Potential Effects of the Affordable Care Act on the Award of Life Care Expenses

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Potential Effects of the Affordable Care Act on the Award of Life Care Expenses

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Abstract

Plaintiffs in personal injury lawsuits are entitled to compensation for future medical expenses. We argue that the "guaranteed issue" and "individual mandate" requirements of the recently passed Affordable Care Act (ACA) will allow victims to address a large portion of their health needs through the purchase of a simple health insurance plan rather than direct compensation for an itemized list of health care needs. As such, damage awards for many health expenditures should be capped at a maximum of $6,250 per year. Therefore, the role of a life care planner should evolve into determining which life care expenses are covered under covered by the minimum insurance requirements mandated by the ACA and which entail additional expenditures beyond those covered by health insurance.

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Introduction

In the context of personal injury cases, the task of the forensic economist is to determine the economic damages to the plaintiff associated with an act of negligence on the part of the defendant. While many potential areas of economic losses exist, one primary area of damage is medical costs. As the overriding goal of civil proceedings is to "make the victim whole," it is critical to identify the medical expenses that a plaintiff would have expected prior to an act of negligence and compare these figures to the expenses that a plaintiff can expect after the accident. In this paper, we plan to address how the Patient Protection and Affordable Care Act (ACA) could potentially impact the estimation of those expenses.[1]

In most cases involving accidents or medical malpractice where the victim will require care and treatment for an extended period beyond the time of the trial, medical experts will prepare life care plans detailing expected costs. Life care plans usually itemize expected future medical care costs rather than simply including a single line-item for the purchase of health insurance despite the fact that typical Americans finance most of their health care needs through insurance.[2] Under the health insurance system that existed in the US prior to the passage of the

[1] The ACA (sometimes referred to as the PPACA) is the commonly used reference term for a pair of 2010 laws that were meant to reform the health insurance payment system in the United States. The two bills were the "Patient Protection and Affordable Care Act" and the "Health Care and Education Reconciliation Act of 2010." Most of the law was upheld as constitutional by the United States Supreme Court in 2012 (Liptak, 2012). While repeal of the ACA was a primary goal of many Republicans in the run-up to the 2012 elections, the re-election of Barack Obama has ensured that the major provisions of will be implemented on schedule and that the law will remain in place at least for the medium term.

[2] According to the Center for Medicare and Medicaid Services, only 12% of 2010 health care expenditures in the U.S. are out-of-pocket while 77% of health care services are paid for through a combination of private and public health insurance (Martin et al. 2012). The remaining share of health services are paid for through various, non-insurance based programs such as school and worksite health care, workers' compensation, general assistance, vocational assistance, and other federal, state, or local programs.

ACA, however, it could be argued that an injured party was unlikely to have adequate access to health insurance markets.

Traditionally, health insurance is acquired through an employer (one's own or that of a family member), the government (through such programs as Medicare, Medicaid, or veterans benefits), or direct purchase from an insurer. It is impractical to assume a victim will be able to pay for future health care costs using employer provided health insurance. First, a plaintiff may not be employed at a job with health insurance benefits and may have little hope of obtaining employment in an occupation that provides such benefits. Surveys have found that the offer rate of employer provided health insurance decreased substantially early in the last decade before stabilizing in the last seven years, falling from 68 percent in 2000 to 60 percent in 2005 and then remaining around this level through 2012 (Kaiser Family Foundation and Health Research and Education Trust, 2012). Second, even if a worker did have health insurance prior to an accident, in many cases injuries will prevent the victim from returning to work in that field. Indeed, loss of employability is a prime motivation for filing a lawsuit in the first place. Finally, even those plaintiffs with insurance who are able to continue working have no guarantee that they will continue to be employed by the same firm, have no guarantee that the firm will continue to offer health insurance benefits, and should not be subject to "job lock" simply to avoid losing health insurance. Similar issues exist for plaintiffs who would normally be covered under the health insurance of a parent or spouse.

It is also impractical to presume that every plaintiff will qualify for government provided insurance. The plaintiff may be too young or have too limited a work history to qualify for Medicare. The victim's injuries may not be severe enough to qualify for a disability exemption

to Medicare, which would also require a two year waiting period after qualification for Social Security Disability Insurance (SSDI). Finally, the victim's household income may be too high to qualify for Medicaid.

A final option would be for the plaintiff to purchase private insurance in the individual insurance market. However, under the laws in effect in most states prior to the passage of the ACA, insurers could examine applications for minor errors that could void existing insurance contracts ("rescission"), limit annual and lifetime health care expenditures for existing and new customers, and reject applications or deny certain expenditures to any individual with a pre-existing condition. The presence of pre-existing injuries from the accident at the heart of any lawsuit/life care plan would often be enough to prevent plaintiffs from being able to purchase an insurance policy in the individual market. All in all, it is reasonable to presume that in the pre-ACA legal setting, victims of accidents would, in many cases be unable to purchase affordable health insurance. Therefore, providing compensation for expected health care expenditures in lieu of simply providing funds for the purchase of health insurance is a proper application of the "make whole" principle.

Insurance and Medical Costs in a Post-ACA World

Under the Patient Protection and Affordable Care Act, three major changes are introduced to health insurance markets.[3] First, the ACA prohibits discrimination based on pre-existing conditions and bans both annual and lifetime expenditure limits. Therefore, under the ACA any victim will be able to purchase health insurance at the same price as any other

[3] The Kaiser Family Foundation (2011) has prepared a thorough summary of the initiatives and changes legislated in the ACA and is the predominant source for the information provided here.

demographically similar individual regardless of the severity of his or her injuries, the magnitude of expected health care costs, or access to employer provided health insurance.[4] Furthermore, the ACA sets minimum standards for covered services and maximum out-of-pocket expenditures for health insurance plans. The Department of Health and Human Services will specify the "essential health benefits" that will be required of any qualified health insurance plans which will include several general categories that commonly appear in life care plans including emergency services, hospitalization, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, and preventative and wellness and chronic disease management (Chaikind, etal., 2010). These categories presumably will cover routine medical services such as doctor visits, durable medical equipment such as wheelchairs, prostheses, and other ambulatory devices, occupational and physical therapy, and both routine and emergency hospitalization. The new out-of-pocket limit will be pegged to the annually adjusted Health Savings Account (HSA) limit which is $6,250 per year for individuals and $12,500 for families as of 2013. Thus, the pre-existing condition provision of the ACA and the quality of insurance requirements serve to limit the annual out-of-pocket costs for covered medical care for any victim of an accident to a maximum of $6,250 plus the cost of a typical health insurance policy in the individual market. This sum may be significantly below the sum of identifiable medical costs in a life care plan.

A second major provision of the ACA provides subsidies for insurance premiums and health care costs to those with low income and who do not receive health insurance through the government or a family member's employer. Those whose family income is more than 133% and

[4] Under ACA, premiums in the new market may only vary by an applicant's age, geographic region, family composition and tobacco use. "The ACA prohibits denials of essential benefits based on age, life expectancy, disability, or degree of medical dependency and quality of life." (Federal Register, 2012: pg. 33134)

less than 400% of the poverty rate are eligible for significant subsidies that limit the share of income spent on premiums for an insurance policy (ranging from 2% to 9.5% of income) and lower limits on out-of-pocket expenditures (one-third to two-thirds of the HSA limit).[5] These provisions serve to further cap the expenditures for medical care for any victim of an accident to a sum that may be both less than the maximum of $6,250 plus the cost of a typical health insurance policy and significantly below the sum of identifiable medical costs in a life care plan before ACA.

The final major piece of the ACA is the individual mandate. This component of the legislation, which is required to prevent adverse selection in the individual policy market, requires that all persons provide proof of adequate insurance, either through their employer, public health insurance, or the individual policy market. Failure to purchase health insurance subjects the individual to a sizable fine. Due to these penalties and the aforementioned subsidies, one should expect most persons to have insurance under the ACA. In Massachusetts, where current health care law has similar provisions to the ACA, the total rate of uninsured is roughly 5%, by far the lowest rate of uninsured in the country (Jones, 2012). The Congressional Budget Office (2011) estimates that the ACA will increase coverage from the current level of 83 percent to about 95 percent of nonelderly, legal residents in 2021. The fact that most individuals will be insured under the provisions of the ACA further reduces the incremental increase in a victim's health care costs due to an accident.

[5] The ACA included a separate provision to expand Medicaid to individuals with a family income of less than 133% of the poverty rate. The 2012 United States Supreme Court decision struck down the requirement that states expand Medicaid in this way or lose current Medicaid funding (Liptak, 2012).

The so-called “but for” principle states that only medical and living expenses that are necessary but would not otherwise have been required in the absence of the accident should be compensated in a tort claim. Given the individual mandate, “but for” the accident the victim would still have been required to hold medical insurance, and due to the prohibition of discrimination based on health status, the individual’s health insurance costs would have been the exactly the same “but for” the accident. Thus, if the individual purchased health insurance from the individual market before the accident, the change in covered medical care costs would be at most the limit of the out-of-pocket costs for health care plans of $6,250 per year. In reality, the losses could also be offset by the expected annual out-of-pocket health care expenses prior to the accident, making the $6,250 per year figure an upper bound for incremental medical care costs.

If instead the plaintiff had received health insurance through his or her employer, and the plaintiff is no longer able to work, the victim will now be forced to purchase insurance on the individual market; however, the lost health insurance benefits would normally be included in calculations of lost compensation and to include the increased cost of purchasing health insurance in a life care plan as well would result in double-counting of losses.

If the individual was uninsured prior to the accident, the additional out-of-pocket costs for medical care for any victim of an accident is a maximum of $6,250 plus the cost of a typical health insurance policy in the individual market less any government subsidies for the policy, the government imposed fine for not purchasing health insurance, and the medical care costs the individual would have expected absent the accident.

Arguably, most individuals' health care costs would not have been met by health insurance prior to the ACA. Therefore, it is reasonable for life care plans to include provisions for expected health expenditures rather than simply providing plaintiffs money with which to purchase health insurance. When the ACA is fully implemented, however, all individuals will be able to purchase affordable health insurance regardless of the extent of their injuries or their employment status, often with the aid of significant government subsidies. Furthermore, as the ACA requires all individuals to purchase health insurance and prevents price discrimination based on health status, most individuals will face identical health insurance costs before and after an accident. Thus, one would expect the incremental increase in health care costs in the overwhelming majority of cases to be limited to the legal maximum out-of-pocket expenses allowable under the ACA of $6,250 per year.

The New Role of the Life Care Planner

This finding also suggests a new task for life care planners. As noted previously, under the old health insurance laws, the task of the life care planner was to identify any medical and living expenses that are necessary for the victim but would not otherwise have been required in the absence of the accident. If governments legislate or Courts hold that medical damages under the ACA can be capped as described, the life care planner also needs to specifically address which health care and living expenses would normally be covered by the minimum insurance requirements mandated by the ACA and which health expenditures would result in out-of-pocket costs to the plaintiff necessitating their inclusion in a damage award. For example, under the

broad guidelines of ACA, it is unclear at this point the level of home health care or institutionalization that insurers will be required to cover.

As a comparison, currently Medicare, the nation's largest health insurance program, covers intermittent at-home skilled nursing care but does not pay for care for individuals requiring round-the-clock care. Similarly, Medicare covers a portion of temporary nursing home stays but does not cover permanent institutionalization. As home health care or facility care is often the largest component of a life care plan, capping insurance-covered expenditures at $6,250 per year is not likely to eliminate large payouts in many cases involving extensive custodial care of the victim. Still, it is common to see life care plans where itemized health care needs, excluding full- or part-time nursing care, far exceed $6,250 per year. The exclusion of medical exams and testing, prescription drugs, physical, occupational, and speech therapy, and durable medical equipment and supplies which are likely to be covered by a qualifying insurance plan could potentially result in a significant difference between a victim's expected out-of-pocket costs compared to a life care plan's expected expenditures. It should also be noted that the specific essential health benefits that insurance plans will have to meet may differ somewhat from state to state compelling life care planners to have detailed knowledge of the state in which they are providing reports or testimony.

Collateral Source Issues

The collateral source rule prohibits the court from considering third-party payments when determining damage awards to plaintiffs in personal injury lawsuits. For example, strict application of the collateral source rule would mean that a victim possessing medical insurance

at the time of an accident would be awarded damages for all of his or her medical expenses even if the expenses were covered by the insurer leading to a financial windfall for the victim. The double payment to the injured party can be avoided through subrogation by allowing the insurer to recover medical costs from the damage award (Posner, 2003).

The economic rationale for the collateral source rule is two-fold. First, the collateral source rule serves to ensure that plaintiffs are not, in effect, penalized for responsibly purchasing various types of insurance. If payments to the plaintiff from insurance companies reduce, dollar for dollar, payments received from the defendant in a tort award, individuals have less incentive to purchase insurance in the first place. In a post-ACA world, however, all individuals already have strong incentives through the individual mandate and health care subsidies to purchase medical insurance, limiting this justification for the rule.

The collateral source rule also tends to lead to efficient levels of deterrence by placing the full cost of accidents on the at-fault party (Posner, 2003). In a world where plaintiffs' damages are limited, the damage done in an accident is not borne by the defendant but is instead spread out among the other individuals in the victim's insurance pool. Of course, this violates standard notions of economic fairness and efficiency, a clear drawback of capping medical damages as described. On the other hand, allowing for plaintiff windfalls, which may increase due to the changes in health insurance laws as a result of the ACA, could lead to an increase in frivolous lawsuits. Public policy must balance the incentives for defendants to engage in appropriate accident prevention with the incentives for plaintiffs to use the court system appropriately.

A well-defined subrogation policy would eliminate both of these problems simultaneously by diverting any excess payments to plaintiffs to the insurance carrier that will be obligated to provide medical care in excess of the victim's policy premiums. Since consumers can freely switch insurers under the ACA, however, it is difficult to see how subrogation for future damages at the time of the damage award would be possible without some sort of government agency or insurance industry group overseeing these excess funds.

The application of the collateral source rule varies widely from state to state and in many circumstances limiting future medical damages as described previously would not conflict with collateral source statutes. As of 2006, damage awards may be "reduced for collateral source income that has been received prior to the date of the verdict" in 40 states, and damage awards are "reduced for collateral source income that is likely to be received in the future" in 28 states (Schap and Feeley, 2008). Finally, since insurance policies are generally reissued on an annual basis, and renewal of medical insurance is guaranteed under the ACA, it is not clear whether medical treatment received from an insurance policy purchased or renewed after the date of trial would even count as a third-party payment with respect to legal statutes, eliminating the collateral source question altogether.

Conclusions

The ACA was opposed by some economists and politicians on the grounds that it did not do enough to control costs. Many argued that any significant health insurance bill should include tort reform in order to rein in spiraling health care costs and were critical of the fact that the ACA did not directly address the issue. The idea put forward in this paper, however, suggests

that the ACA may well indirectly result in a great deal of tort reform. In many personal injury cases, future medical expenses represent a significant portion of the final damage award. The health insurance reforms contained in the ACA may serve to significantly reduce these damage awards by making affordable health insurance available to injured persons in lieu of expensive tort payments to cover future medical care.

The goal in personal injury litigation is to make persons "whole" by providing adequate funding for medical care in order to compensate them from their injuries. The funding of health care through private insurance markets is an equally valid way to accomplish this goal if those markets are available to a victim. The guaranteed issue provisions of the ACA ensure that even accident victims with relatively high expected medical costs will be able purchase affordable medical insurance at a price potentially well below the itemized expected value of their identified future care needs. In addition, the individual mandate to purchase health insurance changes the baseline from which one should evaluate what "whole" entails. Specifically, individuals will now either have insurance or be assessed a penalty if they are injured or not, so a person's legal responsibility to hold insurance will not have changed due to an accident. Of course, policy makers may still wish to make at-fault parties subject to the full cost of their actions in order to promote efficient levels of accident or malpractice deterrence.

As noted by physicist Niels Bohr, prediction is very difficult, especially about the future. Though the majority of the initiatives in the ACA were upheld by the Supreme Court in 2012, the ACA is still open to repeal by the federal government. In fact, the Republican Party has made the repeal of the ACA a primary plank of their election campaigns in both 2010 and 2012 (Sack 2010 and Cooper 2012). Though Republican candidates vary on which specific parts of the

law they would vote to repeal, the individual mandate is the clearest target. Without the mandate, the guaranteed issue requirement of the ACA, which is what would allow plaintiffs to be able to purchase affordable insurance, would not be economically feasible for health insurers. The election results of 2012, however, have put to rest any Republican hopes of overturning the ACA prior to the January 1, 2014 implementation date for the individual mandate and guaranteed issue provisions. At that point forensic economists and life care planners alike should be prepared to potentially encounter a significantly changed landscape for future medical damage awards.

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