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A Good Offense Is a Good Defense: Techniques for Defending Damages as Aggressively as Liability

Large jury verdicts capture headlines and instantly become the plaintiff's bar's justification for their next exorbitant demand. Runaway verdicts threaten the future of jury trials and ramp up the cost of settlements. Traditionally, defense counsel has been reluctant to fully engage in a robust damages defense. Sometimes this is due to a belief that a defense on damages is tantamount to an admission of liability. It has also been due to a concern that it can distract from a strong liability defense. Others believe that all of these issues can be taken care of on cross-examination. Still others are concerned about setting a damages "floor." The result has been, however, that where a jury rejects the liability defense, more often than not, without opposing evidence, juries largely adopt the plaintiff's numbers resulting in these large awards.

Based on a review of cases by one of our presenter's firms, in a given year, nine cases went to verdict, where in each the defense presented an aggressive damages defense with experts. In five of those cases, juries returned defense verdicts. In the other four, the verdicts were 33-90% less than the plaintiff's life care plan. This anecdotal data is consistent with jury research studies which show that juries are able to separate liability and damages defenses and that a strong presentation on damages can provide a valuable anchor for the jury in its deliberations.

In this presentation, we will challenge the traditional approach to defending damages. We will propose a comprehensive, aggressive approach that looks for defendants to utilize new experts, legal arguments and outside data to set and anchor case values.

Challenging Plaintiff's Economic Claims – Real World v. Life Care Plan Fiction

Plaintiffs typically use life care plans to raise the value of their cases. Life care plans have become commonplace in litigation and now have begun creeping into lower value cases where none would ever have been presented before. In one recent case, the life care plan totaled $285 million in future value. Life care plans, however, have absolutely no relation to the costs that will

actually be incurred in the real world. That is because they are often based on several faulty assumptions.

First, life care plans assume that individuals will pay a provider's billed charges for every good or service. It is well understood, however, that billed charges are largely fictions. Most providers do not expect to get paid their billed amounts. As such, those amounts cannot represent the true cost of an item. For example, if an attorney says that his hourly rate is $1,000 an hour, but his client's actually pay him $400 an hour, the value of his services is $400 an hour, not $1,000. Furthermore, if that same attorney had a conversation with a prospective client and said that his value is $1,000, but that he would give a discount to $400 an hour, that would be a fallacy. The attorney would not be giving a $600 discount. He would be providing no discount at all. The health care industry operates similarly, where billed rates are rarely if ever paid, and actual lower paid amounts are the norm. Thus, any life care plan based on billed rates is a pure fiction.

Second, life care plans do consider how goods and services will be actually be purchased and obtained. Insurance, government, community and/or charitable programs will be used to coordinate and purchase that care. In fact, life care plans often include as potential costs case managers, guardians, trustees, and conservators. Each of those individuals has a fiduciary duty to ensure that the plaintiff is able to maximize his/her recovery and that funds are not depleted or wasted by overpayment. Thus, in most cases, the very people tasked with providing for the plaintiff's care would be in breach of their fiduciary obligations if the life care plan as written was ever fully implemented.

Third, life care planners typically are only retained for the purposes of litigation. They are hired merely to create these plans and then have no further interaction with the plaintiff. They have no role in making sure their plan is implemented in the years leading up to the trial or after trial. They also have no data to show the reliability and validity of their future care forecasts. Thus, their ability to use these plans to accurately predict the future has a questionable basis.

From these life care plans, plaintiffs then retain economists who throw high inflation and low discount rates onto the plans to further increase the cost. They then often ignore or overproject life expectancy to further drive up the cost of care.

Defendants have largely bought into this fictitious system by presenting their own life care planners in opposition and matching plaintiff's economic projections with similar, but modified approaches to inflation and discounting. In doing so, this cedes the field to plaintiffs and legitimizes their approach. There are numerous tools and approaches, however, available to defendants to escape from this fantasy world and attempt to return damages to real world costs. Below we discuss some of them and the legal arguments in support.

1. <u>Challenging the Common Law Collateral Source Rule</u>

The biggest impediment to bringing a real world discussion of costs and health insurance into litigation is the common law collateral source rule. While some states have modified their rules, it is still rare for a defendant to be able to present during trial or at a post-trial hearing evidence of health insurance and the costs paid through insurance. With the adoption of the Affordable Care Act (ACA), many in the defense bar began to look into whether the ACA could present new challenges to the common law collateral source rule.[1] And while many courts still resisted, there began to be several victories.

The first significant breakthrough came in Jones v. MetroHealth Medical Center, 68 N.E.3d 281 (Ohio Ct. App. 8th Dist. 2016). In Jones, the Ohio Court of Appeals affirmed the reduction of the plaintiff's future medical damages award based upon the coverage to which the plaintiff would be entitled by virtue of Medicare, Medicaid, and private health insurance made available through the ACA.[2] The next major development came in Stayton v. Delaware Health Corporation, 117 A.3d 521 (Del. 2015). In Stayton, the Delaware Supreme Court held that Medicare payments were not collateral sources and the jury should only be permitted to hear evidence of the Medicare paid rates. Further significant, in a concurrence, the Chief Judge of the Delaware Supreme Court questioned the continuing viability of the common law collateral source rule.[3]

With the 2016 election, however, and renewed efforts to repeal and replace the ACA, many began to question whether this whole approach was still viable. The simple answer is "Yes." The crux of the argument was never about the ACA as a whole, but to focus on its key provisions and structuring arguments in light of, or around, the collateral source rule. The approach has five main pillars: (1) guaranteed issue requirement; (2) focus on insurance coverage that pre-dated the ACA; (3) reasonable value; (4) mitigation of damages; and (5) targeting specific aspects of the life care plan.

a. Guaranteed Issue Requirement

The same politicians who have promised to repeal the ACA have also promised that they will not repeal or eliminate the guaranteed issue requirement, which prevents insurers from

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[1] See, e.g., Ann S. Levin, The Fate of the Collateral Source Rule After Healthcare Reform, 60 UCLA L. REV. 736 (2012); Rebecca Levinson, Allocating the Costs of Harm to Whom They Are Due: Modifying the Collateral Source Rule after Health Care Reform, 160 U. PA. L. REV. 921 (2012); Adam G. Todd, An Enduring, Oddity: The Collateral Source Rule in the Face of Tort Reform, the Affordable Care Act, and Increased Subrogation, 43 McGEORGE L. REV 965 (2012); Joshua Congdon-Hohman & Victor Matheson, Potential Effects of the Affordable Care Act on the Award of Life Care Expenses, JOURNAL OF FORENSIC ECONOMICS 24(2), 2013 at 153-60; Jack Hipp & Caryn L. Lilling, Can the Affordable Care Act be Used to Mitigate Future Damages?, LITIGATION MANAGEMENT MAGAZINE, Winter 2014 at 35-38.

[2] It bears noting that while this ruling was subsequently modified to partially vacate the offset, the initial decision paved the way for continued challenges to the common law collateral source rule. See, Jones v. MetroHealth Med. Ctr., -- N.E.3d --, 2017 WL 3635466 (Ohio Ct. App. 8th Dist. 2017).

[3] Id. at 534-35; see also, Daniels v. Havasu Reg'l Med. Ctr. LLC, 2014 WL 10298104 (Az. Sup. Ct. 2014); Diaz v. United States, Case No. 2:13-cv-01012-JAM-CKD (E.D. Cal. 2015); Valdez v. Hazany, MD, No. 56-2014-00451388-CU-MM-VTA (Cal. Sup. Ct. 2016).

denying coverage based upon pre-existing conditions.[4] The guaranteed issue requirement can therefore be used to argue that insurance is now available and will continue to be available in the future. It enables attorneys, in states that permit collateral source evidence or post-trial offsets, to now demonstrate that insurance will be available for the rest of the plaintiff's life. It also supports arguments for revisiting and/or eliminating the collateral source rule as it is applied in the remainder of states that adhere to the traditional rule. Indeed, all proposed replacements to the ACA have continued to require that insurance companies provide coverage for those with pre-existing conditions.

Thus, defendants can still take the position that a plaintiff will never have to spend the amounts projected in his or her life care plan because the plaintiff will always have access to some form of insurance.

b. Focus on Insurance Coverage that Pre-Dated the ACA

In implementing the ACA, each state was required to select a benchmark plan. The benchmark plan set forth the minimum level of coverage that every insurance policy sold in the state must provide. Importantly, the benchmark plan had to be chosen from among 10 existing plans in each state: (1) the three largest small-group plans in the state, based on enrollment; (2) the three largest state employee health plans, based on enrollment; (3) the three largest federal employee health plans, based on enrollment; and (4) the state's largest commercial HMO plan.[5] Nearly every state adopted their largest small-group plan as their benchmark plan.

An analysis of these plans found that covered items and services were mostly consistent, with only a few exceptions. "For example, across the markets and plans examined, it appears that the following benefits are consistently covered: physician and specialist office visits, inpatient and outpatient surgery, hospitalization, organ transplants, emergency services, maternity care, inpatient and outpatient mental health and substance abuse disorder services, generic and brand name drugs, physical, occupational and speech therapy, durable medical equipment, prosthetics and orthotics, laboratory and imaging services, preventative care and nutritional counseling services for patients with diabetes, and well child and pediatric services such as immunizations."[6] These categories are largely consistent with the 10 minimum essential health benefits categories required under the ACA. The most common non-covered items by pre-ACA employer plans were habilitative services, pediatric oral services, and pediatric visions services. These items are not commonly claimed by plaintiffs.

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[4] See, 42 USC §§ 300gg-19[a] to -39[a]; 42 USC § 18001; Thomas More Law Center v. Obama, 651 F.3d 529, 534 (6th Cir. 2011).

[5] Sabrina Corlette, Kevin W. Luica, & Max Levin, Implementing the Affordable Care Act: Choosing an Essential Health Benefits Benchmark Plan, The Commonwealth Fund pub. 1677, Vol. 15 (March 2013), http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2013/Mar/1677_Corlette_implementing_ACA_choosing_essential_hlt_benefits_reform_brief.pdf.

[6] Essential Health Benefits Bulletin, Center for Consumer Information and Insurance Oversight, December 16, 2011, https://www.cms.gov/CCIIO/Resources/ Files/Downloads/essential_health_benefits_bulletin.pdf.

It is important to recognize, therefore, that the coverage currently offered in each state reflects coverage that was available before the ACA. Furthermore, it represents coverage that was available to the largest small-group plans, based on enrollment. It also represents coverage that is widely provided across the country. Thus, the idea that a plan providing coverage consistent with the benchmark will no longer be available within the state, even if the ACA is repealed, is wholly unrealistic. Any expert who makes projections based on the coverage provided by pre-ACA plans would be well within the bounds of generally accepted standards for making projections about the future to a reasonable degree of certainty just as plaintiff's economist makes predictions about the future based on past data.

c. Reasonable Value

The concept of reasonable value is an issue entirely separate and apart from the ACA and matching a life care plan with available insurance and government benefits programs. As many know, there is often a large disparity between what is listed on a doctor's bill and what is paid. A number of courts have recognized that billed amounts represent fictions and are not a proper measure of reasonable value.[7] Rather, reasonable value is what goods and services are bought and exchanged for in the marketplace, i.e. what people actually pay.[8]

Over the last two years there have been a growing number of states that have held that billed amounts are not reflective of reasonable value, or that juries should be afforded an opportunity to consider both billed and paid rates. In fact, in just the past year there have been favorable decisions in California,[9] Indiana,[10] Illinois,[11] Delaware,[12] Oklahoma,[13] and Montana.[14] Each of these cases have recognized that the plaintiff has the burden of proving that claimed medical expenses are reasonable and the defendant has the right to challenge that claim by defining reasonable value as what is paid in the marketplace as opposed to what is charged. These

[7] See, Howell v. Hamilton Meats & Provisions, Inc., 52 Cal. 4th 541, 561 (2011); Daughters of Charity Health Servs. of Waco v. Linnstaedle, 226 S.W.3d 409, 410 n.1 (Tex. 2007); Vencor, Inc. v. Nat'l States Ins. Co., 303 F.3d 1024, 1029 n.9 (9th Cir. 2002).

[8] See, Children's Hosp. Cent. California v. Blue Cross of California, 226 Cal. App. 4th 1260, 1274 (Cal. App. 2014); Temple Univ. Hosp. v. Healthcare Mgmt. Alternatives, Inc., 832 A.2d 501 (Pa. Sup. 2003). The court in Cuevas, 11 Cal.App.5th 163, extended that rationale to future damages.

[9] Cuevas, 11Cal.App.5th 163; *Diaz v. United States*, Case No. 2:13-cv-01012-JAM-CKD (E.D. Cal. 2015).

[10] In Patchett v. Lee, 60 N.E.3d 1025 (Ind. 2016), the Indiana Supreme Court held that for past medical damages, it is permissible to admit evidence of both billed rates and paid rates for private health insurance and state and federal government payors.

[11] Goranson v. Jaovis, M.D., No. 2009-L-015981 (Cook Cty. Ill. 2016) (Court permitted testimony that medical providers do not expect to be paid their full invoiced amounts and that reasonable value of medical care should be limited to amounts actually accepted as payment in full).

[12] Stayton v. Delaware Health, 117 A.3d 521 (Del. 2015) (holding that Medicare payments were not collateral sources and were dispositive on the question of reasonable value of past medical damages resulting in a reduction of plaintiff's claimed expenses of over $3 million to $262,550.17).

[13] Lee v. Bueno, 381 P.3d 736 (Ok. 2016) (upheld constitutionality of a statute that limited the admissibility of evidence of past medical costs to the amounts paid or owed, rather than the amount billed).

[14] Yeager v. Morris, Case No. DV 14-11, Montana Ninth Judicial District, Glacier Cty. (March 2017).

arguments, therefore, have reshaped the law and provide further opportunities to continue to chip away at life care plans.

d. Mitigation of Damages

Plaintiffs will continue to have access to insurance, whether public or private, and therefore will never have to spend the amounts claimed in a life care plan. Since the duty to mitigate requires plaintiffs to take all reasonable measures to minimize damages, and buying health insurance is no longer unreasonable or impractical, the duty to mitigate should apply.[15] Defendants, therefore, can argue that the plaintiff has a duty to reduce the amount of damages for future medical expenses by utilizing whatever means available to do so. The defendant then would only be responsible to reimburse the plaintiff for the premiums to maintain a policy, annual increases in those premiums and any out-of-pocket expenses such as co-pays, deductibles, or other expenses not covered by insurance.

e. Targeting Specific Aspects of the Life Care Plan

It is important to recognize that private insurance is rarely a stand-alone defense in cases. In most catastrophic injury cases, private insurance may not cover everything in the life care plan. In fact, private insurance often does not cover such significant expenses as home care. Thus, the defense must carefully review the life care plan and the basis for claims for home and facility care and develop targeted arguments to address those categories.

Furthermore, sometimes an individual is not eligible for private insurance coverage. When an individual has Medicare coverage that individual is not currently permitted under the law to buy a private health insurance policy. The plaintiff, however, can remain on Medicare and arguments can be made that damages should be limited to Medicare's reimbursement rates.

With Medicaid, an individual can have both private health insurance and Medicaid. Private insurance serves as the primary payor and Medicaid acts as a secondary payor for those medical goods and services not covered by private insurance. Having private health insurance serve as the primary payor expands the pool of providers that an individual has access to, reduces administrative wait times (to the extent they exist) under Medicaid and reduces the future lien that would be owed to Medicaid. Furthermore, Medicaid coverage, where available, is more expansive than private health insurance and Medicare, often covering such items as home and facility care, which are typically significant portions of life care plans. Thus, private insurance in many cases acts as a compliment to Medicaid coverage, ensuring that nearly all of the items in proposed life care plans will be covered by insurance at reduced costs.

[15] See generally, Sys. Components Corp. v. Florida Dept. of Transp., 14 So 3d 967, 982 (Fla 2009); Pulaski Bank & Trust Co. v. Texas Am. Bank/Fort Worth, N.A., 759 S.W.2d 723, 735 (Tex. App. Dallas 1988) (cert denied); Placer County Water Agency v. Hofman, 165 Cal. App. 3d 890, 897 (1985).

Importantly, a plaintiff can maintain eligibility for Medicaid by creating a special needs trust. A special needs trust has become the standard for management of funds for disabled beneficiaries who, if they were to receive settlement or litigation funds in their own names or in a guardianship, would not qualify for means-tested benefits such as Medicaid. In fact, courts have held that the failure of a plaintiff's attorney to recommend the creation of a special needs trust may be considered legal malpractice.[16] Furthermore, a trustee has a legal obligation to preserve the assets of such a trust.[17] That duty is fulfilled by utilizing available resources to reduce costs, including insurance.

By utilizing a special needs trust, plaintiffs can maintain their Medicaid eligibility and Medicaid would not have a right to reimbursement until plaintiff's death. As such, plaintiffs would not need to have all of the cash on hand today to provide for their medical care. Instead, they could invest that money. Special needs trusts conservatively obtain about four percent annually on their investments. Monies placed within the trust, therefore, can grow and provide not only for sufficient reimbursement on death, but for additional expenditures that can arise during a plaintiff's lifetime thus ensuring that the plaintiff will always have access to all of the medical care and services he/she requires.

Medicaid coverage for the disabled and special needs trusts have long been a part of personal injury cases since before the ACA. Thus, any potential changes to the ACA will not eliminate the utilization of these arguments.

f. Favorable Cases Since the 2016 Election

Through a combination of the arguments outlined above, the number of favorable decisions continued to grow culminating in the landmark decision in Cuevas v. Contra Costa Cty., 11 Cal. App. 5th 163 (Cal. Ct. App. 2017). In Cuevas, the California Court of Appeals held that evidence of the ACA was not too speculative. Notably, this decision followed the 2016 Presidential election, at a time when Congress was pursuing efforts to repeal and replace the ACA. The Court of Appeals acknowledged the legislative climate, but held the ACA remained the law of the land and that the defendant's experts had sufficiently demonstrated that insurance coverage was likely to continue into the future.

In Yeager v. Morris, Case No. DV 14-11, Montana Ninth Jud. Dist., Glacier Cty. (Mar. 2017), pursuant to the Montana Supreme Court's decision in Meek v. Montana Eighth Judicial Court, 379 Mont. 150 (2015), the court denied a motion to prelude holding that the defendants were permitted to offer expert testimony regarding the amounts paid by Medicaid and private health insurance as relevant to the determination of the reasonable value of future medical care. The

[16] Lawrence A. Friedman, Protecting A Disabled Person Whose Parent Becomes Terminally Ill, N.J. Law, 4/98, at 8, 9 (Apr., 1998).
[17] Scott Gardner, Supplemental Needs Trusts: A Means to Conserve Family Assets and Provide Increased Quality of Life for the Disabled Family Member, 32 DUQ. L. REV. 555, 556 (1994).

Court additionally held that the defendant's expert was permitted to testify regarding the ACA since the proposed bill to repeal the law had been pulled.

In Gaddy v. Terex Corporation, 1:14-CV-1928-WSD, 2017 WL 3473872, at *3 (N.D. Ga. July 21, 2017), the defendants presented an expert who provided two analysis. The first analysis was based on a market approach to assessing the reasonable value, amounts paid in the marketplace, for each good and service in the life care plan. It did not rely on the plaintiff's specific insurance as a basis. The second approach did use the plaintiff's specific insurance as its basis and matched that insurance with the life care plan. A federal court judge in Georgia held that the second approach violated the collateral source rule, but the first approach did not and was admissible on the issue of reasonable value. In particular, the court noted that the expert did not rely on the amounts that had been paid for the plaintiff's care to date, but relied on an established methodology for determining what others pay in the marketplace.

Likewise, in Plummer v. Medical Faculty Associates, Inc., Case No. 2016 CA 003998 A (D.C. 2017), a trial court judge in the District of Columbia held defendants were allowed to "challenge the reasonableness of the Plaintiffs' claimed future medical costs by eliciting [expert testimony] regarding the reasonable market value of such costs." The judge explained that such testimony would not violate the collateral source rule since the reasonable value testimony would be "based upon rates generally paid in the marketplace and without any relation to [the plaintiff's] specific insurance or collateral sources."

The California Court of Appeals in Cuevas, 11 Cal. App. 5th 163, also addressed the disparity between billed and paid amounts. Specifically, the court held that separate and apart from the medical malpractice statute involved in the case, the trial court erred in precluding the defendant from presenting evidence of amounts paid in the marketplace for all the goods and services in the plaintiff's life care plan.

Not all recent decisions have been positive. In Dedmon v. Steelman, 2017 WL 5505409, (Tenn. Nov. 17, 2017), the Supreme Court of Tennessee held that the defendant could not offer evidence of the amounts paid by insurance for past medical care. Notably, however, in restricting a defendant's ability to rely on the actual amounts paid on behalf of a plaintiff, the Dedmon court did not specifically foreclose a market-based approach that surveys the amounts paid by all payers in the relevant marketplace for the same goods and services. The court specifically left the door open to other challenges by the defendant that did not violate the collateral source rule. Importantly, unlike the defendants in Plummer and Gaddy, the defendants in Dedmon did not argue that the reasonable value of medical goods and services is not necessarily the amount actually paid on behalf of the plaintiff, but rather an amount that aggregates the payments made by all payers in the relevant marketplace. This approach eliminates focus on a particular plaintiff's insurance, avoiding the collateral source rule and the equal protection problems noted by the Dedmon court. Therefore, even in states such as Tennessee, which have determined that evidence of rates paid for a plaintiff's past care violates the collateral source rule, there are still arguments that can be made that the claimed billed rates are unreasonable.

2. Challenging a Plaintiff's Economist

If life care plans are the gasoline for inflating economic claims, often the economists' report is the accelerant. In one case, a combination of billed rates and high inflation rates, created a plan that was six times what it was actually worth ($12 million versus $2 million). It is important, therefore, for the defendant to give as much attention to challenging the plaintiff's economist as to the life care planner.

a. Alternative Approaches to Use of Treasury Rates

i. Prudent Investor

Where a plaintiff who has sustained catastrophic injuries receives a judgment or settlement, it is common practice for a fiduciary to be appointed or selected for the plaintiff's benefit. A fiduciary for a plaintiff would be required to use the Uniform Prudent Investor Act for portfolio design and management.[18] The Uniform Prudent Investor Act requires a fiduciary to diversify the investment portfolio through considerations of both risk and return. Those rates of return would translate to higher discount rates and thus reduce the present value. In that regard, the Prudent Investor Act is contrary to the traditional economist model. The traditional economist model assumes that an individual will invest 100% in bonds. Anyone managing that money, however, would not in fact invest 100% in bonds and therefore, assuming that they would overinflates present value.

Use of Annuities

As many courts have recognized, life annuities are a valid alternative for calculating present value.[19] Numerous states, including Texas, have previously allowed such evidence.[20] A further advantage of an annuity is that it allows for a discussion of life expectancy without putting the risk on the plaintiff. The annuity company assumes the risk if the plaintiff lives longer than expected.

Of course, whether annuity testimony will provide a strategic advantage over a traditional approach will depend on whether the annuity company receives significant high rated age. Thus, in cases where there is a potential large reduction in life expectancy, one should consult with a structure broker or annuitist to see if this approach would be advantageous. Notably, however, if experts need to be designated, the annuitist should not be the structure broker retained to assist with settlement. That broker may be considered biased by the court since he/she would have a stake in the outcome (i.e. commission). Therefore, it is advisable to retain a separate annuitist.

Some states, like New York, have adopted periodic payment statutes requiring a portion of any judgment to be structured. Thus, while plaintiffs will often resist a discussion of annuities,

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[18] See e.g., TEX. PROP. CODE ANN. § 117.004.

[19] See, e.g., Gallegos ex rel. Rynes v. Dick Simon Trucking, Inc., 110 P.3d 710, 715 (Utah Ct. App. 2004) (recognizing that courts in Indiana and Washington also permit annuity testimony); Scott v. United States, 884 F.2d 1280, 1287 (9th Cir. 1989).

[20] See, Gulf, Colorado & Santa Fe Ry. Co., 358 S.W.2d 690 (Tex. Civ. App.--Eastland 1962) (cert denied).

there may be other reasons outside of the benefit to the plaintiff why annuities should be a part of settlement discussions.

b. Motions

i. Challenging an Economist's Growth Rate Assumption

Growth rates used by economists to project the future or present value of a plaintiff's future medical expenses and/or lost earnings can at times be employed improperly or an economist can use rates which are inherently unreasonable. For example, an economist's use of a negative growth rate should be challenged as an economically nonviable assumption. Present value looks at how much money is needed to be invested today to generate a certain amount in the future. Where the present value exceeds the future value, that assumes negative growth and essentially the collapse of the American economy.

An economist should also be challenged where he uses a single inflationary rate for all life care plan modalities. In this regard, not all items in a life care plan grow at the same rate. For instance, a historical growth rate for medical items and services may demonstrate that medical services have grown at 4% whereas medical care commodities have grown at a rate of 2.8%. Where such historical data exists and an economist fails to use it, defendants should argue that the economist's methodology is unreliable.

ii. "Opening the Door"

Where an economist includes loss of private insurance as a fringe benefit in his or her projection of a plaintiff's economic loss, defendants may file a motion that such testimony has opened the door to a discussion of insurance. Indeed, a plaintiff cannot, on one hand, claim that he is entitled to be compensated for health insurance that he would have received had he not been injured and then, on the other hand, argue that he cannot purchase (or maintain) health insurance in the future, which would reduce the cost of his care.

Notably, some courts have allowed questions regarding health insurance during trial where plaintiff's expert has included lost health insurance in the fringe benefit claim.[21] In Pierce v. Upper Valley Medical Center, (No. 14 CV 567 [Ohio Ct. Com. Pl. 2016]), the court held that the plaintiff's own expert "opened the door" to evidence regarding the ACA and the cost of insurance. The plaintiff's economist included in his calculations of future lost damages the cost of premiums for health insurance as a component of lost fringe benefits. The economist also acknowledged that health insurance would cover some of the plaintiff's future health care costs. The court explained that where a plaintiff, through an economist, injects the issue of insurance, the defendant may be permitted to explore the effect of the insurance and the ACA on the damages sought. The court then gave the plaintiff the option of withdrawing that claim or risk having it open the door to insurance at trial.

[21] Evans v. Yonkers Contracting Co., Doc. No. 107866/09 (N.Y. Sup. Ct., N.Y. Cty. 2016).

3. Defending Against the Runway Pain and Suffering Verdict

The above arguments challenge the main economic claims that comprise plaintiff's damages. The other often larger component is pain and suffering. While some states have caps or appellate review that can reduce jury awards to "reasonable compensation" most states pain and suffering awards remain largely unchecked. In an unchecked, system the risk of a runaway verdict increases. That in turn creates an environment where plaintiff's counsel can leverage that risk to push for larger settlements. Thus, counsel must consider what measures can be taken to try to minimize the risk of a runaway verdict or reliance on that possibility by plaintiff's counsel.

Any approach to defending pain and suffering should look at: (1) potential legal arguments; and (2) trial or discovery tactics. On the legal front, there are some arguments that can be used. For example, in a case involving limited or no consciousness, does that limit or negate a claim for pain and suffering and loss of enjoyment of life? Some jurisdictions will not permit recovery unless there is conscious awareness. If the plaintiff had a prior injury, has the plaintiff properly made a claim for aggravation? What aspects of care would have been needed anyway?

Trial tactics can include trying to eliminate potentially susceptible jurors to runaway verdicts during voir dire. Also during voir dire, counsel can explain to jurors that they are required to defend damages, that it does not mean they concede liability, and would they hold that against them in fairly reviewing the case. Some have proposed suggesting a number in closing statements. Others have suggested trying to explain to a jury what such large proposal mean. For example, the plaintiff's proposal would be the equivalent of going to Disney World every year three times a year for the rest of a person's life.

There is no clear consensus or perhaps even plurality approach, but the hope is that by focusing on these issues more, in the not distant future one can emerge.