPAA compliant authorizations for applications for health insurance coverage, complete health insurance policies including all riders, forms and endorsements, a list of covered and excluded treatment, insurance providers' complete files, and all applications for payments. Defendants should also demand copies of any correspondence from any insurance providers regarding liens asserted by any providers, premium due notices and periodic statements, and plaintiff's out of pocket costs for expenditures not covered by health insurance.

There are also some supplemental deposition questions that address ACA issues, which may vary depending on the factors considered in setting insurance premiums in a given state. The plaintiff should generally be asked about the following matters: marital status; dependents; tobacco use; place of residence and individuals that reside there; health insurance at the time of the incident and at present; whether applied or registered through the health plan marketplace; level of health insurance plan (platinum, gold, silver

or bronze); amount of premium and deductible; Medicaid; Medicare; Social Security Disability; Workers Compensation; and Unemployment Insurance. The plaintiff should also be asked whether he is aware that he is required to pay a penalty to the IRS if he does not have health insurance. It is critical to establish that the plaintiff is aware that tax penalties would be assessed in the event that a plaintiff fails to mitigate his damages.

VIII. A Re-Examination of the Collateral Source Framework

The plaintiff has the burden to prove damages. For example, according to New York State's Pattern Jury Instructions, "a jury may award plaintiff reasonable expenditures for medical services and medicines… in an amount that they find from the evidence to be fair and reasonable… as a result of [plaintiff's] injuries." (N.Y. Pattern Jury Instr.-Civil 2:285). The plaintiff has the burden of demonstrating the necessity or reasonableness of future medical treatment; reasonableness of the cost of future medical expenses; and the period of time over which plaintiff should receive the future award (lifetime/permanent or time frame). Id.

Under the present collateral source framework, plaintiff is permitted to introduce evidence of medical costs and future medical costs at trial. But the defendant is not permitted to address evidence of third party insurance coverage at trial. The defendant also cannot tell the jury that the medical costs have been or will be paid by insurance. The plaintiff gets to recover for medical costs and future medical costs, but the defendant can only get a reduction, post verdict in a collateral source hearing by demonstrating with "reasonable certainty" that medical costs will be replaced or indemnified by health insurance.

There are several problems with the present collateral source framework. The trial is essentially a fiction where plaintiff gets to present evidence of medical costs that he has not, and will not, pay for. The burden of proof is effectively shifted from plaintiff to defendant to show reasonable certainty of indemnification. By preventing the defendant from presenting evidence of actual medical costs, paid by a health insurer, the jury is shielded from the truth. With regard to medical costs, the collateral source doctrine has been extended beyond its logical intent and serves no public policy benefit or societal purpose in the post ACA-landscape.

A re-examination of the present collateral source framework is necessary. There are several significant changes that have been introduced by the passage of the ACA. First, the individual mandate requires that individuals possess and provide proof of health insurance, whether it is through an employer, public health insurance or through purchase on the healthcare marketplace. This means that almost everyone has or will have health insurance. Almost no one will be paying past or future medical costs "out of pocket." Almost no one will require reimbursement for future medical costs. In almost all situations, the health insurer will pay "negotiated rates," not "list rates."

The costs of ACA premiums and out-of-pocket limits are easily ascertainable and demonstrable in court. Offsetting future medical costs with known, predictable, defined

coverage is parallel to offsetting wage loss with replacement income. Therefore, the present collateral source framework is outdated.

Private insurers under the ACA have no lien rights in several states. In several states, private health insurers are prohibited by "Anti-Subrogation" statutes from pursuing liens against the plaintiff against the proceeds of a settlement or verdict. Some of the states with Anti-Subrogation Statutes include: Arizona, Connecticut, Kansas, Missouri, New Jersey, New York, North Carolina and Virginia. For example, New York State's General Obligations Law Section 335 provides as follows:

> No person entering into such a settlement shall be subject to a subrogation claim or claim for reimbursement by an insurer and an insurer shall have no lien or right of subrogation or reimbursement against any such settling person or any other party to such a settlement, with respect to those losses or expenses that have been or are obligated to be paid or reimbursed by said insurer. NY GOL §335.

This distinguishes between private health insurance and Workers' Compensation, Medicare and Medicaid, the later of which do have lien rights.

Since plaintiff has the duty at trial to mitigate damages and to purchase ACA insurance if eligible, the defendant should be permitted the opportunity to present direct evidence at trial (through a licensed ACA broker and a life care planner) as to the cost of ACA health insurance premium and out-of-pocket limits, to establish whether and to what amount plaintiff has mitigated damages.

Since plaintiff has a duty to mitigate damages by securing alternative employment, the defendant is already permitted at trial to establish an alternative stream of income through a vocational expert to offset future lost wages.

Likewise, as plaintiff has the duty to mitigate damages and to purchase ACA insurance if eligible, the defendant should be permitted the opportunity to present direct evidence at trial of the actual negotiated medical costs paid by the ACA health insurance provider. Unless the defendant challenges the evidence of the plaintiff's medical costs at trial, the plaintiff will build his life care plan on list costs for medical care rather than negotiated costs, permitting the plaintiff to significantly inflate his alleged damages. No plaintiffs who are eligible for ACA health insurance will pay list costs for medical treatment.

IX. Courts' Consideration of ACA Benefits in Determining Future Medical Expenses

Some state courts have rejected the "list price" model of compensation, by allowing evidence of what has been "actually paid".

In Kastick v. U-Haul Co. of Western Michigan et al., New York's Appellate Division, Fourth Department, held that the amount of a hospital's "write-off" or discounted hospital bill may not be recovered by the plaintiff, as it is not an item of damages for which the

plaintiff may recover; the plaintiff had never incurred any liability for the discounted amount. 292 A.D.2d 797, 740 N.Y.S.2d (4th Dep't 2002).

The Texas State Supreme Court has held that the Texas Medical Malpractice and Tort Reform Act bars recovery in excess of actual amounts paid, and precludes plaintiffs from offering evidence of the list price of medical care. Haygood v. De Escabedo, 356 S.W.3d 391 (2011).

The California Court of Appeals has held that the full amount billed for medical services is inadmissible and irrelevant to damages for past medical care, future medical care and non-economic damages, because the providers accepted discounted payments from insurers. Corenbaum v. Lampkin, 215 Cal. App. 4th 1308 (2013).

The California Supreme Court has held that the collateral source rule is inapplicable to pre-negotiated discounts between health care providers and insurers because such a discount is not considered a benefit provided in compensation for the plaintiff's injuries. Howell v. Hamilton Meats & Provisions, Inc., 257 P.3d 1130 (Cal. 2011).

The Supreme Court of Delaware has held that the collateral source rule does not apply to Medicare discounts between health care providers and insurers, as the amount paid by Medicare is dispositive of the reasonable value of healthcare provider services. In dicta, the court indicated that because almost everyone will be insured under the ACA, defendants will rarely, if ever, encounter plaintiffs whose medical bills are paid at the full rate. Stayton v. Delaware Health Corp., 117 A.3d 521 (2015).

Courts have begun to consider that a plaintiff's eligibility for ACA benefits should be taken into account when determining future medical expenses.

In Brewington v. United States of America, the United States District Court for the Central District of California held that the ACA ensures that the plaintiff will have access to insurance covering his future medical care needs as a result of his accident. The court considered the parties' life care plans and access to ACA coverage in determining plaintiff's future medical expenses, and awarded damages at a cost of nearly $2 million less than plaintiff claimed. 2015 U.S. Dist. 97720 (Case No. CV 13-07672-DMG (CWx)).

In Donaldson v. Advantage Health Physicians, P.C. et al., the Circuit Court of Kent County Michigan held that "health insurance provided under the Affordable Care Act is reasonably likely to continue into the future and that its discussion before the jury is not precluded by the [collateral source statute]."

In Jones v. Metro Health, the Cayahoga County Court of Common Pleas in Ohio reduced a verdict for plaintiff that included $8 million for future medical expenses to $2.9 million. The Court relied on a combination of coverage through private insurance, Medicare and Medicaid in relation to the offset.

In Christy v. Humility of Mary Health Partners, the Trumball County Court of Common Pleas in Ohio refused plaintiff's demand to bar defendants from referencing the ACA. The Court held that the ACA is the "law of the land" and that defendants should be allowed to present their own damage assessment through future medical costs.

In Crum v. Balz, an Arkansas Court granted defendant's request to introduce evidence regarding the ACA at trial, after plaintiff opened the door to such evidence on the direct testimony of their life care planner.

In Balleras v. Kapiolani, a Hawaii Court permitted defense counsel to cross-examine plaintiff's life care planner regarding the ACA and how much of the life care plan would be covered by insurance.

In closing, there are several concepts that you should take away from today's presentation:

1) The defense needs to qualify the plaintiff for ACA eligibility through discovery, admissions or experts.

2) The defense needs to assert affirmative defenses early to frame the issue.

3) The defense needs to retain a Licensed Health Insurance Broker as an expert to prove eligibility, total cost, best option, and scope of coverage.

4) The defense needs to resist the collateral source framework as out-dated, illogical, and serving no purpose in the era of ACA Health Insurance coverage.

5) Unless the defense bar pushes this issue, we will default into routine collateral source post-trial offset where the defense will bear the burden of proof of establishing the plaintiff's actual medical costs under the ACA.

6) Regardless of whether this is considered to be a collateral source or direct evidence, mediations, settlements and structures will clearly benefit from defined, predictable future medical costs.

7) The ACA should enable significant past and future medical cost reductions in the majority of cases with life care plans.

8) LIMITS of the ACA: ACA offset will not help for illegal aliens, single Plaintiffs with very low income (Medicaid), retired people over age 65 (Medicare) or catastrophic cases with SSDI (Medicare in 2 years).

9) But most such plaintiffs are still insured through the same public insurance plans with lien rights and MSA obligations that existed before the ACA.