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# Life-care Awards in the Age of the Affordable Care Act

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## Abstract

Prior to January 1, 2014, it would have been reasonable to assume that persons injured in an act of negligence would be forced to pay for their future medical care costs out-of-pocket rather than being able to rely on health insurance. The passage of the Affordable Care Act (ACA) has the potential to radically change how victims pay for future medical expenses, and now nearly every tort award that provides money to the plaintiff for the full payment of medical costs without consideration of the availability of health insurance will serve to overcompensate victims for their expected medical costs. New statutory or judicial rulings regarding subrogation and the collateral source rule appear to be required in order to simultaneously achieve the twin goals of making a tortfeasor pay for their damages while also making the victim whole.

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## **Introduction**

Prior to January 1, 2014, in most states it would have been reasonable to assume that a large proportion of persons severely injured in an act of negligence would be forced to pay for their future medical care costs out-of-pocket rather than being able to rely on health insurance to cover their medical needs. The passage and enactment of the Patient Protection and Affordable Care Act (ACA), often colloquially known as “Obamacare,” has the potential to radically change how victims pay for future medical expenses in cases involving personal injury or medical malpractice. In the US in 2012, 48% of people received insurance through their employers, but victims may not have had jobs that provided health insurance or may have been unable to work as a result of their injuries.<sup>1</sup> Another 31% obtained health insurance through a variety of government programs such as Medicare, Medicaid, or the Veteran Administration, but victims may not have been eligible for these government programs due to their age or due to their income or asset levels, especially if they have received a large tort award. About 5% of the population purchased health insurance privately, but in most states insurers were permitted to deny coverage based on any pre-existing conditions, and most accident or malpractice victims would have found privately purchased health insurance to be prohibitively expensive when available. The remaining 15% of the population was uninsured.

As of January 1, 2014, with the implementation of the most significant provisions of the ACA, however, the situation has greatly changed. First, private insurers are no longer allowed to discriminate against customers based on pre-existing conditions. This so-called “guaranteed issue” provision means that even the most severely injured victim is now allowed to purchase health insurance directly from an insurer at exactly the same price as any other customer of the same age

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<sup>1</sup> The Kaiser Family Foundation “State Health Facts. Data Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured” estimates based on the Census Bureau's March 2013 Current Population Survey

and geographical location. What's more, the second major provision of the ACA is the requirement that all individuals purchase adequate health insurance or face penalties. This is known as the individual mandate. Thus, not only are victims now able to purchase health insurance that may significantly reduce their out-of-pocket expenses for health care, they are required by law to do so.

The ACA also identifies "essential health benefits" that must be covered by most health insurance plans. Specifically, the ACA requires that all compliant insurance plans cover a wide range of "essential health benefits" including hospitalization, mental health services, prescription drugs, laboratory services, preventive and wellness services and chronic disease management, pediatric services, including oral and vision care, and rehabilitative and habilitative services and devices which would include prosthetics and wheelchairs as well as physical and occupational therapy. A forensic economist or accountant wishing to consider the effects of the ACA on medical damage awards must clearly identify which components of a life care plan are likely to be covered by a typical health insurance plan, and once non-medical items are excluded, the remaining medical expenses may be relatively small.

### **Example**

Suppose a life care planner has identified \$50 thousand per year in medical expenses that an unmarried male without children will require due to an act of negligence. Abstracting away from the always thorny issue of discounting future expenses back to net present value, if the victim's life expectancy is 20 years, the total expected medical care costs for this victim are \$1 million. If it is likely that he will be forced to pay for all of these costs out-of-pocket, as was the case prior to 2014, then in order to make the victim whole, it is reasonable to award him \$1 million in medical damages.

The reality as of 2014, however, is quite different. Instead of paying for \$50 thousand per year in medical expenses, the victim will instead purchase an insurance plan directly from a local insurer or on the appropriate state or federal health insurance exchange. The private, non-group insurer will not be able to limit the coverage it provides to the victim and will be forced to cover all “essential health benefits.” Of course, but for his injuries, the victim would still have been required to hold insurance due to the mandate, so the cost of purchasing this insurance is not attributable to his accident, and the health insurance company is not allowed to charge the victim a higher price due to his injuries. The ACA caps the out-of-pocket expenditures of plan participants in 2014 at \$6,350 for an individual or \$12,700 for a family. Thus, the victim’s health plan will pay of all of his covered medical costs, and will be able to pass on a maximum of \$6,350 per year in co-pays and deductibles bringing the victim’s out-of-pocket medical costs for these services down to a mere \$127,000 over 20 years. Examples of uncovered costs would be the costs for home renovations and handicapped accessible vehicles, and most importantly custodial care. If the costs of essential health benefits make up the bulk of the \$1 million in expenses identified in the life care plan, the award will be dramatically less than the pre-ACA amount. Indeed, as of 2014, nearly every tort award that provides money to the plaintiff for the full payment of medical costs without consideration of the availability of health insurance will serve to overcompensate victims for their expected medical costs.

### **Current Status of the ACA**

The first challenge facing a practitioner wishing to apply the ACA to a tort case is whether it is reasonable to believe that the ACA will exist in the future with a reasonable certainty. Over the last two years, the future of the ACA has become significantly less precarious. It survived the 2012

federal elections where Republicans had made the repeal of the ACA a major plank of their campaigns as well as the 2013 Supreme Court case questioning the constitutionality of the individual mandate. Despite a rocky rollout of the federal insurance exchange website eight million Americans were able to sign-up for non-group health insurance through the state and federal run marketplaces, which was one million more than the Congressional Budget Office had originally projected.<sup>2</sup> Of those signed up through the program, many were previously uninsured and the large number and demographics of participants appear to be enough to restrain the premium increases to levels consistent with recent trends.<sup>3</sup> Though there are still legal challenges to the law pending, the issues are not likely to undermine the law to the point of non-viability. There is also evidence of support for the major thrusts of the ACA which are necessary for the above changes to calculating life care plans. Specifically, about 70% of those polled say that they support policy guaranteed issue.<sup>4</sup> Though the individual mandate is only supported by 35% of those polled, 60% want to keep the ACA either as is or want to keep the law and work to improve it.

### **Collateral Source**

A much trickier legal issue is the application of the collateral source rule to insurance plans in the wake of the ACA. The collateral source rule prohibits jury members from considering any payments to a plaintiff other than those made by the defendant. Under the rule, a plaintiff can recover full damages from the defendant even after the victim has already received full

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2 U.S. Department of Health and Human Services "Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Enrollment Period", May 1, 2014.

3 Avalere Health LLC, "Average Exchange Premiums Rise Modestly in 2014 and Variation Increases, July 18, 2014, and Jonathan Gruber, "Growth and Variability in Health Plan Premiums in the Individual Insurance Market Before the Affordable Care Act", The Commonwealth Fund Issue Brief, June 2014.

4 The Kaiser Family Foundation, "Kaiser Health Tracking Poll: March 2014"

compensation for damages from the victim's own insurer for the very same event.<sup>5</sup> There is a rational basis for the collateral source rule in that economic efficiency generally requires that a defendant bear the full cost for any damages they impose on victims even if it results in a windfall for plaintiffs. On the other hand, a pre-ACA world where making defendants fully pay for their damages results in an occasional double payment to a victim is much different than a post-ACA world where making defendants pay nearly always results in a plaintiff windfall.

A common tool to make defendants pay while preventing plaintiff windfalls is subrogation, but the right of subrogation is not granted to insurers under the ACA. Unlike for Medicare and workers compensation where subrogation is explicitly required, it is not at all clear how subrogation could even work. While individuals are likely to have their medical costs paid by one source once they are on Medicare or collecting worker's compensation, individuals purchasing insurance in the marketplace can change insurers at will every year and insurers are required by law to charge the same premiums to all customers regardless of preexisting conditions, even if the customer received a legal award to pay for the care of those conditions. If the current private insurer were to receive direct subrogation, it would collect a large amount of money for future health care that other insurance companies may cover. In the case of employer based health insurance, ERISA section 502(a)(3) explicitly allows insurers' claims of reimbursement from litigation or settlements.<sup>6</sup> There is no similar provision in the ACA as it currently stands so it does not appear that private, non-employer based insurers on the exchanges are entitled to the same reimbursement.

It may also be appropriate to think of health care received from an insurance policy as

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<sup>5</sup> David Schap and Andrew Feeley, 2008. "The Collateral Source Rule: Statutory Reform and Special Interests, *The Cato Journal*, Vol. 28:1, pp. 83-99.

<sup>6</sup> Aaron E. Pohlmann, "Equitable Defenses and 'Appropriate Equitable Relief'", *For the Defense*, October 2012.

something different than a collateral source payment but instead more like “discount club” for obtaining health care. In most states, plaintiffs have a duty to mitigate the resulting harm from an act of negligence. If a plaintiff can reduce the cost, or at least the out-of-pocket costs, of treating his injuries by utilizing the medical insurance that he is legally mandated to possess anyway, it would appear incumbent on the plaintiff to do so.

Finally, many collateral source rules are non-statutory judicial rulings that have been formulated based on the health insurance markets that existed prior to the passage of the ACA. The judicial reasoning used in formulating these rules should perhaps be reexamined in light of the radically different health insurance markets that now exist. This shouldn't necessarily be seen as overturning past precedent but instead as updating normative rules in the common law to reflect health care reform.

## **Conclusion**

The purpose of a tort judgment is to make victims whole if negligence is found by the court. Now that the Affordable Care Act appears to be safe for the near term, the implications of the law require a reevaluation of the amounts necessary to meet this goal. Without a statutory change, the courts will be forced to decide whether to adjust life care awards in response to the mitigating availability of guaranteed health insurance at a cost well below the expected cost of medical care. If the courts rule that the injured party should not receive a windfall from the plaintiff for the cost of care that the ACA requires all insurance plans to cover, practitioners will have the added duty of identifying what expected care is likely to be covered by insurance and what health care costs will be borne by the injured individual.