

7-1-2016

# Economic Windfalls and the Affordable Care Act: A Policy Proposal

Joshua Congdon-Hohman  
*College of the Holy Cross*, [jcongdon@holycross.edu](mailto:jcongdon@holycross.edu)

Victor Matheson  
*College of the Holy Cross*, [vmatheso@holycross.edu](mailto:vmatheso@holycross.edu)

Follow this and additional works at: [https://crossworks.holycross.edu/econ\\_working\\_papers](https://crossworks.holycross.edu/econ_working_papers)

 Part of the [Health Policy Commons](#), [Law and Economics Commons](#), and the [Public Health Commons](#)

---

## Recommended Citation

Congdon-Hohman, Joshua and Matheson, Victor, "Economic Windfalls and the Affordable Care Act: A Policy Proposal" (2016).  
*Economics Department Working Papers*. Paper 191.  
[https://crossworks.holycross.edu/econ\\_working\\_papers/191](https://crossworks.holycross.edu/econ_working_papers/191)

# **Economic Windfalls and the Affordable Care Act: A Policy Proposal**

By

Joshua Congdon-Hohman

and

Victor A. Matheson

July 2016

COLLEGE OF THE HOLY CROSS, DEPARTMENT OF ECONOMICS  
FACULTY RESEARCH SERIES, PAPER NO. 16-06\*



Department of Economics  
College of the Holy Cross  
Box 45A  
Worcester, Massachusetts 01610  
(508) 793-3362 (phone)  
(508) 793-3708 (fax)

<http://academics.holycross.edu/economics-accounting>

\* All papers in the Holy Cross Working Paper Series should be considered draft versions subject to future revision. Comments and suggestions are welcome.

# **Economic Windfalls and the Affordable Care Act: A Policy Proposal**

By

Joshua Congdon-Hohman<sup>†</sup>  
College of the Holy Cross

and

Victor A. Matheson<sup>††</sup>  
College of the Holy Cross

July 2016

## **Abstract**

This paper identifies a major issue with windfall payments under either possible interpretation of the ACA as it currently stands. Several alternatives are proposed that would eliminate the windfalls. We advocate the establishment of a tort award funded “Federal Stabilization Fund” to improve the economic efficiency of future health care awards in the age of the Affordable Care Act.

**JEL Classification Codes:** I13, I18, K41

**Keywords:** Affordable Care Act, forensic economics, tort awards, lawsuits, health insurance

---

<sup>†</sup> Department of Economics and Accounting, Box 72A, College of the Holy Cross, Worcester, MA 01610-2395, 508-793-3673 (phone), 508-793-3708 (fax), [jcongdon@holycross.edu](mailto:jcongdon@holycross.edu)

<sup>††</sup> Department of Economics and Accounting, Box 157A, College of the Holy Cross, Worcester, MA 01610-2395, 508-793-2649 (phone), 508-793-3708 (fax), [vmatheso@holycross.edu](mailto:vmatheso@holycross.edu)

## **Economic Windfalls and the Affordable Care Act: A Policy Proposal**

The Affordable Care Act (ACA) represents a major change in the health insurance landscape of the United States. The Act made health insurance available for all eligible citizens, even those with preexisting conditions. This element of the ACA could have an important impact on how the courts in many jurisdictions view the cost of future care when an individual has been injured in an act of maleficence. Prior to the ACA, awards for future medical costs were based on the expected cost of each individual procedure, medication, test, rehabilitation program, and medical device that an individual was predicted to need due to another's actions. It was unlikely that the injured party's care would have been covered by insurance in this period as health insurance providers in the non-group, private market had the right to deny coverage due to preexisting medical conditions or exclude the costs associated with those conditions from coverage, and persons who maintained employer provided insurance were unlikely to require expensive, on-going medical care. Now with the ACA in place, the injured party cannot be denied or have their coverage limited by a health insurance plan. Therefore, many of the costs associated with an injury will now be covered by insurance under the "essential health benefits" requirement of the ACA that sets standard for what must be covered under any plan.

The courts are now determining how to apply the ACA when evaluating losses for future medical care. Though only about 16,000 personal injury cases go to trial each year, the rulings in those cases have a large impact on all cases that settle before going to trial.<sup>1</sup> Assuming about 4% to 5% of cases go to trial, the total number of personal injury claims filed is likely to lie between 320,000 to 400,000 to per year.<sup>2</sup> Of these cases, the majority (61%) are likely motor

---

<sup>1</sup> Department of Justice's Bureau of Justice Statistics estimate based on 2005 data collection of the 70 most populated counties in the U.S.

<sup>2</sup> Percent going to trial from "Pre-trial Settlement Percentage: Statistics on Personal Injury Settlements," by James

vehicle incidents that usually have low dollar value decisions. That said, large dollar value cases for medical malpractice and product liability make-up about 20% of cases that go to trial and have median judgements around \$700,000 in 2005, much of which is likely to be based on future medical costs.<sup>3</sup>

Regardless of how the ACA is applied, the guaranteed issue of insurance in the ACA marketplaces will lead to windfalls for either the plaintiffs or defendants in these cases. The cost of future medical care will now be borne by the insurance industry and will likely be passed on to all customers rather than the liable party. To correct for this, new legal requirements should be put in place to make sure that the appropriate funds are set aside to help alleviate this financial burden on society in an equitable manner similar to how the system worked before the ACA: the liable party should pay for the cost of future medical care but without large windfalls accruing to plaintiffs.

### **The Affordable Care Act and Personal Injury Awards**

The ACA was enacted in an attempt to insure more Americans against expensive medical costs due to illness or injury. In addition to guaranteeing access to all citizens, the ACA also mandated that all individuals purchase health insurance or face a tax penalty, with only a small number of low income earners (as well as undocumented immigrants) granted an exemption. The results have been a significant decrease in the rate of uninsuredness since the law went into effect, thanks in large part to additional coverage under state Medicaid programs and premium subsidies for low income households. To help ensure that these new insurance policies provided

---

Hirby, [The Law Dictionary](http://thelawdictionary.com) at thelawdictionary.com.

<sup>3</sup> Department of Justice's Bureau of Justice Statistics estimate based on 2005 data collection.

adequate coverage, the law has also standardized insurance by setting both guarantees for coverage of essential health benefits and limits on out-of-pocket payments by the insured (currently \$6,850 for an individual or \$13,700 for a family for 2016). Because of the requirement that preexisting conditions cannot be excluded, all individuals with on-going health care needs have access to the same insurance at the same rates as those without such needs, included those injured by another's negligent actions.

To examine the implications of the ACA in the adjudication of awards for future care in personal injury cases, we will use an example. Expert witnesses usually are hired to create life-care plans for the litigators that explicitly identify the expected future care the injured party will need due to the incident in question. In the simplified example below, we have identified a number of common items in a life-care plan for a fictitious individual who will need physical therapy, medications, durable medical goods, surgery, and home nursing care in the year following the trial. Life-care plans are often much more extensive and long-term, but this one-year snapshot should provide an adequate illustration of the current situation. Along with the expected cost of each item that is also estimated by expert witnesses, we have identified which costs are likely to be covered under a state's "essential health benefits," which all plans must cover under the ACA. Specific coverage requirements as detailed by benchmark insurance plans can and do vary from state to state. In particular, it is common to see variations in coverage for home nursing visits and physical/occupational/speech rehabilitation therapy.

**Table 1: Example Life Care Plan**

Health Care Item	Expected Annual Cost	Essential Health Benefit Under the ACA
Regular Doctor's Visits (6 at \$150 each)	\$900	Yes
Specialist Visits (Pre- and Post-Operation at \$300 each)	\$600	Yes
Surgery	\$100,000	Yes
Over-the-counter Medications (Pain, sleep, etc.)	\$400	No
Prescription Medications (Pain, Antibiotics, etc.)	\$3,500	Yes
Testing and Laboratory Work	\$15,000	Yes
Physical Rehabilitation (40 visits at \$150 each)	\$6,000	Yes, but limited to 20 visits per year for all rehabilitation services
Occupational Rehabilitation (20 visits at \$150 each)	\$3,000	Yes, but limited to 20 visits per year for all rehabilitation services
At home nursing care following surgery (3 weeks, 4 hours per day at \$30 per hour)	\$2,520	Yes, but limited to 20 visits per year
Wheel Chair	\$600	Yes

The actual cost to the injured party of the future care listed in the life care plan listed in Table 1 depends on whether the individual is insured. Prior to the ACA, it would be unlikely that a private insurer would issue an individual policy when this injury was identified on the application, or the insurance policy would explicitly exclude the costs related to this pre-existing condition. The individual could get insurance through an employer's group health insurance plan, but there is no guarantee that the individual will be working for a company that provides this benefit, especially after an injury that limits the individual's ability to work. In this case, the individual would be forced to pay the full cost of their medical treatment, which is \$132,520 in the year examined in Table 1.

With the implementation of the ACA in 2014, the injured individual in the above

example would be able to purchase insurance without any impact on the cost or coverage of insurance due to the pre-existing injury. This means that after paying the premium for their insurance, the cost to the injured individual are now limited to their out-of-pocket maximum for all covered care plus the cost of non-essential health benefits. In this case, the covered portion of the full medical costs totals \$126,000 and the total of the uncovered portion is \$6,520, due to the fact that over-the-counter medications are not covered while rehabilitation and in-home nursing services are limited. This does not mean that the cost of care is only \$6,520. Insurance under the ACA is allowed to include cost sharing measures such as co-pays and deductibles. Under the lowest cost plans on public health insurance exchanges (“Bronze” plans), the copay can be as high as 40 percent. Without considering a potential deductible, the 40 percent copay would be well in excess of the statutory maximum coinsurance payment of \$6,850 (\$13,700 for a family). So the total medical cost to the individual of the items in Table 1 would be \$13,370 (\$20,220 if using the family maximum).

The question currently before the courts is how to determine the award if a person or business is found liable for the injuries to another. If the court’s goal is for the company to internalize the full cost of their actions (possibly to deter future maleficence), it would be appropriate to find a medical award of the full cost due to the incident, here \$126,000. If the court set out to make the injured party “whole”, it would simply award an amount that would cover his or her expected medical costs due to the event, here \$13,370.

Though the courts have currently split on which direction to take these awards moving forward, it is clear that the true costs of the bulk of the medical costs will be borne by the insurer,



not the injured party.<sup>4</sup> As such, the courts are simply deciding who will benefit from the fact that an insurer will pay around \$110,000 in medical care costs due to the incident (possibly lower based on the difference between negotiated rates by insurance companies and the list prices for medical care). In the first scenario listed above, the injured party will receive \$112,620 more than they will expect to pay for medical care, on top of any other punitive awards and finding of lost earnings. In the second case, the injurer will only pay \$13,370 even though they've been ruled to have caused \$126,000 in damages.

The above example highlights the impact of the ACA on medical costs in one year. In most personal injury cases, care will extend for a prolonged period of time, often through an individual's life expectancy. Though surgeries are not commonly required annually in most cases, many of the medical costs covered by the ACA will recur annually. The costs of expensive specialist visits, medical testing, prescription drugs, rehabilitation, and the replacement of durable medical equipment will be included for the duration of an injured persons life and can easily add up to millions of dollars. As the ACA will cap annual out-of-pocket maximums for these covered expenses, the cost to the insurance companies that will cover this individual will accumulated dramatically and not be limited to a figure like the one presented above.

---

<sup>4</sup> Thus far, lower courts in Pennsylvania (*Deeds v. University of Pennsylvania Medical Center*, 2015), Minnesota (*Vasquez-Sierra v. Hennepin Faculty Associates*, 2012), New York (*Caronia v. Philip Morris USA*, 2013), California (state court ruling in *Ming-Ho Leung v. Verdugo Hills Hospital*, 2013), and Alabama (*Brewster v. Southern Home Rentals*, 2012) have ruled that the impact of the ACA cannot be considered in evaluating the future medical care costs for a number of reasons including "collateral source" exclusions and the uncertain future of the ACA. On the other side, rulings in Michigan (*Donaldson v. Advantage Health Physicians*, 2015), Ohio (*Jones v. MetroHealth Medical Care*, 2015, and *Christy v. Humility of Mary Health Partners*, 2015), and a California federal court (*Brewington v. United States*, 2015) have found that judgements for medical costs can be adjusting in light of the ACA.

## **Policy Suggestions**

As currently implemented, the ACA leads to situations where one party or another may receive a significant windfall from a tort action. This section of the paper deals with potential ways to handle this situation.

### **Solution 1: Status Quo - Maintain collateral source rule**

One obvious solution is to simply maintain the status quo regarding the collateral source rule in most states. The collateral source rule is a legal concept that prevents defendants from presenting evidence that a plaintiff has received payments from a third party. Payments from a private insurer have typically been considered a collateral source in most jurisdictions that utilize the rule. Maintaining the status quo would result in courts prohibiting testimony regarding the ACA. Juries would continue to make awards based solely on the total costs (before insurance) of providing the needed health care available in a life care plan. From an economic standpoint, the advantage of continuing to apply the collateral source rule is that defendants would not be able to pass the costs of their malfeasance on to a third party (in this case the private insurer), and they would also have the appropriate incentives to engage in behavior that prevents injuries.

The disadvantage of allowing the continued application of the collateral source rule is that plaintiffs will typically have windfalls in any case involving future medical costs. These windfalls will come at the expense of private insurers and their subscribers who are forced to cover plaintiffs' medical costs without being allowed to charge more for the insurance.

### **Solution 2: Reform collateral source rule**

A second obvious solution, and one that seems to be currently under consideration by

courts in a number of states, is to reform the interpretation of the collateral source rule to allow testimony regarding the true out-of-pocket expenses that plaintiffs will be paying in the age of the Affordable Care Act. This would have the advantage of removing the windfall to plaintiffs from the ACA but would allow defendants to pass some portion of damages off to private insurers.

The legal reasoning for disregarding the collateral source rule with respect to the ACA could come from numerous sides. First, since insurance is mandated instead of being a choice, the typical argument that a defendant shouldn't benefit from the wise forethought of the plaintiff and his decision to purchase insurance no longer holds. It could also be argued that health insurance under the ACA isn't really a collateral source at all but rather a simple transaction where the consumer buys a product and receives a set of goods and services in return rather than some sort of payment. In effect, insurance is now more like buying a club membership that entitles the buyer to discount on products rather than a third party transfer. Finally, it could be argued that the plaintiff has the duty to mitigate damages, and the way to obtain needed health care at the lowest price is through the purchase of an insurance plan, one is that legally required anyway.

It should also be pointed out that in many personal injury cases, the plaintiff is also asking for damages from lost compensation which generally include an amount for lost benefits to include health insurance. It appears to be a clear case of double counting to award a plaintiff compensation for lost health insurance and also damages for the health care that this health insurance would normally cover.

### **Solution 3: Eliminate Guaranteed Issue**

The Affordable Care Act could be reformed to exclude persons who have received a tort award from the guaranteed issue provisions of the ACA. This solution is problematic for multiple reasons. First, the entire impetus for passage of the ACA was to provide persons with pre-existing conditions access to health insurance, and this reform would undermine the very core of the ACA. More problematic would be cases where an award doesn't cover the full costs of medical care or prevents a person with medical costs associated with a tort award to obtain health insurance for other medical needs.

#### **Solution 4: Subrogation**

Subrogation is the most obvious tool for eliminating windfalls, but the ACA does not allow for subrogation of future care costs. Under strict subrogation, an insurer would be allowed to recover from the plaintiff any monies the insurer expends on health care if the plaintiff has made a tort recovery for these items. Indeed, this is exactly the method used in cases involving workers comp and Medicare. The Medicare Secondary Payer Act, and specifically the more recent Section 111 reporting requirements that become effective January 1, 2011 for settlements entered into on or after October 1, 2010, required that Medicare's future interests must be taken into account at the time of settlement. Medicare's future interests are required to be considered if: (1) the claimant is a Medicare beneficiary at the time of the settlement and the total amount of the settlement is greater than \$25,000 or (2) the claimant is not a Medicare beneficiary at the time of the settlement but has a "reasonable expectation" of Medicare enrollment within 30 months of the settlement date, and the anticipated total settlement for future medical expenses and disability/loss wages over the life or duration of the settlement agreement is expected to be greater than \$250,000. The rules governing compliance with this law, however, are unsettled and

little guidance is provided by the Center for Medicare Services (CMS) as to how this should be accomplished.

Generally, the vehicle used to protect Medicare's interest is a known as a Medicare Set-Aside Agreement (MSA) which apportions some amount of the settlement to satisfy Medicare's claim on future care costs. In workers compensation cases, the CMS approves settlements. In other liability cases, Medicare's interests must be preserved, but again little guidance is provided by CMS.

One possible solution to the ACA windfall problem would be the creation of "Private Insurer Set-Aside Agreements" (PISAs?). These accounts would not be as simple as is with MSAs since an individual can change insurers every year, and insurance policies vary widely in their coverage, co-pays, and billing rates. However, a PISA would have the advantage of eliminating the windfalls to both the plaintiff and the defendant.

It is also important to note that, unlike Medicare, private insurers under the exchanges have no right to subrogation for future medical costs and therefore have no claim on any past tort awards. Therefore, if the use of PISAs were to be required as a matter of public policy, existing law would have to be changed to accommodate these set-asides as currently there would be no obligation for plaintiffs to share in any settlement or award with future insurers.

The real complication with a "PISA" arrangement, unlike with a workers comp or MSA deal, is the fact the future insurers are unknown at the time of the litigation. Under an MSA, CMS can review the settlement and the MSA to determine whether the arrangement is satisfactory from their standpoint. This sort of pre-clearance clearly assures that Medicare's interests are adequately addressed and frees the parties in the settlement from any future Medicare lien. Under a PISA, pre-clearance is obviously impossible since the future insurers are

not known. Different insurers may have drastically different prices for the same medical services, and the potential variability of needed health services from year to year further complicates matters. In cases where an individual's health needs or an insurer's billing charges are higher than expected in early years after a settlement or payout, the PISA may exhaust its funds leaving future insurers left to cover necessary medical expenses.

### **Solution 5: Market stabilization program**

During the early years of implementation of the ACA, the federal government set up a "market stabilizing" program that was designed to compensate private insurers who attracted disproportionately sicker customer pools. This program was funded by federal tax dollars and reduced the incentive for insurers to try to avoid coverage of sicker individuals and provide incentives for private insurers to enter the individual market by reducing risk. Extending the market stabilization program to cover insurers to take on customers who have pre-existing medical conditions due to injuries suffered in an accident for which they have received a payout would protect insurance companies from unexpected losses but would do nothing to eliminate the windfalls to either plaintiffs or defendants. However, a market stabilization program funded through subrogation of tort awards for future medical care would largely eliminate the windfall problem while protecting insurers and plaintiffs.

Under this proposed market stabilization program, at the time of any court award or settlement, the parties would be required to take the "Federal Stabilization Fund" into account. Payouts for items in the life care plan that are reasonably likely to be covered by insurance (after accounting for the plaintiff's reasonable co-pays) would be paid by the defendant into the fund rather than to the individual, eliminating the windfalls for both plaintiffs and defendants. When

applying for insurance, the customer would be required to disclose if they have received a tort award involving medical costs, but this disclosure would not affect whether the individual was offered insurance or the price they pay, maintaining guaranteed issue. Finally, the insurer would be allowed to use the disclosure to apply for reimbursement from the Fund for any above average expenditures for covering the medical costs of the plaintiff. The Fund would pool the subrogation payments that were made from all sources and allocate the monies in a revenue neutral manner. There would be no expectation that all excess costs would be covered, but a reasonable percentage might be covered, and as an additional benefit, since many life care plans use out-of-pocket costs for care which are typically far higher than the insurer negotiated rates, the cost of coverage might fall drastically.

**Table 2: Example Life Care Plan under Stabilization Fund**

<b>Health Care Item</b>	<b>Expected Annual Cost</b>	<b>Uncovered amount</b>
Regular Doctor's Visits	\$900	\$0
Specialist Visits	\$600	\$0
Surgery	\$100,000	\$0
Over-the-counter Medications	\$400	\$400
Prescription Medications	\$3,500	\$0
Testing and Laboratory Work	\$15,000	\$0
Physical Rehabilitation	\$6,000	\$4,000
Occupational Rehabilitation	\$3,000	\$2,000
At home nursing care	\$2,520	\$120
Wheel Chair	\$600	\$0
<b>Total</b>	<b>\$132,520</b>	<b>\$6,520 + \$6,850 co-pay</b>

Under this scenario, the defendant would pay \$132,520 to cover the medical damages in the case. The Federal Stabilization Fund would claim \$126,000 of this amount for expected future payouts less a maximum \$6,850 in co-pays for a total of \$119,150 leaving the defendant

with \$13,370. The insurer would apply to the Fund when the health services are provided for reimbursement of \$119,150.

Several caveats are in order. The example above does not include payments for legal fees. These will reduce payments both to the plaintiff, the Fund, and ultimately the insurer. Furthermore, under this proposed system, all awards would need to be carefully identified for what is for life care costs versus pain and suffering or lost compensation. There would always be the incentive for plaintiffs to structure settlements such that they are overcompensated for lost wages and undercompensated for future medical costs in order to limit the subrogation to the fund.

## **Conclusion**

This paper identifies a major issue with windfall payments under either possible interpretation of the ACA as it currently stands. Several alternatives are proposed that would eliminate the windfalls. We advocate the establishment of a tort award funded “Federal Stabilization Fund” to improve the economic efficiency of future health care awards in the age of the Affordable Care Act.