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Potential Effects of the Affordable Care Act on Loss Calculations

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Abstract

This chapter examines how the Affordable Care Act might affect the analysis of future care costs in medical malpractice, product or accident liability, or workplace injury cases. Prior to the ACA, it was reasonable to presume that a great deal of a victim's future health care costs would be paid for out-of-pocket as there was little guarantee that the plaintiff would have access to affordable insurance. Since January 2014, however, a plaintiff can obtain insurance that will cover a significant portion of any future medical costs. This paper examines the basic structure of the ACA, how it has affected health insurance markets, and provides examples of how the ACA might be introduced into an analysis of future life care costs. In addition, case law regarding the application of the ACA is examined as well as arguments for and against considering the availability of health insurance in medical litigation. Finally, additional details regarding the application of the ACA by the practicing forensic economist are addressed.

JEL Classification Codes: I13, I18, K41

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Introduction and Background on the Affordable Care Act

In tort cases involving a personal injury like medical malpractice, workplace accidents, and traffic incidents, the cost of future medical care is often the single largest component of a settlement or award for the plaintiff. When a defendant is ruled liable for injuries to a plaintiff, the cost of future medical care should be paid by the injuring party in order to make the injured individual "whole". At the time the award is made, no one can know with certainty what those future costs will be, and therefore a jury or trial judge must rely on expert witnesses to inform them of the best estimate of those costs. First, a life-care planner must identify what care they would expect the injury to necessitate over the course of the injured party's lifetime. Next, a forensic economist (FE) will take the life-care plan and determine what the cost of that future care will be in present value terms. In determining this amount, the forensic economist will consider the amount that the injured party will expect to pay for each treatment or device needed and account for medical care inflation and expected returns on safe investments.

In 2010, the federal government of the United States passed the Affordable Care Act (commonly referred to as the "ACA" or "Obamacare") which will certainly impact the cost of future care paid by the injured party. (The ACA is an abbreviation for the policy changes initiated by two laws, the "Patient Protection and Affordable Care Act" and the "Health Care and Education Reconciliation Act of 2010".) Specifically, the law guarantees access to insurance and prohibits insurance companies from using pre-existing medical conditions to determine who to insure or what premiums to charge. These provisions of the law went into effect on January 1st, 2014. Furthermore, the ACA puts restriction on the amount of cost-sharing for medical expenses beyond the premium charged and contains a number of measures that hope to slow the rate of medical care inflation. The question then becomes how forensic economists should go about

estimating future medical costs in light of these dramatic changes and what other legal doctrine needs to be considered when deciding how to move forward.

In the next section of this chapter, we will provide more details regarding how the ACA has changed the acquisition costs of medical care for patients. Next, we will briefly examine the initiatives in the ACA that are designed to rein in the high growth rate in the cost of medical care. We will then focus on the implications for forensic economists when estimating the costs of a life-care plan and provide an example of how this might be done in practice. We will next examine the issues yet to be resolved by the courts in regard to this application of the ACA and discuss the initial rulings that have been made to date.

Health insurance for those with pre-existing conditions before and after the ACA

Prior to the implementation of the Affordable Care Act, a forensic economist would not consider the possibility that health insurance may defray the cost of the medical care included in a life-care plan. He or she had no reason to believe that an injured party would be insured for a number of reasons. First, the primary source of health insurance was and still is through employers. That said, only about 55 percent of employers offered coverage to their employees in 2014, and an injured individual may no longer be able to work at all or in the type of jobs that commonly offer insurance as a fringe benefit. (Kaiser Family Foundation and Health Research & Educational Trust, 2014) Even if he or she were still able to work in that capacity, they should not be locked into such jobs for the remainder of their life due to the tortuous act of the defendant simply in order to not jeopardize their health benefits.

Other than insurance offered by employers, the injured party's options were significantly limited. There are other government programs such as Medicaid, Veteran's Administration

health care, and Medicare eligibility for those with a disability, but all of these require specific qualifications or means testing which could make it unlikely for the injured party to qualify. In the cases where the individual was covered by a "worker's compensation" insurance plan or was within two years of eligibility of federal Medicare insurance program, these insurance programs may have covered some medical costs but were also statutorily granted subrogation rights from the injured party. Finally, the availability of insurance in the non-group, private market was heavily restricted prior to the ACA. Insurance companies had great leeway to determine who they would insure, what rate they would charge for premiums and co-payments, and what care would be covered. Insurance companies would often deny policies to those with costly preexisting conditions like those of an injured party in a tort case. In cases where companies were willing to issue policies for those with preexisting conditions, the policy would most likely include explicit exclusions of coverage for care related to that condition.

The ACA dramatically changed the market for health insurance by imposing two key limitations on the insurance market: guaranteed issue and standardized insurance offerings. Guaranteed issue insures that all legal citizens in the United States can purchase an insurance policy from a government established marketplace without restrictions based on pre-existing conditions. Insurance companies cannot consider expected costs of anyone who enrolls in their insurance programs when determining eligibility or costs. In fact, insurers can only adjust premiums for a specific plan based on age, tobacco use, and geographic location (U.S. Centers for Medicare & Medicaid Services, 2015a). Therefore, a thirty year old, non-tobacco using resident of New York City will be able to attain health insurance with the same premium on a health insurance exchange regardless of whether he or she is perfectly health, recently diagnosed with cancer, or a victim of a tortious act that will require a life-time of expensive medical care.

Though access to insurance for everyone is an important tenet of the Affordable Care Act, the law's establishment of standardized coverage in those plans insures that insurance companies cannot sort customers based on expected medical care by designing plans that are more desirable for "healthy" individuals. Specifically, the plans that are available on the health insurance exchanges established by the ACA are required to cover ten broad categories of "essential health benefits". Essential health benefits include 1. Ambulatory patient services (outpatient care), 2. Emergency Services (trips to the emergency room), 3. Hospitalization (treatment in the hospital for inpatient care), 4. Maternity and newborn care, 5. Mental health services and addiction treatment, 6. Prescription drugs, 7. Rehabilitative services and devices, 8. Laboratory services. 9. Preventive services, wellness services, and chronic disease treatment, and 10. Pediatric services (U.S. Centers for Medicare & Medicaid Services, 2015b).

Not all services within these broad categories must be covered, but the law requires general coverage within each of these service areas. Individual states are responsible for approving plans subject to federal guidelines. The Center for Consumer Information and Insurance Oversight at the Centers for Medicare and Medicaid Services provides benchmark plans for each state and the District of Columbia as well as lists of individual state required benefits. For each benefit listed in a state's benchmark plan, the state provides a description of the benefit, whether the benefit is covered, a designation as to whether the benefit is considered an essential health benefit subject to out-of-pocket yearly maximums, any quantitative limits on the service, and if any exclusions or additional limitations or restrictions on coverage of the benefits exist. (See https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html)

In addition to coverage standards, the ACA also limits the amount of cost sharing that can be part of the standard insurance policy. Though insurers are still allowed to pass along some

costs in the form of co-payments and deductibles, the Department of Health and Human Services will now set annual limits for the total amount of out-of-pocket medical expenses paid by an insured individual. This limit was set at $6,600 for an individual and $13,200 for a family in 2015, increases to $6,850 and $13,700 for 2016, and increases annually thereafter by the rate of increase of the CPI. (Department of Health and Human Services, 2015) Additionally, the ACA prohibits annual and lifetime maximum benefits for covered expenses.

The ACA and Medical Inflation

The ACA also has provisions designed to curb the explosive growth of health care in the United States. In the thirty-five years prior to the passage of the ACA, health care costs increased at an average annual growth rate of around 6 percent while the consumer price index (CPI) increased by only 3.7 percent. Though medical care costs have consistently grown more quickly than the costs of all goods and services more broadly between 1980 and 2009, Table 1 shows that the gap between the CPI and two medical care cost indexes calculated by the Bureau of Labor Statistics has been narrowing in the last 15 years, even before the ACA. That said, the ACA set out to further narrow that gap by restricting both the premiums that insurance companies can charge and creating programs to stem the growth of medical care payments. In an attempt to limit the growth of premiums, the ACA instituted a twenty percent cap on the share of premium revenue that can be allocated to non-medical care items such as advertising, administrative costs, and profits. The law also requires insurance companies to receive approval for any premium increases over ten percent.

[Table 1 about here]

In regard to the cost of medical care itself, the ACA had a number of initiatives and experiments to attempt to limit the price of care and amount needed. First, by increasing the pool of insured individuals, the rate of unpaid care should decrease significantly and health care providers will not pass along those costs through higher prices for those who do pay. A 2014 Kaiser Family Foundation report estimates that $21.1 billion of medical care was uncompensated in 2013, the last year before the health care mandate took effect (another $63.8 in medical care to uninsured individuals was compensated by other entities—such as federal and state government funded programs--or was explicitly identified as charity). Assuming the cost of uncompensated care resulted in higher prices for those who were insured, this total makes up 2.3% of the total private health insurance expenditures which totaled $925.2 billion that year (Coughlin et al. 2014). Additionally, the law set aside funding for pilot programs to advance health outcomes while reducing the cost of care. Examples of programs that have been funded to date include new payment models that increase efficiency through linking payments to the quality of care provided, penalties for patient readmissions, and bundled payments for services related to a procedure or condition rather than payment on a per service basis (Blumenthal et al 2015). Early results appear to support the effectiveness of the ACA on this front. The gap between the growth of medical costs and overall CPI has narrowed by 25 percent in the five years since the passage of the ACA when compared to the average growth rates between 2005 and 2009. Though the recent economic downturn may have had a different impact on medical costs than the costs of all goods, it should be noted that 2013 and 2014 had the two lowest medical cost growth rates since 1960.

Implications of the ACA when estimating the cost of a life-care plan

The changing landscape of the health insurance marketplace and health care provision may have important implications for forensic economists. If a forensic economist considers the the ACA when formulating lifecare costs, rather than identifying the costs of each item in a life care plan, the expert must start by identifying which services and devices are covered by all insurance policies under the essential benefit mandate and which are not. The annual cost of covered expenses for the injured party will be limited to the insurance premium in the area where the individual lives plus the out-of-pocket maximum. For items in the life care plan that are unlikely to be covered, the forensic economists will identify the likely cost of such treatment or devices as they did prior to the ACA. The forensic economist must then identify the current present cost of the expected lifetime of insurance premiums, out-of-pocket maximum payments, and the cost of uncovered care while taking into consideration the effectiveness of the ACA to control medical costs and insurance premiums.

It should be noted that a strong argument could be made that the insurance premium should not be included in any award. The ACA includes an individual mandate which requires all individuals to acquire health insurance or pay a significant financial penalty. Therefore, the plaintiff would have been required to purchase insurance whether they had been injured or not. At the very least, the forensic economist should include the cost of the penalty associated the individual mandate as an offset to the cost of insurance. Anecdotally, an offer from the defendant to cover the cost of an ACA-compliant insurance plan along with expected out-of-pocket costs has been reported to be an effective negotiating tool in settlement negotiations in cases involving large future medical costs.

Applying the ACA to a Life Care Plan: An example

Suppose an accident to a single, 35-year old adult male results in annual expected future life care costs of $100,000 for home health care, $10,000 for transportation, $20,000 in prescription drugs, $20,000 in routine medical evaluations and diagnostics, and $10,000 in durable medical equipment such as wheelchairs and/or prosthetic devices.

Prior to the ACA, assuming liability on the part of the defendant, this plaintiff has an identifiable increase in their life care costs of $160,000 per year, all of which could reasonably be expected to be paid for out-of-pocket by the plaintiff. Thus, to make the victim whole, $160,000 should be paid annually until life expectancy (appropriately grown and discounted to present value terms).

Applying the ACA to this case, the first step is to identify which items are typically covered by an ACA-compliant insurance plan. Prescription drugs, routine medical care, diagnostic tests, and durable medical equipment are all generally deemed as "essential health benefits," and would therefore be covered by insurance. Home health aides as well as modifications to vehicles and housing are generally not covered by health insurance plans. Thus, the FE is left with $110,000 in uncovered expenses and $50,000 in covered expenses.

Using either the federal government's health exchange or an individual state's insurance exchange website, one can quickly determine a price for a basic health care plan. For example, in 2015 in San Francisco, one could purchase the "Kaiser Bronze 60 HMO" for $332.59/month or $3,991.08 per year. Due to the guaranteed issue provision of the ACA, Kaiser could not refuse the sale of this insurance product to the plaintiff nor could it charge him a higher price than other purchaser, nor could it subrogate any portion of a tort award.

This insurance would cover the plaintiff's $50,000 per year in medical costs while passing on a maximum of $6,600 per year in co-payment in 2015 (indexed to CPI) for a total of $10,591 per year. Combined with the uncovered life care expenses, the new total life care costs have fallen from $160,000 per year to $120,591 per year.

Furthermore, since the ACA mandate requires purchase of insurance whether or not the plaintiff had been the victim of negligence, the $3,991 per year of insurance costs arguably should be removed from damages leaving total medical care costs of $6,600 per year and total life care costs of $116,600 per year. Furthermore, most cases involving large medical awards generally include a claim for lost compensation as well. Lost compensation claims typically include both a wage and benefits component. If the plaintiff is awarded lost benefits, a large portion of which is usually employer-paid health care, also awarding the plaintiff the cost of insurance under the life care plan results in a double award.

It should be noted that even this amount might represent a conservative estimate of the differences between the expenses in the life care plan and the expected out of pocket costs to the plaintiff for several reasons. First, this methodology assumes that but for the accident, the plaintiff would have incurred no out of pocket expenditures for health care. Second, it is assumed that at no time would the plaintiff qualify for the subsidies to purchase health insurance available to low income households under the ACA. Third, it is possible that a portion of home health care, especially for services requiring skilled nursing, would be deemed an essential health benefit and therefore eligible for reimbursement under a typical health insurance plan. As home nursing care is a large component of the life care plan, even partial coverage of this item could result in a significant additional reduction in out of pocket expenses for the plaintiff. Finally, it is assumed that the plaintiff will pay the maximum allowable amount in out-of-pocket payments

each year. Depending on the type of insurance and the co-payment regulations for the insurance product he purchases, he may face total out-of-pocket expenditures below the allowable maximum.

Of course, this is just one possible way to address the ACA in an economic analysis of a life care plan. For example, the FE could assume that 60 percent of medical costs will be paid by the insurer with the rest covered by the plaintiff up to the statutory maximum. The least generous ACA-compliant plans, "Bronze plans," are designed to cover 60 percent of the customer's covered health expenditures on average. Silver, gold and platinum plans which are designed to cover 70, 80 and 90 percent of costs on average are also available in health insurance marketplace. Alternatively, the life care planner or economist could examine the potential coverage of an actual plan available for sale on the exchanges in the defendant's state.

Finally, it is worth noting that the negotiated prices that insurance companies face is quite often lower that the billed prices that individuals might face when paying for medical goods and services out-of-pocket. Thus, not only might and insured plaintiff find a portion of their medical care covered by their ACA policy, but the prices he or she faces for this care may be lower in the first place. The issue of "bill vs. pay" and its connection to the ACA is beyond the scope of this chapter and perhaps outside the domain of forensic economic analysis, but it may become an important factor as the applicability of the ACA to life care awards develops.

Issues still to be resolved

The previous interpretation of the impact of the ACA is not undisputed as there are a number of arguments that could be made to ignore the ACA in estimating damages. The first question is whether the ACA will remain in existence with a reasonable degree of economic

certainty. This is clearly open to opinion, but with each passing year the law becomes more entrenched. The law was passed by Congress, signed by the president, and survived two challenges at the Supreme Court. It is true that public opinion on the ACA remain deeply divided and that Republican candidates for political offices continue to campaign for a repeal of the ACA, but national polling on the ACA shows that only slightly more respondents have a negative opinion on the law than a positive opinion, and full repeal of the law is deeply unpopular (Knowles and Brody, 2015). Furthermore, most proposed alternatives to the law would preserve the most popular aspects of the ACA which include the guaranteed issue provision which is at the heart of this analysis. Finally, while it is a simple task to campaign against a law before it takes effect, it is quite another to repeal one once it has taken hold. An estimated 28 million Americans have received health insurance coverage through provisions of the ACA since the law was passed (Gaba, 2015), many for the first time in their adult lives, and the American uninsurance rate has fallen from 18.0 percent to 11.4 percent (Marken, 2015). It is true that no forensic economist can state with absolute certainty that the ACA will remain in place in its current form for the indefinite future, but if absolute certainty is the bar that must be met, there is indeed little that a forensic economist, or most expert witnesses, could testify to.

Perhaps a larger hurdle is the issue of collateral source. In states where collateral source payments to compensate an injured party are not allowed to be considered by a jury or trial judge in determining an award, insurance payouts are often excluded from the court record. There are at least two economic rationales for excluding collateral source payments from consideration in damage awards. The first is to ensure that people have the proper incentives to make wise investments in insurance products. If insurance benefits serve to reduce tort awards dollar for dollar, why would individuals ever purchase insurance in the first place. This reasoning for

excluding collateral source health insurance benefits disappears under the ACA. The individual mandate serves to ensure that people have strong incentives to purchase health insurance as confirmed by the rapidly falling uninsurance rates following the enactment of the ACA. Furthermore, most of the insurance payments that will be used to cover the costs of future medical treatment will be from policies that were initiated after the injury takes place. If the exclusion of collateral source payments is motivated by the principle of encouraging the public to take prudent precautions against financial shocks, post-event insurance policies would not be precautionary, but instead a reasonable measure to mitigate the expense of the necessary medical care. Assuming the injured party has a "duty to mitigate", the assumption that an injured party will enroll in an available insurance program would seem to be an appropriate measure, especially when one considers the fact that the individual is legally mandated to buy that insurance under the ACA.

The second idea is the rationale that defendants shouldn't benefit from the forethought of plaintiffs or beneficence of other income sources in order to avoid responsibility for payment of damages. This rationale remains in place even under the ACA. In the previous example, the tortfeasor has still caused $50,000 in annual medical costs whose responsibility for payment has shifted from the party who caused the damage to the insurance company. If the goal of an award in a tort case is to make the injured party "whole", clearly we would want to focus on the costs that will be incurred by the plaintiff due to the tortuous act. On the other hand, this amount does not reflect the true financial burden caused by the act in that much of the medical costs have been passed on to the injured individual's future health insurers (and thus all policyholders). If awards are instead motivated to punish the injurer and force them to pay the full cost of their act, an award should consider the costs incurred by all entities, not just the plaintiff. With either

philosophy, the expenses borne by the insurance companies are not being repaid and are instead either being retained by the injurer or being awarded as a windfall to the plaintiff even though he or she will not bear the full costs of the medical care.

Although this is likely an unsatisfactory choice set, there is not an obvious solution or a statutory basis for a more encompassing solution. Subrogation would normally be the appropriate tool to transfer the plaintiff's windfall to the company forced to pay for the increased coverage expenses of the victim, but health insurers in the individual policy market have no right of subrogation for future medical expenses under the ACA. Under the guaranteed issue provision customers have the right to purchase insurance at a uniform price regardless of pre-existing conditions, but subrogation, in effect, would charge customers who have received a tort award a higher price for health insurance by collecting both an insurance premium and a subrogation payment. Allowing subrogation for future care costs would also be exceedingly difficult administratively. Unlike cases where all future medical care for the injured party is likely to be covered by a single program like Medicare or worker's compensation insurance, there is no reason to believe the injured party will have his or her current insurance provider for any longer than the current annual contract. Without long-term insurance contracts, it would be inappropriate to award the current insurer the expected cost of all future medical care and impractical to set up an alternative way to compensate future insurers under current law.

Court Treatment of the Affordable Care Act

Given the recent passage and implementation of the ACA, state and federal courts' treatment of the ACA with respect to medical losses is still rapidly evolving, but several court rulings have addressed the issue arriving at conflicting conclusions. In *Niajah Deeds v.*

University of Pennsylvania Medical Center (2015), the Superior Court of Pennsylvania ordered a new trial after a defense verdict in a medical malpractice case because defense counsel's comments suggesting that the minor-plaintiff's medical costs were being covered by Medicaid and the ACA were a "patent violation of the collateral source rule." Similarly, in *Elvia Vasquez-Sierra v. Hennepin Faculty Associates* (2012), Minnesota state courts rejected the defense's argument that annual medical damages for Ms. Vasquez-Sierra be capped at approximately $7,000 per year, the sum of out-of-pocket medical and insurance premium costs, stating, "[The court]... is not inclined to speculate that the recent and controversial federal health care legislation upends Minnesota's collateral source doctrine. Until the Minnesota legislature passes new legislation regarding collateral sources in light of the Affordable Care Act, this court will not re-write long-standing law regarding collateral sources." Persuaded by the reasoning of *Vasquez-Sierra*, the Minnesota court in *Halsne v. Avera Health* (2014) found that that any benefits received through the Affordable Care Act do not provide a basis for reducing the potential award to Plaintiff.

In *Caronia v. Philip Morris USA* (2013), a New York state case, the plaintiffs sought compensation to cover the cost of monitoring for future smoking-related diseases. The defendant unsuccessfully argued that the ACA would allow the plaintiffs to obtain free access to the monitoring services that they were seeking. And in another court ruling against the use of the ACA in estimating damages, a California state court in *Aidan Ming-Ho Leung v. Verdugo Hills Hospital* (2013), determined that despite defense arguments that the ACA provided guaranteed access to insurance, future health insurance would not be taken into account when calculating the expected future medical costs. Finally, in *Brewster v. Southern Home Rentals* (2012), an Alabama court found that references to "the possibility of future insurance coverage would be

too speculative to be relevant, or if relevant at all, any probative value of this evidence is substantially outweighed by the danger of confusion of the issues and misleading the jury."

Other courts have taken a much more favorable view of considering the ACA, however, especially in more recent rulings. In Michigan, the court in *Donaldson v. Advantage Health Physicians* (2015) ruled in a pre-trial motion 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 [Michigan law]. Accordingly, what medical care and therapies would be provided by insurance through the ACA can be discussed/argued at trial." Two cases in Ohio, *Alijah Jones v. MetroHealth Medical Care* (2015) and *Christy v. Humility of Mary Health Partners* (2015) both allowed the application of the ACA to medical malpractice damage awards. In the case of Alijah Jones, the court limited his damages to $116,000, comprising eight years' worth of $8,000 premiums and $6,500 maximum out-of-pocket expenses. Finally, in *Brewington v. United States* (2015) tried in the US District Court for the Central District of California, the judge wrote that the "ACA ensures that Mr. Brewington will have access to insurance covering his future medical care needs...Thus, this Court finds it appropriate to take insurance benefits available under the ACA into consideration in calculating reasonable future life care plan needs."

Conclusion

Based on the mixed early rulings regarding the application of the ACA to medical awards, it remains unclear how courts will treat the availability of health insurance when assessing tort awards for future medical costs and whether the courts around the country will coalesce around a single interpretation. From an economic standpoint, however, it is clear that the full implementation of the ACA in January 2014 marked a serious change in the way

plaintiffs will finance their future medical care. Prior to the ACA, it was reasonable to presume that a great deal of a victim's future health care costs would be paid for out-of-pocket as there was little guarantee that the plaintiff would have access to affordable insurance. Requiring defendants to bear the full cost for any damages that they imposed on plaintiffs was generally economically efficient because it resulted in a windfall for a plaintiff only in the rare cases where the plaintiff could obtain health insurance and subrogation was not possible.

Conversely, under current health care law, victims will typically obtain insurance that will cover a significant portion of any medical costs up to the maximum annual limit and pay for all covered costs beyond that point. In this post-ACA world, making defendants pay the full cost of their actions nearly always results in a plaintiff windfall. Any analysis of future life care costs that seeks to "make the victim whole" rather than simply "make the tortfeasor pay" must at least be aware of the ramifications of the ACA, and it is likely that forensic economists will increasingly encounter this argument from defense lawyers and experts.

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Table 1: Consumer Price Index (CPI) and Medical Components

Range of Years	CPI	Medical Care CPI		Medical Care Services CPI	
	Average Annual Percent Change	Average Annual Percent Change	Difference with CPI	Average Annual Percent Change	Difference with CPI
Average 1980-2009	3.71%	5.92%	2.21%	6.13%	2.42%
Average 1990-2009	2.78%	4.73%	1.95%	5.04%	2.26%
Average 2000-2009	2.57%	4.13%	1.56%	4.53%	1.96%
Average 2005-2009	2.59%	3.91%	1.32%	4.34%	1.75%
Average 2010-2014	1.99%	2.99%	1.00%	3.19%	1.20%

Source: Authors' calculations based on data from the Bureau of Labor Statistics

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